

## **Bundle Audit Committee 8 May 2025**

- 1 13:00 - PRELIMINARY MATTERS
- 1.1 13:00 - AC25/56 Welcome and Apologies - Verbal (Chair)
- 1.2 13:00 - AC25/57 Declarations of Interest - Verbal (Chair)
- 1.3 13:02 - AC25/58 Unconfirmed Minutes of Meetings held on 04.03.25 - Attached (Chair)  
AC25.58 Minutes from Audit Committee 04.03.25 V0.02 Unconfirmed (Public)
- 1.4 13:05 - AC25/59 Matters Arising and Action Log - Attached (Chair)  
AC25.59 Summary Action Log Audit Committee (Updated 30.04.25) Public
- 2 13:15 - GOVERNANCE
- 2.1 13:15 - AC25/60 Update on Outstanding Audit Recommendations - Presentation (Executive Director of Nursing)  
*Angela Wood to join the meeting for this item*  
AC25.60 Angela Wood AC presentation - May 2025
- 2.2 13:35 - AC25/61 Update on External and Internal Recommendations - Paper (Director of Corporate Governance / Head of Covid-19 and Thirlwall Inquiry)  
AC25.61 Audit tracking report 08.05.25 v1.00  
AC25.61.1 App 1 Closure summary table v1.00  
AC25.61.2 App 2 All unsatisfactory open v1.00  
AC25.61.3 App 3 - Open Limited Assurance v1.00  
AC25.61.4 App 4 - IA recs for AC approval v1.00  
AC25.61.5 App 5 - AW recs for AW AC approval v1.00
- 2.3 13:50 - AC25/62 Risk Impact of Overdue Policies - Paper (Director of Corporate Governance / Head of Covid-19 and Thirlwall Inquiry)  
AC25.62 Policy risk overdue 08.05.2025 v0.04  
AC25.62.1 App 1 - All overdue policies to 31.03.2025 v3.00
- 2.4 14:05 - AC25/63 Internal Audit Explainer Video and Communication Plan - Paper (Director of Corporate Governance / Head of Covid-19 and Thirlwall Inquiry)  
AC25.63 IA Explainer Comms Plan v1.00
- 2.5 14:15 - AC25/64 Corporate Risk Register and Board Assurance Framework - Paper (Head of Risk Management)  
AC25.64.1 Corporate Risk Register Report May 2025 v2  
AC25.64.2 Board Assurance Framework April 25 v11.9 with proposed ratings1
- 2.6 14:30 - AC25/65 Breaches to the Standing Orders - Paper (Director of Corporate Governance)  
AC25.65 Details of Breaches of Standing Orders
- 2.7 14:35 - AC25/66 Declarations of Interest and Gifts & Hospitality Report - Paper (Director of Corporate Governance)  
AC25.66 Declarations of Interest and Gifts & Hospitality Report  
AC25.66a AC Report - Declarations of Interests Gifts and Hospitality- Appendix 1 - Audit Update (002)
- 2.8 14:40 - AC25/67 Welsh Health Circulars and Ministerial Directions - Paper (Director of Corporate Governance)  
AC25.67 WHCs and MDs report v1.00  
AC25.67.1 App 1 WHC 01.09.24-31.03.25 v1.00  
AC25.67.2 App 2 MDs 01.09.24-31.03.25 v1.00
- 2.9 14:45 - AC25/68 Audit Committee Self Assessment - Verbal (Director of Corporate Governance)

- 2.10 14:50 - AC25/89 Response to Audit Enquiries Letter- Paper (Director of Corporate Governance)  
AC25/89 Response to Audit Enquiries Letter cover  
AC25/89 Response to Audit Enquiries Letter
- 2.11 14:55 - BREAK
- 3 15:05 - INTERNAL AUDIT
- 3.1 15:05 - AC25/69 Internal Audit Progress Report - Paper (Head of Internal Audit)  
AC25.69 IA progress report Cover Sheet May 2025  
AC25.69.1 BCUHB Audit Committee progress report May 2025
- 3.2 15:15 - AC25/70 Final Internal Audit Reports - Paper (Head of Internal Audit)  
*Clinical Audit*  
*Follow up: Contracted Patient Services: Quality and Safety Arrangements*  
AC25.70.1 BCU-2425-29 Final Internal Audit Report Clinical Audit  
AC25.70.2 BCU-2425-24 Final Internal Audit Report Contracted Patient Services QS  
Follow up
- 4 15:25 - EXTERNAL AUDIT
- 4.1 15:25 - AC25/71 External Audit Progress Report - Paper (Audit Manager, Audit Wales)  
*An Audit Wales Report entitled No time to lose: Lessons from our work under the Well-being of Future Generations Act has been included in the Audit Committee supporting pack*  
AC25.71 BCUHB Audit Committee Update 08052025
- 4.2 15:35 - AC25/72 Audit Wales Review on Cancer Services in Wales - Paper (Audit Manager, Audit Wales)  
*The full Audit Wales Report on Cancer Services in Wales has been included in the Audit Committee supporting pack*  
AC25.72 Cancer - Policy - Audit Wales - Management Response Form - Cancer Services - (English)
- 5 15:45 - COUNTER FRAUD
- 5.1 15:45 - AC25/73 Local Counter Fraud Service Q4 Report 2024/25 - Paper (Executive Director of Finance)  
AC25.73 Counter Fraud Audit Committee Q4 Report 2024-2025 (Public)
- 6 16:00 - FOR INFORMATION
- 6.1 16:00 - AC25/74 Summary of Business to be Reported from Private - Paper (Head of Corporate Affairs)  
AC25.74 Audit Committee (Summary of Business to be Reported from Private)
- 6.2 16:02 - AC25/75 Forward Workplan - Paper (Head of Corporate Affairs)  
AC25.75 Workplan for Audit Committee (Live Version as at 30.04.25)
- 7 16:04 - CLOSING BUSINESS
- 7.1 16:04 - AC25/76 Agree Items for Referral to Board / Other Committees - Verbal (Chair)
- 7.2 16:06 - AC25/77 Review of Meeting Effectiveness - Verbal (Chair)
- 7.3 16:08 - AC25/78 Date of Next Meeting - 24.06.25
- 7.4 16:08 - 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."*
- 7.5 16:08 - BREAK

**Betsi Cadwaladr University Health Board (BCUHB)**  
**UNCONFIRMED Minutes of the Audit Committee**  
**held in Public on 4 March 2025**  
**in the Boardroom, Carlton Court, St Asaph and via Teams**

<b>Committee Members Present</b>	
<b>Name</b>	<b>Title</b>
Karen Balmer	Independent Member (Chair of Audit Committee)
Urtha Felda	Independent Member
Rhian Watcyn Jones	Independent Member ( <i>via Teams</i> )
<b>In Attendance</b>	
Russell Caldicott	Executive Director of Finance
Pam Wenger	Director of Corporate Governance
Dyfed Edwards	Health Board Chair ( <i>Observer</i> )
Sreeman Andole	Interim Executive Medical Director ( <i>via Teams</i> )
Dave Harries	Head of Internal Audit
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 (part meeting)
Glesni Driver	Head of Covid-19 Inquiry and Thirlwall Inquiry
Nesta Collingridge	Head of Risk Management
Carol Johnson	Head of Information Governance ( <i>via Teams</i> )
Denise Roberts	Head of Capital, Compliance & BI ( <i>via Teams</i> )
<b>Committee Support</b>	
Philippa Peake Jones	Head of Corporate Affairs
Laura Jones	Project Support Manager (Corporate Governance)

## **PRELIMINARY MATTERS**

### **AC25/28 Welcome and Apologies**

The Chair of the Committee welcomed everyone to the meeting and apologies were received for Dyfed Jones.

### **AC25/29 Declarations of Interest**

No declarations of interest were raised at the meeting.

### **AC25/30 Unconfirmed Minutes of Meetings held 16.01.25**

It was resolved that the Committee:

- **AGREED** that the minutes of the meeting held on 16.01.25 were a true and accurate record.

A query was raised in relation to whether the recommendations from 2022 are still pending. It was confirmed that progress is being made, the Team are currently working through the ongoing

outstanding audit recommendations and any recommendations that require further assurance will come back to the Committee in April 2025.

## AC25/31 Matters Arising and Action Log

### Update on Open Audit Recommendations – Final Audit Report on Llandudno Hospital Orthopaedic Surgical Hub

- There was discussion around action AC25/06.3 in relation to the arrangements for a bank account. It was confirmed that a bank account has not yet been established and the Executive Director of Finance and Director of Environment & Estates are following this up with the contractor to ascertain why this has not yet been completed. It was noted that this is a potential regulatory issue as there is a need to start transacting through the account to ensure payments are secure, this issue is being taken forward.

### WRP Penalties – Learning from Events Report (LfER)

- In relation to action AC25/09.1 to share an example of an LFER, it was confirmed that this had been completed and therefore this action was deemed closed. It was noted that a session on LFERs will form part of the Board Development Programme which is currently being developed by the Director of Corporate Governance and the Health Board Chair.

### Centre for Mental Health and Society (CfMHaS)

- There was discussion around action AC24/151.1 and it was confirmed that a review is currently being commissioned externally which needs to go through a procurement process and a report will come back to a future meeting.

### Internal Audit Progress Report

- In relation to action AC24.60.1.8 regarding the quality, safety and commissioned services review it was confirmed that this resulted in a limited assurance report and a follow up review is currently being commissioned. The Executive Lead has now been agreed as the Director of Performance & Commissioning, a final brief has been issued and the outcome will be shared with the Audit Committee before being referred to the QSE Committee.

The Committee reviewed the action log and agreed to close the following actions, after consideration of the papers presented to the Committee where required: AC24/152.1, AC24/152.2, AC24/154.2, AC25/15.1, AC24/147.2, AC25/14.1, AC25/05.1, AC25/06.1, AC25/06.4, AC25/09.2, AC25/11.1, AC25/13.1, AC25/14.2, AC25/14.3, AC25/15.2, AC25/17.1, AC24/127.2 & AC24.62.1.4

## GOVERNANCE

### AC25/32 Information Governance and Records Management Position Update

Members received the report and the Head of Information Governance highlighted:

- An external review of the Health Board's Information Governance and Records Management systems and processes was undertaken during June and July 2023.
- The findings included 8 recommendations with a total of 48 actions and the current position stands with 12 outstanding actions which will continue to be progressed.
- Work has been taking place over the last 18 months with Workforce, IT, Cyber Security and the DDaT Team to close these actions.

- 6 of the actions relate to the asset register, a vast amount of work is being progressed in this area and once complete, the remaining actions will reduce.
- 2 actions remain red and incomplete which relate to the Corporate Records Management function and a records classification scheme.
- In relation to the Corporate Records Management function additional resource is required and the Chief Digital & Information Officer is taking this forward to request funding for the next financial year.
- In relation to the records classification scheme, discussions are taking place with the Assistant Director of Data, Intelligence & Insight to discuss whether this can form part of the information relating to data quality and governance that is already being reported and validated.
- An update was provided on the Local Access Control Policy to confirm this has now been finalised and has gone out for consultation.

In discussing the report, the Committee:

- Queried the competing priorities in relation to the budget and the proposed bid for additional funding and also the implications of not completing the actions highlighted in red. It was confirmed that the information provided by the Chief Digital & Information Officer was not clear in terms of the category of risk.
- Suggested the need for the Executive Committee to take some time to consider the wider context and how we protect information that should not be shared publicly. It was confirmed that when this was presented to the Executive Committee, there was a proposal not to accept the risk as further work, discussion and assurance is required in this area. It was agreed that this needs to go back to the Executive Committee and an update to be presented to the Audit Committee at a future meeting.
- Highlighted that a number of actions should be business as usual such as the Access Control Policy.
- Stated it would be useful for the report to include an appendix showing the actions that have been completed.
- Agreed the need to ensure corporate records are managed and maintained and suggested the Access Control Policy and Record Management Code of Practice are shared outside of the meeting.

#### Actions:

- **AC25/32.1** The Executive Committee to take some time to consider the matter, identify best practice, clarify that the risk is logged and bring the item back to the Committee.
- **AC25/32.2** Access Control Policy and Record Management Code of Practice to be uploaded to the Audit Committee IMs area on the Teams Channel.

It was resolved that the Committee:

- **NOTED** the assurance provided on compliance with the identified recommendations and the next steps required to address the areas of shortfall.

#### AC25/33 Risk Report & Corporate Risk Register

Members received the report and noted the progress made to date; the Head of Risk Management highlighted:

- The report provides an update position on the Corporate Risk Register and the Risk Governance arrangements.
- In relation to the Corporate Risk Register there are a number of target date extensions and also a number of new open risks.
- The risks relating to Challenged Services have been to the QSE Committee who were happy to receive the risks noting that further work is required.
- A number of Corporate risks have seen a reduction in score since September 2024 and a number of actions are being closed.
- The teams are now challenging the scores and since the last Internal Audit there has been a focus on metrics and dashboards where progress is now being made. Teams are also being asked to provide more realistic timescales.
- Assurance was provided to the PPHP Committee that Emergency Preparedness Resilience Response (EPRR) Lead has been reviewing the Corporate Risk Register, work is required to develop the operational risks and this will be a priority area.

In discussing the report, the Committee:

- Highlighted that 11 of the risks relate to capacity and quality and the Interim Executive Medical Director is working with Head of Risk Management to demonstrate the trends in the risks.
- Suggested the need to include realistic target dates and also revise dates included in the report where dates are extended.
- Queried progress in relation to Civil Contingencies, it was suggested that contact can be made with the EPRR Lead to gain a further update in relation to the development of the risks.
- Referred to a number of risks which have maintained the same score over a 12-month period and queried why the mitigations are not having an effect. It was confirmed that discussions are taking place and scores are being reviewed to ensure the actions in place are correct, this is being done on a regular basis by the Risk Management Group who are also facilitating deep dives into specific areas.
- Stated the need to move forward to ensure risks are within the risk appetite and start to see downward trends to provide greater assurance.
- Suggested the detail around specific risks is reviewed in more detail for example an update relating to the failure to embed learning to be discussed at the QSE Committee.
- Noted the HSE Prosecution and Learning from Events Reports (LFERs) querying how this is managed in line with the Health & Safety risk to try and avoid future prosecutions. It was confirmed that this is an area that being discussed in terms of mortality reviews, embedding learning and future risks. It was suggested that information relating to the legal services plan and learning from legal cases is discussed further at a future Committee Development Session.
- Referred to the Internal Audit on Falls Management and the potential for a follow up to highlight any improvements and learning via the QSE Committee. It was noted that a follow up review of Falls Management will be included in the revised Internal Audit Plan.

#### Actions:

- **AC25/33.1** Revise the dates included in the report where dates are extended.
- **AC25/33.2** Share an update on Civil Contingencies with the Audit Committee.
- **AC25/33.3** Share information relating to the legal services plan and learning from legal cases at a future Committee Development Session.

It was resolved that the Committee:

- **NOTED** the Corporate Risk Register as reported to Risk Scrutiny Group in Jan 25\*
- **NOTED** the Risk Governance arrangements paper and updates.

*Denise Roberts joined the meeting*

### **AC25/34 Standing Orders Reservation and Delegation of Powers**

Members received the report and the Director of Corporate Governance highlighted:

- A review of the Standing Orders has taken place and the amendments are highlighted.
- The Board approved the establishment of the Executive Committee to provide more clarity in terms of transparency and further amendments are being made to specific wording.

In discussing the update, the Committee:

- Noted the wording to confirm papers will be made available to the public at least 5 clear days before each meeting of the Board includes weekends.
- Queried the delegated authority for the Chief Executive in relation to the Audit Committee providing assurance to the Board for its arrangements of delegation and reservations and why concerns would not be raised with the Director of Corporate Governance. It was confirmed that there is a schedule of matters reserved for the Board and other matters delegated to the Chief Executive to delegate to other officers in line with the scheme of delegation. Work is taking place to review what should be delegated to who to ensure a clear schedule is produced. It was agreed that the draft would be shared with the Committee.

#### **Action:**

- **AC25/34.1** Share the draft Reservation and Delegation of Powers along with the updated current version.

It was resolved that the Committee:

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

### **AC25/35 Audit Committee Terms of Reference**

Members received the report and the Director of Corporate Governance highlighted:

- The Terms of Reference are due for review and have been amended to provide a more consistent approach with NHS Wales Board level documentation.
- The revised Terms of Reference will go to the Board for approval, subject to any comments.
- Going forward, it would be useful to invite other Executive Directors to join the Committee on a rolling basis to provide further assurance.

In discussing the update, the Committee:

- Queried whether the core membership is consistent with other Health Boards in Wales, it was confirmed that it is and the revised Terms of Reference have been based on a standard model.
- Discussed whether it should be mandated in the Terms of Reference that the Chair requires a financial background, it was confirmed that an accountancy background is optimum but not essential as long as someone on the Committee had a level of financial competence to understand the annual accounts
- Stated that the approval of the Terms of Reference would be noted in the Committee AAA Report.

It was resolved that the Committee:

- **NOTED** and **APPROVED** the Terms of Reference.

### AC25/36 Audit Committee End of Year Review

Members received a verbal update and the Director of Corporate Governance highlighted:

- It was confirmed at the Audit Committee Development Session on 20.02.25 that the Committee would complete a self-effectiveness review which would be based on the Audit Committee Handbook.
- The review will help to inform the Annual Governance Statement and also allow the Chair to identify any areas of improvement.
- The review will be shared with members for their response and the results will be presented to the next meeting.

It was resolved that the Committee:

- **NOTED** the update.

*Carol Shillabeer and Danielle Timmins joined the meeting*

## FINANCIAL FOCUS

### AC25/38 Conformance Report

In presenting the report the Executive Director of Finance highlighted:

- Reference to purchase orders that are non-compliant stating that invoices are kept to a minimum, there is a 'No PO No Pay' policy in place and the Team have been providing procurement training sessions to ensure staff are aware of the importance of raising purchase orders.
- There has been a reduction in trend from Q2 to Q3, however the East continue to have a higher element and the Team are working to address this.
- 11 single source waivers have been approved in Q3 which is a reduction on previous quarters.
- Further work is required in terms of receivables, the current figure stands at approximately £13m, of those receivables, £7.5m are within 30 days so should be cleared within the next month leaving a net of circa £4-5m worth of debt that will have gone beyond the 30-day timeframe and this is being reviewed.
- Reference to salary overpayment stating this is generally caused by late notification and the need to ensure more timely termination forms are processed to avoid the need to recover payments.

- The Public Sector Payment Policy which is based around how cash is transacted within the local economy, the Health Board transact approximately 95% of goods and services locally and this remains within target.
- Learning from Events Reports (LFERs) have been included as an addition within the Conformance Report due to the level of financial risk we could ascertain as a consequence. This is a current area of focus due to the amount of fines that could be received and also in terms of embedding learning to ensure events are not repeated. This is an area that could be referred to the QSE Committee going forward with financial risk due to non-compliance remaining with the Audit Committee.
- There were no Chairs actions to be reported in relation to financial compliance during the period.
- Significant progress has been made in relation to the Contract Procurement Review with 11 procedures being endorsed and 6 of the outstanding policies / procedures are expected to be concluded by the end of March 2025. There is one outstanding procedure related to a Health Board wide contracts database, work is progressing and this should conclude in the next financial year.

In discussing the update, the Committee:

- Queried the extensions to the two contracts for staffing within the Radiology department without appropriate authorisation. It was confirmed that this is not a breach as the cost relates to an extension of the 12-month contract, this has been discussed and agreed with procurement and authorisation can be sought from Welsh Government if required. A file note has been completed by procurement and the Health Board to provide clarity on this issue and it was agreed to expand on this in the notes in future.
- Referred to a long-standing salary overpayment and queried why this has not been concluded. It was confirmed that this is being followed up and further work is required in relation to completing debt write offs in a timely manner.
- Noted that the report did not include page numbers and requested a movement arrow is included in relation to LFERs to show where numbers have changed.
- Acknowledged an increase in LFERs and it was confirmed that further work is required with IHCs and Directors to determine the cause of the delay in responding. This will also be discussed as part of the Integrated Performance Executive Group to provide focus in this area and determine how this can be managed more effectively and it was noted that additional support is being provided in the Central area. It was agreed to share a briefing on LFERs with Independent Members.
- Noted the use of the term redress and it was confirmed this relates to the settlement of low level, largely financial issues and best practice is to ensure an LFER is completed in line with these issues. It was also noted that changes to the redress regulations will be confirmed shortly.
- Highlighted the loss of cash included in the report and the potential reputational issues of cash being stolen. It was confirmed that information on this would be shared outside of the meeting.

#### Actions:

- **AC25/38.1** Add page numbers to the Conformance Report and a movement arrow in relation to LFERs to show where numbers have changed.
- **AC25/38.2** Share a briefing on LFERs with Independent Members.

- **AC25/38.3** Share a briefing on the 5 payments for loss/damage of patient's property, 1 payment for ex-gratia payments and 6 ombudsman payments for delayed and unsatisfactory treatment.
- **AC25/38.4** RATS to be amended to Remuneration Committee on the losses and special payments section.

It was resolved that the Committee:

- **NOTED** and **DISCUSSED** the elements of performance
- **APPROVED** the Losses and Special Payments (October to December 2024)

## INTERNAL AUDIT

### AC25/39 Internal Audit Progress Report

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

- The Health Board is on a positive trend in terms of reasonable assurance.
- There will be two challenging reviews taking place as requested by the Chief Executive relating to Consultant Contracts and the Job Evaluation Process which have been shared with the Committee for consideration
- All outstanding reviews have now been finalised and the main themes highlighted were in relation to information, data accuracy, data quality, governance policies and procedures, financial management control and performance management.
- The Network and Disaster Recovery review received reasonable assurance and some of the key issues were around software versions and testing.
- The Establishment Control review received reasonable assurance, issues were highlighted in relation to procedures not being updated, quarterly audits not being undertaken and budget managers not having the required e-learning.
- The Job Evaluation review was requested by the Chief Executive and the Health Board were unable to provide the required information to fulfil the review. The Senior Associate Director People Services did seek to progress this review however the Trade Unions did not agree to provide the required information. A concern was raised in relation to the timelines assigned to the review as the procedures are non-compliant with the Health Board Scheme of Reservation and Delegation.
- The Transformation & Improvement review was highlighted and it was noted that the aim of the Transformation Team was to bring different Teams together, reduce overheads and prioritise resource. The review highlighted that the outcome from the Team and the impact of major change across the Health Board is not clear.

In discussing the update, the Committee:

- Acknowledged that the Chief Executive has raised a request via the Local Partnership Forum to meet with the Trade Union representatives to discuss job evaluation. It was highlighted that the focus of the review was to provide clarity on systems and processes. The timeframe for the review will be agreed once the meeting has taken place.
- Referred to the limited assurance review relating to Electronic Staff Records and the high amount of whole-time equivalent (WTE) vacancies in place that do not have the required funding. It was confirmed that ESR is reporting more vacancies than the funded establishment and there is a need for essential work to take place in this area. It was

agreed that reconciliation work would take place outside of the meeting and reported back to the Committee.

- Noted that investment in the Transformation Team costs circa £5m for approximately 100 officers, this includes areas such as Continuing Health Care. It was noted that there is an issue around the impact of this function, work is taking place to review the approach and target change expertise into major priority areas. Discussions are taking place in relation to realigning resources into the value and sustainability space to align with the organisation's wider objectives.
- Highlighted the need to align the Transformation Team to progress and deliver in key areas and address how we measure the outcomes and benefits realisation as this will be required as evidence for Welsh Government in terms of accountability for the use of funding received in this area.
- Noted that the management response time had improved from the previously reported amber to green.

**Action:**

- **AC25/39.1** Review ESR and the funded establishment as soon as possible to understand why they are not aligning and bring an update back to the May meeting and alert the People and Culture Committee of this anomaly.

It was resolved that the Committee:

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

**AC25/40 Revised Internal Audit Plan**

Members received the report and the Head of Internal Audit highlighted:

- Thanks to the Health Board and Committee Chairs for their help in reviewing and shaping the Plan.
- The high volume of reviews to be completed was noted as challenging however the Committee confirmed the need for assurance to be provided in high-risk areas.

In discussing the plan, the Committee:

- Noted specific reviews where the scope has been revised to include additional areas.
- Agreed to include a follow up on Falls Management as an addition to the Plan.

**Action:**

- **AC25/40.1** Include a follow up review of Falls Management in the Internal Audit Plan.

**EXTERNAL AUDIT**

**AC25/41 External Audit Progress Report – Item Withdrawn**

**AC25/42 Final Accounts Memorandum, Annual Audit Letter and Audit Plan 2025/26**

Members received the report and the Performance Audit Lead and Financial Audit Manager highlighted:

- The Final Accounts Memorandum includes a summary of the issues and recommendations identified during the 2023-24 confirming that the actions and target dates have been agreed.

- The Annual Audit Report 2024 summarises the work completed over the year and a summary of the financial opinion.
- There are several performance audits that are still underway and these include the Review of Planned Care Services Recovery, Urgent and Emergency Care and Strategic Financial Allocation.
- The Audit Plan 2025 sets out information in relation to the financial audit work and includes areas such as significant risks, fraud and financial targets.
- The failure of financial duty was highlighted as an area of potential breach.
- The governance arrangement of senior officer appointments was referred to as there have been issues with this in the past.
- There is a need to review the information received from the Finance Team with an aim to commencing the audit in April 2025.
- An additional fee of £22k was charged for the 2024 financial statements audit due to additional unplanned work completed in relation to the remuneration report. Due to its complexity, it was agreed that work needed to commence sooner on this report.

In discussing the report, the Committee:

- Reported that Audit Wales will be joining the Board meeting in March to report on the Structured Assessment, Annual Audit Opinion and the focus of the Health Board over the past year.
- Highlighted the unqualified audit opinion for 2023-24 and an unqualified audit opinion in relation to Charitable Funds.
- Thanked Audit Wales for their continued engagement with the Health Board.
- Referred to the note regarding the Health Board's strategic objectives being too high level and not smart. It was confirmed that this has been picked up as part of the discussion with the PPHP Committee and the Board Development Session that the objectives need to be more outcomes focussed and this is being addressed.
- Confirmed that the information required in relation to the remuneration report is being collated as a new process is now in place to ensure this information is captured.

It was resolved that the Committee:

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

## COUNTER FRAUD

### AC25/43 Local Counter Fraud Service Q3 Report 2024/25

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

- The report refers to the request from the Audit Committee for the Community Pharmacy Data Matching Pilot to be reviewed by the Counter Fraud Team. It was noted that the pilot did not identify any systematic fraud or errors which merited any investigative action.
- The Director of Corporate Governance has been appointed as the Counter Fraud Champion by the Executive Director of Finance and this will be endorsed by the Board.

It was resolved that the Committee:

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

### AC25/44 Local Counter Fraud Service Workplan 2025/26

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

- The workplan been approved by Executive Committee and following the amendments highlighted, the workplan went out for comment and no further amendment were requested.

It was resolved that the Committee:

- **APPROVED** the Counter Fraud Annual Workplan for 2025/2026.

### **AC25/45 Local Counter Fraud, Bribery and Corruption Policy**

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

- The roles and responsibilities included in the policy which require specific responsibility for the 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.
- Compliance against this will be monitored via the annual workplan and quarterly reporting to the Audit Committee

It was resolved that the Committee:

- **APPROVED** the revised F03 Counter Fraud, Bribery and Corruption Policy.

### **FOR INFORMATION**

#### **AC25/46 Summary of Business to be Reported from Private**

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

#### **AC25/47 Committee Forward Workplan**

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

### **CLOSING BUSINESS**

#### **AC25/48 Agree Items for Referral to Board / Other Committees**

It was resolved that the following would be referred:

- The Executive to take some time to consider the matter of Information Governance and Records Management and identify best practice ensure that risks are logged and in due course bring the item back to the Committee.
- Reasonable assurances on the recent internal audits were received.
- That there a misalignment of Electronic Staff Record with the approved financial establishment, this is being reviewed urgently.

#### **AC25/49 Review of Meeting Effectiveness**

In discussing the item, the Committee:

- Noted the high quality of papers.
- Referred to the challenges raised and the open and honest responses provided.

- Acknowledged the time spent on significant issues and the balance between regular items and more in-depth discussions.
- Highlighted the contributions made and members being able to raise questions.

**AC25/50 Date of Next Meeting**

Wednesday 30 April 2025, 9.30-1.30pm

**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'*

Unconfirmed



## Audit Committee Action Log (Public)

Updated 30.04.25

Open Actions						
Action No.	Minute Ref.	Date	Agreed Action	Lead	Timescale	Status
<b>REMAIN OPEN</b>						
1	AC25/32.1	04.03.25	<b>Information Governance and Records Management Position</b> The Executive Committee to take some time to consider the matter, identify best practice, clarify that the risk is logged and bring the item back to the Committee.	Pam Wenger Dylan Roberts	June 25	<b>Remain Open</b> <b>19.03.25</b> Dylan Roberts to discuss with Carol Shillabeer and agree how the corporate records management function will be resourced. A paper will be presented to the Executive Committee and come back to a future meeting of the Audit Committee.
2	AC25/32.2	04.03.25	<b>Information Governance and Records Management Position</b> Access Control Policy and Record Management Code of Practice to be uploaded to the Audit Committee IMs area on the Teams Channel.	Carol Johnson Laura Jones	June 25	<b>Remain Open</b> <b>04.03.25</b> A copy of the Records Management Code of Practice and the Information Governance & Records Management Review which includes the recommendations and actions have been circulated via email. The Access Control Policy is being finalised and a copy will be shared once this has been approved.
3	AC25/33.2	04.03.25	<b>Risk Report and Corporate Risk Register</b> Share an update on Civil Contingencies with the Audit	Nesta Collingridge	Aug 25	<b>Remain Open</b> <b>30.04.25</b> An item relating to EPRR will be discussed at the PPHP Committee on 03.07.25 and an



			Committee.			update will come back to the Audit Committee at the meeting on 19.08.25. <b>12.03.25</b> All corporate risks have now been reviewed by the Emergency Preparedness, Resilience and Response (EPRR) Lead. This item is on the agenda for a full update to PPHP when operational risks have been developed. The EPRR Lead has only recently recruited support for the development of risks and they have explained to PPHP that updates will be provided in the next meeting as to the position.
4	AC25/33.3	04.03.25	<b>Risk Report and Corporate Risk Register</b> Share information relating to the legal services plan and learning from legal cases at a future Committee Development Session.	Pam Wenger Matt Joyes	May 25	<b>Remain Open</b> <b>11.03.25</b> This will be included on the agenda for the next Audit Committee Development Session taking place on 20.05.25. Propose this action will be closed after the session has taken place.
5	AC25/34.1	04.03.25	<b>Standing Orders Reservation and Delegation of Powers</b> Share the draft Reservation and Delegation of Powers along with the updated current version.	Pam Wenger Philippa Peake-Jones	May 25	<b>Remain Open</b> <b>30.04.25</b> The Director of Corporate Governance and Executive Director of Finance to work through the draft documents prior to being circulated to the Committee.
6	AC25/38.2	04.03.25	<b>Conformance Report</b> Share a briefing on LFERs with Independent Members.	Pam Wenger Matt Joyes	May 25	<b>Remain Open</b> <b>14.04.25</b> This will be included on the agenda for the next Audit Committee



						Development Session taking place on 20.05.25. Propose this action will be closed after the session has taken place.
7	AC25/39.1	04.03.25	<b>Internal Audit Progress Report</b> Review ESR and the financial establishment as soon as possible to understand why they are not aligning and bring an update back to the May meeting and alert the People & Culture Committee of this anomaly.	Russell Caldicott	May 25	<b>Remain Open</b> <b>30.04.25</b> Funded establishment contains a reduction for vacancy factor (to reflect posts held vacant). The ESR system doesn't reflect these negative wte's & results in a difference in reporting of vacancies within the two systems. The IHC's are working to allocate the negative wte to roles, which will then enable alignment to the ESR data, as these posts are removed from this system. Propose this action is closed.
8	AC25/04.1	16.01.25	<b>Matters Arising and Action Log (Trusted Assessor)</b> Board Development Session focussing on the role of the Trusted Assessor to be arranged.	Pam Wenger	March 25  Revised timescale Sept 25	<b>Remain Open</b> <b>10.02.25</b> 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.
9	AC25/06.2	16.01.25	<b>Update on Open Audit Recommendations – Final Audit Report on Llandudno Hospital Orthopaedic Surgical Hub</b> Review introducing virtual sign off for	Russell Caldicott Pam Wenger	June 25	<b>Remain Open</b> <b>30.04.25</b> The SORD is being reviewed and scheduled to be considered at the Audit Committee in June 25, the review will incorporate

			capital programmes under the SFIs as part of the review of the SORD.			this action. <b>10.02.25</b> 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.
<b>10</b>	<b>AC24/151.1</b>	05.11.24	<b>Centre for Mental Health and Society (CfMHaS)</b> (Title changed from Response to Freedom of Information Request) A full evaluation report to be presented at the next Audit Committee.	Pam Wenger Russell Caldicott	<del>March 25</del> <del>May 25</del>  Revised timescale June 25	<b>Remain Open</b> <b>09.05.25</b> An independent reviewer has been sought on the procurement portal (since 14.03.25). Currently awaiting expressions of interest to complete the work. A report is due to go to the Committee in June 25 dependant on securing an independent reviewer. <b>04.03.25</b> In relation to the Centre for Mental Health it has been agreed to commission a review and this will come back to Committee. <b>03.02.25</b> ToR have now been drafted and awaiting final review before procurement in February 2025. A full evaluation report is due to be presented to the Committee in April 25 (subject to procurement) <b>08.01.25</b> 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.
11	AC24/151.2	05.11.24	<b>Centre for Mental Health and Society (CfMHaS)</b> (Title changed from Response to Freedom of Information Request) Gain the opinion of the Information Commissioner on the FOI.	Pam Wenger Phil Meakin	<del>Jan 25</del> <del>March 25</del> <del>May 25</del>  Revised timescale June 25	<b>Remain Open</b> <b>16.04.25</b> A communication has been received from the ICO (letter dated 31.01.25). The letter confirmed that there has been a complaint made to the ICO and provided the Health Board with guidance and advice on how to resolve and revisit the complaint and clarify a response in accordance with the relevant rules/laws for FOI Requests. The letter from the ICO also requested a copy of the final letter to the complainant which was duly sent on 09.04.25. <b>03.02.25</b> 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. <b>08.01.25</b> 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).
12	AC24.60.1.8	07.05.24	<p><b>Internal Audit Progress Report</b> 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.</p>	Philippa Peake Jones to inform the Quality, Safety and Experience Committee (QSE)	<p>May 24 <del>Nov 24</del> <del>Jan 25</del></p> <p>Revised timescale June 25</p>	<p><b>Remain Open</b> <b>10.04.25</b> A follow up review is being undertaken and the findings will be shared as soon as possible. <b>04.03.25</b> A follow up Audit has been commissioned. <b>12.02.25</b> As the Director of Performance &amp; Commissioning is now post, this will be considered at the QSE Committee in May 25. <b>08.01.25</b> An update on the progress against the Quality, Safety and Commissioned Services Report has been included on the forward plan for the QSE Committee. <b>24.10.24</b> Action to remain open and to be taken forward with the new Director of Planning &amp; Commissioning. <b>02.09.24</b> PPJ confirmed that this has been referred to QSE Committee however the issue has not yet been resolved therefore the action remains open. <b>04.03.25</b> It was noted in Committee</p>



						that this is being taken forward as part of this years Internal Audit and will be led by the Director of Performance & Commissioning
13	AC24.60.1.10	07.05.24	<b>Internal Audit Progress Report</b> 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	June 25	<b>Remain Open</b> <b>10.04.25</b> This has been included on the agenda for the next Chairs Advisory Group which is due to take place on 24.04.25. <b>08.01.25</b> 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. <b>08.10.24</b> 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. <b>12.09.24</b> This will be discussed at the next Committee Chair's Meeting. <b>02.09.24</b> Update to be provided during the meeting. <b>18.07.24</b> To be raised at the next meeting in August 2024 as part of



						feedback from the Audit Committee Chair.
14	AC24/121.1	12.09.24	<b>Speak Up Safely</b> Share benchmarking information from other Health Boards in relation to the number of concerns being raised.	Jason Brannan Tracey Eccles Rebecca Testa <del>Gareth Evans</del>	Nov-24 <del>Jan-25</del> <del>March-25</del> <del>May-25</del>  Revised timescale June 25	<b>Remain Open</b> <b>17.04.25</b> Currently work continues across Wales to implement Guardians in line with the WG framework, currently not all Health Boards have Guardian representation. The current All Wales Group are working in collaboration to align the reporting data through the working in confidence platform using categories already used by the National Guardians Office for Speaking up Safely and this will be implemented once the SBAR cited in AC24/121.2 is approved. <b>19.02.25</b> 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. <b>28.10.24</b> 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.
15	AC24/121.2	12.09.24	<p><b>Speak Up Safely</b> Future update to consider the compliance against the policy/protocol and particularly in the context of raising concerns and Whistleblowing arrangements.</p>	<p>Internal Audit Jason Brannan Tracey Eccles Rebecca Testa <del>Gareth Evans</del></p>	<p><del>Nov 24</del> <del>Jan 25</del> <del>March 25</del> <del>May 25</del></p> <p>Revised timescale June 25</p>	<p><b>Remain Open</b> <b>17.04.25</b> An SBAR has been submitted via Jason Brannan for a review of the referral process of submitting a concern and aligning the reporting data to allow comparison against other Health Boards / Trusts. <b>04.03.25</b> The Audit Committee approved the Internal Audit Plan for 2025/26 which includes Speaking up Safely as review reference 25. It is planned for Q4 but Internal Audit have agreed with management's request to bring the review forward earlier in the year. <b>19.02.25</b> 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</p>



					<p>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.</p> <p><b>28.10.24</b> 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 adaptations to current practice that may be needed in relation to Public Disclosure (Whistleblowing)</p> <p><b>16.09.24</b> Internal Audit will consider Speak Up Safely as a key risk area for the 2025/26 internal audit planning</p>
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						cycle following presentation of the report by Officers and observations made by Committee Members.
16	AC24/124.3	12.09.24	<p><b>Update on Health Board Policies and Written control Documents</b></p> <p>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.</p>	Pam Wenger Glesni Driver	<p>Nov 24 Jan 25</p> <p>Revised timescale June 25</p>	<p><b>Remain Open</b></p> <p><b>12.03.25</b> An update on progress around a revised policy process will be provided to the June 25 meeting.</p> <p><b>03.02.25</b> 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.</p> <p><b>10.12.24</b> 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.</p> <p><b>24.10.24</b> 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.</p>



**ACTIONS PROPOSED FOR CLOSURE**

1	AC25/33.1	04.03.25	<b>Risk Report and Corporate Risk Register</b> Revise the dates included in the report where dates are extended.	Nesta Collingridge	May 25	<b>Action proposed for closure 12.03.25</b> Revised target dates are presented to the Committee as business as usual, going forward we will ensure the rationale is clear and includes details of prior scrutiny and will monitor this closely to ensure target dates are appropriate.
2	AC25/38.1	04.03.25	<b>Conformance Report</b> Add page numbers to the Conformance Report and ensure a movement arrow is included in relation to LFERs to show where numbers have changed.	Russell Caldicott Denise Roberts	May 25	<b>Action proposed for closure 19.03.25</b> The Team are addressing the issues highlighted and these will be implemented ahead of submission of the next Conformance Report.
3	AC25/38.3	04.03.25	<b>Conformance Report</b> Share a briefing on the 5 payments for loss/damage of patient's property, 1 payment for ex-gratia payments and 6 ombudsman payments for delayed and unsatisfactory treatment.	Russell Caldicott Denise Roberts	May 25	<b>Action proposed for closure 30.04.25</b> This information has been circulated to the Committee.
4	AC25/38.4	04.03.25	<b>Conformance Report RATS to be amended to Remuneration Committee on the losses and special payments section.</b>	Russell Caldicott Denise Roberts	May 25	<b>Action proposed for closure 16.04.25</b> This reference will be corrected in the Conformance Report ahead of being issued for the next meeting.
5	AC25/40.1	04.03.25	<b>Revised Internal Audit Plan</b> Include a follow up review of Falls Management in the Internal Audit Plan.	Dave Harris	May 25	<b>Action proposed for closure 07.03.25</b> The plan for 2025/26 has been updated to include Falls Management Follow Up as review reference 36. The Internal Audit



						Team plan to undertake this review in the period April to June 2025 (Quarter 1). The revised plan has been circulated and uploaded to the IMs Teams Channel.
6	AC25/06.3	16.01.25	<b>Update on Open Audit Recommendations – Final Audit Report on Llandudno Hospital Orthopaedic Surgical Hub</b> 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.	Russell Caldicott	March 25  Revised timescale May 25	<b>Action proposed for closure</b> <b>30.04.25</b> Bank account now opened and to be used moving forwards for transactions in regards to this development. <b>25.02.25</b> Further request instructed 23 December 2024 – Health Board representatives seeking clarification as to why this remains outstanding. Escalated to Director of Environment
7	AC25/07.1	16.01.25	<b>Update Report on Internal and External Audit Recommendations</b> 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 May 25	<b>Action proposed for closure</b> <b>09.04.25</b> The Executive Director of Nursing is joining the next meeting in May 25 to provide an update against her Audit Recommendation. <b>10.02.25</b> The Executive Director of Nursing and Executive Director of Public Health are on leave on 4 <sup>th</sup> 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.
8	AC25/10.1	16.01.25	<b>Update on Health Board Policies and Written Control Documents</b>	Pam Wenger Glesni Driver	May 25	<b>Action proposed for closure</b> <b>12.03.25</b> A paper will be presented to



			Summarise the policies that carry the biggest risk and provide a paper to the Committee in April 2025.			the April 25 meeting. <b>04.02.25</b> A paper focussing on overdue policies will be presented to the meeting in April 25.
9	AC24/127.4	12.09.24	<b>Internal Audit Progress Report</b> Consider options for raising awareness and understanding of internal audit.	Pam Wenger Dave Harries	Nov 24 <del>Jan 25</del> <del>March 25</del>  Revised timescale May 25	<b>Action proposed for closure</b> <b>12.03.25</b> Work is ongoing between the Corporate Governance Directorate and Internal Audit to revise the training material, and a revised version and communication plan will be presented to the May 25 meeting. <b>16.01.25</b> 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. <b>28.11.24</b> 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. <b>03.10.24</b> PW to discuss options



						including developing video resource, an update will be provided in Jan 25.
10	AC24/154.5	05.11.24	<b>Internal Audit Progress Report</b> Review the option to include Fire Safety Training within Mandatory Training rather than it being at staff discretion and also review the policy.	Stuart Keen Russell Caldicott	Jan 25 May 25  Revised timescale June 25	<b>Action proposed for closure</b> <b>30.04.25</b> It has been confirmed that Fire Training is mandatory for all BCU staff, and included in the WP30 Statutory Mandatory Training Policy. <b>25.02.25</b> The Director of Environment & Estates is taking this forward to build this into the training modules. <b>09.01.25</b> Update from RC to follow.

**Closed Actions (as agreed at meeting on 04.03.25)**

Action	Minute Ref.	Date	Agreed Action	Lead	Timescale	Status
1	AC24/152.1	05.11.24	<b>Conformance Report: Q2 2024/25</b> 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	<b>25.02.25</b> This is now complete and forms part of the report.
2	AC24/152.2	05.11.24	<b>Conformance Report: Q2 2024/25</b> 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	<b>25.02.25</b> This is now complete and forms part of the report.
3	AC24/154.2	05.11.24	<b>Internal Audit Progress Report</b> 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	<b>25.02.25</b> Escalated by Russ to CS, response forwarded approving final brief by CS. <b>09.01.25</b> Update from RC to follow. <b>06.12.24</b> A draft brief was shared with Russell Caldicott and Chris Stockport has now approved the final brief.



4	AC25/15.1	16.01.25	<b>External Audit Progress Report</b> Further support Independent Members to gain a deeper understanding of the organisation's finances.	Russell Caldicott	March 25	<b>25.02.25</b> Board Development Session took place in January.
5	AC24/147.2	05.11.24	<b>Update on Outstanding Audit Recommendations</b> Work with WOD to understand how budgetary training can link in with ESR.	Russell Caldicott Michelle Jones	<del>Jan 2025</del>  Revised timescale March 25	<b>25.02.25</b> Finance training includes WOD representation.
6	AC25/14.1	16.01.25	<b>Internal Audit Progress Report</b> Russell Caldicott and Simon Cookson to discuss gaining unrestricted access to data outside of the meeting.	Russell Caldicott Simon Cookson	March 25	<b>13.02.25</b> This has been resolved from an Internal Audit perspective, the majority of information has been provided, outstanding information has been approved and being gathered. The Executive Director of Finance has agreed that this action is now closed.
7	AC25/05.1	16.01.25	<b>Update on Outstanding Audit Recommendations</b> 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	<b>07.02.25</b> 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.
8	AC25/06.1	16.01.25	<b>Update on Open Audit Recommendations – Audit Wales Community Pharmacy Data Matching Pilot</b> Head of Counter Fraud to review the Audit Wales Community Pharmacy	Danielle Timmins	March 25	<b>10.02.25</b> 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.



			Data Matching Pilot and provide an update as part of the Counter Fraud Progress Report.			
9	AC25/06.4	16.01.25	<p><b>Update on Open Audit Recommendations – Final Internal Audit Report on Consultant Job Planning</b></p> <p>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.</p>	Pam Wenger Sree Andole Nick Graham	Aug 25	<b>10.02.25</b> 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.
10	AC25/09.2	16.01.25	<p><b>WRP Penalties – Learning from Events Report (LfER)</b></p> <p>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.</p>	Russell Caldicott Matt Joyes	March 25	<b>14.02.25</b> 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.
11	AC25/11.1	16.01.25	<p><b>Board Assurance Framework</b></p> <p>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)</p>	Pam Wenger Nesta Collingridge	March 25	<b>04.02.25</b> The suggested changes have been made and the revised version was presented to the Board in Jan 25.
12	AC25/13.1	16.01.25	<p><b>Annual Report 2024/25 Arrangements</b></p>	Philippa Peake-Jones	March 25	<b>10.02.25</b> The Audit Committee in June will take place on 24.06.25, 9-



			Change the date of the Audit Committee to from 25/06/25 to 24/06/25 (preferably morning).	Laura Jones		12.30pm.
13	AC25/14.2	16.01.25	<b>Internal Audit Progress Report</b> Share full copies of all Internal Audit Reports going forward.	Philippa Peake-Jones Laura Jones	March 25	<b>10.02.25</b> 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.
14	AC25/14.3	16.01.25	<b>Internal Audit Progress Report</b> Circulate the Internal Audit Report on Charitable Funds.	Philippa Peake-Jones Laura Jones	March 25	<b>10.02.25</b> This document has been shared with the Committee via email.
15	AC25/15.2	16.01.25	<b>External Audit Progress Report</b> Share the link for the Cancer Services report.	Fflur Jones	March 25	<b>20.02.25</b> The link has been shared with the Committee via email.
16	AC25/17.1	16.01.25	<b>Local Counter Fraud Service Progress Report (Q2)</b> Include additional information in the report in relation to the risks and progress.	Danielle Timmins	March 25	<b>10.02.25</b> 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.
17	AC24/127.2	12.09.24	<b>Internal Audit Progress Report</b> 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 <del>Jan-2025</del> <del>March-25</del>  Revised timescale April 25	<b>06.02.25</b> 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



						<p>Committee at the March 25 meeting.</p> <p><b>25.11.24</b> An item focussing on the EPRR Risks will be considered by the PPHP Committee at the meeting on 18.02.25.</p> <p><b>03.10.24</b> 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.</p>
18	AC24.62.1.4	07.05.24	<p><b>Local Counter Fraud</b> F03 <a href="#">BCUHB Counter Fraud Policy</a> is due for review – to be approved by August 2024. (Audit Committee Agenda in September)</p>	Russell Caldicott Danielle Timmins Sjef Molmans	<p><del>Sept 2024</del> <del>Nov 2024</del> <del>Jan 2025</del> <del>March 25</del></p> <p>Revised timescale April 25</p>	<p><b>20.02.25</b> The Counter Fraud Policy is included on the agenda for the meeting in March 25.</p> <p><b>10.02.25</b> 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.</p> <p><b>25.10.24</b> 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</p>



						<p>offers a risk in relation to the recent changes in legislation.</p> <p><b>12.09.24</b> RC to review the policy and check whether the legislation is due in September 24.</p> <p><b>05.09.24</b> The Counter Fraud Policy required further work and has been included on the forward workplan for the November meeting.</p> <p><b>26.06.24</b> Counter Fraud Policy F03, is in the process of being reviewed by the team and will be placed out for wider consultation in July.</p> <p><b>20.05.24</b> Item now on CoB for September 2024.</p>
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# Audit Committee

**Executive Director of Nursing update presentation on open Limited assurance audit recommendations**



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

Bwrdd Iechyd Prifysgol  
Betsi Cadwaladr  
University Health Board

**30<sup>th</sup> April 2025**

# Limited Audit Report presented:

Audit body	Report Title	Year	Assurance Level	Number of report recommendations	Number of recommendations implemented/ complete	Total number of report recommendations open
Internal Audit	<b>Falls Management.</b> Recommendation: To review training compliance for all areas relating to Patient Handling training and ensure staff who require training undertake this as soon as possible.	2023	Limited	18	16	2
Internal Audit	<b>Lessons Learnt.</b> Recommendation: Management to review implemented learning to ensure effectiveness.	2023	Limited	9	8	1
Internal Audit	<b>Deprivation of Liberty Safeguards (DoLS) – 2024.</b> Recommendation: Supervisory to continue addressing quality issues with relevant areas and continue to review capacity of BIAs and Mental Health Assessor (a s12(2) Approved Doctor).	2024	Limited	17	16	1



# Falls Management

PROGRESS TO DATE	BARRIERS TO IMPLEMENTATION/ DELIVERY –	MITIGATION IN PLACE TO ENSURE DELIVERY	PLAN AND TIMELINE FOR DELIVERY
<ul style="list-style-type: none"> <li>• Training compliance has shown a positive trend, currently standing at 76.63% overall and 74.5% for bank staff. This marks a significant improvement from 64.95% in October 2024 and 69.66% in November 2024.</li> <li>• Efforts are ongoing to secure additional training venues to support the increase in Manual Handling training sessions and further enhance availability. Despite the introduction of a new booking system, DNA (Did Not Attend) rates remain a challenge, and work is actively being undertaken to address this issue.</li> <li>• Recruitment efforts in Manual Handling Team are progressing well with 3 x Band 6 posts. Internal authorisation has been received, and we are now awaiting the job advertisement to go live.</li> </ul>	N/A	N/A	<ul style="list-style-type: none"> <li>• Recruitment to progress.</li> <li>• Manual Handling Team to secure additional Venues.</li> <li>• Date planned for completion is 31<sup>st</sup> May 2025.</li> </ul>



# Lessons Learnt

PROGRESS TO DATE	BARRIERS TO IMPLEMENTATION/ DELIVERY –	MITIGATION IN PLACE TO ENSURE DELIVERY	PLAN AND TIMELINE FOR DELIVERY
<ul style="list-style-type: none"> <li>• The Integrated Concerns Policy, approved by the Board in July 2024, is now live and embedded. The implementation of several mandatory fields in Datix has successfully resolved numerous issues.</li> <li>• The Patient Safety Team conducts daily reviews of incidents closed within the previous 24 hours to identify any incomplete fields. If necessary, these incidents are reopened, and feedback is provided to the incident manager.</li> <li>• Learning is systematically disseminated through the Clinical Effectiveness Quarterly Reports and the Annual Report, which detail the insights and information gained. The Organisational Learning Forum, launched in 2023, continues to play a pivotal role in this process.</li> <li>• Efforts are ongoing to develop the new Quality Learning Portal, ensuring continuous improvement and enhanced learning opportunities.</li> <li>• A thematic review bi weekly meeting has commenced to identify and address recurrent themes within the organisation. This initiative aims to support service development through shared learning and implementing changes to mitigate recurrence.</li> </ul>	N/A	N/A	<ul style="list-style-type: none"> <li>• Initial completion date: 31<sup>st</sup> March 2025, there have been delays due to pressures in BCUHB Digital Services, these have now been resolved and significant progress has been made with planned delivery date for 31<sup>st</sup> June 2025.</li> </ul>



# Deprivation of Liberty Safeguards (DoLS)

PROGRESS TO DATE	BARRIERS TO IMPLEMENTATION/ DELIVERY –	MITIGATION IN PLACE TO ENSURE DELIVERY	PLAN AND TIMELINE FOR DELIVERY
<ul style="list-style-type: none"> <li>The Deprivation of Liberty Safeguards (DoLS) Standard Operating Procedure (SOP) undergoes an annual review, with governance managed by the Safeguarding and Public Protection Policy and Procedure Group. This process is integrated into the Safeguarding Performance and Governance Group, the Quality, Safety and Experience (QSE) Committee, and the Mental Health Legislative Committee for assurance.</li> <li>Mental Capacity Act (MCA) training is on an upward trajectory and is monitored through the same governance framework. Areas of non-compliance are specifically targeted with bespoke and, where necessary, face-to-face training sessions.</li> <li>Best Interests Assessors (BIAs) now have an increased presence at District General Hospital (DGH) sites, providing on-site support for MCA and DoLS decisions.</li> <li>BCUHB is actively participating in the Welsh Government-led pilot concerning the form of the DoLS application.</li> <li>There has been a significant reduction in the number of errors recorded within DoLS and MCA paperwork, reflecting the dedication and hard work of the team and services across the Health Board. This progress is monitored monthly and reported quarterly.</li> </ul>	<p>Ensuring the Governance process is followed.</p>	<p>Best interest assessors visit the wards a number of times weekly providing advice and support during their visit. The MCA training lead maintains daily contact and visits the DGH's a number of times weekly providing additional bespoke MCA training sessions to areas of low compliance. The Supervisory Body continues to link directly with the wards if there are any issues to highlight.</p>	<ul style="list-style-type: none"> <li>Initial completion date: 31<sup>st</sup> March 2025.</li> <li>Action for closure, monitoring for future compliance and review will be undertaken and delivered at the Mental Health Legislative Committee.</li> </ul>





<b>Teitl adroddiad:</b> <i>Report title:</i>	Update report on Internal and External Audit Recommendations			
<b>Adrodd i:</b> <i>Report to:</i>	Audit Committee			
<b>Dyddiad y Cyfarfod:</b> <i>Date of Meeting:</i>	Thursday, 08 May 2025			
<b>Crynodeb Gweithredol:</b> <i>Executive Summary:</i>	<p>The purpose of this report is to provide the Committee with:</p> <ul style="list-style-type: none"> <li>an update of the current position with regards to open recommendations, and those proposed for closure</li> <li>details of all 'unsatisfactory' or 'limited' assurance recommendations</li> <li>update on Internal Audit recommendations approved for closure by both the Executive Director and Executive Team, and reviewed and approved for closure by Internal Audit but not yet presented for final closure approval to the Audit Committee</li> <li>update on Internal Audit recommendations for their review and consideration for closure by the Audit Committee</li> <li>update on External Audit recommendations approved for closure by both the Executive Director and Executive Team, and now for closure consideration by both Audit Wales and Audit Committee.</li> </ul>			
<b>Argymhellion:</b> <i>Recommendations:</i>	<p>The Committee is asked to:</p> <ul style="list-style-type: none"> <li><b>NOTE</b> the current position with regards to open recommendations, those proposed for closure, and 'unsatisfactory' and 'limited' assurance recommendations</li> <li><b>APPROVE</b> the Internal Audit recommendations outside the scope of the Internal Audit Charter put forward for Audit Committee closure approval</li> <li><b>APPROVE</b> the External Audit recommendations put forward for Audit Wales and Audit Committee closure approval.</li> </ul>			
<b>Arweinydd Gweithredol:</b> <i>Executive Lead:</i>	Pam Wenger, Director of Corporate Governance			
<b>Awdur yr Adroddiad:</b> <i>Report Author:</i>	Glesni Driver, Head of Statutory Compliance and Inquiries			
<b>Pwrpas yr adroddiad:</b> <i>Purpose of report:</i>	I'w Nodi <i>For Noting</i> <input checked="" type="checkbox"/>	I Benderfynu arno <i>For Decision</i> <input type="checkbox"/>	Am sicrwydd <i>For Assurance</i> <input checked="" type="checkbox"/>	
<b>Lefel sicrwydd:</b> <i>Assurance level:</i>	Arwyddocaol <i>Significant</i> <input type="checkbox"/>  <small>Lefel uchel o hyder/tystiolaeth o ran darparu'r mecanweithiau / amcanion presennol</small>  <small>High level of confidence/evidence in delivery of existing mechanisms/objectives</small>	Derbyniol <i>Acceptable</i> <input type="checkbox"/>  <small>Lefel gyffredinol o hyder/tystiolaeth o ran darparu'r mecanweithiau / amcanion presennol</small>  <small>General confidence / evidence in delivery of existing mechanisms / objectives</small>	Rhannol <i>Partial</i> <input checked="" type="checkbox"/>  <small>Rhywfaint o hyder/tystiolaeth o ran darparu'r mecanweithiau / amcanion presennol</small>  <small>Some confidence / evidence in delivery of existing mechanisms / objectives</small>	Dim Sicrwydd <i>No Assurance</i> <input type="checkbox"/>  <small>Dim hyder/tystiolaeth o ran y ddarpariaeth</small>  <small>No confidence / evidence in delivery</small>

<p><b>Cyfiawnhad dros y gyfradd sicrwydd uchod. Lle bo sicrwydd 'Rhannol' neu 'Dim Sicrwydd' wedi'i nodi uchod, nodwch gamau i gyflawni sicrwydd 'Derbyniol' uchod, a'r terfyn amser ar gyfer cyflawni hyn:</b></p> <p><b><i>Justification for the above assurance rating. Where 'Partial' or 'No' assurance has been indicated above, please indicate steps to achieve 'Acceptable' assurance or above, and the timeframe for achieving this:</i></b></p>	
<p>A considerable amount of historical internal and external audit recommendations were approved for closure over the last few months, which has cleansed the audit tracker. Following this process, the recommendations that remain on the audit tracker now need progressing as many of these are overdue both their original and revised implementation dates. As usual, guidance and support will continue to be provided to all recommendation owners and Executive Leads by the Corporate Governance Directorate.</p>	
<p><b>Cyswllt ag Amcan/Amcanion Strategol:</b></p> <p><b><i>Link to Strategic Objective(s):</i></b></p>	<p>Not applicable, other than those relating to individual audit reviews/recommendations.</p>
<p><b>Goblygiadau rheoleiddio a lleol:</b></p> <p><b><i>Regulatory and legal implications:</i></b></p>	<p>Compliance with Internal and External Audit requirements.</p>
<p><b>Yn unol â WP7, a oedd EqIA yn angenrheidiol ac a gafodd ei gynnal?</b></p> <p><b><i>In accordance with WP7 has an EqIA been identified as necessary and undertaken?</i></b></p>	<p>The Equality duty is not applicable. This report is purely administrative in nature and submitted for information only. The associated public sector duties are not engaged, and there are no associated impacts on any of the protected groups</p>
<p><b>Yn unol â WP68, a oedd SEIA yn angenrheidiol ac a gafodd ei gynnal?</b></p> <p><b><i>In accordance with WP68, has a SEIA identified as necessary been undertaken?</i></b></p>	<p>The Socio-Economic duty is not applicable. This report is purely administrative in nature and submitted for information only. The associated public sector duties are not engaged, and the report does not relate to a decision, strategic or otherwise.</p>
<p><b>Manylion am risgiau sy'n gysylltiedig â phwnc a chwmpas y papur hwn, gan gynnwys risgiau newydd (croesgyfeirio at y BAF a'r CRR)</b></p> <p><b><i>Details of risks associated with the subject and scope of this paper, including new risks (cross reference to the BAF and CRR)</i></b></p>	<p>Not applicable, other than those relating to individual audit reviews/recommendations.</p>
<p><b>Goblygiadau ariannol o ganlyniad i roi'r argymhellion ar waith</b></p> <p><b><i>Financial implications as a result of implementing the recommendations</i></b></p>	<p>Not applicable, other than those relating to individual audit reviews/recommendations.</p>
<p><b>Goblygiadau gweithlu o ganlyniad i roi'r argymhellion ar waith</b></p> <p><b><i>Workforce implications as a result of implementing the recommendations</i></b></p>	<p>Not applicable, other than those relating to individual audit reviews/recommendations.</p>
<p><b>Adborth, ymateb a chrynodeb dilynol ar ôl ymgynghori</b></p> <p><b><i>Feedback, response, and follow up summary following consultation</i></b></p>	<p>The report has been prepared following feedback from previous Executive Team and Audit Committee meetings, and ongoing discussions with Internal Audit and Audit Wales.</p>

<p><b>Cysylltiadau â risgiau BAF:</b> (neu gysylltiadau â'r Gofrestr Risg Gorfforaethol)</p> <p><b>Links to BAF risks:</b> (or links to the Corporate Risk Register)</p>	<p>Not applicable, other than those relating to individual audit reviews/recommendations.</p>
<p><b>Rheswm dros gyflwyno adroddiad i fwrdd cyfrinachol (lle bo'n berthnasol)</b></p> <p><b>Reason for submission of report to confidential board (where relevant)</b></p>	<p>Not applicable</p>
<p><b>Camau Nesaf:</b> <b>Gweithredu argymhellion</b></p> <p><b>Next Steps:</b> <b>Implementation of recommendations</b></p> <p>The Corporate Governance Directorate will continue to support recommendation owners and Executive leads with the work around the implementation of audit recommendations.</p>	
<p><b>Rhestr o Atodiadau:</b></p> <p><b>List of Appendices:</b></p> <p>Appendix 1 - Summary of the rationale for closure  Appendix 2 - Tracker with all Open 'Unsatisfactory' Assurance Recommendations  Appendix 3 - Tracker with all Open 'Limited' Assurance Recommendations  Appendix 4 – Internal Audit recommendations for Audit Committee closure consideration  Appendix 5 – External Audit recommendations for Audit Wales and Audit Committee closure consideration</p>	

# **INTERNAL AND EXTERNAL AUDIT RECOMMENDATIONS**

## **1. INTRODUCTION AND BACKGROUND**

This report provides an update on the progress around both internal and external audit recommendations, and those put forward for closure.

It also focusses on the those with 'limited' or 'unsatisfactory' assurance.

This report also provides a proposal to seek final closure approval of a number of Internal Audit recommendations already approved for closure by both the Executive Director and Executive Team, and reviewed and approved for closure by Internal Audit but have not been presented for final closure approval to the Audit Committee.

In addition to the above, within this report is a proposal to seek final closure approval of a number of other Internal Audit recommendations already approved for closure by the Executive Director and Executive Team, but fall outside the scope of the Internal Audit Charter for their review at its meeting on 30<sup>th</sup> April 2025.

This report also provides a proposal to seek approval for the closure a number of External Audit recommendations previously approved for closure by both the Executive Director and Executive Team, and now for closure consideration by both Audit Wales and Audit Committee at its meeting on 30<sup>th</sup> April 2025.

## **2. NEWLY PUBLISHED AUDIT REPORTS**

Since the last update to the Committee, the recommendations from the below newly published Internal and External Audit reports have been added to the tracker, and one External Audit Report:

- Consultant Job Planning
- Structured Assessment 2024 (Audit Wales)
- Review of Cost Savings Arrangements (Audit Wales)
- Network and Disaster Recovery
- Establishment Control
- Job Evaluation
- Transformation and Improvement.

### 3 CURRENT POSITION

#### 3.1 Recommendations for closure approval

Table 1 below provides a summary of all recommendations approved for closure by the respective Executive, together with those awaiting closure approval:

Executive Lead	Approved for closure	Awaiting approval by Executive
Executive Director of Public Health	0	0
Chief Digital and Information Officer	13	0
Chief Executive	4	0
Chief Operating Officer	12	0
Executive Director of Nursing	7	0
Interim Executive Director of Transformation and Strategic Planning	2	0
Executive Director of Allied Health Professions & Health Science	0	0
Deputy Director of People	0	0
Executive Medical Director	0	0
Director of Corporate Governance	3	0
Director of Environment and Estates	0	4
Director of Performance and Commissioning	0	0
Executive Director of Finance	1	0
<b>Total</b>	<b>42</b>	<b>4</b>

A summary of the closure narrative for each of the recommendations is included in Appendix 1.

##### 3.1.1 Recommendations awaiting Executive closure approval

Please note that the recommendations previously awaiting approval for closure by the Chief Executive have now been realigned to the new Director of Environment and Estates, and these are awaiting his approval. However, as the Director is new in post, he will need time to review and therefore approve these recommendations for closure.

## 3.2 Open recommendations

### 3.2.1 'Unsatisfactory' assurance recommendations

Table 2 below shows a summary of all 'unsatisfactory' assurance recommendation, and their status:

Audit report	Executive Lead	'Unsatisfactory' Assurance recs - started	'Unsatisfactory' Assurance recs - pending	Total open 'Unsatisfactory' Assurance recs overdue original implementation date	Total 'Unsatisfactory' Assurance recs put forward for closure	Total 'Unsatisfactory' Assurance recs remaining open
Operating Model	Chief Executive	2	0	2	2	2
Consultant Job Planning	Interim Executive Medical Director; Deputy Director of People	6	10	0	0	16
	<b>Total</b>	<b>2</b>	<b>0</b>	<b>2</b>	<b>2</b>	<b>18</b>

Two recommendations from the Operating Model audit report are being put forward for closure, with two remaining open. The Health Board has established the Foundations for Future Programme that will oversee the work around the new operating model, and progress against the Programme will be overseen by the People and Culture Committee.

The Consultant Job Planning audit report is newly added to the tracker, and some updates on progress have been provided for this report.

A copy of the live tracker, which includes all open high priority - 'unsatisfactory' assurance reports is included in Appendix 2.

### 3.2.2 'Limited' assurance recommendations

Table 3 below shows a summary, by Executive, of all 'limited' assurance recommendations, and their status:

Executive Lead	'Limited' Assurance recs - started	'Limited' Assurance recs - pending	Total open 'Limited' Assurance recs overdue original implementation date	Total 'Limited' Assurance recs put forward for closure
Executive Director of Nursing	4	0	3	7
Chief Executive	0	0	0	1
Interim Executive Director of Transformation and Strategic Planning	2	1	3	1
Chief Operating Officer	3	0	2	4
Deputy Director of People	1	0	1	0
Director of Corporate Governance	3	0	3	2
Executive Director of Finance	0	1	0	1
Interim Executive Medical Director; Deputy Director of People	1	6	0	0
Director of Environment and Estates	9	1	6	0
<b>Total</b>	<b>23</b>	<b>9</b>	<b>18</b>	<b>16</b>

A copy of the live tracker, which includes all open high priority - 'limited' assurance reports is included in Appendix 3.

## 4 SUMMARY OF ALL RECOMMENDATIONS

Table 4 provides information as to number of ALL recommendations, per status, whether newly added to the tracker and being progressed, through to those in the differing stages of closure approvals.

	As at 30/06/2024	As at 31/08/2024	As at 19/11/2024	As at 14/03/2025
Newly added Internal Audit recommendations	19	1*	56	60
Newly added Audit Wales recommendations*	0	0	24**	24
Open - historical and ongoing recommendations	337	193	-	-
Open - historical recommendations pending closure approval, as per report proposals	-	427	-	-
Pending - for Executive approval	16	0	0	4
Pending - for Executive Team approval	81	0	1	42
Pending Internal Audit closure approval, or ongoing work to respond to IA queries	46	77	32	86
Pending Audit Wales closure approval	34	8	0	0
Pending Audit Committee approval***	53	77	38	71
<i>* as at 25/09/2024</i>				
<i>** 3 of these recommendations assigned to others outside the Health Board, therefore recorded as closed</i>				
<i>*** completed Health Board and internal audit review and approval process</i>				

## **5 AUDIT RECOMMENDATIONS FOR CLOSURE CONSIDERATION**

A considerable amount of work has taken place to date to cleanse the information contained within the audit tracker, with the approval to close a number of historical Internal Audit and External Audit recommendations over the last few months.

As part of this continued process, the audit tracker current holds a number of Internal and External Audit recommendations that are awaiting Audit Committee closure. For Internal Audit recommendations, these are

- recommendations that have been approved for closure in line with the approved closure process by both the Executive Director and Executive Team, and reviewed and approved for closure by Internal Audit but not yet presented to the Audit Committee
- recommendations that have been approved for closure in line with the approved closure process by both the Executive Director and Executive Team, but are outside the scope of the Internal Audit Charter for review but need final approval for closure by the Audit Committee.

For External Audit recommendations, these are recommendations that have been approved for closure in line with the approved closure process by both the Executive Director and Executive Team, and the next part of the closure process is approval for closure by Audit Wales and the Audit Committee.

It must be noted that some of the narrative updates and evidence have been approved for closure by the Executive Director and Executive Team for some time, and have been awaiting final closure approval, therefore some evidence will be historical in nature.

It is proposed that these recommendations be presented to the Audit Committee for consideration for closure.

Details of the Internal Audit recommendations are included in Appendix 4.

Details of the External Audit recommendations are included in Appendix 5.

## **6 AUDIT COMMITTEE PRESENTATIONS**

As per the action from the last Audit Committee, the Director of Nursing and Midwifery will provide an update to the April Audit Committee on all outstanding recommendations, and plans to progress the closure of these recommendations.

## **7 CONCLUSION AND RECOMMENDATIONS**

The Audit Committee is asked to NOTE the content of this report.

## **8 BUDGETARY/FINANCIAL IMPLICATIONS**

There are no budgetary implications associated with this paper.

Resources for progressing the work around the audit recommendations lie with the relevant directorate, division, or department as part of business-as-usual functions.

Work is ongoing to source an electronic audit tracking system, which will have a budgetary and resource implication.

## **9 RISK MANAGEMENT**

It is essential that the Health Board progresses work around the audit recommendations as a matter of urgency, and in line with the published implementation dates in order to minimise risks associated with those areas of work.

There are risks to the Health Board relating to audit recommendations as they highlight areas of improvement required by the Health Board, and more so for those that are overdue their original implementation date. Due to this, Director of Corporate Governance holds an overarching Health Board risk on Datix relating to this.

## **10 EQUALITY AND DIVERSITY IMPLICATIONS**

The Equality duty is not applicable to the content of this report as it is purely administrative in nature and submitted for information only.

However, Equality and Diversity compliance should be considered by each recommendation owner and Executive Director lead when implementing changes to processes and procedures in line with the requirements of the audit reports.

**APPENDIX 1 - SUMMARY OF THE RATIONALE FOR CLOSURE**

**APPENDIX 2 - TRACKER WITH ALL OPEN 'UNSATISFACTORY' ASSURANCE RECOMMENDATIONS**

**APPENDIX 3 - TRACKER WITH ALL OPEN 'LIMITED' ASSURANCE RECOMMENDATIONS**

**APPENDIX 4 – INTERNAL AUDIT RECOMMENDATIONS FOR AUDIT COMMITTEE CLOSURE CONSIDERATION**

**APPENDIX 5 – EXTERNAL AUDIT RECOMMENDATIONS FOR AUDIT WALES AND AUDIT COMMITTEE CLOSURE CONSIDERATION**

**SUMMARY OF AUDIT RECOMMENDATIONS PROPOSED FOR CLOSURE  
FOR COMMITTEE APPROVAL**

**Summary of recommendation with rationale for closure**

**EXECUTIVE DIRECTOR OF NURSING**

1	352	Deprivation of Liberty Safeguards (DoLS) - 2024	All mandatory training for Bank, Locum, and Honorary Staff will include MCA Level 1 and Level 2 (where applicable) and this is now extended to Agency Staff and any new 'on-boarded' Agency Staff members. This action is now complete with training data to be supplied monthly to respective services and monitored via the Safeguarding Governance and Performance Group and Mental Health Legislative Committee.
2	356		Support / Q&A Sessions have been held across West, Central and East areas focusing on the quality of the paperwork. The Supervisory Body (DoLS/MCA Team) continues to link directly with wards to request necessary amendments ensuring documentation is satisfactory. The DoLS data and best interest assessments are included in the data dashboard. The DoLS monthly report for December shows improvement to the quality of the paperwork during December 2024. Regular monthly reporting is now in place and this action can be closed. Issues, concerns, good practice is reported into the Mental Health Legislative Committee for oversight and assurance.
3	357		The five Health Board staff members have commenced the BIA qualification course in Q3 and are due to qualify in Q4. Supervision is in place for all staff. The capacity to complete additional assessments and train BIA's is in place. This action can now be closed and will be monitored as part of quarterly SGPG reporting and Mental Health Legislative Committee reporting.
4	358		The data analyst has created a Power BI dashboard to capture key performance data regarding compliance of applications within timescales and other relevant data. Monthly reports are produced to highlight areas where improvement is required. The Supervisory Body, BIA's and the MCA training lead link directly with the areas of low compliance to provide targeted intervention, advice and support if required. Issues, concerns, and good practice is reported into SGPG, Safeguarding Forums and the Mental Health Legislative Committee for assurance and oversight.
5	361		Digitalisation of MCA and DoLS documentation is being led by Welsh Government. The DoLS Form 1 (Application Form) has been produced and agreed by the National group. A pilot of the DoLS Form 1 will commence in Q4. This action is now led nationally and is completed from an internal perspective. BCUIB are leading on the digitalisation of the documentation.
6	364		Support / Q&A sessions have been held across West, Central and East areas focusing on the quality of paperwork. The Supervisory Body (DoLS Team) continues to link directly with wards to request necessary amendments ensuring documentation is satisfactory. The DoLS data and best interest assessments are included in the data dashboard. The DoLS monthly report shows improvement to the quality of the paperwork during December 2024. As per action 356 this is now complete with monitoring and reporting in place.
7	365		Any issues relating to the DoLS paperwork and escalation of low compliance with training data is reported via IHC/MHLD Safeguarding Forums, the Mental Health Legislative Committee and the Safeguarding Governance and Performance Group. The MCA training lead provides additional bespoke training, advice and support if required to areas of high % non-compliance. Data provided for December 2024 highlighted a significant improvement in the quality of the paperwork. This action can now be closed as monitoring, escalation and reporting mechanisms are in place.

**CHIEF DIGITAL AND INFORMATION OFFICER**

1	507	Fragmented Care Records	Symphony has a pan BCU group established with representation from clinicians and operational managers. All change requests are channelled through this forum to be discussed and agreed before implementation. Meetings of the forum are minuted.
2	508		Symphony user group established.
3	529	Digital Operating Model	All posts have now been appointed to - Solution Architect - ECR: 65281. BRM - ECR: 57526.
4	536		Sessions have continued drafting the initial document. This should be available to review by 31st March 2025. Implementation date from 1st June 2025
5	1373	Intelligence Led Organisation	Analysis team meetings with dedicated development sessions in place. December session focussed on statistical process control, future sessions include transformation and innovation methodologies, clinical coding, Finance and costings data, Public Health Intelligence and Quality.
6	1374		Information Analysis Manager appointed, with effect from November 2024.
7	1375		Posts referenced all progressing having had ECR approval. Analysis team - Account manager posts IHC West Acute and community ECR67759 & 69345 and UEC Lead (backfill) ECR 69841 out to advert. Development team Band 6 commenced January 2024 (ECR63100), Band 7 ECR 63257 offer made 09/01/25
8	1377		Workshop held with members of DI&I management and Data Warehouse Teams and the Health Board's newly appointed Data Architect.
9	1384		Paper presented to DDaT Senior leadership team and subsequently to the Clinical Design Authority (CDA) on 5/12/2024 with approval to proceed with an oncology proof of concept around 'booked no outcome' appointments.
10	1387		Analysts identified and feedback arrangements in place through team meetings and development sessions
11	1388		Data Quality statement added to Systems Acceptable use statement
12	1392		As reported against Q3 milestone 5D.2. Data model built and tested on a planned care dataset (RTT open pathways). Work to develop the visualisation of the data quality mark is ongoing
13	1395		As reported against Q3 annual plan milestone 5D.4. Training needs assessment undertaken as part of NHS Executive survey of planned care staff. Operational teams asked to indicate support required, awaiting detail of responses from NHS Executive Team.

INTERIM CHIEF OPERATING OFFICER (approved by Interim Chief Operating Officer)			
1	146	Maternity Cross-Border Arrangements	The commissioning of services is being discussed within the Health Board, and the COCH-commissioned service should not differ to any other. The Health Board is currently discussing commissioning services at Executive Level, including that commissioned from COCH.
2	147		
3	619		
4	310	Waiting List Management: Review of the WG initiated Patient Validation Exercise, Risk Stratification and patient removal from lists	This has been supereceded now with further work on waiting list management in relation to validation. Chatbot added for validation. COO reviewed evidence and is content to close.
5	473	Discharge Arrangements	The HB produces this for WG and this is reported via the RPB, with action plan in place. Each month the RPB partners meet with National Lead PG6 to review the data
6	499	Effective Governance – Women’s Directorate	Womens Services CEG meeting from January 2025 is being moved from the third Wednesday monthly, to the fourth Wednesday monthly to accommodate all three Clinical Site Audit Leads to be able to attend, which will strengthen assurances on Tier 2 and Tier 3 level audits. Both Tier 2 and Tier 3 updates are listed on the standard agenda for all meetings. Updates will be received from the Clinical Effectiveness and Audit Lead and the 3 x site Clinical Audit Leads.
7	1284	Effective Governance – Integrated Health Community (IHC) Central	From December 2024 a Directors Finance Recovery Group meeting was established to review the Financial constraints.
8	1288		<ul style="list-style-type: none"> <li>Facilities Accountability Review (slide deck attached) was praised by the Directors as every Risk that was on the Risk register was discussed as part of the Accountability Review, prior to getting to the Risk section.</li> <li>Pharmacy – another good example of reports – covering escalations and risk and examples of how these are managed – most services discussing new processes they had for monitoring and dealing with risks.</li> <li>Primary Care and Community also brought in challenges of the population data to identify problem areas.</li> </ul> <p>The Accountability reviews are good as risks that can be a ‘footnote’ are instead brought into focus and the wider impact this has on services can be explored. This can lead to productive conversations and an increased engagement with some long standing risks. As part of the next round of Accountability Reviews the risks and escalations mentioned in this round will be evaluated to determine what if any progress has been made.</p>
9	1516	Urgent and Emergency Care: Flow out of Hospital – North Wales Region	This relates to access as part of functional requirements built into the tender / procurement requirements.
10	1517		Currently in the East Region Health Board staff do have access to Wrexham and Flintshire Local Authority information as part of the Integrated Team approach. WCCIS is in the process of being replaced nationally and so an alternative solution will be considered.
11	1518		A review of Home First was undertaken during November 2024, in collaboration with Wrexham and Flintshire Local Authorities and was signed off by the East Senior Leadership Team. This included reviewing and updating all Standard Operating Procedures and Finances to ensure they remained fit for purpose.
12	1519		Currently focussing on embedding the use and consistency of use of STREAM in the Health Setting.

DIRECTOR OF CORPORATE GOVERNANCE			
1	396	Structured Assessment 2023	It is now normal practice to upload Minutes within two days of approval at the meeting.
2	1272	Risk Management - June 2024	The TORs were re-submitted to ET on 04/12/2024 and approved.
3	1274	Standards of Business Conduct - Declarations of Interest, Gifts and Hospitality - June 2024	All the bulletins and the wording is highlighted including the days that they were submitted.

INTERIM EXECUTIVE DIRECTOR OF TRANSFORMATION AND STRATEGIC PLANNING			
1	1324	Orthopaedic Surgical Hub Llandudno Hospital	The PEP was reviewed by the Project Team and updated in December 2024 by Gleeds, as authors of the document, to reflect the move into Stage 4 of the project as per the capital Manual.
2	1460	Structured Assessment 2024	There is an improved process in place for the development of this year’s IMTP, having taken learning from previous years and the Special Measures Independent review of Planning. This has been applied to both Board Member and Partner engagement, which has resulted in both happening more frequently and earlier in the process. Board Members have been engaged multiple times through informal and formal Board meetings and through PPHP and PFIG as lead Board Committees for the IMTP and Financial plans respectively. It is also the case that all Board Committees have contributed to the plan through their cycles of business aligning to the IMTP and in particular when doing deep dives on specific topics such as individual Challenged Services. They have also been engaged along with Partners through SRG, LPF and HPF. Finally the RPB has been involved in contributing to the IMTP, completing a reasonable cross section of stakeholder and partner engagement.

**EXECUTIVE DIRECTOR OF FINANCE**

1	1306	Budgetary Control	The procedure has been approved by the EDoF and is available on the Finance Betsinet page. The handbook (section 3A Budgetary control) has been updated to make reference to the updated procedure on budgetary movements (virements)
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**CHIEF EXECUTIVE**

1	454	Operating Model	Programme has been established to oversee the work required to address the engagement on the Operating Model, including the development of an insights report. Two further vacant executive posts have now been recruited too. Successful applicants should be in post by May 2025. Salary constraints remain an issue for some vacant posts. We continue to work with WG on this. Recommended for closure - whilst the new posts in the senior team have been filled, there is ongoing recruitment taking place. This would be classed as Business As Usual
2	456		OD team structure has now been changed
3	489	Health and Safety - 2024	The regular monitoring, reporting, communication, escalation and de-escalation of Health & Safety issues is included in the terms of reference for the People and Culture Committee
4	1314	Recruitment of substantive and interim executive and senior posts Final Internal Audit Report	The Audit Report considered, and appointments ratified in the Board in November 2024

ALL OPEN 'UNSATISFACTORY ASSURANCE' RECOMMENDATIONS

ID	Internal Audit/ Audit Wales	Report Title	Year	Assurance Level	Priority	Recommendation Title	Recommendation	Management Response	Action Owner	Final Approver	Original implementation date	Revised implementation date	Number of Revisions	Latest update
455	Internal Audit	Operating Model	2024	Unsatisfactory	High	Matter Arising 1: Operating Model (Design and Operation)	<p>1.1 The Health Board, through the Chief Executive should undertake a full review of the operating model including:</p> <ul style="list-style-type: none"> <li>A review of the Operating Model, as implemented, to ensure it is fit for purpose in delivering the Corporate/Strategic Objectives, long-term strategy/medium term plan of the Health Board.</li> <li>A review of all twenty-six services identified as 'Outstanding Design – Clinical' with urgency, noting some represent current risk to the Health Board.</li> <li>Review of the role, remit and accountability of corporate posts where the services they oversee are delivered through Operational Services, for which they have no delegated responsibility or accountability.</li> <li>A review of funding, to ensure any Operating Model/Structure is affordable and transparency in funding is ensured.</li> </ul>	Arana (external consultancy) was commissioned in November to undertake an initial review of the operating model. The Chief Executive, supported by the Senior Associate Director of People in May 2024, will commence an engagement process with the Board and other colleagues to consider changes to the organisational structure. This will take account of the gaps in assurance that have been identified as part of this internal audit.	Jason Brannan, Deputy Director of People; Georgina Roberts	Carol Shillabeer, Chief Executive	30/06/2024	31/03/2025	1	The Foundations for the Future programme is one of the 4 major change programmes for the Health Board. Its scope includes the review of the current model (Discovery Phase) published in Nov 2024. This programme covers the whole organisation so will include the 26 services identified as outstanding in design from the previous change (2022) to the operating model and corporate services. We are currently in the Design Phase with a number of workshops taken place in December 2024 and further workshops in Jan 2025. Any change to the current operating model will include financial affordability.
457	Internal Audit	Operating Model	2024	Unsatisfactory	High	Matter Arising 2: Operational Governance and Accountability Framework (Design and Operation)	The Health Board reviews its Governance and Accountability Framework to ensure it provides the necessary scrutiny and assurance from Ward to Board and vice versa.	As part of the organisational structure review, all accountability frameworks will be reviewed	Pam Wenger, Director of Corporate Governance	Carol Shillabeer, Chief Executive	30/06/2024	31/12/2024	1	This will be updated as part of the Foundations for the Future programme, and timescales updated appropriately around implementation timescale
1427	Internal Audit	Consultant Job Planning	2024	Unsatisfactory	High	Objective 1: There is relevant and up to date procedures in place that are available to staff and align to the All-Wales guidance.	<p>1.1 <b>Health Board Policy</b></p> <p>Health Board Policy The Health Board has no Policy or Procedure detailing the expectations of both management and Consultant in discussing and agreeing the Job Plan in line with the nationally agreed Consultant Contract. Based on our review, it has not had a comprehensive Policy in place for thirteen years, per the original review undertaken by the former Wales Audit Office in 2011.</p> <p>Limited training is provided to all individuals involved in the job plan process.</p>	1.1 Review and update Job Planning policy to be aligned with All Wales guidance and nationally agreed Consultant Contract, which is readily accessible to staff.	Sreeman Andole, Interim Executive Medical Director	Sreeman Andole, Interim Executive Medical Director; Jason Brannan, Deputy Director of People	31/05/2025			<i>Newly added report</i>
1428	Internal Audit	Consultant Job Planning	2024	Unsatisfactory	High	Objective 1: There is relevant and up to date procedures in place that are available to staff and align to the All-Wales guidance.	<p>1.2 <b>Health Board Policy</b></p> <p>The Health Board has no Policy or Procedure detailing the expectations of both management and Consultant in discussing and agreeing the Job Plan in line with the nationally agreed Consultant Contract. Based on our review, it has not had a comprehensive Policy in place for thirteen years, per the original review undertaken by the former Wales Audit Office in 2011.</p> <p>Limited training is provided to all individuals involved in the job plan process.</p>	1.2 Continue with regular updates of compliance to IHC/Division, to reflect organisational job planning status.	Sreeman Andole, Interim Executive Medical Director	Sreeman Andole, Interim Executive Medical Director; Jason Brannan, Deputy Director of People	31/05/2025			<i>Newly added report</i>
1429	Internal Audit	Consultant Job Planning	2024	Unsatisfactory	High	Objective 1: There is relevant and up to date procedures in place that are available to staff and align to the All-Wales guidance.	<p>1.3 <b>Health Board Policy</b></p> <p>The Health Board has no Policy or Procedure detailing the expectations of both management and Consultant in discussing and agreeing the Job Plan in line with the nationally agreed Consultant Contract. Based on our review, it has not had a comprehensive Policy in place for thirteen years, per the original review undertaken by the former Wales Audit Office in 2011.</p> <p>Limited training is provided to all individuals involved in the job plan process.</p>	1.3 Complete a training needs analysis across BCUHB to establish training for medical and management teams by March 2025.	Sreeman Andole, Interim Executive Medical Director	Sreeman Andole, Interim Executive Medical Director; Jason Brannan, Deputy Director of People	31/05/2025			<i>Newly added report</i>
1430	Internal Audit	Consultant Job Planning	2024	Unsatisfactory	High	Objective 1: There is relevant and up to date procedures in place that are available to staff and align to the All-Wales guidance.	<p>1.4 <b>Health Board Policy</b></p> <p>The Health Board has no Policy or Procedure detailing the expectations of both management and Consultant in discussing and agreeing the Job Plan in line with the nationally agreed Consultant Contract. Based on our review, it has not had a comprehensive Policy in place for thirteen years, per the original review undertaken by the former Wales Audit Office in 2011.</p> <p>Limited training is provided to all individuals involved in the job plan process.</p>	1.4 Develop and deliver targeted training sessions for managers and consultants by April 2025.	Sreeman Andole, Interim Executive Medical Director	Sreeman Andole, Interim Executive Medical Director; Jason Brannan, Deputy Director of People	31/05/2025			<i>Newly added report</i>

1431	Internal Audit	Consultant Job Planning	2024	Unsatisfactory	Medium	Objective 1: There is relevant and up to date procedures in place that are available to staff and align to the All-Wales guidance.	<p><b>2.1 Medical Resourcing</b></p> <p>Through discussion with all clinical directorates/divisions, each advised on the limited support available to them in relation to Medical and Dental Contract matters, following the removal of a dedicated medical staffing resource. We have confirmed this was absorbed in 2019.</p> <p>The Office of the Medical Director is responsible for some people related functions, with limited contingency arrangements in the event of annual leave/prolonged absence.</p> <p>There is possibility of duplication within the Health Board through the operation of standalone people systems and development of silo expertise.</p>	2.1 Provide comprehensive training for consultants and managers on job planning processes, focusing on linking individual objectives with organisational goals.	Sreeman Andole, Interim Executive Medical Director	Sreeman Andole, Interim Executive Medical Director; Jason Brannan, Deputy Director of People	30/09/2025			Newly added report
1432	Internal Audit	Consultant Job Planning	2024	Unsatisfactory	Medium	Objective 1: There is relevant and up to date procedures in place that are available to staff and align to the All-Wales guidance.	<p><b>2.2 Medical Resourcing</b></p> <p>Through discussion with all clinical directorates/divisions, each advised on the limited support available to them in relation to Medical and Dental Contract matters, following the removal of a dedicated medical staffing resource. We have confirmed this was absorbed in 2019.</p> <p>The Office of the Medical Director is responsible for some people related functions, with limited contingency arrangements in the event of annual leave/prolonged absence.</p> <p>There is possibility of duplication within the Health Board through the operation of standalone people systems and development of silo expertise.</p>	2.2 Establish clear communication channels for escalating job planning concerns or discrepancies.	Sreeman Andole, Interim Executive Medical Director	Sreeman Andole, Interim Executive Medical Director; Jason Brannan, Deputy Director of People	30/09/2025			Newly added report
1433	Internal Audit	Consultant Job Planning	2024	Unsatisfactory	High	Objective 1: There is relevant and up to date procedures in place that are available to staff and align to the All-Wales guidance.	<p><b>3.1 Ejob Plan First and second sign-off</b></p> <p>Through a review of first and second sign off details in the Ejob plan system, and verification with the seven clinical directorates / divisions, there were several issues noted with the accuracy of the information on the system . This includes gaps in second approvers, officers no longer in post, and inconsistency with operational management included as either first or second sign off. There was also test data included in the live system.</p>	3.1 Develop a standardised and systematic approach to monitor job plan completion rates, reporting results to the appropriate forums.	Sreeman Andole, Interim Executive Medical Director	Sreeman Andole, Interim Executive Medical Director; Jason Brannan, Deputy Director of People	30/04/2025			Newly added report
1434	Internal Audit	Consultant Job Planning	2024	Unsatisfactory	High	Objective 1: There is relevant and up to date procedures in place that are available to staff and align to the All-Wales guidance.	<p><b>3.2 Ejob Plan First and second sign-off</b></p> <p>Through a review of first and second sign off details in the Ejob plan system, and verification with the seven clinical directorates / divisions, there were several issues noted with the accuracy of the information on the system . This includes gaps in second approvers, officers no longer in post, and inconsistency with operational management included as either first or second sign off. There was also test data included in the live system.</p>	3.2 Create escalation protocols for addressing non-compliance promptly and on regular basis and appropriate form.	Sreeman Andole, Interim Executive Medical Director	Sreeman Andole, Interim Executive Medical Director; Jason Brannan, Deputy Director of People	30/04/2025			Newly added report
1435	Internal Audit	Consultant Job Planning	2024	Unsatisfactory	Medium	Objective 1: There is relevant and up to date procedures in place that are available to staff and align to the All-Wales guidance.	<p><b>4.1 Business Continuity</b></p> <p>The Ejob Plan system is a hosted platform on the cloud and is wholly reliant on an internet connection. We have not reviewed the contractual arrangement regarding disaster recovery arrangements with the supplier.</p> <p>We have confirmed there is no documented business continuity plan in place centrally but are unsighted whether there are arrangements in place locally.</p>	4.1 The system is web based so accessible anywhere and backup by Allocate.	Jason Brannan, Deputy Director of People	Sreeman Andole, Interim Executive Medical Director; Jason Brannan, Deputy Director of People	30/09/2024			OMD (EB/DS) are to formalise the BCP and were signposted to the BCP SharePoint site to help develop the BCP.
1436	Internal Audit	Consultant Job Planning	2024	Unsatisfactory	Medium	Objective 1: There is relevant and up to date procedures in place that are available to staff and align to the All-Wales guidance.	<p><b>4.2 Business Continuity</b></p> <p>The Ejob Plan system is a hosted platform on the cloud and is wholly reliant on an internet connection. We have not reviewed the contractual arrangement regarding disaster recovery arrangements with the supplier.</p> <p>We have confirmed there is no documented business continuity plan in place centrally but are unsighted whether there are arrangements in place locally.</p>	4.2 Testing and approval of Medical Dental and Elements report from ESR (sessional payments) which will all periodically audits to verify that job plans reconcile with system records and ensure session payments are accurate.	Jason Brannan, Deputy Director of People	Sreeman Andole, Interim Executive Medical Director; Jason Brannan, Deputy Director of People	30/09/2024			The M&D Dashboard has been developed. OMD have requested an amendment to include service in months to assist with new starter compliance. The Dashboard will require review, engagement with Directorate/Divisions and formal sign off.
1437	Internal Audit	Consultant Job Planning	2024	Unsatisfactory	Medium	Objective 1: There is relevant and up to date procedures in place that are available to staff and align to the All-Wales guidance.	<p><b>4.3 Business Continuity</b></p> <p>The Ejob Plan system is a hosted platform on the cloud and is wholly reliant on an internet connection. We have not reviewed the contractual arrangement regarding disaster recovery arrangements with the supplier.</p> <p>We have confirmed there is no documented business continuity plan in place centrally but are unsighted whether there are arrangements in place locally.</p>	4.3 Automate data entry processes wherever possible to reduce human error in transferring information to ESR.	Jason Brannan, Deputy Director of People	Sreeman Andole, Interim Executive Medical Director; Jason Brannan, Deputy Director of People	30/09/2024			ESR and Job planning data is being pulled into a BI Dashboard, however, the Allocate roadmap has noted 2 phases for data transfer from Allocate Job Plan to ESR Job Plan. DS/EB to review information and arrange a meeting with Allocate to understand more with NG. Original Implementation Date has not been achieved, a revised date will be dependant on the outcome of the Allocate Roadmap.
1443	Internal Audit	Consultant Job Planning	2024	Unsatisfactory	High	Objective 3: Job plans include outcomes that are linked to the Health Board's organisational objectives, and the level of achievement is subject to appropriate assessment.	<p><b>7. Evidencing achievement of the Board objectives</b></p> <p>Whilst there were strategic goals detailed in the Board Outcomes section of the job plan, they did not reflect the current strategic objectives, and there were no measurable outcomes agreed from which it could be evidenced as being worked to/achieved.</p>	7. To revisit with Office of the Medical Director the current outcomes section of the job plan and align more fully with the PADR process for other staff groups to ensure objectives can be aligned to allow Consultant & SAS Doctors to support in achieving them.	Sreeman Andole, Interim Executive Medical Director	Sreeman Andole, Interim Executive Medical Director; Jason Brannan, Deputy Director of People	30/04/2025			Newly added report

1446	Internal Audit	Consultant Job Planning	2024	Unsatisfactory	High	Objective 5: The completion rates of job plans are monitored and reported to an appropriate forum, with further escalation if there is	<p><b>10. Medical and Dental Job Plan reporting</b></p> <p>There is inadequate reporting of medical and dental job plan performance, across the Health Board from operational management to the Executive and associated scrutiny meetings up to Committee for assurance.</p>	10. Compliance report sent out each week to IHCs/Division which breaks down job plan compliance and can be filtered to obtain more detail as required.	Jason Brannan, Deputy Director of People	Sreeman Andole, Interim Executive Medical Director; Jason Brannan, Deputy Director of People	30/04/2025		OMD are issuing the link and files for the compliance report 2/3 times per week. People Services are arranging for the summary tab to be updated weekly."
1447	Internal Audit	Consultant Job Planning	2024	Unsatisfactory	High	Objective 5: The completion rates of job plans are monitored and reported to an appropriate forum, with further escalation if there is low compliance	<p><b>11.1 Medical Workforce Group &amp; People &amp; Culture Executive Delivery Group (EDG)</b></p> <p>The Medical Workforce Group (MWG) has responsibility in its Terms of Reference that it "...will receive regular reports (on job plans) as per its Cycle of Business" but we have been unable to verify they have actually received any reports for assurance recently.</p> <p>Of the ten MWG meetings scheduled to take place this calendar year, only three have taken place (April, June and September 2024).</p> <p>The MWG provides assurance to the People &amp; Culture EDG although we have been advised this meeting has similarly not been taking place, exposing an operational gap in control and assurance across the Health Board.</p>	11.1 To establish the People and Culture EDG which the Medical Workforce Group will report into. The TORs for Medical Workforce are to be reviewed.	Jason Brannan, Deputy Director of People	Sreeman Andole, Interim Executive Medical Director; Jason Brannan, Deputy Director of People	30/04/2025		<i>Newly added report</i>
1448	Internal Audit	Consultant Job Planning	2024	Unsatisfactory	High	Objective 5: The completion rates of job plans are monitored and reported to an appropriate forum, with further escalation if there is low compliance	<p><b>11.2 Medical Workforce Group &amp; People &amp; Culture Executive Delivery Group (EDG)</b></p> <p>The Medical Workforce Group (MWG) has responsibility in its Terms of Reference that it "...will receive regular reports (on job plans) as per its Cycle of Business" but we have been unable to verify they have actually received any reports for assurance recently.</p> <p>Of the ten MWG meetings scheduled to take place this calendar year, only three have taken place (April, June and September 2024).</p> <p>The MWG provides assurance to the People &amp; Culture EDG although we have been advised this meeting has similarly not been taking place, exposing an operational gap in control and assurance across the Health Board.</p>	11.2 Dashboards will be provided to Medical Workforce Group	Jason Brannan, Deputy Director of People	Sreeman Andole, Interim Executive Medical Director; Jason Brannan, Deputy Director of People	30/04/2025		NG to clarify with SA which dashboards are to be provided to MWG.
1449	Internal Audit	Consultant Job Planning	2024	Unsatisfactory	High	Objective 5: The completion rates of job plans are monitored and reported to an appropriate forum, with further escalation if there is low compliance	<p><b>11.3 Medical Workforce Group &amp; People &amp; Culture Executive Delivery Group (EDG)</b></p> <p>The Medical Workforce Group (MWG) has responsibility in its Terms of Reference that it "...will receive regular reports (on job plans) as per its Cycle of Business" but we have been unable to verify they have actually received any reports for assurance recently.</p> <p>Of the ten MWG meetings scheduled to take place this calendar year, only three have taken place (April, June and September 2024).</p> <p>The MWG provides assurance to the People &amp; Culture EDG although we have been advised this meeting has similarly not been taking place, exposing an operational gap in control and assurance across the Health Board.</p>	11.3 Reports are sent out on weekly basis to IHC/Divisions with link to access Power BI to review all relevant data.	Jason Brannan, Deputy Director of People	Sreeman Andole, Interim Executive Medical Director; Jason Brannan, Deputy Director of People	30/04/2025		OMD are issuing the link and files for the compliance report 2/3 times per week. People Services are arranging for the summary tab to be updated weekly.

**ALL OPEN 'LIMITED ASSURANCE' RECOMMENDATIONS**

ID	Internal Audit/ Audit Wales	Report Title	Year	Assurance Level	Priority	Recommendation Title	Recommendation	Management Response	Action Owner	Final Approver	Original implementation date	Revised implementation date	Number of Revisions	Latest update
150	Internal Audit	Nursing Roster Management: Introduction of e-timesheets for Agency staff	2022	Limited	Medium pre 01/10/2024	Matter Arising 1: Policies and Procedures (Operation)	1.1: Policy WP28a requires a review, needs to include a reference to the E-timesheets also include the SOP within the documents to be read alongside the policy section on the first page. 1.2 Draft SOP needs to be approved and activated.	1.1: Policy WP28a has been reviewed and is with Workforce Policy Group for consideration. Policy to be approved and deployed with a clear compliance audit schedule in place and commenced. 1.2 Draft SOP to be reviewed to amend reference to unpaid break to acknowledge the risks associated on safe staffing in conjunction with Corporate Nursing Team. 1.3 Interim SOP (with exception of paid break element) to be approved for a 3 months period to ensure clarity of process and accountability in intervening period.	Clair Tipton, Head of Digital Systems	Jason Brannan, Deputy Director of People	31/07/2022	31/05/2025	5	This action needs to be extended due to competing priorities affecting capacity across the service.
298	Internal Audit	Falls Management	2023	Limited	High	Matter Arising 3: Training (Operation and Design)	3.1a: To review training compliance for all areas relating to Patient Handling training and ensure staff who require training undertake this as soon as possible.	3.1a: Manual Handling (MH) is a Tier One risk on the BCUHB risk register scoring 16 requiring regular review of actions being completed. MH training compliance data cascaded monthly to respective IHC's/Division Director of Operations to include compliance, did not attend rates and available capacity for upcoming 2 months. Capacity within the MH training team to be optimised with focused recruitment drive for Band 6 posts (x3) supported by workforce.	Lynne Bushell - Head of Health, Safety and Security	Angela Wood, Executive Director of Nursing and Midwifery	01/01/2024	31/03/2025	4	Training capacity increased resulting in an increase in compliance from 64.95% in October 2024 for all staff to 69.66% in November 2024. December figures currently being calculated. However, initial indications show a high DNA rate. Staffing challenges remain within the team. However, two B6 Manual Handling Advisor roles to be advertised as secondments whilst awaiting updated job description and person specification. A third B6 Manual Handling Advisor role to be offered as an acting up position to cover long term sickness. Back-fill will be undertaken as required to reach establishment.
304	Internal Audit	Falls Management	2023	Limited	High	Matter Arising 4: Governance (Operation)	4.1b: Lessons learned information included in Datix should be reviewed regularly to ensure learning is communicated/reported as appropriate, and to deter staff entering a full stop or a dash in the section.	4.1b: Action 1 - Each Integrated Health Community (IHC) Health Board has established weekly harms review meeting that includes Inpatient Falls, to improve the sharing of lessons learned the Health Board will develop a SOP to ensure standardised practice across the IHCs.	Chris Lynes, Deputy Executive Director of Nursing	Angela Wood, Executive Director of Nursing and Midwifery	30/12/2023	30/09/2024	4	SOP approved at BCUHB Inpatient Falls Group 11/09/2024 and Patient Safety Group 24/09/2024. Lessons learned information reviewed by Patient Safety Team as a sample audit using all incidents reported to NHS Wales Executive. Details of what needs to be inputted in to Datix covered in BCUHB incident awareness and incident management training
326	Internal Audit	Lessons Learnt	2023	Limited	High	Matter Arising 1: Lessons Learnt (Design)	1.3c: Management to review implemented learning to ensure effectiveness.	1.3c: A new, digital repository of learning and cascade system will be developed. NB: <i>Underpinning all this work is a Learning Improvement Project Plan which is in place and is being delivered as part of the Special Measures Programme – this includes development of a Learning Organisation Framework setting out cultural change (in partnership with Workforce and OD) and the Health Board will work with the national quality team on the creation of a learning healthcare system.</i>	Jo Kendrick, Head of Quality	Angela Wood, Executive Director of Nursing and Midwifery	31/03/2024	31/03/2025	5	At the end of December 24, DDaT received support to look at department workload and this has been adjusted to prioritise this development. Significant progress update due before end of January 2025 and will inform the development/testing group. Head of Quality has meeting in place mid Jan 25 with leads to discuss update and next steps.
359	Internal Audit	Deprivation of Liberty Safeguards (DoLS) - 2024	2024	Limited	High	Matter Arising 2: DoLS authorisations (Design)	2.1a (iv): Supervisory to continue addressing quality issues with relevant areas and continue to review capacity of BIAs and Mental Health Assessor (a s12(2) Approved Doctor).	2.1a (iv): Standard Operating Procedure for MCA and BIA service to be reviewed to strengthen visibility of the team within high risk areas. To include structured weekly visits/daily calls by the MCA Team to high referral areas i.e. DGH and Community Hospitals to increase profile of the MCA Team, provide support for staff, feedback regarding application QA rejection themes (date, signatures) etc.	Chris Walker, Head of Safeguarding Adults	Angela Wood, Executive Director of Nursing and Midwifery	30/09/2024	31/03/2025	2	An additional MCA training package has been produced and will need to be approved following the governance process. Best interest assessors visit the wards a number of times weekly providing advice and support during their visit. The MCA training lead maintains daily contact and visits the DGH's a number of times weekly providing additional bespoke MCA training sessions to areas of low compliance. The Supervisory Body continues to link directly with the wards if there are any issues to highlight. Revised implementation date needed due to alignment with governance for approval locally before the action can be deemed completed.
464	Internal Audit	Discharge Arrangements	2024	Limited	Medium pre 01/10/2024	Matter Arising 2: D2RA performance Measures (Design)	2.2a (iii): Management: <ul style="list-style-type: none"> <li>Remind staff to utilise STREAM to support their ward board rounds and to ensure that patient records are kept up to date.</li> <li>Consider incorporating D2RA pathway field onto STREAM summary pages to provide users with an at a glance overview of ward D2RA pathway</li> </ul>	2.2a (iii): Implement comms and engagement plan - Q4	Jane Trowman, Acting Assistant Director Care Homes Support and CHC Commissioning; Alison Bishop, Programme Director	Tehmeena Ajmal Chief Operating Officer	31/03/2025			Q4 Not Due
491	Internal Audit	Health and Safety - 2024	2024	Limited	Medium pre 01/10/2024	Matter Arising 3: Health & Safety Training (Operation)	3.1a: The Health Board Executive Lead for Health and Safety ensures Policy reference 5.1.3 Training for Health Board Executive Directors and Independent Members is adhered to: "the Health Board will provide suitable and sufficient training and instruction to Members of the Board in respect of H&S Management. This will also include responsibilities under section 37 of the Health and Safety at Work etc. Act 1974 and the Corporate Manslaughter and Corporate Homicide Act 2007".	3.1a: Further training for Executive Team to be arranged, Executive responsibility to ensure attendance	David Maslen-Jones, Acting Assistant Director of Occupational Health, Safety and Security	Stuart Keen, Director of Environment and Estates	01/09/2024			Director for Environment and Estates appointed, and will be in post in February 2025

493	Internal Audit	Health and Safety - 2024	2024	Limited	High	Matter Arising 5: Gap analysis (Operation)	5.1: The gap analysis is reviewed and management identify what further work needs undertaking to ensure areas of risk / focus remain relevant. This should be considered alongside the strategy to inform Health and Safety activity across the Health Board	5.1: The Review of the Gap Analysis has commenced, completion is due in April 2024	David Maslen-Jones, Acting Assistant Director of Occupational Health, Safety and Security	Stuart Keen, Director of Environment and Estates	30/04/2024			The Strategic Plan and Gap Analysis with be reviewed by the Chief Executive before being presented to SOHSG
1273	Internal Audit	Standards of Business Conduct - Declarations of Interest, Gifts and Hospitality - June 2024	2024	Limited	High	Matter Arising 1: Policy (Design)	1.1: Management: <ul style="list-style-type: none"> <li>Update policy to reflect current working practice and systems.</li> <li>Ensure that the requirements regarding mandatory annual declarations of interest for staff that fall outside the documented pay band thresholds are clearly stated.</li> </ul>	1.1: (a) Review and update Policy to ensure that it is in line with the rest of Wales (b) Review Policy to ensure that the pay bands are consistent with the rest of Wales (c) Discuss and agree with the Workforce Directorate ways in which the annual declarations of interest can be embedded into existing mechanisms.	Philippa Peake-Jones, Head of Corporate Affairs	Pam Wenger, Director of Corporate Governance	31/07/2024	31/10/2024	2	(a) Policy Approved at Audit Committee. Final steps are ongoing to get it published.
1281	Internal Audit	Standards of Business Conduct - Declarations of Interest, Gifts and Hospitality - June 2024	2024	Limited	High	Matter Arising 5: BCU staff declarations of interest (Operation)	5.1: Management: <ul style="list-style-type: none"> <li>Ensure line managers are aware of their responsibilities regarding approving declarations of interest (and gifts and hospitality).</li> <li>Ensure staff understand when, and how often, a declaration should be made.</li> <li>Establish controls and /or oversight arrangements to manage and escalate non-responses (from Decision Makers) and failure to approve (by line managers).</li> <li>Ensure data extracted from Declare is reviewed and adjusted appropriately prior to reporting (e.g. to Audit Committee).</li> </ul>	5.1: (a) Draft a new communication plan and SOP for Declarations to include flow charts so that Managers are clear about their responsibilities. (b) Work with the Workforce Directorate on options around including Declarations on PADR templates (c) Regularly review Declarations and identify and escalate non-responses (from Decision Makers) and failure to approve (by line managers)	Philippa Peake-Jones, Head of Corporate Affairs	Pam Wenger, Director of Corporate Governance	30/09/2024	31/10/2024	1	This PADR process and paperwork refresh has recently started with a scoping phase, and setting up a working group, etc., with the aim of developing a new process, set of paperwork and a refresh of the policy (which is out of date). This is likely to be ready by the end of this year; however, in the meantime we do need to refresh the current paperwork to include the new values and behaviours framework, which is likely being launched in April of this year.
1282	Internal Audit	Standards of Business Conduct - Declarations of Interest, Gifts and Hospitality - June 2024	2024	Limited	High	Matter Arising 6: Gifts, Hospitality, and Sponsored Events (Operation)	6.1: Management: <ul style="list-style-type: none"> <li>Ensure all offers of hospitality and sponsored events are declared, reviewed, and approved prior to attending per policy requirements. All retrospective declarations to be escalated.</li> <li>All hospitality and sponsored events to be approved by a Director / Assistant Director.</li> <li>Ensure all declarations pending approval are reviewed and approved / declined.</li> <li>Ensure provider details are recorded to enable effective monitoring per policy requirements.</li> </ul>	6.1: (a) Reviewed gift, hospitality, and sponsored event declarations and produce a SOP and flow chart to ensure clarity. (b) Produce a communications plan to raise awareness and compliance	Philippa Peake-Jones, Head of Corporate Affairs	Pam Wenger, Director of Corporate Governance	31/10/2024			Policy Approved at Audit Committee. Final steps are ongoing to get it published.
1283	Internal Audit	Effective Governance – Integrated Health Community (IHC) Central	2024	Limited	High	Matter Arising 1: Governance arrangements (Operation)	1.1: Working with the Corporate Governance Directorate, review the governance arrangements within the IHC, ensuring all Terms of Reference are reviewed and updated and consider the dates of meetings to always enable quorum	1.1: Central IHC will complete the review of the governance arrangements including frequency of meetings, Terms of Reference (TOR) and Cycle of Business. Suitable Chairs and Vice-Chair will be reviewed within this process.	Gareth Evans, IHC Director - Central	Tehmeena Ajmal Chief Operating Officer	31/07/2024	28/02/2025	2	Chairs of various meetings within the CIHC have been asked to review the ToRs, Cycle of Business and this is taking place, this continues to be part of the ongoing process Revised implementation date 28/02/2025.
1287	Internal Audit	Effective Governance – Integrated Health Community (IHC) Central	2024	Limited	High	Matter Arising 4: Concerns, Complaints, Incidents (Operation)	4.1: The IHC Director: <ul style="list-style-type: none"> <li>Ensures the IHC responds to all complaints according to expected reporting timelines and all learning is shared across the IHC.</li> <li>Ensures operational management review all open incidents</li> </ul>	4.1: The IHC have since developed trajectories to address the backlog of Open and overdue complaints, which will support completion of complaints against the reporting timelines. The QODG will receive assurance through the Patient, Safety Group (PSG). All Services will review their respective open incidents and performance will be monitored at PSG and assurance provided to QODG	Rachel Bowen, Associate Director of Nursing	Tehmeena Ajmal Chief Operating Officer	31/07/2024			An update on progress provided to Audit Committee on 16/01/2025, with an improvement in the position since September 2024. Action expected to be closed by February 2025.
1331	Internal Audit	Orthopaedic Surgical Hub Llandudno Hospital	2024	Limited	High	Matter Arising 5: Project Bank Account (Operation)	5.1: Formal Welsh Government approval is required to avoid using the Project Bank Account at both the enabling and main works contracts.	5.1: Agreed - The contractor is willing to set up a project bank account, we are currently exploring the process and timescale. Contractor have been instructed to progress.	Daniel Eyre, Head of Capital Development	Paolo Tardivel, Interim Executive Director of Transformation and Strategic Planning	31/12/2024			We continue to await confirmation that the bank account has been set up. It will be escalated again via the director meetings.
1337	Internal Audit	Orthopaedic Surgical Hub Llandudno Hospital	2024	Limited	Low	Matter Arising 8: Design sign off (Operation)	8.1: Noting that meetings to discuss design are now held virtually, consideration should be given to how formal sign off can be captured in the future.	8.1: Agreed - Meetings to confirm sign off have been recorded in teams and some responses have also been confirmed by email as evidence. We will review alternative approaches that support virtual sign off going forward.	Ruth Stiles, Senior Project Manager	Paolo Tardivel, Interim Executive Director of Transformation and Strategic Planning	31/08/2024			Review will commence shortly and aims to be completed 25/26. Ongoing action.
1340	Internal Audit	Corporate Legislative Compliance - Fire Safety	2024	Limited	High	Matter Arising 1: Governance (Design)	1.1b Fire safety reporting groups and committees should meet at regular intervals as per their agreed terms of refence. Any issues with attendance should be escalated to the relevant director	1.1b Meeting to take place in accordance with the Terms of Reference of the Strategic Occupational Health and Safety Group	Carol Shillabeer, Chief Executive (in absence of Director of Environment and Estates)	Stuart Keen, Director of Environment and Estates	29/10/2024	10/04/2025	1	The Director of Environment and Estates will commence in role on 3rd February 2025. This role will be the chair of the Strategic Occupational Health and Safety Meeting going forward. A request has been made to revise the implementation date until April 2025
1341	Internal Audit	Corporate Legislative Compliance - Fire Safety	2024	Limited	Medium	Matter Arising 2: Policy for the Management of Fire Safety (Design)	2.1a The Health Board review and update its policy for the Management of Fire Safety to ensure compliance with the Welsh Health Technical Memorandum (WHTM) 05-01 'Firecode – Managing healthcare fire safety', and Welsh Assembly Government NHS Wales Fire Safety Policy.	2.1a Fire Safety Policy to be reviewed and updated to reflect the current management structure and contents in accordance with current legislation and WHTM 05-01 Firecode - Managing healthcare fire safety.	Arwel Hughes, Head of Operational Estates	Stuart Keen, Director of Environment and Estates	20/03/2025			The Fire Safet Policy has been reviewed by the Fire Safety Management Group and is planned to be presented at the next Strategic Occupational Health and Safety Group
1342	Internal Audit	Corporate Legislative Compliance - Fire Safety	2024	Limited	Medium	Matter Arising 3: Fire Risk Assessments (Operation)	3.1a All officers accountable for Fire Risk Assessments ensure documents are reviewed and updated at regular intervals to ensure potential and new risks have been identified and evaluated. This should be monitored and escalated via the Fire Safety Management Group.	3.1a Fire Safety Advisors to ensure Fire Risk Assessments are undertaken within the recognised timeframes contained within HTM05-03: Operational provisions Part K - Guidance on fire risk assessments in complex healthcare premises. Reports will be generated and presented to the Fire Safety Management Group. Results will be escalated as appropriate.	Arwel Hughes, Head of Operational Estates	Stuart Keen, Director of Environment and Estates	26/03/2025			Fire Risk Assessment are undertaken and in-patient areas are prioritised. Work in underway to reduce the backlog. The Health Board is currently 100% compliant with Fire Risk Assessment within in-patient areas and 84% compliant across the entire Estates. Report on compliance is presented at the Fire Safety Management Group

1343	Internal Audit	Corporate Legislative Compliance - Fire Safety	2024	Limited	High	Matter Arising 4: Fire Training (Operation)	4.1a The Health Board ensure compliance with its Fire Safety Policy and ensure full participation of its employees through a tailored training programme applicable to their individual needs. This should be constantly monitored through the Fire Safety Management Group to ensure staff compliance.	4.1a Fire Safety training to be carried out in accordance with the Fire Safety Training Delivery Plan contained within Fire Safety Policy ES04. Staff compliance levels will be reported through the Fire Safety Management Group. Data will be collected from ESR and reported accordingly. Training needs analysis will be reviewed against the new HTM 05-03 Part A.	Arwel Hughes, Head of Operational Estates	Stuart Keen, Director of Environment and Estates	20/03/2025		Fire Safety Training is being delivered by the Fire Safety Team in accordance with the training delivery plan, staff compliance level are reported through the Fire Safety Management Group. Training need analysis to be reviewed in Q4
1345	Internal Audit	Corporate Legislative Compliance - Fire Safety	2024	Limited	High	Matter Arising 6: Site Specific Issues / Documentation (Operation)	6.1a (i) Management ensure issues identified in Appendix C of this report should be progressed through local arrangements and assurance provided to the Fire Safety Management Group on progress / completion.	6.1a (i) Action plan has been generated to address the issues raised in Appendix C of this report and progress on resolving the findings will be reported to the Fire Safety Management Group.	Arwel Hughes, Head of Operational Estates	Stuart Keen, Director of Environment and Estates	20/03/2025		The Action Plan is presented and the Fire Safety Management Group and updated accordingly. Current compliance with action plan is 60% completed.
1346	Internal Audit	Corporate Legislative Compliance - Fire Safety	2024	Limited	High	Matter Arising 6: Site Specific Issues / Documentation (Operation)	6.1a (ii) Management ensure issues identified in Appendix C of this report should be progressed through local arrangements and assurance provided to the Fire Safety Management Group on progress / completion.	6.1a (ii) Review the current arrangements for the undertaking of pre-planned maintenance and present the findings and recommendations to the Fire Safety Management Group.	Arwel Hughes, Head of Operational Estates	Stuart Keen, Director of Environment and Estates	20/03/2025		Contract awarded for maintenance of fire fighting equipment and update presented at the Fire Safety Management Meeting in January 2025
1347	Internal Audit	Corporate Legislative Compliance - Fire Safety	2024	Limited	High	Matter Arising 6: Site Specific Issues / Documentation (Operation)	6.1a (iii) Management ensure issues identified in Appendix C of this report should be progressed through local arrangements and assurance provided to the Fire Safety Management Group on progress / completion.	6.1a (iii) Report the number and results of Fire Drills to the Fire Safety Management Group.	Arwel Hughes, Head of Operational Estates	Stuart Keen, Director of Environment and Estates	27/11/2024		Fire Drills are reported within the Fire Safety Management Meeting, however they are currently being reported through Fire Officer's update and not through a specific reporting item. New reporting structure will be in place for the Fire Safety Management Meeting which will be held on 26th March 2025
1348	Internal Audit	Corporate Legislative Compliance - Fire Safety	2024	Limited	High	Matter Arising 6: Site Specific Issues / Documentation (Operation)	6.1a (iv) Management ensure issues identified in Appendix C of this report should be progressed through local arrangements and assurance provided to the Fire Safety Management Group on progress / completion.	6.1a (iv) Review the current arrangements for the undertaking of Fire drills across BCUHB and present the findings and recommendations to the Fire Safety Management Group.	Arwel Hughes, Head of Operational Estates	Stuart Keen, Director of Environment and Estates	27/11/2024		Fire Drills are reported within the Fire Safety Management Meeting, however they are currently being reported through Fire Officer's update and not through a specific reporting item. New reporting structure will be in place for the Fire Safety Management Meeting which will be held on 26th March 2025
1438	Internal Audit	Consultant Job Planning	2024	Limited	High	Objective 2: Job plans accurately reflect both the individual and organisation activity requirements and are completed in a timely manner.	5.1 <b>Job Plan annual review</b>  Through our review meetings, we were advised that undertaking the job plan within one month of the incremental date is not something that is actively followed as the system does not capture the data.  The Health Board is not compliant with its responsibility for ensuring annual job plan reviews are undertaken every twelve months and ensuring adequate narrative is completed around additional SPA sessions and place of work.	5.1 The Medical Dental and Elements pay report from ESR once approved will identify employment start date, which would be their incremental date.	Sreeman Andole, Interim Executive Medical Director; Jason Brannan, Deputy Director of People	Sreeman Andole, Interim Executive Medical Director; Jason Brannan, Deputy Director of People	30/04/2025		<i>Newly added to tracker</i>
1439	Internal Audit	Consultant Job Planning	2024	Limited	High	Objective 2: Job plans accurately reflect both the individual and organisation activity requirements and are completed in a timely manner.	5.2 <b>Job Plan annual review</b>  Through our review meetings, we were advised that undertaking the job plan within one month of the incremental date is not something that is actively followed as the system does not capture the data.  The Health Board is not compliant with its responsibility for ensuring annual job plan reviews are undertaken every twelve months and ensuring adequate narrative is completed around additional SPA sessions and place of work.	5.2 Use the power BI compliance report as an evaluation framework to assess the level of achievement of these outcomes regularly.	Sreeman Andole, Interim Executive Medical Director; Jason Brannan, Deputy Director of People	Sreeman Andole, Interim Executive Medical Director; Jason Brannan, Deputy Director of People	30/04/2025		<i>Newly added to tracker</i>
1440	Internal Audit	Consultant Job Planning	2024	Limited	High	Objective 2: Job plans accurately reflect both the individual and organisation activity requirements and are completed in a timely manner.	5.3 <b>Job Plan annual review</b>  Through our review meetings, we were advised that undertaking the job plan within one month of the incremental date is not something that is actively followed as the system does not capture the data.  The Health Board is not compliant with its responsibility for ensuring annual job plan reviews are undertaken every twelve months and ensuring adequate narrative is completed around additional SPA sessions and place of work.	5.3 To ensure detailed information around SPA sessions is captured within job plans by IHC/Division.	Sreeman Andole, Interim Executive Medical Director; Jason Brannan, Deputy Director of People	Sreeman Andole, Interim Executive Medical Director; Jason Brannan, Deputy Director of People	30/04/2025		<i>Newly added to tracker</i>

1441	Internal Audit	Consultant Job Planning	2024	Limited	High	Objective 2: Job plans accurately reflect both the individual and organisation activity requirements and are completed in a timely manner.	<p><b>6.1 Directorate/Specialty objectives are explicit</b></p> <p>There is a generic statement within the Service Outcomes section of job plans "To ensure service and jobplan aligned to deliver CPG and wider BCU Strategic direction", (sic). The Service Outcomes section overall was either incomplete or noted "During job plan discussions need to review this".</p> <p>From our review, we are unclear how management are approving job plans without expected service objectives.</p> <p>We note different approaches taken in agreeing team objectives where colleagues collectively agree on the service requirements and then meet individually as part of the job plan approach to agree individual objectives. These should be SMART and recorded in the system.</p>	6.1 Establish with the team a cross-departmental assessment to address identified areas not complete, for example service outcomes not recorded.	Sreeman Andole, Interim Executive Medical Director	Sreeman Andole, Interim Executive Medical Director; Jason Brannan, Deputy Director of People	30/04/2025			Newly added to tracker
1442	Internal Audit	Consultant Job Planning	2024	Limited	High	Objective 2: Job plans accurately reflect both the individual and organisation activity requirements and are completed in a timely manner.	<p><b>6.2 Directorate/Specialty objectives are explicit</b></p> <p>There is a generic statement within the Service Outcomes section of job plans "To ensure service and jobplan aligned to deliver CPG and wider BCU Strategic direction", (sic). The Service Outcomes section overall was either incomplete or noted "During job plan discussions need to review this".</p> <p>From our review, we are unclear how management are approving job plans without expected service objectives.</p> <p>We note different approaches taken in agreeing team objectives where colleagues collectively agree on the service requirements and then meet individually as part of the job plan approach to agree individual objectives. These should be SMART and recorded in the system.</p>	6.2 Schedule regular reviews of job planning practices to ensure continuous improvement and compliance with audit standards.	Sreeman Andole, Interim Executive Medical Director	Sreeman Andole, Interim Executive Medical Director; Jason Brannan, Deputy Director of People	30/04/2025			Newly added to tracker
1444	Internal Audit	Consultant Job Planning	2024	Limited	High	Objective 4: Completed job plans reconcile to system records and session payments are correct.	<p><b>8. Regular review of payments to agreed job plan commitments</b></p> <p>We identified six (27%) of the twenty-two job plans with a variance between the sessions paid and that recorded on the job plan.</p> <p>We also found a variance in Intensity Band payments and are unclear whether these payments are subject to annual review or simply roll-over.</p> <p>The payment of only whole sessions could adversely impact the Health Board to deliver against its waiting lists as this does not always</p>	8. Medical Dental and Elements report from ESR (under development) will be able to flag up issues with sessional pay, intensity bandings.	Jason Brannan, Deputy Director of People	Sreeman Andole, Interim Executive Medical Director; Jason Brannan, Deputy Director of People	30/04/2025		The M&D Dashboard has been developed. OMD have requested the Dashboard to be amended to include service in months to assist with new starter compliance. The Dashboard will require review, engagement with Directorate/Divisions and formal sign off.	
1445	Internal Audit	Consultant Job Planning	2024	Limited	Medium	Objective 4: Completed job plans reconcile to system records and session payments are correct.	<p><b>9. Additional sessions undertaken outside of the substantive post</b></p> <p>We found instances where some Consultants are undertaking additional sessional work for the Health Board, but these are not fully reflected/declared within their substantive job plan – This could lead to a Working Time Directive breach.</p>	9. IHC/Divisions need to have detailed meetings with Consultants to breakdown the job plan, to identify what sessions are additional and justification of still being required to be completed.	Sreeman Andole, Interim Executive Medical Director	Sreeman Andole, Interim Executive Medical Director; Jason Brannan, Deputy Director of People	30/09/2025		Newly added to tracker	
1501	Internal Audit	Establishment Control	2025	Limited	High	Objective 3: ESR staff in post figures are accurate and subject to regular validation.	<p><b>5. Data discrepancies – ESR and Ledger Funded posts on the General Ledger should match the information of the establishment (position WTE) for all posts on ESR.</b></p> <p>Through testing the data provided by Finance Business Systems and People and OD we have identified through data matching a variance of 391.84 WTE where the ESR position establishment WTE is higher than the actual funded WTE in the</p>	5. Finance will review the process for negative budgets with Chief Finance Officers and IHC Directors to ensure a consistent approach is utilised and applied to aid matching information in ESR and the Ledger.	Nick Graham, Associate Director - Workforce Optimisation; Joanna Garrigan Finance Director - Commissioning and Strategy	Russell Caldicott, Executive Director of Finance	31/03/2025		Newly added to tracker	
1513	Internal Audit	Transformation & Improvement	2025	Limited	High	Objective 3: Progress and achievements are reported through to the Health Board via its Committees / Groups to provide assurance.	<p><b>3. Assurance reporting</b></p> <p>We have been unable to determine the Transformation and Improvement team are subject to effective oversight or scrutiny through their reporting via the Health Board's governance structure, concerning areas they are supporting or accountable for through to whether changes made in transformation have made a difference.</p>	Agree schedule of regular oversight reporting to the Executive Committee through to the appropriate Board Sub Committee	Paolo Tardivel, Interim Executive Director of Transformation and Strategic Planning	Paolo Tardivel, Interim Executive Director of Transformation and Strategic Planning	30/04/2025		Newly added to tracker	

**INTERNAL AUDIT RECOMMENDATIONS FOR AUDIT COMMITTEE CLOSURE CONSIDERATION**

ID	Report Title	Year	Assurance Level	Priority	Recommendation Title	Recommendation	Management Response	Action Owner	Final Approver	Original implementation date	Revised implementation date	Number of Revisions	Last update	Evidence to support closure of recommendations outside Internal Audit review scope	Approvals to date, and action required
057	Quality Improvement Strategy	2020	Limited	High	Reporting progress of Quality Improvement Strategy (QIS)	For the planned publication and launch of a new QIS for 2020 onwards, management should ensure the QIS: is underpinned by a clear and concise implementation plan that records what actions/tasks are expected, by when and how success will be measured. Regular reports of progress should include clear performance and delivery per the implementation plan.	The planning of the new QIS is in progress currently and has built in a clear, concise and robust implementation plan with clear identified milestones, that will highlight progress against the clear aims of the QIS and its implementation. The new QIS will have clear mechanism for regular monitoring of progress/reporting against the aims of the QIS and the QIS implementation plan as agreed by QSE.	Matthew Joyce, Deputy Director of Quality	Angela Wood, Executive Director of Nursing and Midwifery	01/08/2020	31/03/2024	12	During 2024-25, the Health Board will complete the redesign of an appropriate Quality Management System (QMS) for deployment across the organisation. The Health Board will apply the emerging QMS to arising quality improvement initiatives, so that they follow a whole system QMS ethos, and to also learn so that the overall QMS deployment is successful. During 2025-27 the Health Board will continually review and monitor the impact of the QMS iterating it as appropriate to ensure it meets the objectives laid out within the Duty of Quality. Due to this, this action can be closed. Screenshots provided as evidence for closure		Approved for closure by: • Executive Director • Executive Team • reviewed and approved for closure by Internal Audit  Now needs final endorsement of closure by Audit Committee.
249	Recruitment of Substantive and Interim Executive and Senior Posts (ESP)	2023	Limited	High	Matter Arising 3: Remuneration & Terms of Service Committee – Reports for assurance (Design)	3.1: Management must ensure Committee Members are appropriately involved in determining the information they require for assurance and subsequent reporting/providing advice to the Full Board. As a minimum, any report to be submitted to the RATS Committee in relation to the appointment of an interim must incorporate assurance on compliance on key matters of control in Standing Orders, Standing Financial Instructions and Welsh Government instructions.	3.1: R&TS committee Terms of Reference is being updated and will be ratified in May 2023. The R&TS committee will define the required parameters of the reporting structure and make it's recommendations to board. 3.2 A new reporting template for R&TS and the Executive Management Team will be implemented, to incorporate all JESP/VSM appointments, both interim and substantive, and whether the appointments are compliant with standing orders, SFIs and WG instructions. In addition, the report will include details of permanent recruitment timeframes when a post has been filled by an interim.	Ali Mirza, Head of Strategic Recruitment	Jason Brannan, Deputy Director of People	30/09/2023		0	The REMCOM terms of reference were approved, and have been provided as evidence. The senior interim report that was agreed in September 2023 will be provided to every meeting (bi-monthly) until further notice.		Approved for closure by: • Executive Director • Executive Team • reviewed and approved for closure by Internal Audit  Now needs final endorsement of closure by Audit Committee.
252	Risk Management and Board Assurance Framework	2023	Limited	High	Matter Arising 3: Board Assurance Framework (Operation)	3.1: The process for reviewing and updating the BAF should be documented and implemented. 3.2: The BAF should be updated when objectives of the Health Board are agreed, to ensure focused actions. 3.3: The sections of the BAF should be fully completed. 3.4: The level of detail in action plans should be reviewed to ensure there is sufficient information included to provide assurance to members that appropriate actions are in place to address risks identified.	3.1: Document the process for reviewing and updating the BAF with implementation date. 3.2: Ensure objectives of the Health Board is incorporated into the BAF with focused actions. 3.3: It is paramount that all sections of the BAF be completed for robust scrutiny and assurance. (see action 3.4 below). 3.4: Review the action plans to ensure sufficient information is included in the BAF with appropriate actions.	Nesta Collingridge, Head of Risk Management	Pam Wenger, Director of Corporate Governance	30/08/2023	31/03/2024	2	The process for reviewing and updating the BAF will be evidenced in the May 2024 Audit Committee with new Strategic Objectives approved by the Board in March 2024. It is proposed that this can be closed as the BAF has been reported under the only available "currency" before this which were strategic deliverables. A copy of the 'Board Assurance Framework Report' to the Risk Management Group on 09/04/2024 is attached to support closure.		Approved for closure by: • Executive Director • Executive Team • reviewed and approved for closure by Internal Audit  Now needs final endorsement of closure by Audit Committee.
254	Risk Management and Board Assurance Framework	2023	Limited	High	Matter Arising 5: Oversight and scrutiny of Divisions / IHCs (Operation)	5.1 Review of all meetings attended across the three areas by the Risk Management Department is required. This will give a better understanding of what meetings are taking place as well as providing a more consistent and robust approach towards the Divisions/IHCs risk management arrangements. 5.2: Clarification required on how the West IHC will provide assurance on its risk management arrangements without a IHC meetings Risk Management Group meeting taking place.	5.1: At the Risk Team Meeting, Regional Managers were asked to produce an excel spreadsheet of meetings which review and scrutinise risks for the rest of the year. Any cancellation of meetings and reasons why to be fed back during the Risk Team with repeat assurance on its risk management arrangements without the Risk Management Group meeting taking place. Meeting arranged with IHC Medical Director, Interim Head of Risk Management and Regional Manager West on the 1st June 2023 for further discussion and action (additional IA comments to the Management Response - Actions will need to be reviewed following the outcome of the meeting on 1st June 2023).	Nesta Collingridge, Head of Risk Management	Phil Meakin, Associate Director of Governance	30/08/2023	28/02/2024	3	All meetings have been mapped by the team and signed off by the Head of Risk Management before closing. Additional evidence in the form of Risk Meeting tracker provided to support closure.		Approved for closure by: • Executive Director • Executive Team • reviewed and approved for closure by Internal Audit  Now needs final endorsement of closure by Audit Committee.
268	Performance Management – Quality and Performance Reporting and Accountability Arrangements	2023	Limited	High	Matter Arising 3: Accountability meetings (Design)	3.1: The Health Board continue with the improvement plan to review and update Performance and Accountability Framework, ensuring meetings are scheduled regularly and the information discussed in performance meetings is captured, with expected outcomes clearly communicated to senior managers.	3.1: Agreed – Interim Director of Performance working closely with Interim CEO to agree/consult on direction of travel. Underway and first draft anticipated Q2, 2023/24.	Edward Williams, Acting Director of Performance	Russell Caldicott, Interim Executive Director of Finance	31/03/2024		0	Executive Delivery Integrated Performance Group now embedded within the HB, reporting throughout and external to HB completed. Additional evidence of Group TORs, action log and minutes provided to support closure.		Approved for closure by: • Executive Director • Executive Team • reviewed and approved for closure by Internal Audit  Now needs final endorsement of closure by Audit Committee.
269	Performance Management – Quality and Performance Reporting and Accountability Arrangements	2023	Limited	High	Matter Arising 3: Accountability meetings (Design)	3.2: Review current action tracker to determine whether actions are still relevant.	3.2: Action tracker to be reviewed for relevance by end of July 2023.	Edward Williams, Acting Director of Performance	Russell Caldicott, Interim Executive Director of Finance	31/07/2023	29/02/2024	1	Accountability meetings now underway. Action to be closed. Monthly Integrated Performance Executive Delivery Group set up chaired by CEO, monthly meetings held every third Wednesday.		Approved for closure by: • Executive Director • Executive Team • reviewed and approved for closure by Internal Audit  Now needs final endorsement of closure by Audit Committee.
270	Performance Management – Quality and Performance Reporting and Accountability Arrangements	2023	Limited	High	Matter Arising 3: Accountability meetings (Design)	3.3: The process for reviewing actions should be revisited, to ensure actions from meetings are SMART, and progress is regularly provided (with reference to further detail in meeting minutes as required)	3.3: This action will be aligned with the revised PAF process for Q2 Reviews, scheduled for Sept 2023.	Edward Williams, Acting Director of Performance	Russell Caldicott, Interim Executive Director of Finance	30/09/2023	30/06/2024	2	Actions are formally logged in an Action Log for each meeting. Updates for these are sought and updated in the Action Log prior to the next meeting, and are signed off for accuracy at the meeting. Copy of action log for the 'IPEDG Integrated Performance Group' is provided as evidence to support closure.		Approved for closure by: • Executive Director • Executive Team • reviewed and approved for closure by Internal Audit  Now needs final endorsement of closure by Audit Committee.
273	Hergest Unit Notice of Contravention (NoC) Action Plan	2023	Limited	High	Matter Arising 1: Action Plan evidence (Operating)	1.1: The action plan evidence is reviewed immediately and updated to demonstrate all actions are embedded both at Hergest, with wider assurance to the Health Board on practice across the Division	1.1: The Notice of Contravention (NoC) Group will continue until just after the revised Court hearing (postponed from 03.08.2023) and will take forward the findings of this internal audit to direct further work and provide further evidence, as well as ongoing monitoring arrangements and intervention where recovery actions are required. Post-hearing, the NoC Action Plan (and Group) will be transferred to the Special Measures NCCU Action Plan and associated leadership/assurance arrangements to ensure alignment with the inpatient quality and safety programme, the special measures programme and to ensure ongoing sustainability of the actions.  A working group led by the Deputy Executive Director of Nursing will meet monthly for the next three months, culminating at the end of October 2023, to peer review, scrutinise and challenge the additional work and further evidence as a means of providing assurance to the HSE prosecution task force led by the Executive Director of Nursing and Midwifery (who commissioned the internal audit) in relation to improvements following the internal audit findings and closure of the NoC plan and transfer to the NCCU action plan.	Jain Wilkie, Interim Director MHL	Teresa Owen, Health Board Lead for MHL and Welsh Language	31/10/2023	31/01/2024	1	The HSE NoC court hearing occurred on 18th December 2023. The outcome of the court case was a fine of £200,000 with £13,000 court costs. As agreed by Divisional, Corporate and Welsh Government the NoC Action plan has been transferred to the National Collaborative Commissioning Unit (NCCU) Action plan with the associated leadership, governance and assurance arrangements in place to ensure the Division continues on their improvement journey. The NCCU Inpatient Safety Delivery Group continue to meet fortnightly to progress the actions of the NCCU Action plan aligned to the eight recommendations made from the NCCU and NHS Executive Inpatient review undertaken during May 2023. A MH&LD Update report on progress of the action plan has been submitted through due Governance and submitted to the NCCU and NHS Executive, who are due to undertake a Follow Up Review during February 2024. The overall aim of the Follow Up Review will be to observe and evidence where improvements have been made and sustained and outstanding actions have been completed or are progressing towards completion. Action to be marked as complete		Approved for closure by: • Executive Director • Executive Team • reviewed and approved for closure by Internal Audit  Now needs final endorsement of closure by Audit Committee.

275	Accounts Receivable	2023	Reasonable pre 01/10/2024	High	Matter Arising 1: Cash Deficit / Surplus (Design)	1.1 The Health Board should ensure that any discrepancies between money banked and payments receipts be fully investigated and formally reported to establish reasons and prevent further occurrences.	1.1: The discrepancies identified between receipts and bankings have all now been confirmed as being timing differences, which were subsequently banked in all cases. Timing differences arise when cash is taken late in the day and therefore can only practically be banked the following day. Prompt action has been taken to meet with the Catering Manager in Denbigh and Ruthin where the audit findings were discussed and immediate changes to their banking processes have been enacted which will ensure any discrepancies arising from timing differences are explicitly followed through and secure banking confirmed as a matter of routine. Initial meetings have also been held with the Manager and Assistant Manager of YGC Catering, and we are now setting up more robust processes relating to the 'Midnight Till' and where cash is held over before being transferred to General Office. Turnover of cash is reducing due to the fact that card machines are now in the majority of our Community Hospitals. The General Office Manger continues to remind staff of the procedures to follow and actively provides re-fresh training to staff. A planned half-day targeted session with all Community Hospital General Offices is taking place in October, and this will be a further opportunity to reiterate the requirements set out in our procedures and to respond to any practical queries that they may have and to look at best practice.	Ronnie Bright, General Office Manager	Russell Caldicott, Interim Executive Director of Finance	17/08/2023		0	Further evidence to support closure provided.		Approved for closure by: • Executive Director • Executive Team • reviewed and approved for closure by Internal Audit  Now needs final endorsement of closure by Audit Committee.
280	Clinical Audit – Tier 1 National Audits	2023	Limited	High	Matter Arising 4: Progress reporting of Tier 1 audits (Operation)	4.1: The Health Board must ensure appropriate meetings within the governance structure take place as required and include clinical audit as an agenda point to allow adequate review and scrutiny of the issues affecting the Tier 1 process.	4.1: The quarterly reports that are produced from Clinical Audit Team capture which audits have been published in relevant quarter and includes all BCU identifiable data – plus process and completed actions and outstanding issues. These are followed up by Clinical Audit Facilitator at local CEGs. We have recently set up an Audit /NICE monthly meeting and we would capture any areas of concern that need taking to Strategic CEG to close the loop. A cycle of business (COB) has been developed to ensure relevant papers go to appropriate meetings.	Joanne Shillingford, Head of Clinical Effectiveness	Nick Lyons, Executive Medical Director	31/03/2024		0	In Clinical Effectiveness Department, we ensure through our processes that we monitor and review any issues effecting the Tier 1 process. These are raised with local Clinical Effectiveness Groups to be aware and discussed how to manage. If failure to address these issues is not met then they will be escalated to Strategic Clinical Effectiveness Group, to discuss and if cannot be addressed would be raised in Chairs Report to Quality Delivery Group for decision making. Clinical Audit Facilitator at local CEGs. Our new process is to share on a monthly basis to all IHCs and Divisions an update of current situation with Tier 1, Tier 2 and NICE Compliance in the process and this is shared with Head of Clinical Effectiveness and Deputy Executive Medical Director. Within our CE team we have set up a monthly Audit /NICE monthly meeting and where we discuss areas of concern that need taking to Strategic CEG to close the loop. A cycle of business has been developed to ensure relevant papers go to appropriate meetings. Additional evidence to support closure provided.		Approved for closure by: • Executive Director • Executive Team • reviewed and approved for closure by Internal Audit  Now needs final endorsement of closure by Audit Committee.
290	Falls Management	2023	Limited	Medium pre 01/10/2024	Matter Arising 1: Policy (Design)	1.1a: The Policy requires review to ensure staff are provided with up to date requirements and guidance relating to falls. We understand this process is currently underway.	1.1a: Policy NU06 The Prevention and Management of Adult Inpatient Falls will be: Review/consultation by Health Board Inpatient Falls Steering group	Chris Lynes, Deputy Executive Director of Nursing	Angela Wood, Executive Director of Nursing and Midwifery	30/11/2023		0	Complete - Policy NU06 ratified by BCUHB Patient Safety Group. Policy disseminated via Nurse Directors and uploaded to BetsiNet. Copy of policy provided as evidence to support closure.		Approved for closure by: • Executive Director • Executive Team • reviewed and approved for closure by Internal Audit  Now needs final endorsement of closure by Audit Committee.
291	Falls Management	2023	Limited	Medium pre 01/10/2024	Matter Arising 1: Policy (Design)	1.1a: The Policy requires review to ensure staff are provided with up to date requirements and guidance relating to falls. We understand this process is currently underway.	1.1a: Policy NU06 The Prevention and Management of Adult Inpatient Falls will be: Approval required by the Health Board Patient Safety Group	Chris Lynes, Deputy Executive Director of Nursing	Angela Wood, Executive Director of Nursing and Midwifery	30/11/2023		0	Complete - Policy NU06 ratified by BCUHB Patient Safety Group. Policy disseminated via Nurse Directors and uploaded to BetsiNet. Copy of policy provided as evidence to support closure.		Approved for closure by: • Executive Director • Executive Team • reviewed and approved for closure by Internal Audit  Now needs final endorsement of closure by Audit Committee.
292	Falls Management	2023	Limited	Medium pre 01/10/2024	Matter Arising 1: Policy (Design)	1.1a: The Policy requires review to ensure staff are provided with up to date requirements and guidance relating to falls. We understand this process is currently underway.	1.1a: Policy NU06 The Prevention and Management of Adult Inpatient Falls will be: Health Board Clinical and Written Documents policy process for uploading, communication and replacing of the current version on BetsiNet.	Chris Lynes, Deputy Executive Director of Nursing	Angela Wood, Executive Director of Nursing and Midwifery	31/12/2023		0	Complete - Policy NU06 ratified by BCUHB Patient Safety Group. Policy disseminated via Nurse Directors and uploaded to BetsiNet. Copy of policy provided as evidence to support closure.		Approved for closure by: • Executive Director • Executive Team • reviewed and approved for closure by Internal Audit  Now needs final endorsement of closure by Audit Committee.
293	Falls Management	2023	Limited	High	Matter Arising 2: All Wales Falls and Bone Health Multifactorial Assessment (FBHMA) (Operation)	2.1a: Staff should be reminded, through training, of the requirement to ensure the FBHMA and documentation pertaining to patient falls, provides sufficient information to fully understand the patients needs and requirements to minimise the risk of a potential fall. Compliance with this should be reviewed through existing audit mechanisms.	2.1a: Health Board mandatory training Falls Prevention E learning module 1b relating to the FBHMA has been updated.	Chris Lynes, Deputy Executive Director of Nursing	Angela Wood, Executive Director of Nursing and Midwifery	31/08/2023		0	Good practice examples shared pan BCUHB alongside ongoing peer review process. In addition, as of January/February 2024 many staff will be required to update their Mandatory Training (which will be via the updated modules). IHC Leads will provide ongoing assurance of local Mandatory Training levels via the monthly Falls Steering Group.		Approved for closure by: • Executive Director • Executive Team • reviewed and approved for closure by Internal Audit  Now needs final endorsement of closure by Audit Committee.
294	Falls Management	2023	Limited	High	Matter Arising 2: All Wales Falls and Bone Health Multifactorial Assessment (FBHMA) (Operation)	2.1a: Staff should be reminded, through training, of the requirement to ensure the FBHMA and documentation pertaining to patient falls, provides sufficient information to fully understand the patients needs and requirements to minimise the risk of a potential fall. Compliance with this should be reviewed through existing audit mechanisms.	2.1a: How to guide/good practice guide to support Adult Inpatient with completion and quality of FBHMA to be developed and implemented across all Adult Inpatient wards;	Chris Lynes, Deputy Executive Director of Nursing	Angela Wood, Executive Director of Nursing and Midwifery	30/11/2023		0	How to guide shared across all IHCs. Evidence relating to Falls Programme provided to support closure.		Approved for closure by: • Executive Director • Executive Team • reviewed and approved for closure by Internal Audit  Now needs final endorsement of closure by Audit Committee.
295	Falls Management	2023	Limited	High	Matter Arising 2: All Wales Falls and Bone Health Multifactorial Assessment (FBHMA) (Operation)	2.1a: Staff should be reminded, through training, of the requirement to ensure the FBHMA and documentation pertaining to patient falls, provides sufficient information to fully understand the patients needs and requirements to minimise the risk of a potential fall. Compliance with this should be reviewed through existing audit mechanisms.	2.1a: In addition to the established Health Board monitoring mechanisms, an additional level of monitoring/coaching to improve the quality of the risk assessments will be implemented across the Adult Inpatient wards, this will be a peer review process completed by suitably trained registrant. This will be a pilot of 3 months, evaluate outcomes and present recommendation to the Strategic inpatient falls Group for sustainable model.	Chris Lynes, Deputy Executive Director of Nursing	Angela Wood, Executive Director of Nursing and Midwifery	01/02/2024		0	Complete: How to guide with peer review process shared across all IHC's evidence of peer review process via metrics and IHC reporting template. How to guide developed for Agency worker shared with temporary staffing. In addition Accreditation team are delivering training to Student Nurses within both Universities regarding FBHMA and Patient Handling Risk Assessments. To date over 150 Students Nurses have completed training session. Evidence relating to Falls Programme provided to support closure.		Approved for closure by: • Executive Director • Executive Team • reviewed and approved for closure by Internal Audit  Now needs final endorsement of closure by Audit Committee.
297	Falls Management	2023	Limited	High	Matter Arising 2: All Wales Falls and Bone Health Multifactorial Assessment (FBHMA) (Operation)	2.1c Reminder to staff that all FBHMAs are to be completed upon patient transfer between wards. Compliance with this should be reviewed through existing audit mechanisms.	2.1c: Training resources outlined 2.1a: will include the re enforcement of when the FBHMA requires review and updating in line with national standard. The B6 Clinical MH Advisors now lead the patient risk assessment bedside learning programme (for falls and patient handling risk assessments) for the H&S team.	Chris Lynes, Deputy Executive Director of Nursing	Angela Wood, Executive Director of Nursing and Midwifery	30/10/2023		0	New Welsh Nursing Care Record upgrade flags on transfer to ward to complete Risk Assessments. A reminder to complete is also included in the training. The monitoring of compliance as stated is continually monitored and reviewed via existing ward metrics and now also with the peer reviews.		Approved for closure by: • Executive Director • Executive Team • reviewed and approved for closure by Internal Audit  Now needs final endorsement of closure by Audit Committee.

301	Falls Management	2023	Limited	High	Matter Arising 3: Training (Operation and Design)	3.1d Determine what training agency staff receive relating to patient falls and whether it is in line with training that the Health Board staff undertake and sufficient to ensure effective completion of falls documentation.	3.1d: Falls lead to include Safeguarding matrix within the revised Falls Policy NU06 to support staff as to when to refer/engage Safeguarding following recurrent falls. Bedside learning programme to be recommended as a formal programme of training that will be implemented collaboratively with IHC Practice Development Nurses, Corporate Patient Safety team and Health and Safety team.	Clair Tipton, Head of Digital Workforce and Resourcing	Angela Wood, Executive Director of Nursing and Midwifery	01/12/2023		0	Following the HSE report, a process has been implemented where agencies are able to request accounts for learning@wales for their workers who are active in BCUHB to enable them to complete Falls modules on this platform. However, we do not on-board any workers, and have not since October, without some form of falls training having been completed via the Agency and we advocate once on-boarded they must completed the falls modules via learning@wales platform. Some agencies have reported a backlog in their workers receiving their login information and we are following this up with the team. Evidence to support closure provided.	Approved for closure by: • Executive Director • Executive Team • reviewed and approved for closure by Internal Audit  Now needs final endorsement of closure by Audit Committee.	
302	Falls Management	2023	Limited	High	Matter Arising 3: Training (Operation and Design)	3.1d Determine what training agency staff receive relating to patient falls and whether it is in line with training that the Health Board staff undertake and sufficient to ensure effective completion of falls documentation.	3.1d: Scope of what training agency staff (58 external agencies part of the All Wales Framework) receive relating to patient falls and whether it is in line with training that the Health Board staff undertake and sufficient to ensure effective completion of falls documentation. - Temporary Staffing team for the Health Board to ensure the agencies have access to the Health Board e learning packages and are encouraged to complete; - the Health Board are amending and implementing the agency worker ward induction documentation to include familiarisation with risk assessments.	Clair Tipton, Head of Digital Workforce and Resourcing	Angela Wood, Executive Director of Nursing and Midwifery			0	Monthly report now to be submitted to ward accreditation lead nurse to inform on falls training for agency workers. Additional evidence to support closure provided.	Approved for closure by: • Executive Director • Executive Team • reviewed and approved for closure by Internal Audit  Now needs final endorsement of closure by Audit Committee.	
303	Falls Management	2023	Limited	High	Matter Arising 4: Governance (Operation)	4.1a: The development of a standardised strategy that routinely identifies themes, trends, and lessons learned could enhance health boards' response to patient falls.	4.1a: The revised Health Board policy NU06 outlines the following process for inpatient falls to support identification of themes, trends and learning as follows: - Hot debrief on the ward following the fall for immediate learning and mitigation; - All falls are reviewed daily by local quality teams; - All falls are subject to focused review contained within Datix system; - All falls identified as harm being Moderate or above will have a Make it safe review within 72 hrs; - All falls identified as serious harm will have an executive led Rapid Learning Panel (RLP) which may then lead to an external investigation to identify potential additional learning opportunities. - The Health Board will communicate the revised policy NU06 via Health Board communication channels in addition core Health Board meetings.	Chris Lynes, Deputy Executive Director of Nursing	Angela Wood, Executive Director of Nursing and Midwifery	01/12/2023		0	Policy NU06 ratified by BCUHB Patient Safety Group. Policy disseminated via Nurse Directors and uploaded to BetsiNet. This action can be closed as copy of 'NU06 -The Prevention and Management of Adult In-Patient Falls Policy - V5.0' provided as additional evidence.	Approved for closure by: • Executive Director • Executive Team • reviewed and approved for closure by Internal Audit  Now needs final endorsement of closure by Audit Committee.	
306	Falls Management	2023	Limited	High	Matter Arising 4: Governance (Operation)	4.1b: Lessons learned information included in Datix should be reviewed regularly to ensure learning is communicated/reported as appropriate, and to deter staff entering a full stop or a dash in the section.	4.1b: Action 3 - The Health Board Patient Safety team will provide training and support to clinical teams to include best practice, lessons learned etc due to commence November 2023 and will be an ongoing programme of training and support across the Health Board.	Chris Lynes, Deputy Executive Director of Nursing	Angela Wood, Executive Director of Nursing and Midwifery	20/11/2023		0	Weekly dates are arranged up until end of March 2024 and include face to face and virtual sessions. Further dates will be commissioned. Training advertised on BetsiNet, Nursing newsletter and disseminated to governance leads. Evidence of training posters provided to support closure	Approved for closure by: • Executive Director • Executive Team • reviewed and approved for closure by Internal Audit  Now needs final endorsement of closure by Audit Committee.	
321	Lessons Learnt	2023	Limited	High	Matter Arising 1: Lessons Learnt (Design)	1.2a: Management to ensure all relevant fields within Datix are completed appropriately prior to closing the incident.	1.2a: Lessons have been learned from the initial implementation of the Once for Wales Datix System whereby handlers of incidents were able to close incidents without completing all mandatory fields – this is being changed forcing completion of the mandatory fields.	Sarah Musgrave, Lead Manager - Learning	Angela Wood, Executive Director of Nursing and Midwifery	29/02/2024		0	This action can be closed as the fields have been made mandatory, and therefore must be updated prior to closing a record. Additional evidence provided to support closure.	Approved for closure by: • Executive Director • Executive Team • reviewed and approved for closure by Internal Audit  Now needs final endorsement of closure by Audit Committee.	
322	Lessons Learnt	2023	Limited	High	Matter Arising 1: Lessons Learnt (Design)	1.2b: Management to ensure all relevant fields within Datix are completed appropriately prior to closing the incident.	1.2b: The ability for incident managers to by-pass steps in the incidents process within the system has also been identified. This issue will be fed back into the national team for development and where this is identified, then education and training will be offered to services/individuals.	Tracey Radcliffe, Head of Patient Safety	Angela Wood, Executive Director of Nursing and Midwifery	29/02/2024		0	This action can be closed as the fields have been made mandatory, and therefore must be updated prior to closing a record. Additional evidence provided to support closure.	Approved for closure by: • Executive Director • Executive Team • reviewed and approved for closure by Internal Audit  Now needs final endorsement of closure by Audit Committee.	
323	Lessons Learnt	2023	Limited	High	Matter Arising 1: Lessons Learnt (Design)	1.2c: Management to ensure all relevant fields within Datix are completed appropriately prior to closing the incident.	1.2c: A regular audit has started and is ongoing providing services with information on where managers are not completing the process.	Tracey Radcliffe, Head of Patient Safety	Angela Wood, Executive Director of Nursing and Midwifery	29/02/2024		0	Incidents that have been closed in the previous 24 hours are reviewed by the Patient Safety Team to identify any incomplete fields and if required are reopened with feedback back to the incident manager. Evidence to support closure provided - daily/weekly report identifying gaps. Also included is a copy of communication sent to individual responsible for closing, with incident moved back to 'awaiting closure'.	Approved for closure by: • Executive Director • Executive Team • reviewed and approved for closure by Internal Audit  Now needs final endorsement of closure by Audit Committee.	
328	Lessons Learnt	2023	Limited	High	Matter Arising 2: Make it Safe (Plus) (Design)	2.2: Management to ensure all Make it Safe (Plus) reviews are documented and recorded appropriately i.e. through regular audit / review.	2.2: The Patient Safety Team (PST) review and report on completion of MIS Plus and timescales. This information is shared with services. The PST will undertake a weekly audit/review to provide assurance that reviews are documented and recorded appropriately.	Tracey Radcliffe, Head of Patient Safety	Angela Wood, Executive Director of Nursing and Midwifery	31/03/2024		0	Monthly audits of MIS+ are being completed as part of the Patient Safety Team (PST) audit cycle, and a copy is included as additional evidence to support closure. In regards to incidents being closed with no management review within Datix, the PST consistently report these back to services, noting those areas where a high incidence of this action is recurring. In March/April 2024 this number has been n= 88 and n = 95 and the majority of those closed without Management Review are in the 'none' and 'low' severity range. Reinforcement of how to complete the fields correctly and the rationale for doing so is now included in incident management training delivered by the PST. NB: The practice of uploading notes to Datix rather than completing the Datix fields may affect the audit figures, correction of this practice is being directed through PST.	Approved for closure by: • Executive Director • Executive Team • reviewed and approved for closure by Internal Audit  Now needs final endorsement of closure by Audit Committee.	
330	Adult and Older Persons Mental Health Unit	2023	Reasonable pre 01/10/2024	Low	Matter Arising 2: PEP Sign - Off (Operation)	2.1 The Project Execution Plan (PEP) should be formally approved by the Project Board at the earliest opportunity	2.1 Project Execution Plan (PEP) added to the Adult and Older Persons Mental Health Unit (A&OPMHU) agenda for 28/11/23 for sign off.	Jill Timmins, Programme Director for the AOPMHU Redevelopment	Teresa Owen, Health Board Lead for MHL and Welsh Language	28/11/2023			Project Execution Plan (PEP) was signed off at project board on 28/11/2023.	Copy of PEP and minutes of Project Board dated 28/11/2023, where the PEP was approved provided as evidence for closure.	Approved for closure by: • Executive Director • Executive Team  but not within IA review scope.  Needs closure approval by Audit Committee.
331	Adult and Older Persons Mental Health Unit	2023	Reasonable pre 01/10/2024	Medium pre 01/10/2024	Matter Arising 3: Risk Register (Operation)	3.1 The costed version of the Risk Register should be shared regularly with the Project Board.	3.1 The Cost Advisors will provide a costed risk register in advance of the business case submission for scrutiny by the Project Board.	Jill Timmins, Programme Director for the AOPMHU Redevelopment	Teresa Owen, Health Board Lead for MHL and Welsh Language	31/01/2024	30/06/2024	2	The Project Board receives regular updates. The next Programme Board is in July 2024.	Copy of AOPMH Unit Costed Risk Register provided as evidence	Approved for closure by: • Executive Director • Executive Team  but not within IA review scope.  Needs closure approval by Audit Committee.
342	Water Safety	2024	Limited	Medium pre 01/10/2024	Matter Arising 4: Risk management (Operation)	4.2: Management to review risk assessments per the Water Safety Plan requirements to ensure continued relevance.	4.2: Risk Assessment monitoring spreadsheet has been developed and are being implemented within Operational Estates. The spreadsheet will have details of future review dates of assessments. The monitoring spreadsheet will be presented at future Water Safety Groups to ensure oversight and governance.	Arwel Hughes, Head of Operational Estates	Russell Caldicott, Interim Executive Director of Finance	01/03/2024		0	Risk Assessment monitoring spreadsheet now in use within Operational Estates. Spreadsheets presented at the Water Safety Group meeting on 10/04/2024. Information already received by the chair of the meeting. Risk Assessment Monitoring Tools for East, Centre and West attached as evidence to support closure.	Approved for closure by: • Executive Director • Executive Team • reviewed and approved for closure by Internal Audit  Now needs final endorsement of closure by Audit Committee.	

486	CITO Programme	2024	Substantial	Medium pre 01/10/2024	Matter Arising 1: Resource (Operation)	1.1: The Health Board should decide whether it intends to move forward with the whole programme as set out in the PID. If so then resource should be made available, and if not the programme should be formally rescope to only include the delivered / ongoing phases.	1.1: DDaT are in the process of developing proposals including an Electronic Health Record Outline Business Case to include scanning of records and an Optimisation Programme that will look at legacy systems. These will supersede existing plans in these areas within the Cito Programme. Cito Programme Board has recently approved the commencement of a Digital Casenote Options Appraisal, to be completed by June 2024. Recommendations from this will inform decisions to be taken by the Clinical Effectiveness Group and Patient Safety Quality Group in relation to Cito, epro and WCP. Following which a revised PID will be produced to formally reflect any adjustments and provide clarity in relation to the resources available for each phase.	Sarah Watkins-Lennon, Interim Cito Programme Manager & Cito Project Manager	Dylan Roberts, Chief Digital and Information Officer	31/12/2024			Further meeting took place with the Clinical leads on 07/08/2024 presenting the recommendation on the optimisation of the 4 clinical system, Cito/Epro/WCP and EPOC (please see attached). The outcome of this meeting included the future use of WCP as the main clinical system and all process should be tried and tested within WCP before utilising any other local system. It was agreed that CITO would be used as an Electronica Document Management System (EDRMS) and further work is needed to establish how eForms should be created and stored. It recommended that work be undertaken to establish the route to decommission EPOC and establish the correct applications to replace the functionality. It was recommended and agreed that EPRO will be used as a Digital Dictation system only in accordance with the current license agreement. It was also agreed that a full audit be undertaken on the system to understand the extent of use beyond the current agreement. It was agreed that the resources for this work will be the current CITO Programme team.	Copy of Casenote Statement of Direction presentation provided as evidence for closure	Approved for closure by: • Executive Director • Executive Team  but not within IA review scope.  Needs closure approval by Audit Committee.
497	Effective Governance – Women’s Directorate	2024	Reasonable pre 01/10/2024	Medium pre 01/10/2024	Matter Arising 1: Governance arrangements (Operation)	1.1: Working with the Corporate Governance Directorate, review the governance arrangements within the Directorate, ensuring Terms of Reference are reviewed and updated. All Directorate meetings below Tier 2 should be reviewed, with the purpose of meetings and assurance flows through to the Senior Leadership Team clearly defined. Terms of Reference for the Women’s North Wales Service Board is reviewed and clarity on its accountability and purpose are clearly defined	1.1: Terms of Reference for all Tier 1 and Tier 2 Governance meetings within the Women’s Directorate will be reviewed with support from the Corporate Governance Team to ensure that assurance flows to the Senior Leadership Team is clearly defined in all	Faye Pritchard, Business and Performance Manager, Womens Services	Angela Wood, Executive Director of Nursing and Midwifery	30/05/2024	31/12/2024	1	Following review by Pam Wenger (Director of Corporate Governance) the Women’s Service Senior Leadership Team Terms of Reference were updated to ensure that the purpose of meetings and assurance flows through to the Senior Leadership Team are clearly defined. They were approved by the Women’s Service Board on 23rd August 2024. The following Womens Services meetings sit at Tier 2 that will now follow the review process of the Terms of Reference: - Womens Transformation Group (SDG) - Quarterly - Womens Quality, Safety and Experience Group (SDG) (inc H&S) - Monthly - Womens Integrated Performance Group (SDG) - Monthly - Womens People and Culture Group (SDG) - Monthly	Women’s Services Operating Governance Structure document and Womens’ Senior Leadership Team TORs provided as evidence	Approved for closure by: • Executive Director • Executive Team  but not within IA review scope.  Needs closure approval by Audit Committee.
501	Effective Governance – Women’s Directorate	2024	Reasonable pre 01/10/2024	High	Matter Arising 4: Concerns, Complaints, Incidents et al (Operation)	4.1b: The Director of Midwifery and Women’s Services: • Ensures the Directorate responds to all complaints according to expected reporting timelines and all learning is shared across the Directorate. • Reviews the reasons why Celyn Ward, Ysbyty Glan Clwyd is an outlier with complaints and takes steps to address the issues raised. • Ensures the reporting of all concerns, complaints, incidents et al is reported and scrutinised in accordance with the Directorate’s governance structure.	4.1b: The Directorate will review the total number of concerns relating to Celyn Ward, to assess if this particular area of the service is an outlier and take steps to address any themes or trends. The findings and recommendations of this review will be shared with and monitored by the Women’s SLT. A report will also be provided to QEDG as part of the Directorate’s monthly reporting cycle. The Directorate will ensure that all concerns and incidents are reported and scrutinised in accordance with the Women’s Governance Structure and that learning is shared across the Directorate in all relevant meetings and in the monthly Governance Newsletter.	Liz Davies, General Manager and Business Lead	Imran Devji, Interim Chief Operating Officer	30/06/2024	30/09/2024	1	The first North Wales Postnatal Forum meeting took place on 23rd September 2024. The Terms of Reference were approved at the meeting. There is a section on the agenda for service user feedback. Civica data was reviewed in the September meeting. The forum will be responsible for advising and communicating on any governance risks or resource implications that impact on the provision of high quality postnatal care. COO content to proposed for closure.	Copy of North Wales Postnatal Forum meeting agenda provided as evidence.	Approved for closure by: • Executive Director • Executive Team  but not within IA review scope.  Needs closure approval by Audit Committee.
502	Effective Governance – Women’s Directorate	2024	Reasonable pre 01/10/2024	Medium pre 01/10/2024	Matter Arising 5: Risk Management arrangements (Operation)	5.1: Management to review consistency of reporting and provision of assurance in accordance with the governance structure and consider how it records ‘Never Events’ as a risk for effective management through its control environment	5.1: A Recommendation will be made to the Women’s Service Risk Management Group (RMG), at the May 2024 meeting, that Never Events are added to the Risk Management Group agenda as a specific agenda item. This agenda item will also identify any known risks which require a Risk Assessment for consideration by the Women’s RMG for inclusion onto the Women’s Service Risk Register (this will include recording of no event). A Recommendation will be made to the RMG at the May 2024 meeting, that an update is made to the Terms Reference, under section 8.0 Reporting Arrangements into the Group, to specifically include the reporting of Never Events on a monthly basis (this will include recording of no event). A written report will be submitted monthly to the Women’s Quality Services Delivery Group (QSDG), following the monthly RMG meeting, rather than provide a verbal update at QSDG. This will highlight if there has been a Never Events and whether there are any associated risk which are being asessed, for consideration for inclusion on the Risk Register (this will include recording of no event). All Never Events will be escalated immediately to the Women’s SLT, managed at the weekly Women’s Concerns & Incident Monitoring	Christopher Lube, Clinical Lead for Governance and Risk; Liz Davies, General Manager and Business Lead	Imran Devji, Interim Chief Operating Officer	31/07/2024			This is monitored closely through surveillance on a weekly basis. The escalation process is active. COO content to proposed for closure.	Copy of RMG agenda and SLT agenda provided as evidence	Approved for closure by: • Executive Director • Executive Team  but not within IA review scope.  Needs closure approval by Audit Committee.
509	Adult and Older Persons Mental Health Unit	2023	Reasonable pre 01/10/2024	Medium pre 01/10/2024	Matter Arising 5: Contractual Appointments (Operation)	5.1 Outstanding contracts/confirmation notices should be subject to signing under seal at the earliest opportunity	5.1 Supply Chain Partner & Project Manager – Contract and Confirmation Notice No.1 complete. Cost Advisor – Contract complete, pending receipt of Confirmation Notice No.1. Cost Advisors are aware of the importance of completion.	Daniel Eyre, Head of Capital Development	Teresa Owen, Executive Director of Allied Health Professionals and Health Science	31/01/2024			Contracts and instructions completed	A number of contract-related documents provided as evidence for closure	Approved for closure by: • Executive Director • Executive Team  but not within IA review scope.  Needs closure approval by Audit Committee.
510	Adult and Older Persons Mental Health Unit	2023	Reasonable pre 01/10/2024	Medium pre 01/10/2024	Matter Arising 5: Contractual Appointments (Operation)	5.2 At future projects Contracts should be executed prior to the commencement of works / duties.	5.2 While we note this can be a challenge due to the process of completing contract documents, the Health Board will review the process for options to ensure contracts are executed prior to commencement of works or duties going forward.	Daniel Eyre, Head of Capital Development	Teresa Owen, Executive Director of Allied Health Professionals and Health Science	31/02/2024			Contracts completed	A number of contract-related documents provided as evidence for closure	Approved for closure by: • Executive Director • Executive Team  but not within IA review scope.  Needs closure approval by Audit Committee.
511	Adult and Older Persons Mental Health Unit	2023	Reasonable pre 01/10/2024	Medium pre 01/10/2024	Matter Arising 6: Timely sign-off of design sheets (Operation)	6.1 Sign off deadlines should be enforced to reduce the risk to the scheme	6.1 Sign off meeting will be arranged face to face to achieve sign off the same day until an electronic method for sign off can be established.	Ruth Stiles, Senior Project Manager	Teresa Owen, Health Board Lead for MHL and Welsh Language	31/01/2024			Electronic sign off of all AOPMHU user group areas has been achieved.	Included as evidence for closure is either signed off PDF C-Sheets, or email confirming sign off of area, as evidence if required to close out.	Approved for closure by: • Executive Director • Executive Team  but not within IA review scope.  Needs closure approval by Audit Committee.
512	Adult and Older Persons Mental Health Unit	2023	Reasonable pre 01/10/2024	Medium pre 01/10/2024	Matter Arising 7: Planning – Ecology Surveys (Operation)	7.1 At future projects The UHB in conjunction with its advisers should ensure that all risks to planning include consideration of limitations placed on the timing of ecology surveys	7.1 Planning risks to be identified and challenged earlier in the project and noted on the risk register to provide early focus	Daniel Eyre, Head of Capital Development	Teresa Owen, Health Board Lead for MHL and Welsh Language	31/01/2024			Noted all conditions for planning applications to be considered as part of design team meeting, and escalated to project board if required.	Copy of AOPMH Unit Costed Risk Register provided as evidence	Approved for closure by: • Executive Director • Executive Team  but not within IA review scope.  Needs closure approval by Audit Committee.
524	Digital Operating Model	2023	Reasonable pre 01/10/2024	Medium pre 01/10/2024	Matter Arising 1: Governance (Operation)	1.1a (ii): (shown as 1.1a (iii) in Audit Report) An Independent Member with responsibility for digital should be defined.	1.1a (ii): (shown as 1.1a(iii) in Audit Report) To appoint an Independent Member with specific responsibility for digital.	Pam Wenger, Director of Corporate Governance	Dylan Roberts, Chief Digital and Information Officer	31/04/2024			At present, there is no intention to appoint a IM with responsibility for Digital. This action can be closed.		Approved for closure by: • Executive Director • Executive Team  but not within IA review scope.  Needs closure approval by Audit Committee.

525	Digital Operating Model	2023	Reasonable pre 01/10/2024	Medium pre 01/10/2024	Matter Arising 1: Governance (Operation)	1.1b: The operation of the relevant committee for Digital should recommence.	1.1b: Recommend the Board Committee with responsibility for digital. This will be established with the new committees which the Board Secretary is working through.	Pam Wenger, Director of Corporate Governance	Dylan Roberts, Chief Digital and Information Officer	31/04/2024			The Planning, Partnership and Population Health Committee is now in place, and copy of approved Terms of Reference included for evidence for closure	Approved for closure by: • Executive Director • Executive Team  but not within IA review scope.  Needs closure approval by Audit Committee.
526	Digital Operating Model	2023	Reasonable pre 01/10/2024	Medium pre 01/10/2024	Matter Arising 1: Governance (Operation)	1.1c: A number of Board developments session should be provided on Digital, its role and potential	1.1c: Board development session to be scheduled for first part of 2024	Philippa Peake-Jones, Head of Corporate Affairs	Dylan Roberts, Chief Digital and Information Officer	31/05/2024			A Board Development Session is on the plan for 2024/25	Approved for closure by: • Executive Director • Executive Team  but not within IA review scope.  Needs closure approval by Audit Committee.
530	Digital Operating Model	2023	Reasonable pre 01/10/2024	High	Matter Arising 3: Business Relationships (Operation)	3.2: Work to develop a network of champions across the Health Board should continue.	3.2: Digital Champions will continue to be identified for each system implementation where appropriate. With regard to a network of champions please refer to action 2.1a.	Jason Walker, Chief Clinical Information Officer	Dylan Roberts, Chief Digital and Information Officer	30/04/2024	31/07/2024	1	Lists of liaisons are now complete. The Office of the CCIO now has a list of individuals who can be contacted in each clinical department across BCU.	A number of CCIO liaison-related documents are included as evidence for closure  Approved for closure by: • Executive Director • Executive Team  but not within IA review scope.  Needs closure approval by Audit Committee.
533	Digital Operating Model	2023	Reasonable pre 01/10/2024	Medium pre 01/10/2024	Matter Arising 5: National Systems (Operation)	5.1: The process by which BCU can challenge WG at a senior level, to ensure that all systems fully align with Health Board needs should be strengthened.	5.1: There is the means by which the Health Board can refuse to commit to Nationally imposed schemes. This requires the right discussions, understanding and agreement by Welsh Government with due regards to the context that BCU are in.	Dylan Roberts, Chief Digital and Information Officer	Dylan Roberts, Chief Digital and Information Officer	31/03/2024			The Chief Digital and Information Officer and the Assistant Director of Digital Delivery, Strategy and Engagement will ensure that Service Management Meeting agendas cover this issue for more immediate in year aspects. In the meantime the Health Board have now prioritised which projects and programmes are important to them as it relates to the organisations priorities as they are. This clearly shows some National Programmes that will be put on hold and why - this has been communicated to DHCW and to Welsh Government	Copy of BCUHB priorities provided as evidence for closure  Approved for closure by: • Executive Director • Executive Team  but not within IA review scope.  Needs closure approval by Audit Committee.
534	Digital Operating Model	2023	Reasonable pre 01/10/2024	Medium pre 01/10/2024	Matter Arising 6: Transformation (Operation)	6.1: The link between the Transformation Team and DDaT should be strengthened with DDaT representation in development of transformation plans.	6.1: Where possible there has been working together between DDaT and Transformation Team. However, the focus of the Transformation Team has shifted onto other things – such as Special Measures.  Digitally enabled change capacity and capability is included within the revised DDaT Project Mandate Process. A Group has been set up to review all mandate requests which has representation from the Transformation Team DDaT project mandates, DDaT and importantly business teams.	Dylan Roberts, Chief Digital and Information Officer; Russell Caldicott, Interim Executive Director of Finance; Chris Stockport, Executive Director of Transformation and Strategic Planning	Dylan Roberts, Chief Digital and Information Officer	30/04/2024			- The Chief Digital and Information Officer and the Director of Transformation meet on a monthly basis to ensure both service areas are aware of what each other are doing. - The Digital Delivery, Strategy and Engagement (DDSE) Team meet with the Pathway Leads on a monthly basis to enable better working together and knowledge sharing. - The Director of Transformation is leading a multi-disciplinary review of the Business Case, the Assistant Director Digital Delivery, Strategy and Engagement is part of this review.	Approved for closure by: • Executive Director • Executive Team  but not within IA review scope.  Needs closure approval by Audit Committee.
535	Digital Operating Model	2023	Reasonable pre 01/10/2024	Medium pre 01/10/2024	Matter Arising 7: Refresh (Operation)	7.1: The essential services programme should be finalised, prioritised and an appropriate refresh programme implemented that keeps digital equipment up to date	7.1: The Essential Services Programme (ESP) will be finalised and prioritised in order to work with the organisation to establish an appropriate and consistent level of funding to meet its needs to deliver a robust and measured replacement programme at all tiers of infrastructure to effectively deliver the digital operating model.	Sion Jones, Assistant Director/Chief Technology Officer	Dylan Roberts, Chief Digital and Information Officer	30/09/2024			In-year ESP budget has been committed as planned and will provide limited levels of replacement technologies restricted to Core LAN and End User Devices. Opportunities may arise to further this if any WG Capital becomes available. It is unlikely that the allocation for the next financial year will change unless more discretionary Capital comes available to BCU.  ESP Revenue situation remains unchanged. Current estimates are that the desktop estate will be c.3,000 devices short of that required to achieve Windows 11 when Windows 10 ceases to have security patch support.	Approved for closure by: • Executive Director • Executive Team  but not within IA review scope.  Needs closure approval by Audit Committee.
659	Waste Management	2022	Reasonable pre 01/10/2024	Medium pre 01/10/2024	Matter Arising 1 – Effective Communication of Waste Management Policy / Training (Design)	1: Mandatory training on waste management should be made available to all staff groups across the Health Board, this will ensure effective communication of the waste management policy and other associated documents.	1: Estates and Facilities have contributed to and adopted an All-Wales online mandatory training module for all BCUHB staff covering waste, environment and energy management. The e-module is currently only available to some staff through ESR. In compliance with this recommendation the Director of Estates and Facilities will work with Senior WOD colleagues who have responsibility for mandatory training, to ensure that the e-learning module is available to all staff via ESR	Rod Taylor, Director Of Estates And Facilities	Russell Caldicott, Interim Executive Director of Finance	30/06/2022			Training is now live on ESR for all users under the code 000 NHS WALES - ENVIRONMENTAL, WASTE & ENERGY	Approved for closure by: • Executive Director • Executive Team  but not within IA review scope.  Needs closure approval by Audit Committee.
1199	Wrexham Maelor Continuity Phase 1	2023	Reasonable pre 01/10/2024	Medium pre 01/10/2024	Matter Arising 1: Formal Appointment of SRO (Operation)	1.0: The appointment of an SRO should be prioritised for Phase 1 in line with the requirements of the HB's Capital Procedure Manual and in keeping with the governance structure of the scheme as outlined in the PEP.	1.0: Agreed. The requirement for a specific SRO for Phase 1 will be reviewed as part of governance arrangements post OBC/ FBC approval.	Russell Caldicott, Interim Executive Director of Finance (until Project Director appointed)	Russell Caldicott, Interim Executive Director of Finance	30/06/2023			Russell Caldicott confirmed as SRO. Daniel Eyre confirmed as Interim PD in lieu of Director of Environment.	Copy of BCUHB Estates Business Case Tracker provided as evidence for closure  Approved for closure by: • Executive Director • Executive Team  but not within IA review scope.  Needs closure approval by Audit Committee.
1203	Wrexham Maelor Continuity Phase 1	2023	Reasonable pre 01/10/2024	High	Matter Arising 5: Formal Record Keeping Signing of Contracts under Seal (Operation)	5.1: The outstanding Cost Adviser contract will be completed as a matter of priority	5.1: Agreed. The outstanding Cost Adviser contract will be completed as a matter of priority.	Russell Caldicott, Interim Executive Director of Finance (until Project Director appointed)	Russell Caldicott, Interim Executive Director of Finance	30/06/2023			Closed - Contract are complete	Copy of the Call Off Contract for the Appointment of the Consultant Cost Advisor for the Wrexham Maelor Business Continuity Programme provided as evidence  Approved for closure by: • Executive Director • Executive Team  but not within IA review scope.  Needs closure approval by Audit Committee.
1205	Wrexham Maelor Continuity Phase 1	2023	Reasonable pre 01/10/2024	Medium pre 01/10/2024	Matter Arising 6: Limited tender response- appointment of Cost Advisers (Operation)	6.0: The HB should review the reasoning for the poor response to the Cost Adviser appointment to inform future lettings.	6.0: Agreed. A review will be made of the process to better understand the issues involved.	Daniel Eyre, Head of Capital Development	Russell Caldicott, Interim Executive Director of Finance	31/12/2023			The new SES frameworks covering cost advisor will be available during October 2025 . This will mitigate the previous issue.	Copy of NHSBW2 Framework Procurement ITT Report for Strategic Framework Board on Wednesday 6th March 2024 provided as evidence  Approved for closure by: • Executive Director • Executive Team  but not within IA review scope.  Needs closure approval by Audit Committee.
1206	Wrexham Maelor Continuity Phase 1	2023	Reasonable pre 01/10/2024	Medium pre 01/10/2024	Matter Arising 7: Assurance of Parent Company Guarantees – Supply Chain Partner (Operation)	7.0: The HB should review the contracts and Parent Company Guarantee for the Supply Chain Partner to ensure it reflects recent changes in the corporate structure of the Supply Chain Partner.	7.0: Actioned NWSSP- SES have confirmed validity of contracts and PCG	Russell Caldicott, Interim Executive Director of Finance (until Project Director appointed)	Russell Caldicott, Interim Executive Director of Finance	30/04/2023			Complete closed	Approved for closure by: • Executive Director • Executive Team  but not within IA review scope.  Needs closure approval by Audit Committee.
1225	Mental Health & Learning Disabilities Division	2023	Reasonable pre 01/10/2024	Medium pre 01/10/2024	Matter Arising 3: Appropriate governance arrangements in place (Operation)	3.1a (ii) The division to review ToRs for meetings to ensure these are in place, dated and approved.	3.1a (ii): Review TOR's highlighted to ensure these are in place, dated and approved for the following meetings – MH&LD Finance and Performance Group	Iain Wilkie, Interim Director MHL	Iain Wilkie, Interim Director MHL				MH&LD Finance and Performance Group TOR's reviewed and approved. Signed and dated ToR embedded as evidence.  Action to be marked as completed.	Copy of MHLD Locality Senior Leadership Team: Finance Meeting Terms of Reference and Operating Arrangements provided as evidence  Approved for closure by: • Executive Director • Executive Team  but not within IA review scope.  Needs closure approval by Audit Committee.

1226	Mental Health & Learning Disabilities Division	2023	Reasonable pre 01/10/2024	Medium pre 01/10/2024	Matter Arising 3: Appropriate governance arrangements in place (Operation)	3.1a (iii) The division to review ToRs for meetings to ensure these are in place, dated and approved.	3.1a (iii): Review TOR's highlighted to ensure these are in place, dated and approved for the following meetings – MH&LD Clinical Strategy Group	Alberto Salmoiraghi, MH&LD Medical Director	Iain Wilkie, Interim Director MHL			MH&LD Clinical Strategy Group renamed MH&LD Service Transformation Delivery Group following the corporate Governance Framework changes aligned to the new Operating Model. The MH&LD Service Transformation Delivery Group TOR's reviewed and approved. Dated and signed ToR embedded as evidence.	Copy of MHL Service Transformation Delivery Group Terms of Reference provided as evidence	Approved for closure by: • Executive Director • Executive Team but not within IA review scope.
1227	Mental Health & Learning Disabilities Division	2023	Reasonable pre 01/10/2024	Medium pre 01/10/2024	Matter Arising 3: Appropriate governance arrangements in place (Operation)	3.1b Formal reporting of information through the tiers is required, consideration needs to be given as using Divisional QSE as an exemplar.	3.1b: To ensure, upon agreement of the revised Cycle of Business, all TOR's are reviewed aligned to agreed Governance Framework of the new MH&LD Operating Model.	Adrienne Jones, MH&LD Operational Business Lead; Francine Moore, Head of Governance	Iain Wilkie, Interim Director MHL			MH&LD Governance Framework reviewed and strengthened. An Audit was completed completed in April 2024 aligned to evidence of up to date signed ToRs, Agendas and reporting cycle of business for each meeting within the Governance Framework and presented in OLM and DSLT. Report embedded as evidence and latest copy of the MH&LD Governance Framework. Another Audit will be completed in July 2024.	Copy of MH&LD Governance Framework update report to the Divisional Senior Leadership Team on 09/04/2024, and MH&LD Meeting & Reporting Cycle of Business provided as evidence	Approved for closure by: • Executive Director • Executive Team but not within IA review scope. Needs closure approval by Audit Committee.
1228	Mental Health & Learning Disabilities Division	2023	Reasonable pre 01/10/2024	Medium pre 01/10/2024	Matter Arising 3: Appropriate governance arrangements in place (Operation)	3.1c (i) Cycle of business needs completion - this will underpin any formal reporting requirements from the tiers.	3.1c (i): Formal reporting throughout all meeting tiers to be implemented, with all meeting Agenda's amended aligned to agreed reporting structure	Adrienne Jones, MH&LD Operational Business Lead; Francine Moore, Head of Governance	Iain Wilkie, Interim Director MHL			MH&LD Governance Framework reviewed and strengthened. An Audit was completed completed in April 2024 aligned to evidence of up to date signed ToRs, Agendas and reporting cycle of business for each meeting within the Governance Framework and presented in OLM and DSLT. Report embedded as evidence and latest copy of the MH&LD Governance Framework. Another Audit will be completed in July 2024.	Copy of MH&LD Governance Framework update report to the Divisional Senior Leadership Team on 09/04/2024, and MH&LD Meeting & Reporting Cycle of Business provided as evidence	Approved for closure by: • Executive Director • Executive Team but not within IA review scope. Needs closure approval by Audit Committee.
1229	Mental Health & Learning Disabilities Division	2023	Reasonable pre 01/10/2024	Medium pre 01/10/2024	Matter Arising 3: Appropriate governance arrangements in place (Operation)	3.1d Cycle of business needs completion - this will underpin any formal reporting requirements from the tiers.	3.1d: MH&LD Cycle of Business populated with each meeting Chair, secretariat, meeting frequency, TOR, Agenda template, minute template, RAID Log and either Chairs Assurance reports template or Exceptions report template included for reporting throughout Tiered governance framework structure.	Adrienne Jones, MH&LD Operational Business Lead; Francine Moore, Head of Governance	Iain Wilkie, Interim Director MHL			MH&LD Cycle of Business developed and populated with each meeting Chair, secretariat, meeting frequency, TOR, Agenda template, minute template, RAID Log and either Chairs Assurance reports template or Exceptions report template included for reporting throughout Tiered governance framework structure. Audit undertaken in April 2024 and re-audit due to commence in July 2024.  Action marked as complete.	Copy of MH&LD Meeting & Reporting Cycle of Business provided as evidence	Approved for closure by: • Executive Director • Executive Team but not within IA review scope. Needs closure approval by Audit Committee.
1275	Standards of Business Conduct - Declarations of Interest, Gifts and Hospitality - June 2024	2024	Limited	High	Matter Arising 2: Declare System (Operation)	2.1: Management: • Ensure all scheduled notifications are functioning as intended. • Ensure published data is accurate and can be reconciled to source data. • Ensure published guidance documentation is consistent with NHS Wales requirements and relevant to Health Board staff.	2.1a: • Review monthly scheduled notifications	Philippa Peake-Jones, Head of Corporate Affairs	Pam Wenger, Director of Corporate Governance	30/06/2024		Action plan to address the recommendations from the report presented to Audit Committee on 18th July 2024. This has been completed, and go out monthly and are monitored		Approved for closure by: • Executive Director • Executive Team • reviewed and approved for closure by Internal Audit Now needs final endorsement of closure by Audit
1328	Orthopaedic Surgical Hub Llandudno Hospital	2024	Limited	High	Matter Arising 4: Works Procurement (Operation)	4.4: The UHB should ensure that changes of works packages post tender are appropriately reported and approved.	4.4: Agreed - Changes to works packages are approved in line with the health board's capital procedures manual and the change control process noted within the PEP. Going forward full cost report will be issued to the project board for information / approval. Cost report No 6 included in September Project Board Meeting. Any significant variations are highlighted within PM highlight report.	Ruth Stiles, Senior Project Manager	Chris Stockport, Executive Director of Transformation and Strategic Planning	30/09/2024		Actioned - Current variations that were highlighted at the September 2024 Project Board were approved as per the Capital Manual process. Copy of Project Board minutes provided as evidence for closure		Approved for closure by: • Executive Director • Executive Team • reviewed and approved for closure by Internal Audit Now needs final endorsement of closure by Audit

EXTERNAL AUDIT RECOMMENDATIONS FOR AUDIT WALES AND AUDIT COMMITTEE CLOSURE CONSIDERATION

ID	Report Title	Year	Assurance Level	Priority	Recommendation Title	Recommendation	Management Response	Action Owner	Final Approver	Original implementation date	Last update	Evidence to support closure of recommendations	Approvals to date, and action required
382	Structured Assessment 2022	2023	N/A	High	Recommendation 2: Review of performance management assurance reporting	R2: The Health Board is continuing to refine performance reporting into board and committees. However, there remain concerns around the quality of the performance report and the extent that stated actions will lead to the intended improvements. The Health Board should improve its performance assurance reporting, focussing more on the impact of performance improvement actions.	R2: The Health Board is currently developing a revised Integrated Performance Framework that incorporates feedback from the Structured Assessment Review. The Framework will clarify roles and responsibilities of Board, Board Committees and include criteria for escalation of performance matters. The intention of the report will be to provide a more concise high-level overview of Board Performance against NHS Wales Operating Framework Metrics, supplementary analysis in visual form to support better / easier understanding of key issues and a summarised assessment of key performance areas of significant concern and notes comparative improvement/deterioration either against target/plan/trajectory or expectation. Key areas will include: • BCU Delivery Framework KPI summary which aligns with NHS Wales existing assessment convention • A full review of Performance against all NHS Wales Performance Framework Metrics • Actual v target or trajectory and whether the Board is compliant with that indicator • Comparative benchmarking against all Wales Health Boards (where available), • Performance against BCU submitted to NHS Wales performance trajectories • 12-month trend sparks • A summary of performance against the Board's submitted trajectories – included as part of the Annual Plan. • Exception Reporting and the mitigations in place to manage risk.	Paolo Tardivel, Director of Transformation and Improvement	Russell Caldicott, Interim Executive Director of Finance	31/07/2023	Plan monitoring has moved over to the Transformation Team since April 2023		Approved for closure by Executive and Executive Lead.  Now for Audit Wales and Audit Committee consideration for closure
385	Structured Assessment 2022	2023	N/A	High	Recommendation 4: Review Health Board policies	R4b: The Health Board has a significant number of policies overdue for renewal, which exposes the organisation to service and administrative risks. The Health Board should review and update Health Board policies, prioritising high importance policies first, including the policy on policies.	R4b: The key actions now are to approve an updated "policy on policies" and then agree a priority list of policies to address based on the views of the responsible Executive Team view of priority. The prioritised list / workplan will report through to the Executive Team and Audit Committee.	Glesni Driver, Head of Covid-19 Inquiry and Thirlwall Inquiry	Pam Wenger, Director of Corporate Governance	30/09/2023	The Policy for the Management of Health Board Wide Policies, Procedures & Other Written Control Documents was reviewed and approved by the Executive Team on 30/08/2023; Audit Committee on 15/09/2023; Executive Team on 28/02/2024 and Audit Committee on 15/03/2024, and effective on 15/03/2024. All overdue policies now have an identified owner, and quarter for update listed on the Policy Management System, and a plan is in place for the Corporate Governance Directorate to ensure that this is being progressed. Regular updates on progress will be provided to the Executive Team and Audit Committee.	Copy of example update report to Audit Committee provided as evidence	Approved for closure by Executive and Executive Lead.  Now for Audit Wales and Audit Committee consideration for closure
389	Structured Assessment 2022	2023	N/A	Medium pre 01/10/2024	Recommendation 8: Reporting on the impact of value based healthcare initiatives	R8: Audit Wales found limited evidence of how the Health Board is implementing value-based healthcare operationally to its services to maximise value and efficiency. The Health Board should ensure reporting on its value-based healthcare programme focusses on the outcomes achieved.	R8: The approach to Value-Based Health Care will be further considered as part of the development of the Internal Planning Framework for the organisation. This will enable clarity of the Board-led strategic commitment to take forward this approach systematically. In addition, specific VBHC pieces of work are underway e.g. Lymphoedema & Cellulitis, Heart Failure, Long-term Diabetes Hub, PROM led follow up arthroplasty, Non-Emergency Patient Transport Services (NEPTS), PROMs platform.	Paolo Tardivel, Director of Transformation and Improvement; Robert Ellis, Head of Innovation and Analytics (providing update)	Chris Stockport, Executive Director of Transformation and Strategic Planning	31/12/2023	The Health Board's VBHC 24/25 programme continues to invest in Lymphoedema & Cellulitis, Heart Failure, Long-term Diabetes Hub, Non-Emergency Patient Transport Services (NEPTS), PROMs platform, Rehabilitation cancer-specific and non-cancer specific rehabilitation and minimal access surgery in gynaecology (endometriosis). Systematic delivery of VBHC objectives have been integrated into the internal planning framework via the Annual Delivery Plan; specifically 1E: Value and Sustainability. Value-Based Health Care delivery and outcomes are also being reported to the Wales Value in Health Centre, All Wales Value and Sustainability Programme and to Welsh Government via the bi-annual NHS Planning Framework 22/25 Policy Assurance Assessment.	Copy of Lymphoedema End of Year Report; £5M Value Funding – Welsh Value in Health Centre - BCUHB - Value Based Health Care Projects update; NHS Performance Framework 2023/24 - Project Assurance Assessment - Value Based Healthcare; and VBHC Update to PFIG provided as evidence	Approved for closure by Executive and Executive Lead.  Now for Audit Wales and Audit Committee consideration for closure
393	Structured Assessment 2022	2023	N/A	N/A	Recommendation 12: Improve performance and financial oversight for digital and estates	R12a: There is a need to put in place arrangements to understand the impact of digital and estates strategies, as well as the financial feasibility of the strategy. The Health Board should: • review any funding gaps in the digital and estates strategies to determine if they are financially feasible. Update the relevant committee on the findings of the financial feasibility review and how any associated risks will be managed. • introduce periodic committee reports that not only focus on actions completed but the impact its digital and estates strategies are having on the organisation.	R12a: A number of key mechanisms will be introduced and where in existence, strengthened to support improved planning and oversight relating to digital and estates. These include a new Planning Framework and Integrated Performance Framework. Furthermore, the management of corporate business and governance has been reviewed and in line with commitments in the Special Measures Response Plan, will be revised and strengthened during Q3 2023-24. In accordance with good governance principles, committee self-assessments will be conducted annually as a minimum to include reference to digital and estates strategies.	Dylan Roberts, Chief Digital and Information Officer; Russell Caldicott, Interim Executive Director of Finance	Russell Caldicott, Interim Executive Director of Finance	31/12/2023	The "Our Digital Future" Strategy 2021-2024 has concluded, and a revised Digital Roadmap is being developed for the years ahead which will be full costed at an strategic and outline level. This has been going through the engagement process over the last six months and the roadmap is close to publication. In the meantime, DDaT working with Executive Management Team, Planning Population Health and Partnership and the Health Board have establish the following six workstreams for delivery which are included in the Annual Plan. 1.The Health Board will work with stakeholders across BCUHB and Wales to develop and secure agreement for investment in an Electronic Healthcare Record (EHR) transformation. Due to the safety concerns in Mental Health, the Health Board will commence the accelerated procurement and implementation of a tactical Mental Health specific EHR starting in 2024. 2.The Health Board will work to optimise the use of current systems and capabilities to deliver the most value for patients and clinicians, mitigating the risks associated with duplication of systems and processes. 3.The Organisation will continue to modernise the running and delivery of Digital, Data and Technology. This will bring in the minimum capabilities and skills necessary to improve DDaT maturity against industry benchmarks. 4.Essential Services Programme. The Health Board	Detail included in the Annual Plan	Approved for closure by Executive and Executive Lead.  Now for Audit Wales and Audit Committee consideration for closure
395	Structured Assessment 2023	2023	N/A	N/A	Transparency of board and committee business	R1: Currently, there is confusion about how many days in advance of meetings papers for Board and committee papers should be made publicly available. The Health Board should agree and communicate a consistent target date for publishing agendas ahead of Board and committee meetings.	R1: Agreed. The Health Board has confirmed the standard target date of Board and Committee papers will be 7 days' notice in advance of meetings. The Director of Corporate Governance will communicate this timescale to all Board and Executive Team Members to ensure there is no confusion of timescales.	Philippa Peake-Jones, Head of Corporate Affairs	Pam Wenger, Director of Corporate Governance	31/03/2024	It is normal practice to publish 7 days in advance of the meeting, however, given the changes to Standing Orders when we were placed in Special Measures breaches will only be reported from 5 days in advance.		Approved for closure by Executive and Executive Lead.  Now for Audit Wales and Audit Committee consideration for closure
397	Structured Assessment 2023	2023	N/A	N/A	Changing trends in complaint numbers 2023-24	R3: There has been a significant unexplained drop in the number of complaints received for the first six months of 2023-24 compared to the previous year. The Health Board should urgently work to discover the reason to ensure complaints are not being missed or mis-reported.	R3: Agreed. The Executive Director of Nursing & Midwifery with the Director of Digital, Data and Technology will lead work to check the data quality, that information is still being received and no specific reason for this drop has been confirmed. The Health Board has also committed to the development of a Quality Management System that will enable learning from complaints / feedback to be fully understood and reflected in the Health Board's quality planning process. A draft of the Quality Management System will be considered by an informal Executive Team meeting by the end of May 2024.	Angela Wood, Executive Director of Nursing and Midwifery; Dylan Roberts, Chief Digital and Information Officer	Angela Wood, Executive Director of Nursing and Midwifery	30/06/2024	The Quality Management System was approved at Board in May 2024.	Board papers (item 20) from May 2024 provided as evidence for closure	Approved for closure by Executive and Executive Lead.  Now for Audit Wales and Audit Committee consideration for closure

398	Structured Assessment 2023	2023	N/A	N/A	Recommendation tracking	R4: Our work identified that not all Audit Wales recommendations made in 2023 were added to the audit tracker. The Health Board should ensure there is a process to add all recommendations made by Audit Wales to the audit tracker in a timely fashion.	R4: Agreed. A process has been agreed with the Executive Team and Chair of the Audit Committee which includes Audit recommendations being received at Executive Team Meetings (bi monthly) prior to risks being received for formal closure at Audit Committee. This process will allow for Executive Team to check that Audit Wales recommendations are added to the audit trackers in a timely fashion before updates are received at the Audit Committee for assurance. This allows Audit Wales colleagues (who attend Audit Committee) to check compliance with this process. Whilst this process has been agreed and has commenced a further cycle of it needs to have taken place before this recommendation can be evidenced as being effective and complete.	Glesni Driver, Head of Covid-19 Inquiry and Thirlwall Inquiry	Pam Wenger, Director of Corporate Governance	31/05/2024	A new approval process for recommendations proposed for closure has been implemented, with final approval of this process at the July Audit Committee. The Tracker and associated progress continues to be reported to the Executive Team and Audit Committee, and any approval of proposed closed recommendations by the action owners quality assured by the Corporate Governance Directorate, then approved by the Executive Lead prior to submission to the Executive Team, then onward to Internal Audit and then finally the Audit Committee. Reporting to the Executive Team and Audit Committee includes a focus on 'no' or 'limited' assurance recommendations. The Corporate Governance Directorate has provided a significant level of support to this process to ensure consistency and quality of the status updates, and feedback provided where necessary. Internal Audit sampling of closed recommendations provides further assurance that the recommendations are being appropriately and effectively addressed. From the feedback received from Internal Audit, there are opportunities for learning across the board around the quality of update and narrative required to close recommendations.	Copy of approved process, with updated reports to Executive Team and Audit Committee provided as evidence	Approved for closure by Executive and Executive Lead.  Now for Audit Wales and Audit Committee consideration for closure
401	Structured Assessment 2023	2023	N/A	N/A	Recommendation tracking	R5c: Currently, there is insufficient committee oversight to monitor progress made against recommendations made by non-audit bodies. The Health Board should introduce effective committee oversight for monitoring progress made against recommendations of regulators, including, but not limited to, Healthcare Inspectorate Wales, the Coroner, Welsh Language Commissioner, the Health and Safety Executive and the Public Services Ombudsman for Wales.	R5c: The Health Board has also committed to the development of a Quality Management System that will enable learning from regulatory reports to be fully understood and reflected in the Health Board's quality planning process. A draft of the Quality Management System will be considered by an informal Executive Team meeting by the end of May 2024.	Matthew Joyes, Deputy Director of Quality	Angela Wood, Executive Director of Nursing and Midwifery	31/07/2024	The Quality Management System was approved at Board in May 2024.	Board papers (item 20) from May 2024 provided as evidence for closure	Approved for closure by Executive and Executive Lead.  Now for Audit Wales and Audit Committee consideration for closure
403	Structured Assessment 2023	2023	N/A	N/A	Financial strategy	R7: It is difficult to see the extent to which the Health Board's improvement initiatives and aims set out in the 2023-24 Annual Plan were financially affordable. The Health Board should develop a financial strategy, supported by a medium-term financial plan with the aim of supporting good quality and sustainable service models and reducing the Health Board's deficit and underlying deficit.	R7: Agreed. The Board approved the financial plan in May 2023 with the Annual Plan approved at the end of June 2023 following agreement with Welsh Government. The HB developed revised plans in year with the expressed intention of balancing improvements in quality and performance within an affordable financial envelope. The focus from close of 23/24 financial year and moving into 24/25 and beyond has been to endorse a value and sustainability approach to delivery of improvements for staff, patients and visitors that will also result in a sustainable financial for future health care.	Russell Caldicott, Interim Executive Director of Finance	Russell Caldicott, Interim Executive Director of Finance	31/07/2024	The Board approved the 24/25 annual plan, which incorporates an improved forecast outturn of £19.7m deficit. A Board also endorsed a value and sustainability approach to delivery of improvements for staff, patients and visitors that will also result in a sustainable financial position for future health care. The value and sustainability approach has been adopted to identify the savings plan opportunities in 24/25. Themes covering CHC, Workforce, Medicines management, non pay and clinical variation are being progressed by assigned executive leads and support teams. At the end of Quarter 1 opportunities of circa £30m have been identified with circa £24m converted into finalised schemes.		Approved for closure by Executive and Executive Lead.  Now for Audit Wales and Audit Committee consideration for closure
404	Structured Assessment 2023	2023	N/A	N/A	Monitoring progress against accounting issues	R8: Ensure that the Audit Committee receives assurance on the progress that the Health Board is making to address the complete range of issues identified in the Audit Wales 2021-22 and 2022-23 audit of accounts, and the subsequent EY review has been slower than intended.	R8: Agreed. Progress reports will be schedule of part of the Audit Committee Programme of work.	Russell Caldicott, Interim Executive Director of Finance	Russell Caldicott, Interim Executive Director of Finance	31/08/2024	Progress against the issues raised has been well documented both within the special measures action plan and the finance special measures action plan (incorporating the former financial control environment plan). Closure of open actions has been endorsed by the WG, and therefore is recommend this action is closed. Also the 2023/24 Audit Wales opinion is that the Financial Accounts state a true and fair position.		Approved for closure by Executive and Executive Lead.  Now for Audit Wales and Audit Committee consideration for closure
421	Review of Board Effectiveness	2023	N/A	N/A	Responding to independent reviews and investigations	1a: Take the necessary action in response to the findings from the investigations into whistleblowing disclosures that relate to Executive Directors and senior management (noting that any actions in respect of concerns about Independent Members would be matters for the Minister).	No management response within report	Pam Wenger, Director of Corporate Governance	Carol Shillabeer, Chief Executive	N/A	The Chief Executive has undertaken a review of the Executive Portfolios to improve governance and accountability in April 2024. Implementation of the conclusions of this review was then implemented. Portfolios have been amended to reflect the review and JD's for vacancies amended and submitted to WG for consideration of remuneration. A number of these post have been through the recruitment process. By the end of March 2024 the Board now has a full complement of Independent Members - by end of March 2024. The action taken formed part of Special Measures cycles 1-3 and have been well documented through this process. Deliverables contained within the BCUHB Three Year Plan have been aligned to the portfolio of each Executive Director and are evaluated in a Directorate Performance Review (commenced in June 2024) <b>This recommendation is proposed for closure.</b>		Approved for closure by Executive and Executive Lead.  Now for Audit Wales and Audit Committee consideration for closure
422	Review of Board Effectiveness	2023	N/A	N/A	Responding to independent reviews and investigations	1b: Resolve quickly any issues arising from the Ernst Young review.	No management response within report	Pam Wenger, Director of Corporate Governance	Carol Shillabeer, Chief Executive	N/A	There are matters of confidentiality that relate to individuals that cannot be reported in detail in this update but are being overseen by the Chief Executive. The Chair and Chief Executive updated the Senedd Public Administration Committee on what they could during 2023/24, whilst carefully considering confidentiality. The CEO has moved this matter forwards significantly towards a conclusion. This recommendation is proposed for closure.		Approved for closure by Executive and Executive Lead.  Now for Audit Wales and Audit Committee consideration for closure
423	Review of Board Effectiveness	2023	N/A	N/A	Responding to independent reviews and investigations	1c: Fully support any investigations the National Counter Fraud Service need to undertake in response to the Auditor General's audit of the 2021-22 accounts and the subsequent Ernst Young review.	No management response within report	Pam Wenger, Director of Corporate Governance	Carol Shillabeer, Chief Executive	N/A	Close working with the Counter Fraud service and North Wales Police took place throughout 2022/23 and 2023/24 and have been the subject of a briefing to the Senedd Public Administration Committee during 2023/24 and their involvement has now come to an end. There are matters of confidentiality that relate to individuals that cannot be reported in detail in this update but are being overseen by the Chief Executive. This recommendation is proposed for		Approved for closure by Executive and Executive Lead.  Now for Audit Wales and Audit Committee consideration for closure
425	Review of Board Effectiveness	2023	N/A	N/A	Rebuilding and strengthening senior leadership capacity	2b: Critically review the use of interim senior appointments and management consultants with a view to reducing reliance on such appointments within the senior leadership structures	No management response within report	Jason Brannan, Deputy Director of People	Carol Shillabeer, Chief Executive	N/A	This work was undertaken as part of the interim review work under special measures. Since March 24 there have been no senior agency interims in the organisation. This action can be closed.		Approved for closure by Executive and Executive Lead.  Now for Audit Wales and Audit Committee consideration for closure

426	Review of Board Effectiveness	2023	N/A	N/A	Rebuilding and strengthening senior leadership capacity	2c: Act urgently to bolster senior staff capacity in the Finance Team to mitigate the impact on business continuity.	No management response within report	Jason Brannan, Deputy Director of People	Carol Shillabeer, Chief Executive	N/A	This work has been actioned over the last 12 months as part of the special measures work with a series of appointments to the Finance team and a restructure of roles at a senior level, with the appointment of a Interim Executive Director of Finance and a secondment of a Director of Finance from Welsh Government. Audit Wales and Welsh Government have confirmed that there is much more resilience in the finance team. This action can now be closed.	Approved for closure by Executive and Executive Lead.  Now for Audit Wales and Audit Committee consideration for closure
430	Review of Board Effectiveness	2023	N/A	N/A	Building a more cohesive and effective board and Executive Team	3d: Take urgent action to create a more collegiate and unified approach to leadership of the organisation, which involves: • Establishing an agreed level of risk appetite and tolerance between Executives and Independent Members.	No management response within report	Pam Wenger, Director of Corporate Governance	Carol Shillabeer, Chief Executive		Suggest further review of the recommendation by Audit Wales as the Internal Audit on Risk Management "reasonable"	Copy of Internal Audit 'Board Assurance Framework and Risk Management' Audit Report  Director of Corporate Governance updated  Now for Audit Wales consideration
432	Review of Board Effectiveness	2023	N/A	N/A	Building a more cohesive and effective board and Executive Team	3f: Take urgent action to create a more collegiate and unified approach to leadership of the organisation, which involves: • Using appropriate external facilitators and mediators to work through the above issues as part of a wider board development programme which is informed by the King's Fund's reflections on the previous board development programme.	No management response within report	Pam Wenger, Director of Corporate Governance	Carol Shillabeer, Chief Executive		Board Effectiveness Survey undertaken and reported to the Board in March.	Copy of March Board papers  Director of Corporate Governance updated  Now for Audit Wales consideration
433	Review of Board Effectiveness	2023	N/A	N/A	Building a more cohesive and effective board and Executive Team	3g: Take urgent action to create a more collegiate and unified approach to leadership of the organisation, which involves: • Aligning Independent Member portfolios to Executive Director portfolios to support information and knowledge sharing.	No management response within report	Pam Wenger, Director of Corporate Governance	Carol Shillabeer, Chief Executive	N/A	The Chief Executive has undertaken a review of the Executive Portfolios to improve governance and accountability in April 2024. Implementation of the conclusions of this review was then implemented. Portfolios have been amended to reflect the review and JD's for vacancies amended and submitted to WG for consideration of remuneration. A number of these post have been through the recruitment process. By the end of March 2024 the The Board now has a full complement of Independent Members - by end of March 2024. The action taken formed part of Special Measures cycles 1-3 and have been well documented through this process. Deliverables contained within the BCUHB Three Year Plan have been aligned to the portfolio of each Executive Director and are evaluated in a Directorate Performance Review (commenced in June 2024) <b>This recommendation is proposed for closure.</b>	Approved for closure by Executive and Executive Lead.  Now for Audit Wales and Audit Committee consideration for closure



<b>Teitl adroddiad:</b> <i>Report title:</i>	Risk Impact of Policies Overdue their Review Dates			
<b>Adrodd i:</b> <i>Report to:</i>	Audit Committee			
<b>Dyddiad y Cyfarfod:</b> <i>Date of Meeting:</i>	Thursday, 08 May 2025			
<b>Crynodeb Gweithredol:</b> <i>Executive Summary:</i>	<p>The purpose of this report is to provide the Committee with:</p> <ul style="list-style-type: none"> <li>• an update on all policies overdue their review date</li> <li>• the risk of these policies being overdue their review date</li> </ul>			
<b>Argymhellion:</b> <i>Recommendations:</i>	<p>The Committee is asked to:</p> <ul style="list-style-type: none"> <li>• NOTE the position on all overdue policies</li> <li>• NOTE the risk impact of the current overdue policies</li> <li>• NOTE the proposals around reviewing overdue policies</li> <li>• NOTE the request for update information in relation to three outstanding policies</li> <li>• AGREE any areas of escalation by Executive Directors</li> </ul>			
<b>Arweinydd Gweithredol:</b> <i>Executive Lead:</i>	Pam Wenger, Director of Corporate Governance			
<b>Awdur yr Adroddiad:</b> <i>Report Author:</i>	Glesni Driver, Head of Statutory Compliance and Inquiries			
<b>Pwrpas yr adroddiad:</b> <i>Purpose of report:</i>	<p>I'w Nodi <i>For Noting</i></p> <p><input type="checkbox"/></p>	<p>I Benderfynu arno <i>For Decision</i></p> <p><input checked="" type="checkbox"/></p>	<p>Am sicrwydd <i>For Assurance</i></p> <p><input checked="" type="checkbox"/></p>	
<b>Lefel sicrwydd:</b> <i>Assurance level:</i>	<p>Arwyddocaol <i>Significant</i></p> <p><input type="checkbox"/></p> <p>Lefel uchel o hyder/tystiolaeth o ran darparu'r mecanweithiau / amcanion presennol</p> <p><i>High level of confidence/evidence in delivery of existing mechanisms/objectives</i></p>	<p>Derbyniol <i>Acceptable</i></p> <p><input type="checkbox"/></p> <p>Lefel gyffredinol o hyder/tystiolaeth o ran darparu'r mecanweithiau / amcanion presennol</p> <p><i>General confidence / evidence in delivery of existing mechanisms / objectives</i></p>	<p>Rhannol <i>Partial</i></p> <p><input checked="" type="checkbox"/></p> <p>Rhywfaint o hyder/tystiolaeth o ran darparu'r mecanweithiau / amcanion presennol</p> <p><i>Some confidence / evidence in delivery of existing mechanisms / objectives</i></p>	<p>Dim Sicrwydd <i>No Assurance</i></p> <p><input type="checkbox"/></p> <p>Dim hyder/tystiolaeth o ran y ddarpariaeth</p> <p><i>No confidence / evidence in delivery</i></p>

<p><b>Cyfiawnhad dros y gyfradd sicrwydd uchod. Lle bo sicrwydd 'Rhannol' neu 'Dim Sicrwydd' wedi'i nodi uchod, nodwch gamau i gyflawni sicrwydd 'Derbyniol' uchod, a'r terfyn amser ar gyfer cyflawni hyn:</b></p> <p><b><i>Justification for the above assurance rating. Where 'Partial' or 'No' assurance has been indicated above, please indicate steps to achieve 'Acceptable' assurance or above, and the timeframe for achieving this:</i></b></p>	
<p>A considerable amount of work has taken place to date by the Corporate Governance Directorate to work with and support policy owners and Executive Directors who have overdue policies. However, despite this, a number of policies remain overdue their review, which has the potential to impact patient safety, financially and reputationally. The Corporate Governance Directorate will continue to provide support and guidance to policy owners and Executive Directors to progress this work.</p>	
<p><b>Cyswllt ag Amcan/Amcanion Strategol:</b></p> <p><b><i>Link to Strategic Objective(s):</i></b></p>	<p>Not applicable, other than those relating to individual policies and written control documents</p>
<p><b>Goblygiadau rheoleiddio a lleol:</b></p> <p><b><i>Regulatory and legal implications:</i></b></p>	<p>It is essential that the Health Board has up to date and accurate policy documents in order to comply with relevant legislation and minimise any associated risk</p>
<p><b>Yn unol â WP7, a oedd EqlA yn angenrheidiol ac a gafodd ei gynnal?</b></p> <p><b><i>In accordance with WP7 has an EqlA been identified as necessary and undertaken?</i></b></p>	<p>The Equality duty is not applicable. This report is purely administrative in nature and submitted for information only. The associated public sector duties are not engaged (there are no associated impacts on any of the protected groups).</p>
<p><b>Yn unol â WP68, a oedd SEIA yn angenrheidiol ac a gafodd ei gynnal?</b></p> <p><b><i>In accordance with WP68, has an SEIA identified as necessary been undertaken?</i></b></p>	<p>The Socio-Economic duty is not applicable. This report is purely administrative in nature and submitted for information only. The associated public sector duties are not engaged (the report does not relate to a decision, strategic or otherwise).</p>
<p><b>Manylion am risgiau sy'n gysylltiedig â phwnc a chwmpas y papur hwn, gan gynnwys risgiau newydd (croesgyfeirio at y BAF a'r CRR)</b></p> <p><b><i>Details of risks associated with the subject and scope of this paper, including new risks (cross reference to the BAF and CRR)</i></b></p>	<p>There are risks relating to policies and written control documents that have passed their 1-year or 3-year mandatory review period following initial approval. It is essential that the Health Board has up-to-date and accurate policies and written control documents in order to comply with relevant legislation and minimise any associated risk</p>
<p><b>Goblygiadau ariannol o ganlyniad i roi'r argymhellion ar waith</b></p> <p><b><i>Financial implications as a result of implementing the recommendations</i></b></p>	<p>Not applicable, other than those relating to individual policies or written control documents</p>
<p><b>Goblygiadau gweithlu o ganlyniad i roi'r argymhellion ar waith</b></p> <p><b><i>Workforce implications as a result of implementing the recommendations</i></b></p>	<p>There will be a resource implementation due to the need to update outdated policies and written control documents</p>
<p><b>Adborth, ymateb a chrynodeb dilynol ar ôl ymgynghori</b></p> <p><b><i>Feedback, response, and follow up summary following consultation</i></b></p>	<p>This paper forms an update on Health Board policies to the Committee</p>

<p><b>Cysylltiadau â risgiau BAF:</b> (neu gysylltiadau â'r Gofrestr Risg Gorfforaethol)</p> <p><b>Links to BAF risks:</b> (or links to the Corporate Risk Register)</p>	<p>Not applicable, other than those relating to individual policies and written control documents.</p>
<p><b>Rheswm dros gyflwyno adroddiad i fwrdd cyfrinachol (lle bo'n berthnasol)</b></p> <p><b>Reason for submission of report to confidential board (where relevant)</b></p>	<p>Not applicable</p>
<p><b>Camau Nesaf:</b> <b>Gweithredu argymhellion</b></p> <p><b>Next Steps:</b> <b>Implementation of recommendations</b></p> <p>The Corporate Governance Directorate will continue to engage and support Executive Directors and policy owners in order to ensure that any those overdue documents are updated as timely as possible.</p> <p>Work will continue to identify changes to process to be incorporated into the Health Board's Policy around the management of policies and written control documents.</p>	
<p><b>Rhestr o Atodiadau:</b></p> <p><b>List of Appendices:</b></p> <p>Appendix 1 – All overdue policies with updates on progress to date</p>	

# **RISK IMPACT OF POLICIES OVERDUE THEIR REVIEW DATES**

## **1. INTRODUCTION AND BACKGROUND**

As has previously been reported, the Health Board is committed to having a suite of current and relevant policy and written control documents (WCDs), and has pledged, in Special Measures to prioritise outstanding policies and WCDs by the end of 2024/25.

The Corporate Governance Directorate has continued to engage with policy/WCD owners and Executive Directors in order to progress work around the review of overdue policies/WCD. This work will continue until the Executive Committee and Audit Committee are satisfied that the Health Board has fulfilled its commitment around overdue policies and WCDs.

A paper relating to all Health Board overdue policies and written control documents was presented to the Audit Committee at its meeting on 16<sup>th</sup> January 2025. Following this, the Audit Committee requested an update to summarise the policies that carry the biggest risk at its April 2025 meeting. This paper is in response to that request.

## **2 REVIEW OF OVERDUE POLICIES**

A review of all overdue policies, and those due a review by 31<sup>st</sup> March 2025 was undertaken by the Corporate Governance Directorate. The Policy Management System held information relating to 57 documents that were classified as a 'policy' that were due a review up to 31<sup>st</sup> March 2025.

### **2.1 Progress update**

Each of these 57 policies were reviewed, and a number were identified as potentially not policies, but rather a procedure or guidelines. The Corporate Governance Directorate submitted a request to the policy owners to review the classification of their policy document as part of their document review process, and an update on progress to review these overdue policies.

As at 31<sup>st</sup> March 2025, there were 45 overdue policies, a reduction from 57 reported to the January 2025 Audit Committee. The classification of 12 of the remaining 45 are currently being considered as part of the review process, therefore the number of overdue policies may reduce further, albeit it still means that there is a policy-related document overdue a review.

There is an inherent risk from any policy being overdue its review date, in line with the Health Board Policy on this matter, however, those policies that have the potential to impact patient safety are those which pose the highest risk. All policies which have a risk impact relating to patient safety are listed below, in order of those the longest overdue their review date potentially posing the most risk:

Name	Category	Review Date	Responsible Director
<a href="#">MHLD 0029 - Perinatal Mental Health Operational Policy - V0.1.pdf</a>	Patient safety; Joint working/Collaboration	01/06/2019	Executive Director of Allied Health Professions and Health Science
<a href="#">MHLD 0027 - BCUHB Mental Health Division - Open Door Policy - V0.1pdf.pdf</a>	Patient safety; Legal	01/07/2020	Executive Director of Allied Health Professions and Health Science
<a href="#">MM05 - Intrathecal Chemotherapy Policy - V3.pdf</a>	Patient safety	01/03/2021	Executive Medical Director
<a href="#">MHLD 0035 - Home Treatment Team Operational Policy - V0.5 (a).pdf</a>	Patient safety; Legal	01/04/2021	Executive Director of Allied Health Professions and Health Science
<a href="#">MD17 - Interventions Not Normally Undertaken (INNU) Policy - V1.1.pdf</a>	Patient safety	01/09/2021	Executive Medical Director
<a href="#">MHLD 0040 - Ty Llywelyn Postal Packets &amp; Section 134 (MHA 1983 2007) Policy - V0.1.pdf</a>	Patient safety	01/08/2021	Executive Director of Allied Health Professions and Health Science
<a href="#">CW01 - BCUHB Paediatric Escalation Policy - V3.pdf</a>	Patient safety	01/09/2019	Chief Operating Officer
<a href="#">MM37 - Medical Gases - Staff Responsibilities across BCUHB - V1.1.pdf</a>	Patient safety	01/05/2021	Executive Medical Director
<a href="#">MM01 - BCUHB Medicines Policy .pdf</a>	Patient safety	01/07/2022	Executive Medical Director
<a href="#">MM42 - Unlicensed Medicines Policy - V1.pdf</a>	Patient safety	01/07/2022	Executive Medical Director
<a href="#">MM15 - Policy for Administration &amp; Use of Emergency &amp; Non Emergency Oxygen in Adults in Managed Services - V2.1.pdf</a>	Patient safety	01/02/2022	Executive Medical Director
<a href="#">MM02 - Injectable Medicines Policy.pdf</a>	Patient safety	08/07/2022	Executive Medical Director
<a href="#">Mat 74 - BCUHB Breastfeeding Policy.pdf</a>	Patient safety	01/12/2023	Chief Operating Officer
<a href="#">MHLD 0008 - Threats to the Person and Environment within Forensic Establishments Policy (Ty Llywelyn Medium Secure Unit).pdf</a>	Patient safety	01/01/2024	Executive Director of Allied Health Professions and Health Science
<a href="#">MM10 - Antimicrobial Prescribing Policy - V4.pdf</a>	Patient safety	01/05/2024	Executive Medical Director
<a href="#">MHLD 0020 - S-CAMHS to Adult Transition Policy - V3.pdf</a>	Patient safety; Joint working/Collaboration	01/03/2024	Executive Director of Allied Health Professions and Health Science
<a href="#">NU28 - Nurse Staffing Levels Policy.pdf</a>	HR/Staff; Patient safety	01/01/2025	Executive Director of Nursing
<a href="#">IPC06 - Infection Prevention Hand Hygiene Policy &amp; Procedure (An Element of Standard Infection Control Precautions).pdf</a>	Patient safety	01/03/2025	Executive Director of Nursing

### **3 NEXT STEPS**

The next step is for the above policies to be prioritised for review as a matter of urgency, with a report on progress submitted to a future Audit Committee.

In addition to this, all other overdue policies listed in Appendix 1 are to be progressed for review as a priority.

In order to progress this work, it will need support from the Executive Directors to drive this work, and ensure that the review is progressed in a timely manner.

The Corporate Governance Directorate will continue to support the policy leads and Executives in this work.

### **4 BUDGETARY/FINANCIAL IMPLICATIONS**

There are no budgetary implications associated with this paper.

Resources for maintaining compliance with updating policies and WCDs lie with the relevant directorate, division, or department as part of business-as-usual functions.

### **5 RISK MANAGEMENT**

It is essential that the Health Board has up-to-date and accurate policies and written control documents in order to comply with relevant legislation and minimise any risks associated with those areas of work.

There are risks to the Health Board relating to policies and WCDs that have passed their 1-year or 3-year mandatory review period following initial approval, and the Director of Corporate Governance holds an overarching Health Board risk relating to this on Datix.

### **6 EQUALITY AND DIVERSITY IMPLICATIONS**

The Equality duty is not applicable to the content of this report as it is purely administrative in nature and submitted for information only.

However, in relation to each policy and WCD, Equality and Diversity compliance is required for each in accordance with Procedure WP7, and no policy will be approved for review by the Executive Policy Oversight Group or any WCD for publication unless clear evidence that an assessment has been undertaken is provided to the Corporate Governance Directorate as part of their quality assurance review.

**APPENDIX 1 – ALL OVERDUE POLICIES WITH UPDATES ON PROGRESS TO DATE**

## APPENDIX 1 - ALL OVERDUE POLICIES

As at 31/03/2025

Name	Category	Review Date	Responsible Director	Update
<a href="#">ISU03 - Volunteering Policy - V0.1.pdf</a>	HR/Staff	12/01/2017	Executive Director of Workforce and Organisational Development	Review due Q2
<a href="#">MD10 - Medical &amp; Dental Staff Study Leave Policy - V0.1.pdf</a>	HR/Staff	20/10/2017	Executive Medical Director	Author will consider the classification of document when reviewing. Update from OMD Still on target for completion end of Q1
<a href="#">MD11 - Medical &amp; Dental Staff Professional Leave Policy - V0.1.pdf</a>	HR/Staff	20/10/2017	Executive Medical Director	Still on target for completion end of Q1
<a href="#">MD13 - Annual Leave &amp; Special Leave Policy for Medical &amp; Dental Staff - V0.1.pdf</a>	HR/Staff	20/10/2017	Executive Medical Director	Still on target for completion end of Q1
<a href="#">MHLD 0029 - Perinatal Mental Health Operational Policy - V0.1.pdf</a>	Patient safety;#Joint working/Collaboration	01/06/2019	Executive Director of Allied Health Professions and Health Science	Author will consider the classification of document when reviewing. Going through MHLD approval prior to sending to PSG for approval in March.
<a href="#">MHLD 0027 - BCUHB Mental Health Division - Open Door Policy - V0.1.pdf.pdf</a>	Patient safety;#Legal	01/07/2020	Executive Director of Allied Health Professions and Health Science	Remains outstanding, requires a full rework
<a href="#">MM05 - Intrathecal Chemotherapy Policy - V3.pdf</a>	Patient safety	01/03/2021	Executive Medical Director	Author will consider the classification of document when reviewing. On track for completion
<a href="#">MD09 - Medical &amp; Dental Staff - Sabbatical Leave Policy - V0.2.pdf</a>	HR/Staff	31/03/2018	Executive Medical Director	On target for completion by end of Q4
<a href="#">PTR02 - Claims Management Policy.pdf</a>	Legal;#Financial	05/06/2017	Director of Corporate Governance	The Executive Team approved the Case for Change covering Legal Services in January 2025 which now provides a fundamentally different approach. The new policy continues to be drafted however acute staffing pressures in one team has taken up management time meaning the Q4/March 2025 target is at risk, and may slip to the May 2025 Board for approval.
<a href="#">TU1 - Policy &amp; Procedure for Top up Payments - V0.2.pdf</a>	Financial	01/05/2017	Executive Medical Director	Still waiting for information back from the national group on the All Wales Top Up Policy. Move to Quarter 1 NEW as not response received on All Wales policy as yet. Hannah has chased again 14.02.25
<a href="#">WP29 - BCU Relocation Expenses Policy V0.3.pdf</a>	HR/Staff	05/12/2019	Executive Director of Workforce and Organisational Development	All Wales Policy delayed, summary review Q1 of local policy
<a href="#">WP52 - Study Leave Policy - (Applies to all staff apart from Medical &amp; Dental) - V0.2.pdf</a>	HR/Staff	01/01/2018	Executive Director of Workforce and Organisational Development	Review underway due Q2
<a href="#">WP58 - Electronic Staff Record (ESR) System Policy - V0.1.pdf</a>	HR/Staff;#IT	01/06/2019	Executive Director of Workforce and Organisational Development	This policy will be reviewed in Q1
<a href="#">MHLD 0035 - Home Treatment Team Operational Policy - V0.5 (a).pdf</a>	Patient safety;#Legal	01/04/2021	Executive Director of Allied Health Professions and Health Science	Author will consider the classification of document when reviewing. Minor amendments following consultation, author asked to consider if a procedure rather than a policy.
<a href="#">MD17 - Interventions Not Normally Undertaken (INNU) Policy - V1.1.pdf</a>	Patient safety	01/09/2021	Executive Medical Director	Still under discussion - talk of a National Policy, all HBs are now considering beginning to initiate their own reviews - no movement yet though
<a href="#">MHLD 0040 - Ty Llywelyn Postal Packets &amp; Section 134 (MHA 1983 2007) Policy - V0.1.pdf</a>	Patient safety	01/08/2021	Executive Director of Allied Health Professions and Health Science	Awaiting confirmation of review date, prior to upload onto BetsiNet. Awaiting update from Author
<a href="#">CW01 - BCUHB Paediatric Escalation Policy - V3.pdf</a>	Patient safety	01/09/2019	Chief Operating Officer	Author to consider classification of document when reviewing. The document has been reviewed, but not submitted to the Policies Team for QA

<a href="#">MM37 - Medical Gases - Staff Responsibilities across BCUHB - V1.1.pdf</a>	Patient safety	01/05/2021	Executive Medical Director	Author will consider the classification of document when reviewing. On MPPP agenda for 22.01.25 - on track. Classification of the document as a policy has been considered, and should remain - There is a more general Estates operational procedures document for medical gas pipeline systems (OPD HTM 02-01) that could include this information which is overdue review but think it will be a while until it has been reviewed by estates and therefore I think we need MM37 in the meantime.
<a href="#">MM01 - BCUHB Medicines Policy .pdf</a>	Patient safety	01/07/2022	Executive Medical Director	Storage of medicines chapter of MM01 was sent out on 18.02.25 for consultation, author has split up MM01 as it so large and much more manageable as different docs. CD one and storage will go to MPPPG on 5th March then DTG end of March. Once the author has finished the comments for the CD doc, there are a lot unfortunately, and has that submitted to MPPPG they will then work on rest of MM01. Author currently on planned sick leave for an operation so is unlikely to be ready by end of March it will definitely be complete by end of quarter 1.
<a href="#">MM42 - Unlicensed Medicines Policy - V1.pdf</a>	Patient safety	01/07/2022	Executive Medical Director	Approved by EQDG on 10.02.25 - on track.
<a href="#">MM15 - Policy for Administration &amp; Use of Emergency &amp; Non Emergency Oxygen in Adults in Managed Services - V2.1.pdf</a>	Patient safety	01/02/2022	Executive Medical Director	Document being finalised now that the mandatory training is sorted. Some outstanding work on the some of the appendices
<a href="#">MM02 - Injectable Medicines Policy.pdf</a>	Patient safety	08/07/2022	Executive Medical Director	Has been consulted upon and changes identified but need to update these into the document and then get it to policies and procedures group, in March. Need to move to new Qtr1 2025/26
<a href="#">Mat 74 - BCUHB Breastfeeding Policy.pdf</a>	Patient safety	01/12/2023	Chief Operating Officer	The document is on the agenda for the April EPOG meeting for review and approval.
<a href="#">MHLD 0008 - Threats to the Person and Environment within Forensic Establishments Policy (Ty Llywelyn Medium Secure Unit).pdf</a>	Patient safety	01/01/2024	Executive Director of Allied Health Professions and Health Science	Policy has been approved at EPOG, EqIA reviewed on old template. Amended EqIA being approved by author.
<a href="#">NU21 - Levels of Enhanced Care for Adult Inpatients Policy.pdf</a>	HR/Staff	08/12/2023	Executive Director of Nursing	This policy has been approved and has been returned from the Policy team as there are a small number of amendments/updates required to the front page, which are being completed and finalised, before it is presented to EPOG and then the Executive Committee.
<a href="#">BCUHB - Claims Governance Policy Clinical Negligence and Personal Injury - V8.pdf</a>	Legal;#Financial	01/07/2021	Director of Corporate Governance	The Executive Team approved the Case for Change covering Legal Services in January 2025 which now provides a fundamentally different approach. The new policy continues to be drafted however acute staffing pressures in one team has taken up management time meaning the Q4/March 2025 target is at risk, and may slip to the May 2025 Board for approval.
<a href="#">ES03 - Waste Management Policy - V5.pdf</a>	Health and Safety	01/09/2023	Director of Environment and Estates	Author to consider classification of document when reviewing. The Director of Environment and Estates is new in post, and will need time to review this policy.
<a href="#">ES04 - Policy for the Management of Fire Safety - V0.4.pdf</a>	Health and Safety	01/04/2022	Director of Environment and Estates	Author to consider classification of document when reviewing. The Director of Environment and Estates is new in post, and will need time to review this policy
<a href="#">F017 - Revenue Business Case Policy Approved.pdf</a>	Financial	24/10/2022	Executive Director of Transformation, Strategic Planning and Commissioning	A proposal to retire the policy was presented to the Executive Policy Oversight Group on 16/01/2024, and submitted to the Executive Committee on 22/01/2024. The Interim Executive Director of Finance requested an opportunity to review the document and has subsequently determined that the policy remains extant and that a Standard Operating Procedure or equivalent mechanism be developed in support. Working party members to deliver a SOP have been identified and a meeting was held on the 19/02/25 to develop the outline process.
<a href="#">MHLD 0034 - MHLD Policy for Section 5(2) Doctors Holding Power in Psychiatric Units.pdf</a>	Legal	01/10/2023	Executive Director of Allied Health Professions and Health Science	To be submitted to EQDG
<a href="#">MHLD 0051 - Community Treatment Order Policy MHA 1983 - V0.1.pdf</a>	Legal	01/05/2022	Executive Director of Allied Health Professions and Health Science	Author will consider the classification of document when reviewing. Author is currently on long term out of office. Will seek further advice and consideration regarding procedure rather than policy and how best to progress with Deputy Director for Legal Services.

<a href="#">RD04 - NHS R&amp;D Finance Policy - V1.0.pdf</a>	Medical Research	20/07/2019	Executive Medical Director	No updates yet available with regards to All Wales finance policy.
<a href="#">WP30 - Statutory Mandatory Training Policy and Procedure - V0.3.pdf</a>	Legal;#Health and Safety	01/02/2022	Executive Director of Workforce and Organisational Development	This policy will be reviewed in Q1
<a href="#">MM10 - Antimicrobial Prescribing Policy - V4.pdf</a>	Patient safety	01/05/2024	Executive Medical Director	Approved by DTG on 5th Feb - Advised authors that this will need most probably SCEG (although to send to both Nicky and Cindy for clarity), and will need exec quality group approval as a policy. On track for 31.03.25.
<a href="#">MHLD 0020 - S-CAMHS to Adult Transition Policy - V3.pdf</a>	Patient safety;#Joint working/Collaboration	01/03/2024	Executive Director of Allied Health Professions and Health Science	Following review it was agreed policy needed a complete overhaul and has therefore been re-written. This is still in draft as author advised they struggled to gain engagement however, they are aiming to include in next scheduled Steering Grp meeting on 26th March 2025.
<a href="#">NU28 - Nurse Staffing Levels Policy.pdf</a>	HR/Staff;#Patient safety	01/01/2025	Executive Director of Nursing	The delay is unfortunately due to absence of Lead Reviewer and review temporarily was paused. Lead reviewer has since returned to review the staffing policy and NSA calculation procedure concurrently. Both documents are anticipated to be ready for further progress by the end of week 20th April 2025.
<a href="#">INF03 - Informatics Change Management Policy - V1.pdf</a>	IT	13/01/2023	Chief Digital Information Officer	Policy INF03 IT SYSTEMS CHANGE MANAGEMENT POLICY and the associated ICT procedure are both currently going through the approval process as per guidance, we understand it has been shared with the organisation for feedback on comments and is due to go to the ITIG Meeting for review and approval.
<a href="#">IPC06 - Infection Prevention Hand Hygiene Policy &amp; Procedure (An Element of Standard Infection Control Precautions).pdf</a>	Patient safety	01/03/2025	Executive Director of Nursing	The hand hygiene policy is due to go to SIPG this month on 27th March
<a href="#">RD03 - Policy for Intellectual Property - V2.pdf</a>	Medical Research	01/08/2022	Executive Medical Director	No update on the All Wales IG policy. Local policy continues to be under review.
<a href="#">ES05 - Policy for the Management of Ventilation Systems - V1.0.pdf</a>	Health and Safety	08/03/2025	Director of Environment and Estates	This policy has now transferred to the Director of Environment and Estates, who will need to undertake a review of this policy
<a href="#">F02 - Lease Car &amp; Pool Vehicle Policy and Procedure - V.03.pdf</a>	Financial	15/08/2024	Executive Director of Finance	Author has considered the classification of document when reviewing. The policy and procedure are currently being updated to reflect guidance on National Minimum Wage and mileage rates. Update and consultation scheduled to be completed by 31 March 2025.
<a href="#">HS23 - CCTV and Body Worn Video (BWV) Policy V1.0.pdf</a>	Health and Safety	15/03/2025	Executive Director of Workforce and Organisational Development	Review due Q2
<a href="#">WP69 - Employer Pension Contributions – Alternative Payment Policy.pdf</a>	Financial	01/03/2025	Executive Director of Workforce and Organisational Development	Review underway due Q1



<b>Teitl adroddiad:</b> <i>Report title:</i>	Internal Audit explainer video presentation and communication plan			
<b>Adrodd i:</b> <i>Report to:</i>	Audit Committee			
<b>Dyddiad y Cyfarfod:</b> <i>Date of Meeting:</i>	Thursday, 08 May 2025			
<b>Crynodeb Gweithredol:</b> <i>Executive Summary:</i>	<p>The purpose of this report is to provide the Audit Committee with:</p> <ul style="list-style-type: none"> <li>an update on the Internal Audit explainer video presentation that has been developed</li> <li>an update on the communication plan in relation to this explainer video presentation.</li> </ul>			
<b>Argymhellion:</b> <i>Recommendations:</i>	<p>The Audit Committee is asked to:</p> <ul style="list-style-type: none"> <li><b>NOTE</b> the Internal Audit explainer video presentation that has been developed</li> <li><b>AGREE</b> the communication plan detailed within this paper.</li> </ul>			
<b>Arweinydd Gweithredol:</b> <i>Executive Lead:</i>	Pam Wenger, Director of Corporate Governance			
<b>Awdur yr Adroddiad:</b> <i>Report Author:</i>	Glesni Driver, Head of Statutory Compliance and Inquiries Philippa Peake-Jones, Head of Corporate Affairs			
<b>Pwrpas yr adroddiad:</b> <i>Purpose of report:</i>	<b>I'w Nodi</b> <i>For Noting</i> <input checked="" type="checkbox"/>	<b>I Benderfynu arno</b> <i>For Decision</i> <input checked="" type="checkbox"/>	<b>Am sicrwydd</b> <i>For Assurance</i> <input checked="" type="checkbox"/>	
<b>Lefel sicrwydd:</b> <i>Assurance level:</i>	<b>Arwyddocaol</b> <i>Significant</i> <input type="checkbox"/> Lefel uchel o hyder/tystiolaeth o ran darparu'r mecanweithiau / amcanion presennol  <i>High level of confidence/evidence in delivery of existing mechanisms/objectives</i>	<b>Derbyniol</b> <i>Acceptable</i> <input checked="" type="checkbox"/> Lefel gyffredinol o hyder/tystiolaeth o ran darparu'r mecanweithiau / amcanion presennol  <i>General confidence / evidence in delivery of existing mechanisms / objectives</i>	<b>Rhannol</b> <i>Partial</i> <input type="checkbox"/> Rhywfaint o hyder/tystiolaeth o ran darparu'r mecanweithiau / amcanion presennol  <i>Some confidence / evidence in delivery of existing mechanisms / objectives</i>	<b>Dim Sicrwydd</b> <i>No Assurance</i> <input type="checkbox"/> Dim hyder/tystiolaeth o ran y ddarpariaeth  <i>No confidence / evidence in delivery</i>

<p><b>Cyfiawnhad dros y gyfradd sicrwydd uchod. Lle bo sicrwydd 'Rhannol' neu 'Dim Sicrwydd' wedi'i nodi uchod, nodwch gamau i gyflawni sicrwydd 'Derbyniol' uchod, a'r terfyn amser ar gyfer cyflawni hyn:</b></p> <p><b><i>Justification for the above assurance rating. Where 'Partial' or 'No' assurance has been indicated above, please indicate steps to achieve 'Acceptable' assurance or above, and the timeframe for achieving this:</i></b></p>	
<p>Even though a considerable amount of work has been undertaken by action owners and Executive Directors to update progress against Internal Audit recommendations, there is still work to be done around the suitability of the evidence provided to support closure. Also, due to the historical nature of some of the recommendations, and the changes that have taken place within the Health Board over the last few years, new staff now in post have inherited internal audit recommendations, and they may therefore not be aware of the reason for such audits to take place, and the process around the implementation of recommendations.</p>	
<p><b>Cyswllt ag Amcan/Amcanion Strategol:</b></p> <p><b><i>Link to Strategic Objective(s):</i></b></p>	<p>Not applicable, other than those relating to individual audit reviews/recommendations.</p>
<p><b>Goblygiadau rheoleiddio a lleol:</b></p> <p><b><i>Regulatory and legal implications:</i></b></p>	<p>Compliance with Internal Audit requirements.</p>
<p><b>Yn unol â WP7, a oedd EqlA yn angenrheidiol ac a gafodd ei gynnal?</b></p> <p><b><i>In accordance with WP7 has an EqlA been identified as necessary and undertaken?</i></b></p>	<p>The Equality duty is not applicable. This report is purely administrative in nature and submitted for information only. The associated public sector duties are not engaged, and there are no associated impacts on any of the protected groups</p>
<p><b>Yn unol â WP68, a oedd SEIA yn angenrheidiol ac a gafodd ei gynnal?</b></p> <p><b><i>In accordance with WP68, has a SEIA identified as necessary been undertaken?</i></b></p>	<p>The Socio-Economic duty is not applicable. This report is purely administrative in nature and submitted for information only. The associated public sector duties are not engaged, and the report does not relate to a decision, strategic or otherwise.</p>
<p><b>Manylion am risgiau sy'n gysylltiedig â phwnc a chwmpas y papur hwn, gan gynnwys risgiau newydd (croesgyfeirio at y BAF a'r CRR)</b></p> <p><b><i>Details of risks associated with the subject and scope of this paper, including new risks (cross reference to the BAF and CRR)</i></b></p>	<p>Not applicable, other than those relating to individual audit reviews/recommendations.</p>
<p><b>Goblygiadau ariannol o ganlyniad i roi'r argymhellion ar waith</b></p> <p><b><i>Financial implications as a result of implementing the recommendations</i></b></p>	<p>Not applicable, other than those relating to individual audit reviews/recommendations.</p>
<p><b>Goblygiadau gweithlu o ganlyniad i roi'r argymhellion ar waith</b></p> <p><b><i>Workforce implications as a result of implementing the recommendations</i></b></p>	<p>Not applicable, other than those relating to individual audit reviews/recommendations.</p>
<p><b>Adborth, ymateb a chrynodeb dilynol ar ôl ymgynghori</b></p> <p><b><i>Feedback, response, and follow up summary following consultation</i></b></p>	<p>The report has been prepared in response to a request by the Audit Committee for training material to be prepared and disseminated</p>

<p><b>Cysylltiadau â risgiau BAF:</b> (neu gysylltiadau â'r Gofrestr Risg Gorfforaethol)</p> <p><b>Links to BAF risks:</b> (or links to the Corporate Risk Register)</p>	<p>Not applicable, other than those relating to individual audit reviews/recommendations.</p>
<p><b>Rheswm dros gyflwyno adroddiad i fwrdd cyfrinachol (lle bo'n berthnasol)</b></p> <p><b>Reason for submission of report to confidential board (where relevant)</b></p>	<p>Not applicable</p>
<p><b>Camau Nesaf:</b> <b>Gweithredu argymhellion</b></p> <p><b>Next Steps:</b> <b>Implementation of recommendations</b></p> <p>The Corporate Governance Directorate will progress the recommendations within this report, if approved by the Audit Committee.</p>	
<p><b>Rhestr o Atodiadau:</b></p> <p><b>List of Appendices:</b></p> <p>N/A</p>	

# **INTERNAL AUDIT EXPLAINER VIDEO AND COMMUNICATION PLAN**

## **1. INTRODUCTION AND BACKGROUND**

Following a request by the Audit Committee, this report provides an update on the Internal Audit explainer video presentation that has been prepared, and the communication plan for its dissemination.

## **2 EXPLAINER VIDEO PRESENTATION**

The Corporate Governance Directorate, in collaboration with Internal Audit, has prepared an explainer video presentation on the role of Internal Audit at the Health Board. The video presentation covers how Internal Audit helps the Health Board to strengthen its governance and assurance processes, and also the purpose of Internal Audit, the approach, reporting and how internal audit reports and responses are managed at the Health Board.

The explainer video presentation is 15 slides in total, and should be reviewed in 'slideshow mode' within Microsoft PowerPoint as this will enable the viewer to hear a narrative update on the content of each slide. The first slide provides instructions to this effect. Once the narrative update has finished, the viewer should continue to the next slide, where they will hear the narrative update for that slide.

As there are video and audio recordings within the explainer video presentation, this makes the document large in size, and due to this, it cannot be circulated via e-mail. A previous version of the presentation was shared with the Independent Members on their Teams Channel on 10<sup>th</sup> February 2025, but the presentation has since been updated to reflect feedback following the Audit Committee Development Session on 20<sup>th</sup> February 2025.

Due to the size of the presentation, it has been shared on the IM Teams channel for members to view.

Work is also ongoing to translate the slide and recordings to the Welsh Language.

### 3 COMMUNICATION PLAN

In order to disseminate the explainer video presentation within the Health Board, the following communication plan is proposed:

Communication method	Targeted audience	Comments
Independent Members Teams Channel	Independent Members	This will provide access to the material at any time through the IM Teams Channel.
Corporate Governance intranet site	All Health Board employees	This will provide access to the material to any Health Board member at any time.
Weekly Bulletin	All Health Board employees	In line with the publication of the material on the Corporate Governance Intranet page, a communication message to be included in the Weekly Bulletin, signposting and providing a link to the material on the Corporate Governance intranet page. This message to be repeated on a quarterly basis.
E-mail	Executive Directors	An e-mail to the Executive Directors signposting and providing a link to the material on the Corporate Governance intranet page
E-mail	Single point of contact individuals involved in audit tracking updates	An e-mail to the SPOCs identified for the audit tracking update work signposting and providing a link to the material on the Corporate Governance intranet page. This can then be shared with new recommendations owners

#### **4 CONCLUSION AND RECOMMENDATIONS**

It is proposed that the Audit Committee APPROVE the content of the revised Internal Audit Explainer Video Presentation, and the proposed communications plan.

#### **5 BUDGETARY/FINANCIAL IMPLICATIONS**

There are no budgetary implications associated with this paper.

#### **6 RISK MANAGEMENT**

It is essential that the Health Board progresses work around the audit recommendations as a matter of urgency, and does so in a timely manner, providing sufficient evidence of action taken to progress the recommendation in order to ensure timely closure of Internal Audit recommendations to the satisfaction of both Internal Audit and the Audit Committee.

#### **7 EQUALITY AND DIVERSITY IMPLICATIONS**

The Equality duty is not applicable to the content of this report as it is purely administrative in nature and submitted for information only.

<b>Teitl adroddiad:</b> <b>Report title:</b>	Corporate Risk Register
<b>Adrodd i:</b> <b>Report to:</b>	Audit Committee
<b>Dyddiad y Cyfarfod:</b> <b>Date of Meeting:</b>	Thursday, 08 May 2025
<b>Crynodeb Gweithredol:</b> <b>Executive Summary:</b>	<p>The purpose of this standing agenda item is to provide an update position of the Corporate Risk Register (Appendix 2)</p> <p>The Committee is asked to note changes approved by the Executive Team:</p> <ul style="list-style-type: none"> <li>• <b>Target dates extensions:</b> <ul style="list-style-type: none"> <li>○ CRR24-10 – Urgent and Emergency Care</li> <li>○ CRR24-18 – Operational Planning for Transmittable Diseases and Outbreaks</li> <li>○ CRR24-20 – Oncology Services</li> </ul> </li> <li>• <b>Risks opened:</b> <ul style="list-style-type: none"> <li>○ CRR24-27 – Neurodevelopment Waiting List</li> <li>○ CRR24-28 – External Recommendations and Response plans.</li> </ul> </li> </ul> <p>The group is asked to agree the newly opened Corporate Risk CRR24-28 'External Recommendations and Response plans' as the risk will sit under the Audit Committee's remit.</p> <p><b>Gaps in assurance</b> for escalate to the Group:</p> <ul style="list-style-type: none"> <li>• Risk not updated by the service:           <ul style="list-style-type: none"> <li>○ CRR24-22 – Orthodontic Services</li> <li>○ CRR24-25 – Dermatology &amp; Plastic Surgery Services</li> </ul> </li> </ul> <p>At the time of reporting 2 risks were not updated for inclusion in the March 2025 Corporate risk register update report.</p> <p>No reduction in current risk score were proposed during the last iteration of the Corporate Risks.</p> <p><b>To note:</b> Good progress on actions; Of the 26 Corporate Risks, 172 actions have been developed to mitigate the risks, 142 actions are progressing and on track (39 of which have revised due dates), 2 new actions have been identified and 25 actions have been closed since the last update. 3 actions overdue.</p> <p>Appendix 1 – Corporate Risk Register Dashboard March 2025          Appendix 2 - Full Corporate Risk Register as of March 2025.</p>

<p><b>Argymhellion:</b></p> <p><b>Recommendations:</b></p>	<p>The Committee is asked to <b>agree</b>:</p> <ol style="list-style-type: none"> <li>1. New risk CRR24-28 'External Recommendations and Response plans'</li> </ol> <p>The Committee is asked to <b>note</b>:</p> <ol style="list-style-type: none"> <li>1. The Corporate Risk Register as reported to Risk Scrutiny Group Mar 25*</li> </ol>			
<p><b>Arweinydd Gweithredol:</b></p> <p><b>Executive Lead:</b></p>	<p>Pam Wenger, Director of Corporate Governance</p>			
<p><b>Awdur yr Adroddiad:</b></p> <p><b>Report Author:</b></p>	<p>Nesta Collingridge Head of Risk Management</p>			
<p><b>Pwrpas yr adroddiad:</b></p> <p><b>Purpose of report:</b></p>	<p>I'w Nodi <i>For Noting</i></p> <p><input checked="" type="checkbox"/></p>	<p>I Benderfynu arno <i>For Decision</i></p> <p><input checked="" type="checkbox"/></p>	<p>Am sicrwydd <i>For Assurance</i></p> <p><input checked="" type="checkbox"/></p>	
<p><b>Lefel sicrwydd:</b></p> <p><b>Assurance level:</b></p>	<p>Arwyddocaol <i>Significant</i></p> <p><input type="checkbox"/></p> <p>Lefel uchel o hyder/tystiolaeth o ran darparu'r mecanweithiau / amcanion presennol</p> <p><i>High level of confidence/evidence in delivery of existing mechanisms/objectives</i></p>	<p>Derbyniol <i>Acceptable</i></p> <p><input checked="" type="checkbox"/></p> <p>Lefel gyffredinol o hyder/tystiolaeth o ran darparu'r mecanweithiau / amcanion presennol</p> <p><i>General confidence / evidence in delivery of existing mechanisms / objectives</i></p>	<p>Rhannol <i>Partial</i></p> <p><input type="checkbox"/></p> <p>Rhywfaint o hyder/tystiolaeth o ran darparu'r mecanweithiau / amcanion presennol</p> <p><i>Some confidence / evidence in delivery of existing mechanisms / objectives</i></p>	<p>Dim Sicrwydd <i>No Assurance</i></p> <p><input type="checkbox"/></p> <p>Dim hyder/tystiolaeth o ran y ddarpariaeth</p> <p><i>No confidence / evidence in delivery</i></p>
<p><b>Cyfiawnhad dros y gyfradd sicrwydd uchod. Lle bo sicrwydd 'Rhannol' neu 'Dim Sicrwydd' wedi'i nodi uchod, nodwch gamau i gyflawni sicrwydd 'Derbyniol' uchod, a'r terfyn amser ar gyfer cyflawni hyn:</b></p> <p><b>Justification for the above assurance rating. Where 'Partial' or 'No' assurance has been indicated above, please indicate steps to achieve 'Acceptable' assurance or above, and the timeframe for achieving this: N/A</b></p>				
<p><b>Cyswllt ag Amcan/Amcanion Strategol:</b></p> <p><b>Link to Strategic Objective(s):</b></p>	<p>Detailed in the BAF report and how the CRR aligns to the revised BAF</p>			
<p><b>Goblygiadau rheoleiddio a lleol:</b></p> <p><b>Regulatory and legal implications:</b></p>	<p>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.</p>			
<p><b>Yn unol â WP7, a oedd EqIA yn angenrheidiol ac a gafodd ei gynnal?</b></p> <p><b>In accordance with WP7 has an EqIA been identified as necessary and undertaken?</b></p>	<p>Not applicable for this report</p>			
<p><b>Yn unol â WP68, a oedd SEIA yn angenrheidiol ac a gafodd ei gynnal?</b></p>	<p>Not applicable for this report</p>			

<b><i>In accordance with WP68, has an SEIA identified as necessary been undertaken?</i></b>	
<b>Manylion am risgiau sy'n gysylltiedig â phwnc a chwmpas y papur hwn, gan gynnwys risgiau newydd (croesgyfeirio at y BAF a'r CRR)</b>  <b><i>Details of risks associated with the subject and scope of this paper, including new risks( cross reference to the BAF and CRR)</i></b>	Board Assurance Framework due for review
<b>Goblygiadau ariannol o ganlyniad i roi'r argymhellion ar waith</b>  <b><i>Financial implications as a result of implementing the recommendations</i></b>	The effective and efficient mitigation and management of risks has the potential to leverage a positive financial dividend for the Health Board through better integration of risk management into business planning, decision-making and in shaping how care is delivered to our patients thus leading to enhanced quality, less waste and no claims.
<b>Goblygiadau gweithlu o ganlyniad i roi'r argymhellion ar waith</b>  <b><i>Workforce implications as a result of implementing the recommendations</i></b>	Failure to capture, assess and mitigate risks can impact adversely on the workforce.
<b>Adborth, ymateb a chrynodeb dilynol ar ôl ymgynghori</b>  <b><i>Feedback, response, and follow up summary following consultation</i></b>	Quality assurance by Corporate Risk Management Team and some have been updated and presented to Risk Scrutiny Group, Executive Team and relevant Committees.
<b>Cysylltiadau â risgiau BAF:</b> (neu gysylltiadau â'r Gofrestr Risg Gorfforaethol)  <b><i>Links to BAF risks:</i></b> ( <i>or links to the Corporate Risk Register</i> )	See the individual risks for details of the related links to the Board Assurance Framework.
<b>Rheswm dros gyflwyno adroddiad i fwrdd cyfrinachol (lle bo'n berthnasol)</b>  <b><i>Reason for submission of report to confidential board (where relevant)</i></b>	<b>N/A</b> <b>Cyber risk CRR24-17 excluded from the paper</b>
<b>Camau Nesaf / Next Steps:</b>  <ol style="list-style-type: none"> <li>1. Further scrutiny of all corporate risks by Executive Team as per normal reporting cycle.</li> <li>2. Submission of Corporate Risks to Board.</li> <li>3. Continuation of Risk Audits carried out within services.</li> </ol>	
<b>Rhestr o Atodiadau:</b> <b><i>List of Appendices:</i></b> <ul style="list-style-type: none"> <li>• Appendix 1 – Corporate Risk Register Dashboard Mar 25</li> <li>• Appendix 2 – Corporate Risk Register Report Mar 25</li> </ul>	



# Corporate Risk Register





## 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

Risks have been reviewed and updated by the relevant services.

Extensions to the Target Risk due dates for the following risks:

- **CRR24-10** 'Urgent and Emergency Care' –Extend the target risk due date from the 31/03/2025 to 30/06/2026 to align with the updated programme of action due dates following the identification of new actions required to reduce the risk.
- **CRR24-18** 'Operational Planning for Transmittable Diseases and Outbreaks – Health Protection' – Extend the target risk due date from the 31/01/2025 to the 31/03/2026 as significant time has been taken up with working on the High Consequence Infectious Disease response. This has included the development and testing of pathways, reporting to the NHS Exec, provision of training to primary care etc. The delivery of a health board communicable disease plan has been aligned to one of three major work programmes of the Health Protection Service, allowing further time to ensure that this piece of work is delivered effectively and appropriately.
- **CRR24-20** 'Oncology Services' – Extend the target risk due date from the 31/04/2025 to 31/03/2026 to align with action due dates and allow implementation of identified actions required.

The Committee is asked to note lack of updates and developments at the time of reporting, March 2025:

- **CRR24-22** – Orthodontic Services
- **CRR24-25** – Dermatology & Plastic Surgery Services

Requests have been made for review/updates prior to the next iteration and onward reporting to relevant Board Committees in order to report on updates to the Corporate Risks.

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

March 2025:

- **CRR24-01** – People, Culture and Wellbeing
- **CRR24-16** – Leadership

April 2025:

- **CRR24-21** – Ophthalmology Service
- **CRR24-23** – Vascular Service
- **CRR24-24** – Renal Service

## 1.2 Changes in Score

None

## 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)
CRR24-27	Neurodevelopment Waiting List	Chief Operating Officer	15 (5x4)
CRR24-28	External Recommendations and Response Plans	Director of Corporate Governance	16 (4x4)

- **CRR24-27** 'Neurodevelopmental Waiting List – Current score for the risk sits at 20 (Impact, 5 x Likelihood, 4 = 20) resulting in the newly escalated risk currently scoring **above** the tolerance range set in the appetite.
- **CRR24-28** 'External Recommendations and Response Plans' – The Committee is asked to **agree** the newly opened Corporate Risk CRR24-28 'External Recommendations and Response plans' as the risk will sit under the Audit Committee's remit.

## 1.4 Overdue/Delayed Actions

The corporate risk register report was produced at the beginning of **March 2025** for review and approval by the Executive Team. At the time of producing three actions was 'overdue' however some actions are noted for being completed end of March 2025.

As per the normal cycle of reporting, the May 2025 updates are being sought for current updates on all of these actions. The status of these actions will be included in the next update/iteration of the risk register.

## 1.5 Risks above Health Board 24/25 appetite

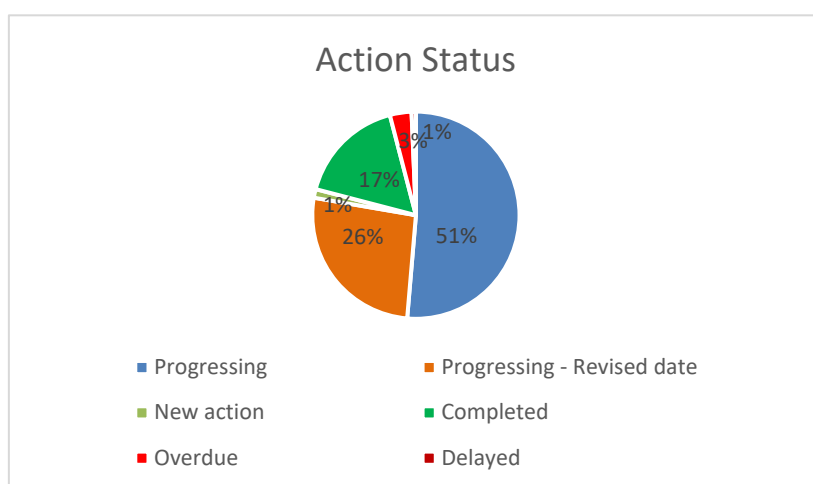
Nine risks reported to committee score **above** the tolerance range set in the appetite (including one new risk CRR24-27).

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

Risk Ref	Risks	Lead Exec Director	Current Risk Score	Risk Tolerance Range in Appetite Score
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
CRR24-21	Ophthalmology Service	Interim Chief Operating Officer	20	Quality 15-19
CRR24-27	Neurodevelopmental Waiting List	Chief Operating Officer	20	Quality 15-19

## 1.6 Action Plan status of Corporate Risks

Out of the 26 corporate risks, 172 actions have been developed to mitigate the risks, 142 actions are progressing and on track (39 of which have revised due dates), 2 new actions have been identified and 25 actions have been closed since the last update. 3 actions overdue.

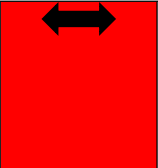
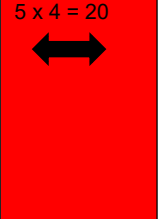
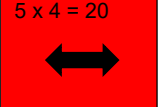
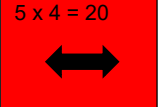
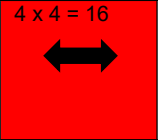
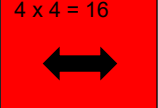
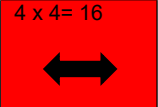
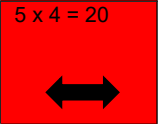


## Next steps

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 Mar 2025

Lead	Ref	Risk Title	Current Score (Impact x Likelihood)	Risk Target Score	Appetite Main Risk Type	Lead Board Committee	Risk Management Commentary
					Appetite Level		
EDoW	CRR24-01	People, Culture and Wellbeing	4 x 4 = 16 ↔	8	Quality Open <16	People & Culture Committee	Opened Dec 23. 12 actions identified, 2 completed, 6 progressing with 4 progressing with revised due dates.
EDoN	CRR24-02	Patient Safety	4 x 4 = 16 ↔	12	Quality Open <16	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).
EDoN	CRR24-04	Failure to Embed Learning	5 x 3 = 15 ↔	5	Quality Open <16	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.
EDoF	CRR24-05	Financial Sustainability	5 x 4 = 20 ↔	12	Financial Open <16	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.  <b>Risk Score above tolerance set in risk appetite.</b>
DoE	CRR24-06	Suitability and Safety of Sites	4 x 5 = 20 ↔	12	Quality Open <16	Performance, Finance and Information Governance Committee	Opened March 24, 4 actions identified, 3 progressing, 1 overdue overdue  <b>Risk Score above tolerance set in risk appetite.</b>
CDIO	CRR24-07	Fragmented Patient Care Record	4 x 4 = 16 ↔	12	Quality Open <16	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 <16	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.
COO	CRR24-09	Primary Care	4 x 5 = 20	12	Quality		

					Open <16	Quality, Safety and Experience Committee	Opened Feb 24, 7 actions identified, all 7 progressing, with 3 revised due dates. The <b>inherent and current risk scores are both 20</b> , indicating the controls are not yet reducing the risk.  <b>Risk Score above tolerance set in risk appetite.</b>
COO	CRR24-10	Urgent and Emergency Care	5 x 4 = 20 	12	Quality Open <16	Performance, Finance and Information Governance Committee	Opened Feb 24, 5 actions progressing, with 2 revised dates.  <b>Risk Score above tolerance set in risk appetite.</b>  <b>Extended the Target risk due date to allow sufficient time to complete and implement identified actions, from the 31/03/2025 to the 30/06/2026.</b>
COO	CRR24-11	Planned Care	5 x 4 = 20 	8	Quality Open <16	Performance, Finance and Information Governance Committee	Opened Feb 24, 5 actions identified, 3 progressing, with 1 action completed.  <b>Risk Score above tolerance set in risk appetite.</b>
COO	CRR24-13	Timely Diagnostics	5 x 4 = 20 	5	Quality Open <16	Quality, Safety and Experience Committee	Opened Feb 24, 6 actions progressing, with 1 revised date.  <b>Risk Score above tolerance set in risk appetite.</b>
EDoTH	CRR24-14	Harm from the Medical Devices/ Equipment	4 x 4 = 16 	8	Quality Open <16	Quality, Safety and Experience Committee	Opened Feb 24, 5 actions identified, all 3 progressing with revised due dates and 1 closed action.  No update from service.
DoE	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.
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
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.  <b>Target score of 15 not in line with appetite.</b>
EDoPH	CRR24-18	Operational Planning for Transmittable	4 x 4 = 16	12	Quality		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

		Diseases and Outbreaks			Open <16	Planning, Population Health & Partnership Committee	- November 2024, resulting in the risk now within the tolerance set within the risk appetite. <b>Extended the Target risk due date to allow sufficient time to complete and implement identified actions, from the 31/01/2025 to the 31/03/2026.</b>
COO	CRR24-19	Community Care Provision	4 x 5 = 20 	12	Quality Open <16	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.  <b>Risk Score above tolerance set in risk appetite.</b>
EMD	CRR24-20	Oncology Services	3 x 5 = 15 	9	Quality Open <16	Quality, Safety and Experience Committee	Risk approved Nov 24, 7 actions in total, 3 completed actions, 4 progressing.  <b>Extended the Target risk due date to allow sufficient time to complete and implement identified actions, from the 30/04/2025 to the 31/03/2026.</b>
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, 2 progressing, 2 overdue  <b>Risk Score above tolerance set in risk appetite. Partially updated, no update on actions</b>
COO	CRR24-22	Orthodontic Services	4 x 4 = 16 	4	Quality Open <16	Quality, Safety and Experience Committee	Risk approved Nov 24, 11 actions in total, 3 completed actions, 8 progressing. No update from service.
COO	CRR24-23	Vascular Services	4 x 4 = 16 	12	Quality Open <16	Quality, Safety and Experience Committee	Risk approved Nov 24, 9 actions in total, 9 progressing. No update from service.
COO	CRR24-24	Renal Services	4 x 4 = 16 	12	Quality Open <16	Quality, Safety and Experience Committee	Risk approved Nov 24, 4 actions in total, 4 progressing. No update from service.
EMD	CRR23-25	Dermatology & Plastic Surgery Services	3 x 5 = 15 	9	Quality Open <16	Quality, Safety and Experience Committee	Risk approved Nov 24, 5 actions in total, 5 progressing. No update from service.
EMD	CRR24-26	Urology Services	4 x 4 = 16 	6	Quality Open <16	Quality, Safety and Experience Committee	Risk approved Nov 24, 4 actions in total, 1 completed actions, 3 progressing.

COO	CRR24-27	Neurodevelopmental Waiting List	5 x 4 = 20	15	Quality	Quality, Safety and Experience Committee	New Risk, 14 actions identified and progressing.
					Open <16		
DCG	CRR24-28	External Recommendations and Response Plans	4 x 4 = 16	6	Regulatory	Audit Committee	New Risk, 13 actions identified and progressing.
					Seek 20-25		

Committee	
Performance, Finance and Information Governance Committee	PFIGC
Quality, Safety and Experience Committee	QSE
People & Culture Committee	P&C
Audit Committee	AC
Planning, Population Health & Partnership Committee	PPHP

Executive Lead	
Executive Director of Workforce	EDoW
Executive Director of Nursing & Midwifery	EDoN
Executive Director of Finance	EDoF
Chief Digital Information Officer	CDIO
Executive Director of Public Health	EDoPH
Director of Environment	DoE
Chief Operating Officer	COO
Director of Corporate Governance	DCG
Executive Director of Therapies and Allied Health Professions	EDoTH

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

## Appendix 2 – Corporate Risk Register March 2025

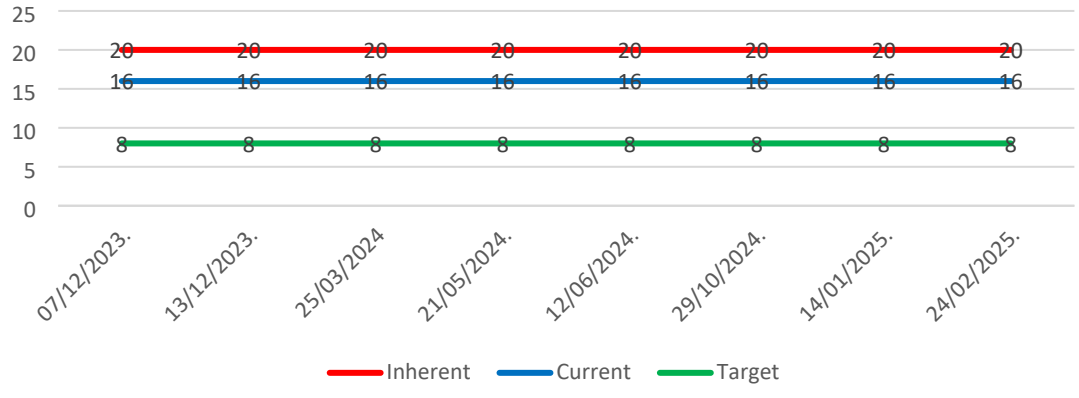
CRR 24-01	<b>Risk Title:</b> People, Culture and Wellbeing		<b>Date Opened:</b> 07/12/2023
	<b>Assuring Committee:</b> People & Culture Committee		<b>Date Last Committee Review:</b> 13/02/2025
<b>Date Last Reviewed:</b> 24/02/2025	<b>Director Lead:</b> Deputy Director of People & Organisational Development	<b>Link to BAF:</b>	<b>Target Risk Date:</b> 31/03/2026
<p>There is a risk that BCU do not have a <b>highly skilled</b>, engaged and <b>motivated</b> workforce which could impact on safe delivery of care. This could be caused by <b>staffing shortfalls</b>, organisational reputation and staff not feeling psychologically safe which could lead to burnout. This could lead to the inability to attract and retain high quality and skilled people.</p>			
<b>Mitigations/Controls in place</b>		<b>Additional Controls required</b>	
<ol style="list-style-type: none"> <li>1. The Strategic Recruitment team in place to oversee efficient and effective professional recruitment for all senior leadership and medical &amp; dental consultant appointments across the Health Board</li> <li>2. Local IHC Resourcing Teams are in place across all IHC/Pan Services to drive forward recruitment and staffing priorities.</li> <li>3. The Recruiting well and Joining Well programmes in operation.</li> <li>4. Organisational Retention lead in post for BCU linked with national retention work through Health Education Improvement Wales (HEIW)</li> <li>5. Dedicated Nurse Retention Lead in place to deliver the Nurse Retention Implementation Plan for the organisation</li> <li>6. New All Wales Flexible working policy has been ratified and is in place</li> <li>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</li> <li>8. Speak out Safely Multi Disciplinary Team in place</li> <li>9. Work in Confidence platform for staff to safely raise concerns.</li> <li>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</li> <li>11. The Culture Change Plan, which incorporated the results from the Staff Survey</li> </ol>		<ol style="list-style-type: none"> <li>a) The programme of work through a new Education Governance Group to be established</li> <li>b) Implementation of the Employee Engagement plan and having a suite of clear indicators that measure employee engagement</li> <li>c) Development of a programme of work to ensure line manager's full involvement in employee engagement</li> <li>d) Feedback from the HEIW Nurse retention tool.</li> <li>e) Targeted management of sickness absence rates</li> <li>f) Engagement and operational effectiveness with Medical and Dental workforce</li> <li>g) an embedded workforce planning function</li> </ol>	



<p>12. Staff facing version of the Learning Organisation Framework developed for use in work-based learning contexts</p> <p>13. The key themes of the 2023 staff survey have been shared with the organisation</p> <p>14. Approval of the new culture change and Behaviours Framework (ref CRR24-16)</p> <p>15. International recruitment drives, both local and all Wales</p> <p>16. People Managers Forums in place that include sessions on compassionate leadership and our values and behaviours framework</p>		
Actions	Due Date	Progression Analysis
<p>REF Gaps in controls; A. Education and Learning Committee is being established as a control measure</p> <p>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</p> <p>Work to setup the Education Governance Group is still ongoing however, the Terms of Reference and membership is still to be agreed.</p> <p><a href="#">Due to unforeseen absences in the People Service Leadership team this action was extended. Work is underway with the Nursing Leadership Team to establish this group.</a></p>	30/04/2025	Progressing (Revised date from 31/10/2024 then 31/3/2025)
<p>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</p> <p><a href="#">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.</a></p>	30/05/2025	Progressing
<p>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</p> <p><a href="#">The Discovery Report in Foundations for the future (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</a></p>	01/06/2025	Progressing (Revised date from 31/10/2024)
<p>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</p>	31/03/2025	Progressing (Revised

<p>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</p> <p>Following extensive engagement over 5 months the Board formally approved our refreshed values and behaviours framework in November 2024. There is a Communication &amp; Socialisation plan in place and a high-level Embedding Plan in place was agreed by ET and P&amp;CC. A more detailed version of the Embedding Plan will be provided to the CEO for approval.</p> <p>A Design Group is in place which supports the co-production and co-design of all work related to Culture Development.</p> <p><a href="#">A more detailed deployment plan to embed the values and behaviours has been drafted and will be submitted to the Executive Team in March 2025.</a></p>		date from 28/02/2025)
<p>REF Gaps in controls; B, A toolkit on how to use the values and behaviours is in development</p> <p><a href="#">This is progressing and is expected to be completed in March 2025</a></p>	31/03/2025	Progressing
<p>The Culture, Leadership &amp; 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</p> <p><a href="#">This is on track to be completed in March, notwithstanding any requested changes</a></p>	31/03/2025	Progressing
<p>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 People &amp; Organisational Development (POD) leadership in February 2025.</p> <p><a href="#">This will be discussed at POD leadership on 3<sup>rd</sup> March then will be added to Datix</a></p>	31/03/2025	Progressing (Revised date from 28/2/2025)
<p>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</p>	30/06/2025	Progressing
<p>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.</p>		Progressing (Revised

<p>The programme for Recruiting Well, Joining Well, Leaving Well will now be incorporated into the <b>Staff Journey</b> programme of work.</p> <p>An illustrative map is currently being developed showing all areas within People Services and OD that employees typically encounter, from Hire to Retire'. Work is 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.</p> <p>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 <i>Corporate and Local Induction, Shortlisting timescales, Advertising in recruitment</i> and the <i>Leaving Well booklet</i>. These initial workstreams are planned to be completed by the end of December 2024.</p> <p>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.</p> <p>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</p> <ol style="list-style-type: none"> <li>The leaving well booklet</li> <li>Improving shortlisting timescales</li> <li>Advertising well in recruitment</li> </ol>	31/12/2025	date from 31/12/2024)		
<p>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 2025 and 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</p>	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
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**Rationale for Corporate Risk**

KPIs to that inform our risk in this area as at January 2025;

Overall Vacancy rate of 8.2% (down 0.8% from Jan 24). The staff groups pushing up the vacancy rates are M&D, Estates & Ancillary and A&C. Nursing are showing a positive downturn in vacancy rates compared to this time last year with effective international recruitment campaigns contributing.

Turnover is on a steady downward trend, currently our lowest score since January 2022, at 7.9% and down 0.6% in the last 12 months. Additional clinical services, AHPs and Healthcare scientists reporting increased turnover in the last 12 months. This is mirrored by a steady improvement in staff retention over the previous 12 months.

Rolling sickness absence spiked in December 2024 and remains high at 6.7% for January25, 0.5% higher than the same period last year. Stress, anxiety and depression continues as the highest reported reason despite also showing a reduction in time lost.

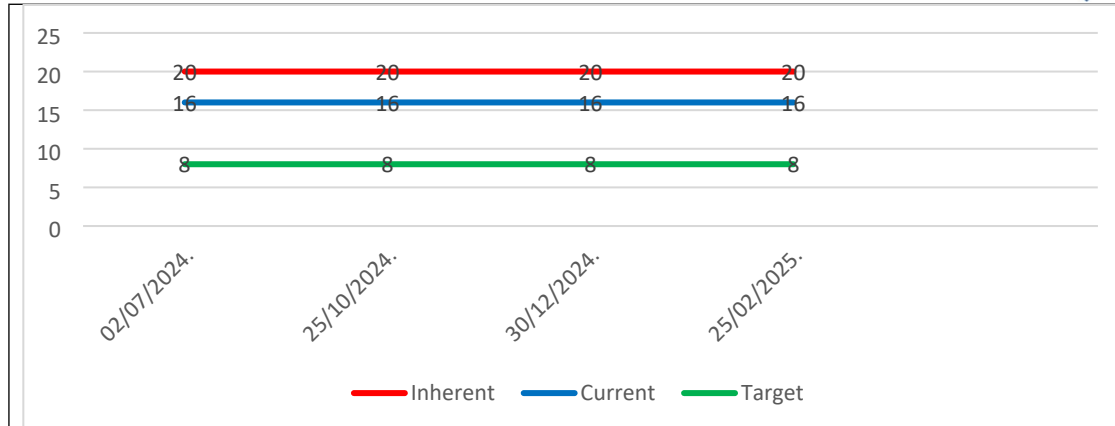
There has been a decline in the number of emergency salary payments in the past 12 months. E-rosters approved within policy timescales has improved in the last we months but work still needs to be done to meet the 80% KPI.

CRR 24-02	<b>Risk Title:</b> Patient Safety		<b>Date Opened:</b> 02/07/2024
	<b>Assuring Committee:</b> Quality, Safety and Experience Committee		<b>Date Last Committee Review:</b> 20/02/2025
<b>Date Last Reviewed:</b> 25/02/2025	<b>Director Lead:</b> Executive Director of Nursing and Midwifery	<b>Link to BAF:</b> BAF24-06	<b>Target Risk Date:</b> 30/09/2025
<p>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.</p>			
<b>Mitigations/Controls in place</b>		<b>Additional Controls required</b>	
<ol style="list-style-type: none"> <li>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.</li> <li>2. Review of patient safety incidents at a local level supported by integrated concerns meetings and harms reviews for learning meetings.</li> <li>3. Strategic groups that report into the Health Board Patient Safety Group, e.g. Falls Group, Prevention and Management of Pressure Ulcers Group, <a href="#">Improving Nutrition and Catering Standards</a>, <a href="#">Safer Medicines Steering Group</a>, Sepsis Triggers Escalation &amp; Antibiotic Stewardship Review for learning and improvement.</li> <li>4. Escalation to Quality Delivery Group and Quality, Safety and Experience Committee.</li> <li>5. Cycle of business to Patient Safety Group that includes IHC/Divisional deep dives of progress and action.</li> <li>6. BCUHB wide Improvement plans for falls, Hospital Acquired Pressure Ulcers, <a href="#">Nutrition and Medicines safety</a></li> <li>7. Incident management process including rapid reviews, focused reviews and learning panels.</li> <li>8. <a href="#">All Staff induction, training and competency</a></li> <li>9. Organisational Learning Forum for shared learning and improvement</li> <li>10. Regular patient safety incident alerts issued to staff as and when required</li> </ol>		<ol style="list-style-type: none"> <li>a. Sustained compliance of &gt;85% of patient safety related mandatory training</li> <li>b. Timely update of policies and procedures in line with evidence based practice and as per governance cycle for review.</li> <li>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.</li> <li>d. <a href="#">Continued work on the 6 goals and Urgent and Emergency Care pathways to reduce the risk of patient safety incidents.</a></li> <li>e. <a href="#">Continued work on the planned care delays and backlog harms reviews associated with long delays.</a></li> <li>f. <a href="#">Continued work with People services to ensure robust assurance measures are in place for our temporary workforce to ensure they have the skills and competencies required to maintain patient safety.</a></li> </ol>	



- 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 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.	15/01/2025	Complete		
Strategy for increasing compliance with patient safety related mandatory training. Positive increase noted in compliance and will be ongoing as oxygen administration mandatory training is delivered.	31/03/2025	Progressing (revised date from 30/01/2024)		
Deliver all the actions from the Internal Audit of falls. Combined HSE and Internal Audit action plan in place. Evidence 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	Quality		<16
<b>Position &amp; Intended Outcome for Risk</b>				

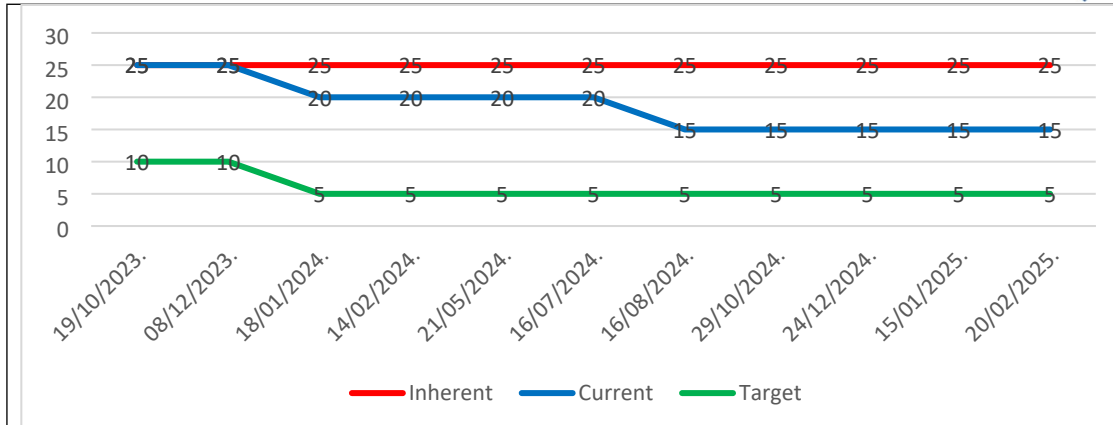


There are circa 38,000 patient safety incidents reported in the last financial year of which approximately 25% graded as moderate harm or above by the reporter. Feedback has also been received from His Majesty's Coroner in the form of regulation 28 prevention of future deaths around risks from timely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

To support the planned target score improvement have been noted in the reduction of all open incidents, NRI and overdue NRI. Falls and HAPU as our highest number of incidents are on a reducing trajectory. No Reg 28 or Never events have been reported in 2025. Reduction in RIDDOR reportable incidents noted.

CRR 24-04	<b>Risk Title:</b> Failure to Embed Learning		<b>Date Opened:</b> 19/10/2023
	<b>Assuring Committee:</b> Quality, Safety and Experience Committee		<b>Date Last Committee Review:</b> 20/02/2025
<b>Date Last Reviewed:</b> 20/02/2025	<b>Director Lead:</b> Executive Director of Nursing and Midwifery	<b>Link to BAF:</b> BAF24-06	<b>Target Risk Date:</b> 30/09/2025
<p>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.</p>			
<b>Mitigations/Controls in place</b>		<b>Additional Controls required</b>	
<ol style="list-style-type: none"> <li>1. Clinical policies, procedures, guidelines, pathways, supporting documentation &amp; IT systems. Integrated Concerns Policy</li> <li>2. Senior sign-off process for National Reportable Incidents (NRIs) and Complaints</li> <li>3. Clinical staff recruitment, induction, mandatory and professional training, registration &amp; re-validation</li> <li>4. Putting Things Right and clinical review processes and monitoring</li> <li>5. Quality governance framework of meetings and reporting structured</li> <li>6. Quality Dashboard and access to quality data from ward/team to Board</li> <li>7. Patient and carer feedback and involvement processes</li> <li>8. Defined nurse staffing levels for all wards &amp; departments as per Nurse Staffing Act</li> <li>9. Ward accreditation schemes and ward manager/matron checks/audits.</li> <li>10. Getting it Right First Time (GIRFT), localised deep dives, reports and action plans</li> <li>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</li> <li>12. <a href="#">Organisational Learning Forum (OLF) Betsinet shared learning page</a></li> <li>13. 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.</li> </ol>		<ol style="list-style-type: none"> <li>a. Implementation of a Quality Management System (QMS) setting out an integrated approach to Quality Planning, Control, Assurance and Improvement (dashboard completed).</li> <li>b. Clarity on quality leadership, structures and accountabilities</li> <li>c. Development of a quality learning framework, aligned to the overall learning organisation programme</li> <li>d. Resolution of outstanding overdue positions for incidents, complaints, claims, mortality reviews and inquests</li> <li>e. <a href="#">Ongoing embedding and training of a new Learning from Events (LEFR) process to improve divisional ownership and completion of a recovery plan to address the overdue position</a></li> <li>f. Medical engagement to ensure active participation and commitment from medical staff in learning and improvement.</li> <li>g. Integration of LFER/Claims – To enhance the management and resolution of claims, ensuring they are addressed promptly and effective</li> <li>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.</li> </ol>	

<p>14. 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.</p> <p>15. 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.</p> <p>16. 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.</p>				
Actions	Due Date	Progression Analysis		
<p>A central and digital library of learning will be established which will be launched alongside a revised approach to the collation, analysis and dissemination of learning. Development work continues with a revised aim of <b>May 2025</b>. 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.</p>	<p>31/05/2025 – delayed due to DDAT priorities</p>	<p>Progressing  (Date Revised from 31/03/2025)</p>		
<p>Implementation of the new/approved QMS Framework within the identified pilot sites.</p>	<p>31/03/2025</p>	<p>Progressing</p>		
<p>Implementation of the QMS progressing in the test sites with other early adopters identified, this will be ongoing.</p>				
<p>Implementation of the new Learning from Events Report (LFER) process</p>	<p>31/01/2025</p>	<p>Completed</p>		
<p>Delivery of overdue LFER recovery plans by each IHC/Division to eliminate the overdue position</p>	<p>31/06/2025</p>	<p>Progressing</p>		
		Impact	Likelihood	Score
	Inherent Risk Rating	5	5	25
	Current Risk Rating	5	3	15



Target Risk Score	5	1	5
Risk Appetite	Quality		<16

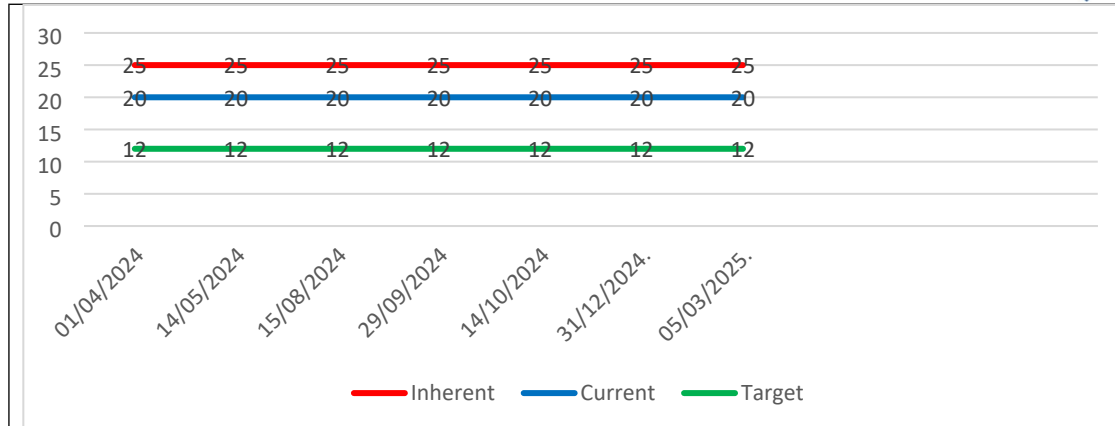
**Position & Intended Outcome for Risk**

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	<b>Risk Title:</b> Delivery of the Annual Financial Plan		<b>Date Opened:</b> 01/04/2024
	<b>Assuring Committee:</b> Performance, Finance and Information Governance Committee		<b>Date Last Committee Review:</b> 25/02/2025
<b>Date Last Reviewed:</b> 05/03/2025	<b>Director Lead:</b> Executive Director of Finance	<b>Link to BAF:</b> BAF24-03	<b>Target Risk Date:</b> 31/03/2025
<p>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.</p>			
<b>Mitigations/Controls in place</b>		<b>Additional Controls required</b>	
<ol style="list-style-type: none"> <li>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.</li> <li>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</li> <li>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.</li> <li>4. Continuation of the Enhanced Establishment Control Group (executive approval before advertising) to review all requests for A&amp;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.</li> <li>5. Cease use of non-patient facing agency with exceptionality process put in place through the enhanced establishment control process</li> <li>6. Non-Pay – all discretionary non-clinical expenditure to be directed to Executive Director of Finance for scrutiny and approval</li> <li>7. Internal scrutiny by Central Finance Team, of the Divisional financial assumptions, overspends and forecasts.</li> </ol>		<ol style="list-style-type: none"> <li>a. Welsh Government (WG) expectation to achieve financial balance, due to the financial settlement/allocations to Health Boards and to enter into financial stability.</li> <li>b. 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.</li> <li>c. 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</li> <li>d. 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.</li> <li>e. 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.</li> </ol>	



<p>8. Financial reporting to Welsh Government on a monthly basis, with the Monthly Monitoring Return (MMR).</p> <p>9. Regular communication with Welsh Government regarding £82m strategic funding with regards to making this recurrent.</p> <p>10. Early identification of emerging issues through horizon scanning and trends in run rate and alerting Operational Management to changes to regularity requirements.</p> <p>11. 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.</p>			
<b>Actions</b>	<b>Due Date</b>	<b>Progression Analysis</b>	
<p>The Integrated Performance – Executive Delivery Group (IP-EDG) endorsed implementation of expenditure controls within the areas and directorates (from November 2024) as a measure to 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. These measures were expanded to cover controls over expenditure discretionary expenditure (non-patient related) in January 2025 within IP-EDG.</p> <p>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. <b>Maintain increased controls.</b> Continued oversight and holding to account via the Integrated Performance Executive Delivery Group, and holding to account against expenditure control reductions identified for the remainder of the financial year.</p>	31/03/2025	Progressing	
	Impact	Likelihood	Score
Inherent Risk Rating	5	5	25
Current Risk Rating	5	4	20
Target Risk Score	4	3	12
Risk Appetite	Financial		<16
<b>Position &amp; Intended Outcome for Risk</b>			



M10 - Year to date position is reporting a deficit of £12.9m. This represents an £5.7m adverse variance compared to 10/12ths of the full year £8.6m planned deficit. The year to date deficit above plan is driven by additional capacity areas remaining open (substantial patients clinically stable and medically fit awaiting discharge), Out of Area Mental Health placements, CHC increased activity and Primary & Secondary Care Drug costs .

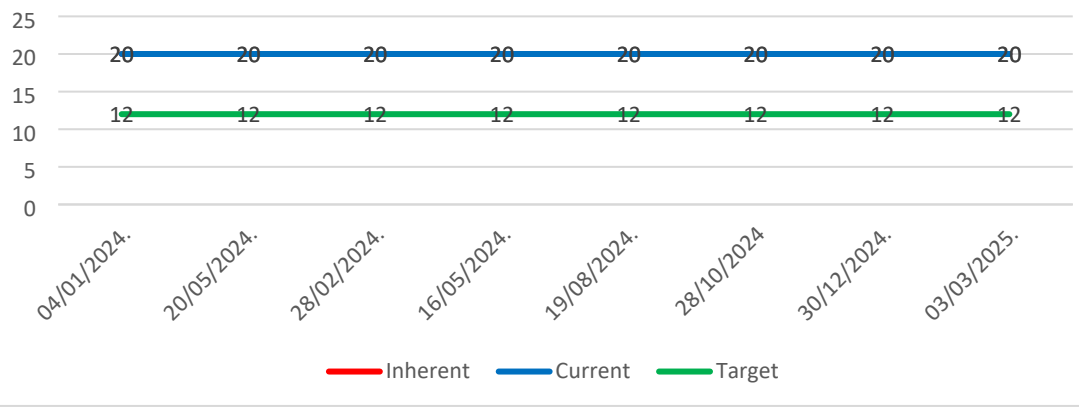
CRR 24-06	<b>Risk Title:</b> Suitability and Safety of Sites		<b>Date Opened:</b> 04/01/2024
	<b>Assuring Committee:</b> Performance, Finance and Information Governance Committee		<b>Date Last Committee Review:</b> 25/02/2025
<b>Date Last Reviewed:</b> 03/03/2024	<b>Director Lead:</b> Director of Environment	<b>Link to BAF:</b> BAF24-03	<b>Target Risk Date:</b> 31/03/2026 (10 year capital investment requests aligns with the capital prioritisation form that will be submitted to Welsh Government – completion target date 2035).
<p>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.</p>			
<b>Mitigations/Controls in place</b>		<b>Additional Controls required</b>	
<ol style="list-style-type: none"> <li>1. Estates Strategy developed and approved by the Health Board in January 2023.</li> <li>2. Internal Governance for capital allocation in place within the Health Board.</li> <li>3. Business Cases to Welsh Government to resolve major infrastructure issues in line with the Estates Strategy</li> <li>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.</li> <li>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</li> <li>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.</li> </ol>		<ol style="list-style-type: none"> <li>a. 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.</li> <li>b. Assurance around the development control plan that it is aligned with both the Estates strategy and the Clinical strategy.</li> <li>c. Business Case Review Group to be set up to review all business cases to provide scrutiny prior to submission to Executive team.</li> <li>d. 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.</li> <li>e. Ensure that the Health Board has an Estates rationalisation programme in place that will support the capital prioritisation programme and reduce backlog maintenance.</li> </ol>	



<p>7. Operational Estates Safety Groups in place to provide assurance, the safety groups are as detailed below and oversee risks relevant to the groups:</p> <ul style="list-style-type: none"> <li>a. Fire Management</li> <li>b. Asbestos Management</li> <li>c. Water Safety,</li> <li>d. Ventilation Safety</li> <li>e. Electrical Safety</li> </ul> <p>8. Welsh Government Capital Resource Meetings in place to provide route for escalation.</p> <p>9. Estates and Facilities Performance Management System (EFPMS) reporting template and recording of backlog maintenance</p> <p>10. Capital Allocation from Welsh Government – additional capital funding of £4.16M allocated to the Health Board to focus on Backlog Maintenance</p> <p>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.</p> <p>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.</p> <p>13. Capital Funding from Welsh Government – additional capital funding of £2M allocated to the Health Board in year for slippage bids.</p>	<ul style="list-style-type: none"> <li>f. Internal Audit review of Fire Safety – Agreed Management Action Plan being implemented <b>and being managed through the Fire Safety Management Group</b></li> <li>g. Timely progression of major Capital Schemes which address Estates Safety such as Wrexham Maelor Continuity Plan – Phase</li> <li>h. Completion of applications for the Welsh Government (Capital, Estates &amp; Facilities) Targeted Estates Fund for NHS Wales 2025-2027</li> <li>i. <b>Review of Reinforced Autoclaved Aerated Concrete (RAAC) to be completed by the Health Board’s approved structural engineers – Curtin’s</b></li> </ul>
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Actions	Due Date	Progression Analysis
<p>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 12<sup>th</sup> September 2024. <a href="#">Estate’s rationalisation plan is being reviewed and updated taking into account disposals that have been approved in 2024-2025 and opportunity for disposals in 2025-2026 as part of rationalisation of our estates that supports the Caledfryn Project.</a></p>	31/01/2025	Overdue

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. A review of the 6 facet survey programme is to be undertaken with support from Director of Environment and Estates with a plan to adopt an All Wales approach to surveys which is being led by NWSSP Specialist Estates Services.	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	31/03/2025	Progressing



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

	Impact	Likelihood	Score
Inherent Risk Rating	4	5	20
Current Risk Rating	4	5	20
Target Risk Score	2	4	12
Risk Appetite	Quality		<16

**Position & Intended Outcome for Risk**

Current Risk score of 20 aims to be reduced to a 12 by April 2035. Backlog maintenance is the cost to bring estate assets that are below acceptable standards (either physical condition or compliance with mandatory fire safety requirements and statutory safety legislation) up to an acceptable condition. Total 2021/22 backlog costs for all BCUHB properties was £348.4m. Cost to achieve physical condition B is c. £213m. Cost to achieve condition B for fire and safety statutory compliance is c. £136m. Total risk adjusted backlog is c. £240m. The majority (73%) of backlog relates to the 3 acute hospitals. Backlog for MH&LD, Community and Local Hospitals, and Community Facilities each comprise c.10% of total backlog.

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



	<p>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.</p> <p>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 Rosset 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.</p>
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CRR 24-07	<b>Risk Title:</b> A Fragmented Patient Care Record		<b>Date Opened:</b> 06/12/2023
	<b>Assuring Committee:</b> Partnerships, People and Population Health Committee		<b>Date Last Committee Review:</b> 18/02/2025
<b>Date Last Reviewed:</b> 13/02/2025	<b>Director Lead:</b> Chief Digital and Information Officer	<b>Link to BAF:</b> BAF24-02	<b>Target Risk Date:</b> 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.			
<b>Mitigations/Controls in place</b>		<b>Additional Controls required</b>	
<ol style="list-style-type: none"> <li>1. Current paper file identified as the Master Copy of the full record.</li> <li>2. Access to current clinical systems to print clinical information ready to store in the Master File.</li> <li>3. CITO Contract in place to house scanned document as a repository.</li> <li>4. Mandate process in place to control the adoption of new functionality within existing systems to capture patient data.</li> <li>5. Current system training and standard operating procedures around searching for and registering new patients to prevent the creating of duplicate records in place.</li> <li>6. Dashboard in place which flags any new duplicate patient record created to allow immediate record merge.</li> <li>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.</li> <li>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.</li> <li>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.</li> <li>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.</li> </ol>		<ol style="list-style-type: none"> <li>a. Lack of current system capabilities to integrate into the fuller Electronic Health Record. Optimisation programme underway with a focus on Electronic Point of Care (EPOC), EPRO (Digital Dictation System Supplier) and Welsh Clinical Portal (WCP) to review current systems interoperability and functionality. CITO has been agreed as the Electronic Document Management System for the Health Record.</li> <li>b. Availability of current paper records within digital environment. The business case for a scanning strategy for the Health Board is currently in draft and will provide options, costs and resource requirements for scanning of records.</li> <li>c. Standard practice registration across the three acute sites. Proposal developed including resource funding required based on the East Health Records service coverage. Non-recurrent allocation of resource secured, which will support addressing the standardisation across the three sites on a limited timeframe. Further request has been presented to secure recurrent funding.</li> <li>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 with request for additional resources currently being presented for consideration.</li> <li>e. 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.</li> </ol>	

<p>11. Clinical Decision Authority now in place with agreed terms of reference and meeting on a bi-monthly basis to ensure that the design and use of digital systems does not compromise the safety, quality and effectiveness of care.</p>	<p>f. Continued delay in confirmation of membership at the Patient Safety and Quality Group. Progress chasing monthly in place. g. 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.</p>	
<b>Actions</b>	<b>Due Date</b>	<b>Progression Analysis</b>
<p>Establish the cost and resource requirements to back scan all live records</p> <p><a href="#">Proposal to close as this is now covered as part of the Scanning Strategy development.</a></p>	31/03/2025	Completed
<p>Develop a Health Board Scanning Strategy</p> <p><a href="#">Third Party appointed and visits to all main sites have been undertaken. Workshops commenced with next steps to look at requirements to develop options and proposals for approval. this will include the costs for scanning live records. Action due date revised to accommodate year end and annual leave processes.</a></p>	31/05/2025	Progressing (revised date from 31/03/2025)
<p>Standardise the way in which using existing systems (paper and electronic) as part of the DDaT optimisation workstreams</p> <p><a href="#">Training Strategy completed, awaiting formal approval at the DDaT Senior Leadership Meeting and will then be implemented. Due date extended to take into consideration the need to develop the plan to support the strategy.</a></p>	30/06/2025	Progressing (revised date from 31/03/2025)
<p>Undertake a review of all current systems to ensure these can be integrated into an Electronic Health Record</p> <p><a href="#">This remains ongoing as part of the draft Outline Business Case for the Electronic Health Record.</a></p>	30/04/2025	Progressing
<p>Accelerating the business case, approvals, procurement and implementation of an Electronic Patient Record for Mental Health (minimum 2-year project)</p>	30/04/2025	Progressing
<p>Recruitment of additional health records staff to standardise the registration practice across three acute sites.</p> <p><a href="#">Non-recurrent funding secured till 31/03/2025. Bid for recurrent funding currently being presented to the Executive Team following support from the Planned Care Programme Board.</a></p>	31/05/2025	Progressing (revised date from 31/11/2024)
<p>Engage with the Estates Rationalisation Programme to secure the future of "fit for purpose" file libraries for legacy paper records.</p>	30/06/2025	Progressing

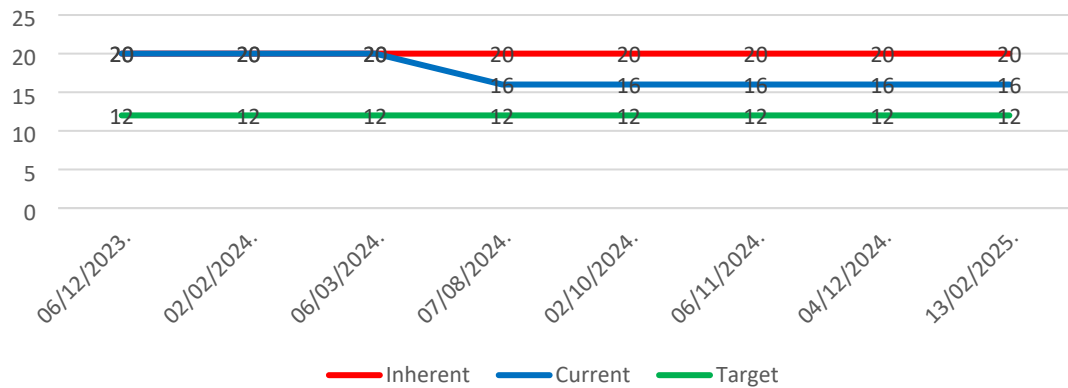
Structural Survey authorised, awaiting confirmation of date to commence.

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.

Final Report for the West in draft and the findings will be presented to the West Integrated Health Community before onwards submission for assurance to the Information Governance Group. Due date delayed due to length of time taken to complete each area and the resources required.

30/11/2025

Progressing  
(revised date  
from  
31/08/2025)



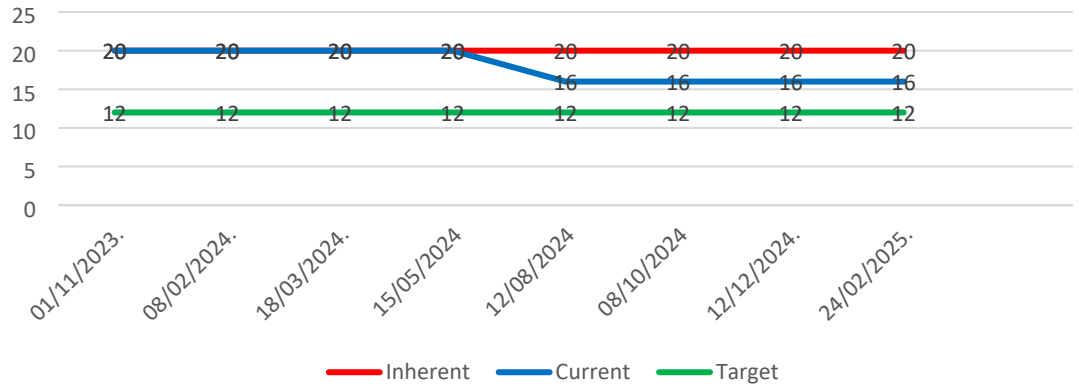
	Impact	Likelihood	Score
Inherent Risk Rating	4	5	20
Current Risk Rating	4	4	16
Target Risk Score	4	3	12
Risk Appetite	Quality		<16
<b>Position &amp; Intended Outcome for Risk</b>			
Organisational wide risk based on potential patient safety and negative impact if the risk were to materialise. In addition, the financial and resource requirement to implement the controls and mitigations required are significant.			

CRR 24-08	<b>Risk Title:</b> Delivering a population health approach to health and wellbeing		<b>Date Opened:</b> 01/11/2023
	<b>Assuring Committee:</b> Partnerships, People and Population Health Committee (PPPH)		<b>Date Last Committee Review:</b> 18/02/2025.
<b>Date Last Reviewed:</b> 24/02/25	<b>Director Lead:</b> Executive Director of Public Health	<b>Link to BAF:</b> BAF24-06	<b>Target Risk Date:</b> 30/04/2025
<p>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.</p> <p>This may lead to continuation and increases in largely preventable non-communicable diseases including Type 2 Diabetes, Respiratory conditions, Cardiovascular disease, Cancer, Musculoskeletal conditions, mental health and wellbeing and multiple co-morbidities. It may also lead to increasing rates of infectious disease. Failure to address the risk could potentially lead to avoidable morbidity and mortality within the population of North Wales</p>			
<b>Mitigations/Controls in place</b>		<b>Additional Controls required</b>	
<ol style="list-style-type: none"> <li>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</li> <li>2. Annual development of IHC data packs and headline report support Health Board planning to reflect current and emerging need.</li> <li>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.</li> <li>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.</li> <li>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</li> <li>6. Interviews have taken place for 2 x vacant Consultant in Public Health posts and appointed to, ensuring the team is adequately staffed to</li> </ol>		<ol style="list-style-type: none"> <li>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.</li> <li>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.</li> <li>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.</li> <li>d. The Deputy Director of Public Health post is currently vacant</li> </ol>	

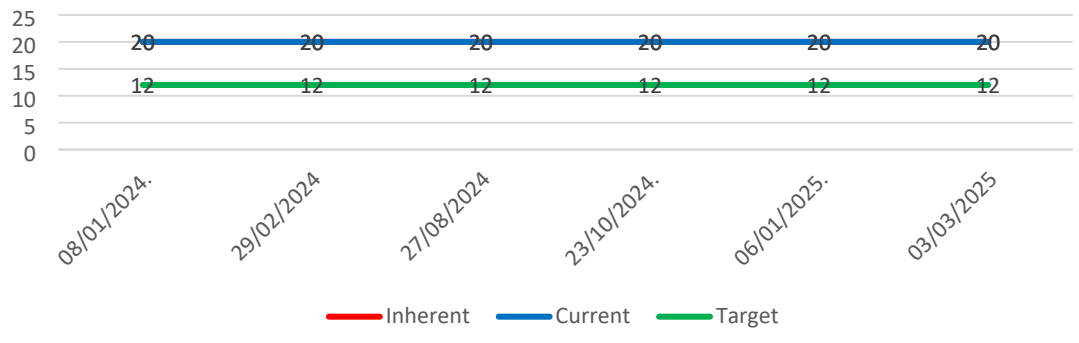
<p>maintain effective public health management and mitigate the risk of gaps in expertise</p> <ol style="list-style-type: none"> <li>7. Board Awareness session regarding the 'shift to Prevention' focus has taken place in July 24 to ensure leadership is aligned with strategic priorities and mitigating the risk of insufficient understanding or support for the prevention agenda</li> <li>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.</li> <li>9. Quarter 1, 2 and 3 Prevention deliverables within the Health Board Plan 24/25-26/27 have been achieved.</li> <li>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</li> <li>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</li> <li>12. Population Health Executive Delivery Group – Workshop 'Prevention – Priorities, Planning and Delivery' to inform direction and planning has taken place.</li> <li>13. 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.</li> <li>14. 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.</li> <li>15. PPHP Committee received delivery update by Health Protection Team (Aug 24).</li> </ol>	<ol style="list-style-type: none"> <li>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.</li> <li>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</li> </ol>
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<p>16. Executive Director of Public Health appointed</p> <p>17. A continuation of non-recurrent grant funds for Smoking and Weight (prevention and early years fund) and also Healthy Schools and Whole School Approach to Mental wellbeing have been confirmed for 25/26.</p> <p>18. key milestones addressing data gaps and intelligence in relation to Population health have been included in the Health Board Plan. This will also help us to identify the impact of our current prevention offer and develop future models and approaches.</p>		
Actions	Due Date	Progression Analysis
<p>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.</p> <p>Unable to close this action until IHC Plans have been reviewed.</p> <p>Board to receive Health Board Plan and submission to Welsh Government in March</p>	31/03/2025	Progressing (revised date from 30/11/2024)
<p>Recruitment to the post of Executive Director of Public Health.</p> <p>24/2/25 – Process complete</p>	01/02/2025	Completed
<p>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.</p> <p>Board to receive Health Board Plan and submission to Welsh Government in March 2025.</p>	31/03/2025	Progressing
<p>Health Board Annual Plan / 3 year milestones and associated activity.</p> <p>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.</p> <p>Board to receive Health Board Plan and submission to Welsh Government in March 2025.</p>	31/03/2025	Progressing
<p>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</p>	31/03/2025	progressing

<p>Health Board 5 Strategic Objectives. Draft deliverables have been submitted and approved by the Executive Director of Public Health. Board to receive Health Board Plan and submission to Welsh Government in March 2025.</p>																																																									
<p>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.</p>	31/03/2025	Completed																																																							
<p>Programme plans developed for Health Protection, Health Improvement, Health Inequalities and Healthcare Public Health which contribute to the additional controls required  24/2/25 – Programme plans are being finalised for the Public Health Teams with Consultants in PH as SROs. Programmes will be loaded into the PMO Portal.</p>	31/03/2025	Progressing																																																							
 <table border="1"> <caption>Risk Score Data</caption> <thead> <tr> <th>Date</th> <th>Inherent</th> <th>Current</th> <th>Target</th> </tr> </thead> <tbody> <tr><td>01/11/2023</td><td>20</td><td>20</td><td>12</td></tr> <tr><td>08/02/2024</td><td>20</td><td>20</td><td>12</td></tr> <tr><td>18/03/2024</td><td>20</td><td>20</td><td>12</td></tr> <tr><td>15/05/2024</td><td>20</td><td>20</td><td>12</td></tr> <tr><td>12/08/2024</td><td>20</td><td>16</td><td>12</td></tr> <tr><td>08/10/2024</td><td>20</td><td>16</td><td>12</td></tr> <tr><td>12/12/2024</td><td>20</td><td>16</td><td>12</td></tr> <tr><td>24/02/2025</td><td>20</td><td>16</td><td>12</td></tr> </tbody> </table>	Date	Inherent	Current	Target	01/11/2023	20	20	12	08/02/2024	20	20	12	18/03/2024	20	20	12	15/05/2024	20	20	12	12/08/2024	20	16	12	08/10/2024	20	16	12	12/12/2024	20	16	12	24/02/2025	20	16	12	<table border="1"> <thead> <tr> <th></th> <th>Impact</th> <th>Likelihood</th> <th>Score</th> </tr> </thead> <tbody> <tr> <td>Inherent Risk Rating</td> <td>4</td> <td>5</td> <td>20</td> </tr> <tr> <td>Current Risk Rating</td> <td>4</td> <td>4</td> <td>16</td> </tr> <tr> <td>Target Risk Score</td> <td>4</td> <td>3</td> <td>12</td> </tr> <tr> <td>Risk Appetite</td> <td colspan="2">Quality</td> <td>&lt;16</td> </tr> </tbody> </table>		Impact	Likelihood	Score	Inherent Risk Rating	4	5	20	Current Risk Rating	4	4	16	Target Risk Score	4	3	12	Risk Appetite	Quality		<16
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<p>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</p>																																																									

CRR 24-09	<b>Risk Title:</b> Primary Care		<b>Date Opened:</b> 08/02/2024	
	<b>Assuring Committee:</b> Quality, Safety and Experience Committee		<b>Date Last Committee Review:</b> 20/02/2025	
<b>Date Last Reviewed:</b> 04/03/2025	<b>Director Lead:</b> Executive Director Transformation and Strategic Planning	<b>Link to BAF:</b> BAF24-07	<b>Target Risk Date:</b> 31/03/2026	
<p>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.</p>				
<b>Mitigations/Controls in place</b>		<b>Additional Controls required</b>		
<ol style="list-style-type: none"> <li>1. Primary Care Board established in 2024 to ensure executive oversight of services.</li> <li>2. Primary Care sub groups established in 2024 that focus on specific key elements of service overview including governance and quality, workforce and contracting.</li> <li>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.</li> <li>4. Established Cluster and Collaborative Leads across the 14 cluster areas in BCU.</li> <li>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.</li> </ol>		<ol style="list-style-type: none"> <li>a. Primary care plan needed to set out long term strategy for services</li> <li>b. Programme management approach needed to monitor and drive strategic and operational priorities.</li> <li>c. Consistent approach to managing primary care services across BCU is needed. Currently most services are managed at an IHC level.</li> <li>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.</li> <li>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</li> </ol>		
<b>Actions</b>			<b>Due Date</b>	<b>Progression Analysis</b>
Primary Care strategic plan			31/03/2025	Progressing

<p>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.</p>																						
<p>Implementation of recommendations from the National Strategic Programme for Primary Care.</p> <p>Workshop planned to review the recommendations and programme of work for 24/25 in April</p>	31/03/2025	Progressing (revised date from 30/06/2024)																				
<p>Primary Care Academy to utilise SPPC monies to further progress multi-professional working</p> <p>Work ongoing to develop local health board response to the national strategy and year 1 priorities as set out by HEIW/SPPC.</p>	31/03/2025	Progressing (revised date from 31/12/2024)																				
<p>A review of cluster monies spend to allow introduction of new roles, ways of working and models of service delivery</p>	31/03/2025	Progressing (revised date from 31/12/2024)																				
<p>Deep dive / diagnostic into general dental and community dental services</p> <p>Report is with Executives for consideration</p>	31/03/2025	Progressing																				
 <p>25 20 15 10 5 0</p> <p>08/01/2024. 29/02/2024 27/08/2024 23/10/2024. 06/01/2025. 03/03/2025</p> <p>— Inherent — Current — Target</p>	<table border="1"> <thead> <tr> <th></th> <th>Impact</th> <th>Likelihood</th> <th>Score</th> </tr> </thead> <tbody> <tr> <td>Inherent Risk Rating</td> <td>4</td> <td>5</td> <td>20</td> </tr> <tr> <td>Current Risk Rating</td> <td>4</td> <td>5</td> <td>20</td> </tr> <tr> <td>Target Risk Score</td> <td>4</td> <td>3</td> <td>12</td> </tr> <tr> <td>Risk Appetite</td> <td colspan="2">Quality</td> <td>&lt;16</td> </tr> </tbody> </table>		Impact	Likelihood	Score	Inherent Risk Rating	4	5	20	Current Risk Rating	4	5	20	Target Risk Score	4	3	12	Risk Appetite	Quality		<16	<p><b>Position &amp; Intended Outcome for Risk</b></p> <p>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.</p>
	Impact	Likelihood	Score																			
Inherent Risk Rating	4	5	20																			
Current Risk Rating	4	5	20																			
Target Risk Score	4	3	12																			
Risk Appetite	Quality		<16																			
<p><b>N.B. Inherent and Current score lines stacked as both are 20.</b></p>																						

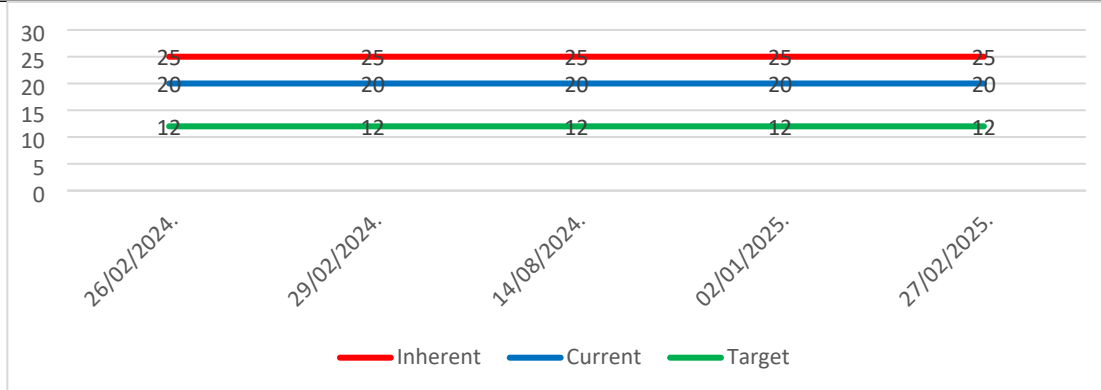
CRR 24-10	<b>Risk Title:</b> Urgent and Emergency Care (UEC)		<b>Date Opened:</b> 26/02/2024
	<b>Assuring Committee:</b> Performance, Finance and Information Governance Committee		<b>Date Last Committee Review:</b> 25/02/2025
<b>Date Last Reviewed:</b> 27/02/2025	<b>Director Lead:</b> Chief Operating Officer	<b>Link to BAF:</b> BAF24-07	<b>Target Risk Date:</b> 30/06/2026
<p>There is a risk of mortality in relation to <b>critically ill</b> patients being seen in a <b>timely</b> manner through unscheduled <b>care</b> routes. This may be caused by delayed dispatching of ambulances, ambulance queues at emergency departments, Out of Hours access and Emergency Departments (ED) and Urgent Treatment Centres (UTCs) being at capacity. This could impact on pressures for other services, reputation and litigation implications.</p>			
<b>Mitigations/Controls in place</b>		<b>Additional Controls required</b>	
<ol style="list-style-type: none"> <li>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.</li> <li>2. Ambulance handover guidance shared and utilised as part of the system resilience calls. Ambulance escalation process to support peak periods of demand.</li> <li>3. UEC programme governance and reporting structure realigned into 4 workstreams (brings together all relevant improvement projects into a single improvement programme).</li> <li>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.</li> <li>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.</li> <li>6. 0800-2000hrs funded GP service working alongside Welsh Ambulance Services Trust (WAST)/111 to reduce ambulance responses and manage patients through alternative pathways reducing the need for ambulance attendances</li> <li>7. Workstream 2 focused on providing direct access to services as a safe alternatives to Emergency Departments (EDs)</li> <li>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</li> </ol>		<ol style="list-style-type: none"> <li>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.</li> <li>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.</li> <li>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.</li> <li>d. Trusted assessors development, ongoing work for the last 18 months, support required to progress at pace.</li> </ol>	



<p>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.</p> <p>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.</p> <p>10. Workstream 3 in place improving patient flow and therefore reducing overcrowding in EDs and subsequent ambulance handover delays at the front door</p> <p>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.</p> <p>12. Regular reviews of long stay patients in acute &amp; community hospitals to reduce average length of stay.</p> <p>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).</p> <p>14. Review of Complex Care arrangements in place to improve system improvements and to reduce delays, managed each IHC's Clinically optimised weekly meetings.</p> <p>15. Adverse discharge meetings in place as real time feedback, ensure lessons learnt and build trust across organisations.</p> <p>16. Trusted Assessors (in 4 areas) reducing time for assessment.</p> <p>17. Workstreams are all in place focused on key areas within the patient pathway, with reporting of progress through the UEC programme structure and operational delivery groups at IHC level.</p>	<p>e. 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</p> <p>f. All audit reports need to be reviewed to ensure all recommendations have been implemented and learning shared.</p>
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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. <a href="#">The process of review is in place and will be led by workstream 1 of UEC programme. New model for Single Point of Access to be developed Q1 2025/26 and work commenced</a>	31/01/2025	Complete
BCUHB agreement on IHC to trial the Continuous flow model and implement prior to August 2024- East 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. <a href="#">This action is not being implemented. Focus will be on embedding the Optimal Hospital Flow Framework, supported by monitoring through the system resilience hub, to ensure efficient patient flow, minimise numbers of clinically optimised patients remaining in acute hospitals beds thereby reducing LoS.</a>	31/03/2025	Complete

<p>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;</p> <ol style="list-style-type: none"> <li>1. Support at the individual's front door</li> <li>2. Hospital front door</li> <li>3. Hospital flow</li> <li>4. Discharge from hospital</li> </ol> <p>Workstreams are all in place with workstream leads, workstream plans have been developed and new plans for 25/26 being developed and agreed. Reporting of progress is through the UEC programme structure and also through operational delivery groups at IHC level.</p>	31/01/2025	Complete		
<p>Review of all outstanding audit, Get It Right First Time (GIRFT) and Health Inspectorate Wales (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.</p> <p>Reports are being reviewed along with NHS Executive reports. A process is being established to ensure that all audit reports relating to UEC are managed through one central point to ensure recommendations are implemented and learning is shared. Improvement actions will sit within the relevant workstream.</p>	31/03/2025	Progressing		
<p>Annual plan narrative for 25/26 delivery drafted, awaiting planning guidance for 25/26, due 23<sup>rd</sup> 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.</p> <p>Ministerial templates utilising planning guidance, which incorporates the national 6 goals planning framework, completed and out for review. Annual plan narrative to be reviewed to ensure alignment with changes in the planning framework. Draft 6 goals plan developed based on the above and submitted for feedback. UEC trajectories developed aligned to Ministerial Priorities, 6 goals expectations and de-escalation measures.</p>	31/03/2025	Progressing		
<p>As part of workstream 4 a rapid improvement cycle 'Recovering What matters' was completed in February 2025. This focused on ensuring all patients D2RA pathway, PDD were in place within 24 hours and themes of constraints for complex patients were identified and escalated within the same day with LA colleagues. The final evaluation report is being completed and recommendations will be taken forward as part of workstream 4 to ensure that discharge pathways are efficient and the correct process/protocols in place for escalation when required.</p>	31/03/2025	New Action		
<p>New model for Single Point of Access to be developed</p>	30/06/2025	New Action		
		Impact	Likelihood	Score



Inherent Risk Rating	5	5	25
Current Risk Rating	5	4	20
Target Risk Score	4	3	12
Risk Appetite	Quality		<16

**Position & Intended Outcome for 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.



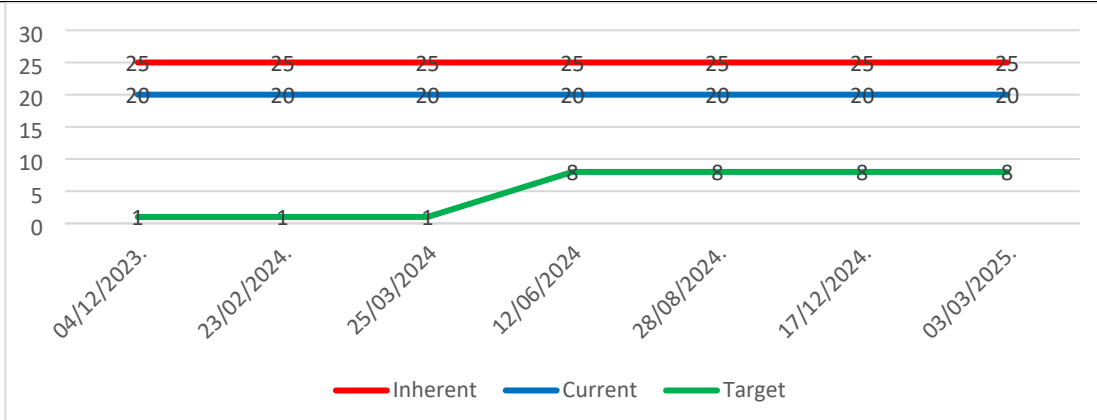
CRR 24-11	<b>Risk Title:</b> Planned Care		<b>Date Opened:</b> 04/12/2023
	<b>Assuring Committee:</b> Performance, Finance and Information Governance Committee		<b>Date Last Committee Review:</b> 25/02/2025
<b>Date Last Reviewed:</b> 03/03/2025	<b>Director Lead:</b> Chief Operating Officer	<b>Link to BAF:</b> BAF24-07	<b>Target Risk Date:</b> 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
<ol style="list-style-type: none"> <li>1. Routine prioritisation of patients by clinical risk according to national Referral to Treatment Time (RTT) guidance (Cancer &gt; Urgent &gt; Routine)</li> <li>2. Performance monitored via weekly corporate access meeting and locally via IHC weekly access meetings including long waits and clinical prioritisation.</li> <li>3. Clinical prioritisation and review of waiting lists ongoing.</li> <li>4. Validating waiting list cohorts.</li> <li>5. Joint Patient Admin and Booking Centre.</li> <li>6. <a href="#">Leadership, Chief Operating Officer now recruited for both interim and substantive.</a></li> </ol>	<ol style="list-style-type: none"> <li>a. Need a substantial in sourcing/outsourcing commissioning piece of work over a longer timeframe 2-3 years</li> <li>b. Capacity and demand modelling and trajectory tracking</li> <li>c. Clinically led development of sustainable service models to secure long term safe quality provision</li> <li>d. Implementation of GiRFT (Get it Right First Time) and wider recommendations from service review processes (including from Clinical Implementation networks nationally)</li> <li>e. Application of GiRFT and other performance improvement approaches (monitor progress of implementation via planned care board and performance outputs via access).</li> <li>f. The planned care funds require quicker mobilisation in future years</li> <li>g. Refresh and renew INNU policy to ensure referrals are appropriate.</li> <li>h.</li> </ol>

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	30/06/2025	Progressing
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 <a href="#">Demand and capacity plan (in progress) completed to inform specialty level position for 2025/26 and targeted support where shortfalls identified</a>	31/03/2025	Progressing

Process to minimise escalation into elective capacity through UEC improvement programme. Monitoring and escalated impact on elective care will be BAU.	31/01/2025	Completed
Ensure specialty plans reflect sustained additional capacity to the existing baseline aligned to the demand and capacity outputs for 2025/26.	30/06/2025	Progressing



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

**Position & Intended Outcome for 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.

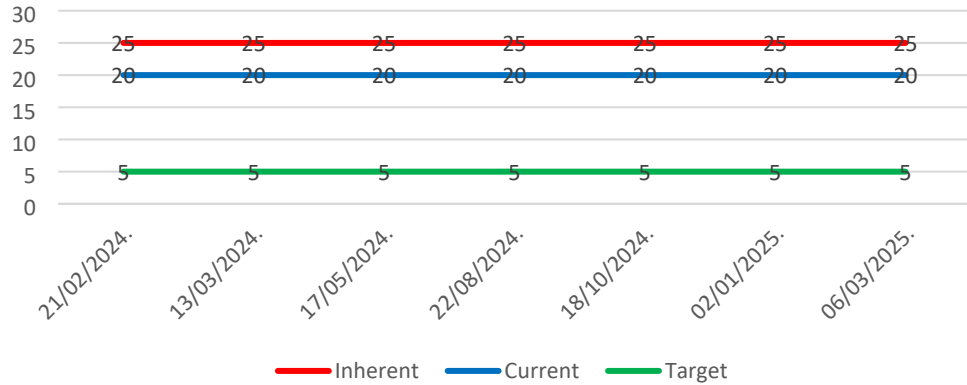
RTT 52 week waits all stages - NHS Wales Performance Framework 2024-25  
Target 0 by 30.06.2025 Follow up backlog 100% overdue - Target reduction compared to same month last year. East has a bigger share of stage ones over 52w by 2k so there is room to make the pan-BCU list more equitable. Continue to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

CRR 24-13	<b>Risk Title:</b> Timely Diagnostics		<b>Date Opened:</b> 21/02/2024
	<b>Assuring Committee:</b> Quality, Safety and Experience Committee		<b>Date Last Committee Review:</b> 20/02/2025
<b>Date Last Reviewed:</b> 06/03/2025	<b>Director Lead:</b> Chief Operating Officer	<b>Link to BAF:</b> BAF24-07	<b>Target Risk Date:</b> 31/12/2025
<p>There is a risk of delay in diagnostics, service failure, poor performance or disruption to <b>radiology, pathology and other diagnostic</b> 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</p>			
<b>Mitigations/Controls in place</b>		<b>Additional Controls required</b>	
<ol style="list-style-type: none"> <li>1. Insourcing of CT, MRI and ultrasound to deliver required capacity</li> <li>2. Significant guidance and steer with National Imaging Programme workforce work.</li> <li>3. Outsourcing of radiology reporting to maintain Welsh government turnaround times</li> <li>4. Waiting list &amp; capacity and demand management is in place to monitor radiology required resources.</li> <li>5. New all Wales contract with Everlight from 1st November 2024 to maintain provision of radiology reporting</li> <li>6. Active participation by pathology in the nation pathology programme</li> <li>7. Diagnostic services have well embedded QMS (Quality Management System) systems for accreditation and regulation. Supporting the BCU QMS development with knowledge and learning</li> <li>8. Endoscopy insourcing</li> <li>9. OBC for PETCT/Nuclear Medicine consolidation approved by board and submitted to WG</li> </ol>		<ol style="list-style-type: none"> <li>a. Replacement of Radiology Informatics System (RISP) – implementation underway go live delayed till July 2025</li> <li>b. Replacement of LINC (national pathology IT system) - Contract signed with current supplier plans to implement by September 2025 being progressed nationally</li> <li>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</li> <li>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. <a href="#">Discussions held with OMD and a plan is being put in place for a task and finish group to update procedure MD23 - Revision drafted and almost ready for wider consultation</a></li> <li>e. PHW Collaborative Executive group.</li> <li>f. Diagnostic Strategy for BCU needs to be developed</li> <li>g. <a href="#">Work commenced on new radiology staffing model for the identification of significant restructuring of the service with succession planning, career development, staff wellbeing etc.</a></li> </ol>	

	<ul style="list-style-type: none"> <li>h. Complete demand and capacity reviews across diagnostic services to identify improvement plans</li> <li>i. Progression the development of the medical illustration service to support the teledermoscopy service</li> <li>j. Complete estates reviews for all diagnostic services, with prioritisation and progression of identified improvement projects</li> <li>k. Progression of Regional Diagnostics Hub project within the Planned Care Programme</li> <li>l. Progression of diagnostic business cases e.g. Endoscopy, Nuclear Medicine / PET-CT and Digital Cellular Pathology business cases</li> <li>m. Identify capacity for work focused on transformational change including opportunities for AI</li> </ul>	
Actions	Due Date	Progression Analysis
Replacement of Radiology Informatics System (RISP) – implementation with anticipated go live date of the 19/05/2025. Delayed till July 2025	01/07/2025	Progressing (revised date from 14/04/2025)
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		<16		
<b>Rationale for Corporate Risk</b>					
<p>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. <a href="#">Demand in radiology continues to increase.</a>  <a href="#">MDT demand in terms of numbers of patients on an MDT is at unsafe levels.</a>                      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</p>					



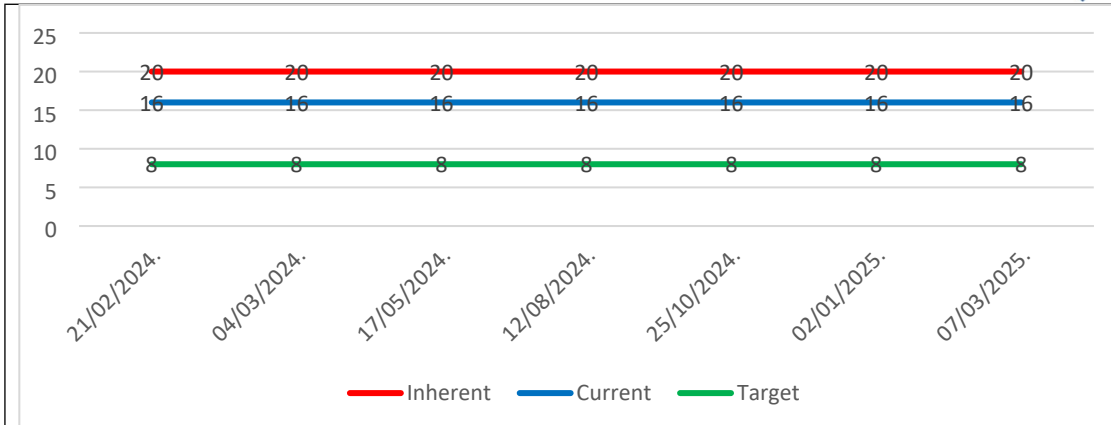
CRR 24-14	<b>Risk Title:</b> Harm from the Medical Devices/Equipment		<b>Date Opened:</b> 21/02/2024
	<b>Assuring Committee:</b> Quality, Safety and Experience Committee		<b>Date Last Committee Review:</b> 20/02/2025
<b>Date Last Reviewed:</b> 07/03/2025	<b>Director Lead:</b> Executive Director of Allied Health Professions & Health Science	<b>Link to BAF:</b> BAF 24-07	<b>Target Risk Date:</b> 31/03/2026

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
<ol style="list-style-type: none"> <li>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.</li> <li>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.</li> <li>3. Scrutiny and assessment of the capital programme at Capital Programme Management Team (CPMT) and Capital Investment Group (CIG).</li> <li>4. Welsh Government Capital review meeting to escalate and discuss potential risks and requirements for key medical equipment e.g. Linac.</li> <li>5. An effective medical devices management system is utilised through Electric Biomedical Engineer Department (EBMD)</li> <li>6. EBMD 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.</li> <li>7. Audits on affected equipment in line with regulatory compliance completed.</li> </ol>	<ol style="list-style-type: none"> <li>a. Internal risk assessment and priorities are flagged in the context of fully depreciated equipment (£34.659m) to understand priorities and potential risks.</li> <li>b. Lack of medical device training and good governance of safety of equipment has been lacking and documented as a risk since 2016.</li> <li>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 <a href="#">replacement to be taken forward as part of the 26/27 submission for capital bids</a>.</li> <li>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 Executive Director AHPS and Health Science for escalation to Executive team.</li> <li>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 <a href="#">be developed following review of current preparedness</a></li> </ol>



<p>8. Radiology fully engaged with the National Imaging Capital Equipment Group peer review programme.</p> <p>9. External links with National Imaging and Pathology Diagnostic Programmes are documented and appropriately reported through correct channels to ensure transparency and potential benchmarking.</p> <p>10. <a href="#">Working group assessing compliance with the Medical Devices Regulations and confirm governance arrangements for medical devices</a></p>				
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)	
<p>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.</p> <p><a href="#">Full testing programme in place across BCU and assurance being provided to the BCU ultrasound Governance group</a></p>		31/03/2025	Completed	
<p>Directorate teams to review their medical devices capital replacement plans to ensure all services have a medical device replacement programme in place.</p> <p><a href="#">Directorate teams are linking with Capital to update their replacement plans.</a></p>		31/03/2025	Progressing (Revised from 31/09/2024)	
<p>Recruitment to Head of Clinical Engineering and associated posts within the medical devices team</p> <p><a href="#">Head of Clinical Engineering appointed start date being agreed post holder will review of regulations and compliance, chair of local medical devices group and risk management</a></p>		06/03/2025	Completed	
<p><a href="#">Long term management plans with equipment, regulation and compliance and discussions around improving governance</a></p>		30/06/2025	Progressing	
		Impact	Likelihood	Score
		Inherent Risk Rating	4	5
				20



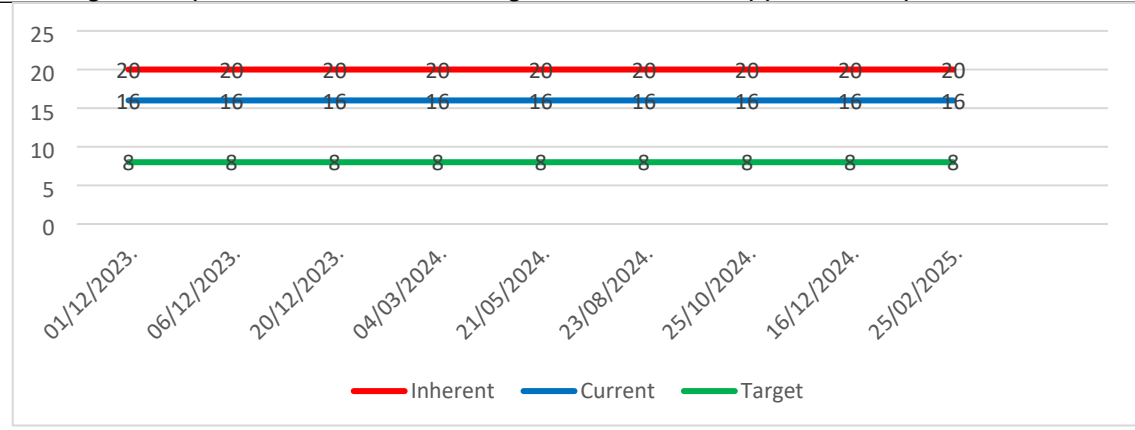
Current Risk Rating	4	4	16
Target Risk Score	4	2	8
Risk Appetite	Open		<16

**Position & Intended Outcome for 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. Intended outcome to ensure compliance and any gaps in medical device regulation supported by robust process for medical equipment capital replacement.

CRR24-15	<b>Risk Title:</b> Health and Safety		<b>Date Opened:</b> 01/12/2023
	<b>Assuring Committee:</b> People & Culture Committee		<b>Date Last Committee Review:</b> 13/02/2025
<b>Date Last Reviewed:</b> 25/02/2025	<b>Director Lead:</b> Deputy Director of People	<b>Link to BAF:</b> N/A	<b>Target Risk Date:</b> 31/03/2026
<p>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.</p>			
<b>Mitigations/Controls in place</b>		<b>Additional Controls required</b>	
<ol style="list-style-type: none"> <li>1. Three-year Occupational Health, Safety and Security strategy.</li> <li>2. Health and Safety Policies report into the Strategic Occupational Health &amp; Safety Group.</li> <li>3. Health and Safety eLearning and short courses in place.</li> <li>4. Gap Analysis has been reviewed. Strategy and plan to March 2026.</li> <li>5. Health and Safety Policies and Procedures are on BetsiNet.</li> <li>6. Programme of Health and Safety Reviews are in place.</li> <li>7. Programme of Health and Safety Self-Assessments are in place for completion twice yearly.</li> <li>8. <a href="#">Health and Safety presentation delivered to Board members in February 2025, to raise awareness of requirements.</a></li> </ol>		<ol style="list-style-type: none"> <li>a. NHS Employer Health and Safety Standards are being developed</li> <li>b. A review of resources required following the internal audit.</li> <li>c. BCUHB Executive Team and Board of Directors to complete health and safety training.</li> <li>d. The business model aligned to the NHS Manual Handling Passport Scheme to be reviewed</li> <li>e. Investment in training venues is required for manual handling training delivery.</li> <li>f. Senior Leaders to nominate staff to support with Divisional delivery of manual handling refresher training.</li> <li>g. Review of health and safety policies within the next 12-24 months.</li> <li>h. A Health and Safety Risk Assessment and Management Framework needs developing.</li> <li>i. A pan BCUHB Health, Safety and Security Training Needs Analysis is required.</li> <li>j. Utilise the Violence Prevention and Reduction Standards to provide a framework for a safer environment.</li> <li>k. Intranet pages for Health, Safety and Security Services require development.</li> </ol>	
<b>Actions</b>			<b>Due Date</b>
A new approach is required supplemented by a clear strategy and framework.			31/12/2025
			<b>Progression Analysis</b>
			Progressing (Revised date from 31/12/2024)

The Health and Safety Policies and procedures require a review. Compliance spreadsheet included in the SOSHG Agenda.	31/03/2025	Complete
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 presentation to be arranged for the Board. <a href="#">Presentation delivered on the 27/02/2025.</a>	31/03/2025	Complete
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 <a href="#">under development and will be issued in readiness for the April Self-Assessment Cycle.</a>	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



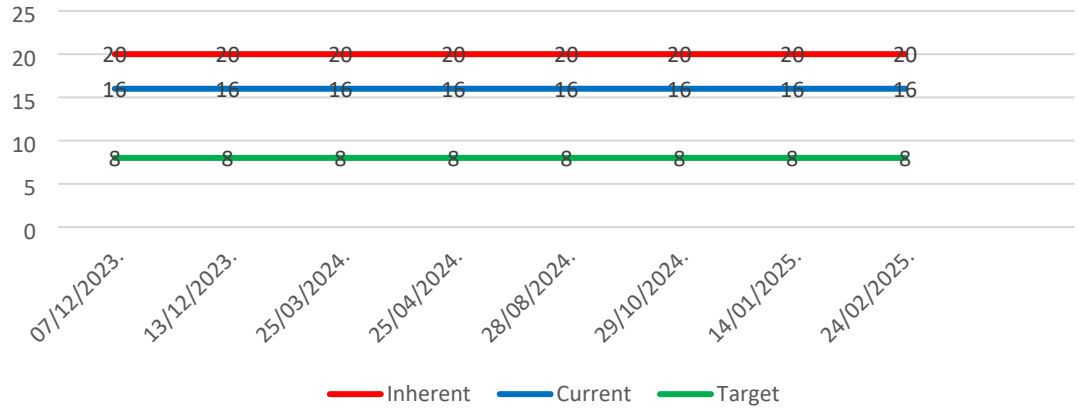
GIG  
CYMRU  
NHS  
WALES

Bwrdd Iechyd Prifysgol  
Betsi Cadwaladr  
University Health Board

	<p>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.</p>
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CRR 24-16	<b>Risk Title:</b> Leadership		<b>Date Opened:</b> 07/12/2023	
	<b>Assuring Committee:</b> People & Culture Committee		<b>Date Last Committee Review:</b> 13/02/2025	
<b>Date Last Reviewed:</b> 24/02/2025	<b>Director Lead:</b> Deputy Director of People & OD	<b>Link to BAF:</b>	<b>Target Risk Date:</b> 31/03/2026	
<p>There is a risk of traditional models of leadership which do not define the expectations, values and behaviours of our leaders to transform the organisation. We recognise a compassionate leadership approach supports the delivery of safe and reliable care. This could be caused by inadequate governance arrangement and lack of integrated leadership development pathways across the Health Board. This could have an impact on the sustainability of staffing and subsequently patient care and safety and service delivery.</p>				
<b>Mitigations/Controls in place</b>			<b>Additional Controls required</b>	
<ol style="list-style-type: none"> <li>1. Integrated Leadership Development Framework (ILDF)</li> <li>2. Culture change and Behaviours Framework.</li> <li>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</li> <li>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.</li> <li>5. Full Board now in place and all committees now chaired and attended by full complement of Independent Members</li> <li>6. Culture change agents in place across the organisation</li> <li>7. The Board formally signed the NHS Wales' Compassionate Leadership Pledge in September 2024.</li> <li>8. A compassionate behaviour resources, video co-produced with HEIW.</li> <li>9. Compassionate leadership modules are now integrated into all leadership and management development programmes.</li> <li>10. An approved Culture Leadership and Development Plan</li> </ol>			<ol style="list-style-type: none"> <li>a. Further embedding of Integrated Leadership Development Framework.</li> <li>b. Implementation and measurement of compassionate approach to leadership and how to adopt it, aligned with the work on values and behaviours</li> <li>c. Formal Culture Change Plan and accompanying Comms and Engagement plan</li> <li>d. A Behaviours Framework (will be derived from the culture change workstream)</li> <li>e. Appropriately resourced Culture Change programme and realignment of resources within the OD function.</li> <li>f. Extended gaps in Executive Team</li> </ol>	
<b>Actions</b>			<b>Due Date</b>	<b>Progression Analysis</b>
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
<p>Participation scores and feedback mechanisms are now in place for those attending ILDF courses which will help assess the content and course structure. The new Culture BI dashboard, used alongside the People Operations</p>				

Report, provides a suite of KPIs to monitor the effectiveness of leadership in the organisation. The next step is to confirm the benchmarks for each of our KPIs that will determine the level of risk.				
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; 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  In light of the three conferences in 2024 and further development of the topics to be covered, the next conference has been pushed back and will be held in the summer 2025.		30/09/2025	Progressing (revised from 31/03/2025)	
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	
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 – <a href="#">Post filled</a> 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
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**Rationale for Corporate Risk**

KPIs to that inform our risk in this area as at January 2025;

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

PADR compliance showed improvement in January 2025 increasing 0.8% to 78.8% compared to Jan 24

The number of Grievance cases has dropped in the previous three months to 6, from a spike of 17 in July 2024.

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.

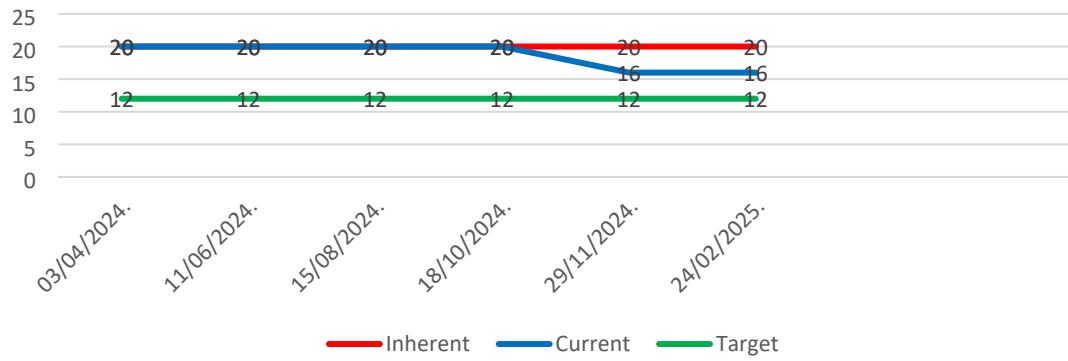
Speak out safely cases have risen to 9 compared to 4 in January 2024

CRR24-18	<b>Risk Title:</b> Operational Planning for Transmittable Diseases and Outbreaks - Health Protection		<b>Date Opened:</b> 03/04/2024
	<b>Assuring Committee:</b> Planning, Population Health and Partnerships Committee		<b>Date Last Committee Review:</b> 18/02/2025
<b>Date Last Reviewed:</b> 24/02/2025	<b>Director Lead:</b> Executive Director of Public Health	<b>Link to BAF:</b> BAF24-06	<b>Target Risk Date:</b> 31/03/2026
<p>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 variety 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, interruption of health board services and in some cases death.</p>			
<b>Mitigations/Controls in place</b>		<b>Additional Controls required</b>	
<ol style="list-style-type: none"> <li>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.</li> <li>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)</li> <li>3. Pathways established for response measures to specific diseases, for example, HNIG pathway and vaccination outbreak response for measles.</li> <li>4. Health Protection Service responsible for the management of COVID-19 incidents in closed settings in North Wales</li> <li>5. Strong links with Health Protection Partners including Public Health Wales and each of the 6 Local Authority Environmental Health teams.</li> <li>6. Strong links with the Communicable Disease Surveillance Service to support the monitoring of trends in communicable diseases</li> <li>7. Multi-agency simulation exercise undertaken in September 2023 in North Wales to test preparedness measures for specific outbreaks.</li> </ol>		<ol style="list-style-type: none"> <li>a. No approved comprehensive procedure/plan in place for the management of communicable disease outbreaks (in and out-of-hours) within BCUHB.</li> <li>b. Communicable disease preparedness group identified with a first meeting planned for April 2025.</li> <li>c. Initial discussions begun around exercise Pegasus – to take place in Autumn 2025</li> </ol>	



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 HCID preparedness measures identified areas of good practice in relation to highlighting the HCID pathway within primary care
17. Awareness sessions held with primary care practices across North Wales in December and January to highlight responsibilities for the identification and management of possible HCID cases.

<p>18. Multi-agency training event (PHW, Local Authorities) attended in February 2025 on enteric fevers and the management of food-borne illness.</p> <p>19. Identification of scope of health-protection medicines to include in a BCUHB communicable disease plan</p>				
Actions		Due Date	Progression Analysis	
<p>To establish an operational group within BCUHB for the developing and shaping a communicable disease outbreak management plan</p> <p>The High Consequence Infectious Disease (HCID) group has been officially stood-down, but will be reconvened on 29<sup>th</sup> April 2025 as a Strategic Communicable Disease Preparedness Group. Terms of Reference and membership to be confirmed.</p>		01/05/2025	Progressing (revised date from 01/03/2025)	
<p>To prepare a draft copy of a communicable disease outbreak management plan</p> <p>This will extend as Strategic Communicable Disease Preparedness Group will be meeting for the first time on the 29<sup>th</sup> April 2025.</p>		01/10/2025	Progressing (revised date from 01/12/2024)	
<p>To run a simulation exercise across the Health Board to test the functionality and contents of the communicable disease outbreak management plan</p>		01/02/2026	Progressing (revised date from 01/02/2025)	
<p>Further revision of the plan following simulation exercises</p>		14/02/2026	Progressing (revised date from 01/04/2025)	
<p>Approval and agreement of the communicable disease outbreak management plan with an agreed schedule of simulation events.</p>		31/03/2026	Progressing (revised date from 31/03/2025)	
		Impact	Likelihood	Score
		Inherent Risk Rating	4	5
				20



Current Risk Rating	4	4	16
Target Risk Score	4	3	12
Risk Appetite	Quality		<16

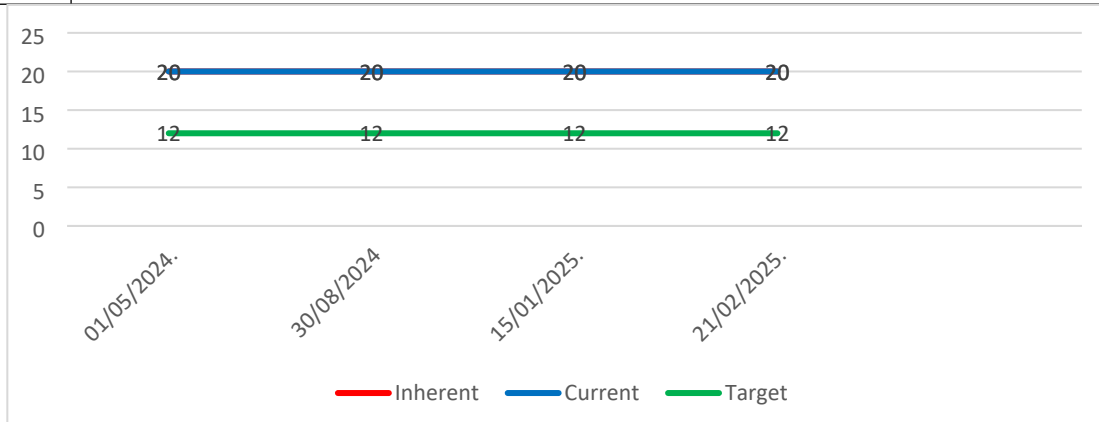
**Position & Intended Outcome for Risk**

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

CRR 24-19	<b>Risk Title: Community Care Provision</b>		<b>Date Opened: 01/05/2024</b>
	<b>Assuring Committee:</b> Quality, Safety and Experience Committee		<b>Date Last Committee Review:</b> 20/02/2025
<b>Date Last Reviewed:</b> 21/02/2025	<b>Director Lead:</b> Executive Director Transformation and Strategic Planning	<b>Link to BAF:</b> BAF24-07	<b>Target Risk Date:</b> 31/03/2026
<p>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, Discharge To Recover and Assess, Care Home support services and continuing health care (CHC) services. This may be caused by insufficient provision of care in the community, the fragility of independent providers (domiciliary care and care homes), delays of joint assessments, staffing shortages and gaps in service provision out of hours. 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.</p>			
<b>Mitigations/Controls in place</b>		<b>Additional Controls required</b>	
<ol style="list-style-type: none"> <li>6. Daily patient flow meetings including focus on long-stay patients and partnership with Local Authorities</li> <li>7. 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.</li> <li>8. Community Resources Team model bringing together agencies and professionals supporting locality populations.</li> <li>9. North Wales care homes single action plan overseen by Regional Commissioning Board and Regional Partnership Board.</li> <li>10. Care home Quality Assurance Framework and tools in place</li> <li>11. Established Continuing Healthcare (CHC funding) teams and processes including escalation where delays occur</li> <li>12. Agreed joint escalation processes with Local Authorities for care homes of concern</li> <li>13. 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.</li> </ol>		<ol style="list-style-type: none"> <li>a. Escalation and sustainability report requires commissioning to address risks associated with workforce and workload pressures allows for early identification and management.</li> <li>b. Programme management to be implemented to monitor and drive strategic priorities.</li> <li>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</li> <li>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.</li> <li>e. Additional Resourcing of CIVICA system (scheduling system for District Nurses), access to EMIS (GP Patient record system)</li> </ol>	

		<p>community for teams. Connecting Care Implementation for community services.</p> <p>f. Financial systems that support transformative systems in line with Primary Care Model for Wales outcome 13.</p> <p>g. Improved joint planning with local Mental Health services.</p> <p>h. Improved planning for access to diagnostics in the community setting</p> <p>i. Community Care and CHC services audits of sustainability matrix ongoing periodically – Programmes to be put in place to undertake the audits</p> <p>j. Equity of resource to support community care and CHC transformation, innovation, management and governance.</p> <p>k. Improved discharge planning and support in line with All Wales good practice guidance, this is being taken forward by UEC workstream 4</p> <p>l. Implementation of Pathways of Care Regional Action Plan</p> <p>m. Develop surge plans jointly with Local Authorities for winter pressures – did not happen to be progressed again.</p> <p>n. Complete pre-placement agreements with all providers and implement strengthened contract monitoring</p>	
Actions		Due Date	Progression Analysis
1	Community Care and CHC strategic plan to be drafted to inform the Health Board strategic plans.	31/03/2025	Progressing
2.	Programme management to be implemented to monitor and drive strategic priorities. <a href="#">Raised through 25/26 Ministerial Template process that programme management approach is required but not in place, a request has been made through the planning process for identified Executive Leadership and Programme Management Resource.</a>	31/10/2025	Progressing
3	Community Care and Continuing Healthcare services audits of sustainability matrix ongoing periodically – Audit programme already in place, <a href="#">this is now available to view on IRIS dashboard</a>	31/03/2025	Complete

4.	Equity of resource to support community care and Continuing Healthcare transformation, innovation, management and governance.  <a href="#">Value and Sustainability CHC Group established and will finalise priorities for 25/26</a>	31/03/2025	Progressing
5	Establish a health board group to agree a strategy, vision and aligned 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.	30/06/2025	Progressing
6	Joint commissioning plan with Local Authorities to increase domiciliary care capacity <a href="#">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. 97 providers have now been successful and contracts will be issued on 11/3/25</a>	25/04/2025	Progressing
7	Review of community services model and development of business case to address gaps in capacity (linked to action 8.) <a href="#">Linked to action 2.</a>	31/03/2026	Progressing
8	Determine required level of Quality Assurance Framework increased frequency of visits, resource requirement and plans to implement. <a href="#">Final version of SOP for Clinical Quality Support Tools under the QAF is awaiting approval at the next Patient Safety Group on January 28th.</a>	28/02/2025	Complete



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

**Position & Intended Outcome for Risk**



GIG  
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NHS  
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University Health Board

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.

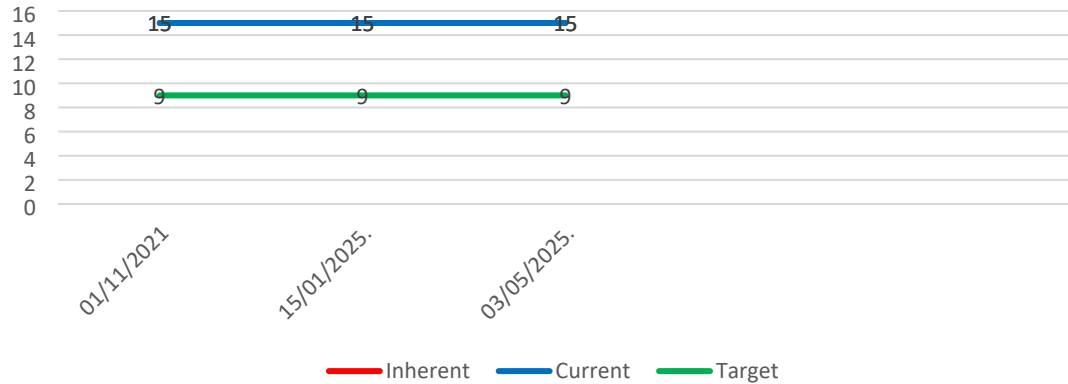
Recognition of inherent score currently further controls needed.

Lack of adequate investment and provision in domiciliary care.

The Ministerial Priorities referred to - Building Community Capacity.

CRR 24-20	<b>Risk Title:</b> Oncology Services		<b>Date Opened:</b> November 2024
	<b>Assuring Committee:</b> Quality, Safety and Experience Committee		<b>Date Last Committee Review:</b> 20/02/2025
<b>Date Last Reviewed:</b> 20/02/2025	<b>Director Lead:</b> Executive Medical Director	<b>Link to BAF:</b> BAF24-07	<b>Target Risk Date:</b> 31/03/2026
<p>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 ongoing/long term oncological treatment. 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.</p>			
<b>Mitigations/Controls in place</b>		<b>Additional Controls required</b>	
<ol style="list-style-type: none"> <li>1. Medical locums in place to support gaps in substantive provision</li> <li>2. Escalated requirement to support recruitment of medical oncology trainees within next 12 months</li> <li>3. Supporting 2 NHS Locums to complete <i>Certificate of Eligibility of Specialist Registration</i> (CESR) and additional competencies to be eligible to become substantive in the future.</li> <li>4. Development plan in place for 2 Senior Clinical Fellows with aim to train them to become substantive Consultants within 2-3 years.</li> <li>5. Systemic anti-cancer treatment (SACT) Operational group established to improve processes and systems – collaboration with pharmacy.</li> <li>6. Radiotherapy Oversight meeting established to monitor progress against plan and maintenance of target.</li> <li>7. Developed extended non-medical nursing roles to support medical gaps including immunotherapy toxicity, cancer of unknown primary and metastatic breast and colorectal services.</li> <li>8. Developed an extended non-medical radiotherapy role to support prostate cancer patients who require radiotherapy</li> <li>9. Clinical Leads (Joint role) appointed.</li> </ol>		<ol style="list-style-type: none"> <li>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%.</li> <li>b. Lack of available high-quality data to provide robust capacity and demand modelling per tumour site, per clinical/medical oncologist</li> <li>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)</li> <li>d. Inability to respond effectively to increasing demand for oncological treatments and new NICE-approved regimes</li> <li>e. Home care service is saturated meaning no further treatments can be transferred out of the day units to release capacity (this would also release funding as VAT is exempt).</li> <li>f. Lack of physical estate to expand services and/or recruit more staff.</li> <li>g. Outsourcing opportunities for the highest risk tumour sites, remains a gap, further exploration required.</li> </ol>	

	<ul style="list-style-type: none"> <li>h. Gap and lack of clinical oncology trainees with multiple gaps limiting ability to 'grow our own'.</li> <li>i. Collaboration with recruitment agencies to explore overseas consultant opportunities.</li> <li>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</li> </ul>			
Actions	Due Date	Progression Analysis		
<p>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. Professor-level post agreed with medical school, job description awaiting approval from Royal College – position confirmed</p>	30/04/2025	Progressing (revised date from 30/01/2025)		
<p>Complete Planning to repatriate the delivery of Stereotactic Ablative Radiotherapy into the Health Board A letter is being submitted to the Joint Commissioning Committee requesting approval to proceed according to the established process commence as per process. Meeting arranged awaiting approval.</p>	30/04/2025	Progressing		
<p>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 Initial conversations have happened with Clatterbridge but needs further executive to executive conversations – date to complete needs to be extended</p>	30/08/2025	Progressing revised date from 30/04/2025)		
<p>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. Specific Oncology training for managing the waiting list has been undertaken; data quality issues regarding BANO has been resolved as backlog has been agreed to be removed by the 'robot'; plan to improve more data issues has been established for 25/26</p>	31/03/2026	Progressing (revised date from 31/03/2025)		
	Impact	Likelihood	Score	
	Inherent Risk Rating	3	5	15
	Current Risk Rating	3	5	15



Target Risk Score	3	3	9
Risk Appetite	Quality		<16

**Position & Intended Outcome for Risk**

The combination of multiple factors, *including*;

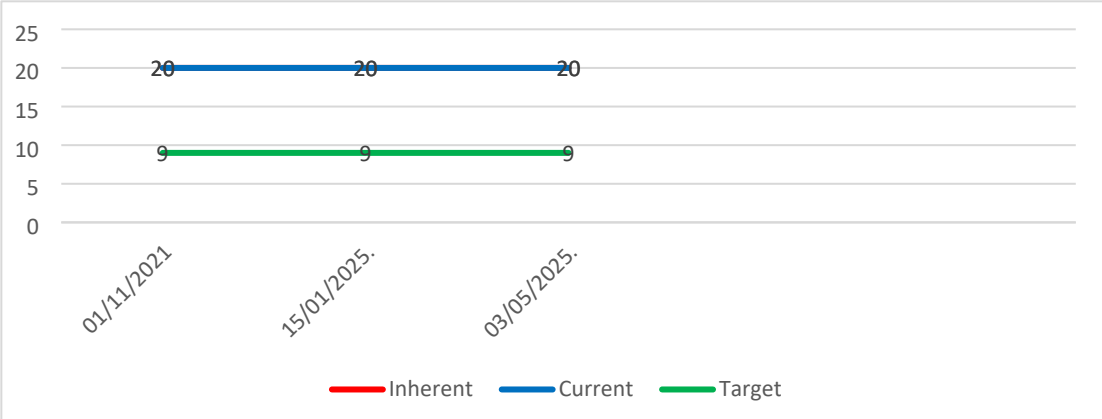
- the inability to recruit substantially to Senior Medical posts,
- increasing reliability on availability of Locums
- large number of temporary staff, as a result of RIGA and increasing demand for oncological treatments, which has resulted in service gaps which have increased waiting times for patients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

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.

Extreme risk within gynae, breast and upper GI remain as a result of unavailability of suitable locums and lack of capacity within current staffing. The highest risk is with the availability of a consultant to cover the medical oncology element of care to patients with a gynae cancer in East.

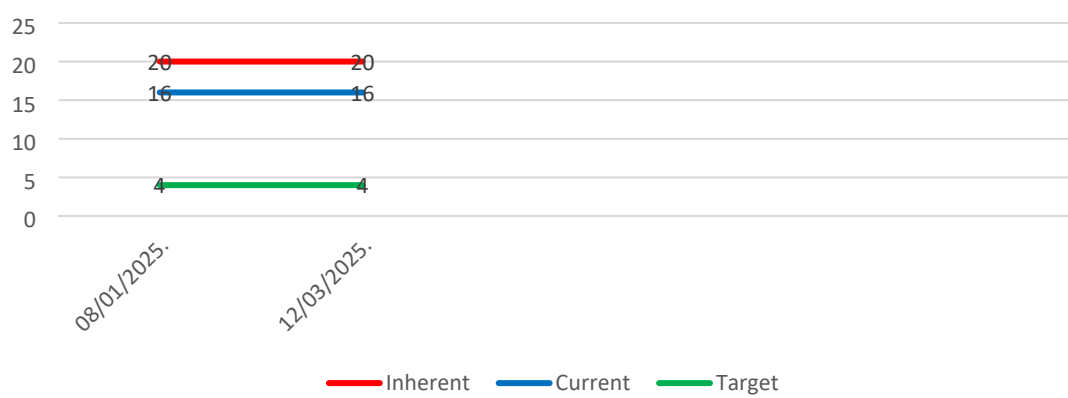
CRR 24-21	<b>Risk Title:</b> Ophthalmology Services		<b>Date Opened:</b> November 2024	
	<b>Assuring Committee:</b> Quality, Safety and Experience Committee		<b>Date Last Committee Review:</b> 20/02/2025	
<b>Date Last Reviewed:</b> 05/03/2025	<b>Director Lead:</b> Chief Operating Officer	<b>Link to BAF:</b> BAF24-07	<b>Target Risk Date:</b> 31/12/25	
There is a risk that patients may come to harm caused 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 litigation due to prolonged wait times.				
<b>Mitigations/Controls in place</b>			<b>Additional Controls required</b>	
<ol style="list-style-type: none"> <li>1. Train and Treat initiative in place to increase the number of procedures that can be done in a community/high street optometry setting. <a href="#">Train and Treat embedded and successfully expanded to two site delivery (Deeside Glaucoma and Holywell Hospital Independent Prescribing: meeting delivery targets).</a></li> <li>2. Outsourcing solution for cataract procedures in place.</li> <li>3. Development of High flow lists for cataracts in place with West</li> </ol>			<ol style="list-style-type: none"> <li>a. Appoint Health Board clinical lead to secure professional oversight and leadership</li> <li>b. Development of a sustainable service model</li> <li>c. Ensure specialty demand, capacity and planning is delivered along with further mitigations to be developed to close any gaps in delivery.</li> <li>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</li> </ol>	
<b>Actions</b>			<b>Due Date</b>	<b>Progression Analysis</b>
b. Convene a Health Board wide Ophthalmology summit to identify subspecialty leads to support service redesign, agree priorities and initiate work plan <a href="#">Sustainability plan informing Speciality Plan development. Funding clarification being explored with Clinical Lead Operations. New date to be determined with COO.</a>			28/02/2025 to be revised	Overdue
c. <a href="#">Development of High flow lists for cataracts in place progression in Central and East. Pathway currently being reviewed against All Wales pathway to inform short medium and long term improvement plan, initial draft to be delivered March 25.</a>			31/03/2025	Progressing
a. <a href="#">To Appoint a Health Board Clinical Lead Office of Medical Director is progressing recruitment. (progression/funding clarification being explored with Clinical Lead Operations)</a>			30/06/2025	Progressing (revised date from 31/12/204)

b. Develop a work programme for service design and development (output of summit). <a href="#">New date to be determined with COO.</a>	28/02/2025	<b>Overdue</b>																																			
d.Resource activity as previously identified and reinstate eye care performance fund that has been reduced through RIGAI financial prioritisation <a href="#">funding clarification being explored with Clinical Lead Operations</a>	01/04/2025	<b>Progressing</b>																																			
 <table border="1" data-bbox="185 416 1283 837"> <caption>Risk Score Data</caption> <thead> <tr> <th>Date</th> <th>Inherent</th> <th>Current</th> <th>Target</th> </tr> </thead> <tbody> <tr> <td>01/11/2021</td> <td>20</td> <td>20</td> <td>9</td> </tr> <tr> <td>15/01/2025</td> <td>20</td> <td>20</td> <td>9</td> </tr> <tr> <td>03/05/2025</td> <td>20</td> <td>20</td> <td>9</td> </tr> </tbody> </table>	Date	Inherent	Current	Target	01/11/2021	20	20	9	15/01/2025	20	20	9	03/05/2025	20	20	9	<table border="1"> <thead> <tr> <th></th> <th>Impact</th> <th>Likelihood</th> <th>Score</th> </tr> </thead> <tbody> <tr> <td>Inherent Risk Rating</td> <td>4</td> <td>5</td> <td style="background-color: red; color: white;">20</td> </tr> <tr> <td>Current Risk Rating</td> <td>4</td> <td>5</td> <td style="background-color: red; color: white;">20</td> </tr> <tr> <td>Target Risk Score</td> <td>3</td> <td>3</td> <td style="background-color: yellow;">9</td> </tr> <tr> <td>Risk Appetite</td> <td colspan="2">Quality</td> <td style="background-color: red; color: white;">&lt;16</td> </tr> </tbody> </table>		Impact	Likelihood	Score	Inherent Risk Rating	4	5	20	Current Risk Rating	4	5	20	Target Risk Score	3	3	9	Risk Appetite	Quality		<16
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Risk Appetite	Quality		<16																																		
<p style="text-align: center;"><b>Position &amp; Intended Outcome for Risk</b></p> <p>Significant harm may occur including irreversible sight loss in high risk R1 &amp; 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+</p>																																					

CRR 24-22	<b>Risk Title:</b> Orthodontics Services		<b>Date Opened:</b> November 2024	
	<b>Assuring Committee:</b> Quality, Safety and Experience Committee		<b>Date Last Committee Review:</b> 20/02/2025	
<b>Date Last Reviewed:</b> 12/03/2025	<b>Executive Lead:</b> Chief Operating Officer	<b>Link to BAF:</b>	<b>Target Risk Date:</b> 31/03/2026	
<p>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.</p>				
<b>Mitigations/Controls in place</b>		<b>Additional Controls required</b>		
<ol style="list-style-type: none"> <li>1. Appropriate referrals pathway/ triage implementation (as per national pathway)</li> <li>2. Dentist with Specialist Interest (DESI) and Tier 2 – wider, easily accessible pathways</li> <li>3. PAN BCUHB approach dating patients according to length of wait into additional Waiting List Initiative (WLI) activity</li> <li>4. Health prevention/promotion within primary care</li> <li>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</li> <li>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.)</li> </ol>		<ol style="list-style-type: none"> <li>a. Continued shortfall of workforce across BCUHB needs recruitment strategy</li> <li>b. Continued conversations with external providers indicates limited outsourcing opportunity</li> <li>c. No restorative consultant service available</li> <li>d. No proactive comms to patients and stakeholders agreed</li> <li>e. Current service provision indicates ongoing service delivery shortfalls with recovery in excess of 5 years</li> </ol>		
<b>Actions</b>			<b>Due Date</b>	<b>Progression Analysis</b>
Agreement of BCUHB to advertise Consultant Orthodontists at top of scale following submission of SBAR in September 2023			31/07/2024	Complete

Successful appointment of 0.7 WTE Consultant Orthodontist	31/08/2024	Complete
Attempted but unsuccessful recruitment of Agency & NHS Locums <i>Unable to complete</i>	31/12/2025	Progressing
Review of workload of consultants across BCUHB to improve equity of access within BCUHB	28/02/2024	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	28/02/2024	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 request 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
GIRFT Recommendations following completion of the review. Report to be formally signed off by Health Board and to then implement the recommendations for service improvement.	TBC	Progressing

 <p>08/01/2025. 12/03/2025.</p> <p>— Inherent — Current — Target</p>		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
<b>Rationale for Corporate Risk</b>				
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.				

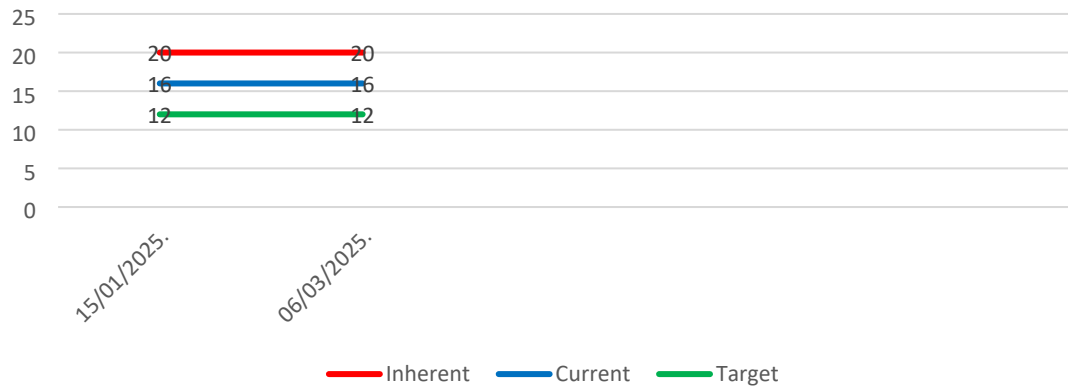


	<p>Poor provision in some geographical areas. Lack of stability from Welsh Government around future Dental contracts. Patients awaiting treatment completion are dating back to referrals first received in 2017 highlighting significant delays in treatment pathways. Patients awaiting Patients referred for 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 &amp; estate restrictions on expanding Medical workforce. Current model of care is disjointed and lacking fluidity between primary &amp; 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.</p>
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CRR 24-23	<b>Risk Title:</b> Vascular Services		<b>Date Opened:</b> November 2024
	<b>Assuring Committee:</b> Quality, Safety and Experience Committee		<b>Date Last Committee Review:</b> 20/02/2025
<b>Date Last Reviewed:</b> 06/03/2025	<b>Director Lead:</b> Chief Operating Officer	<b>Link to BAF:</b> BAF24-07	<b>Target Risk Date:</b> 31/03/2026
<p>There is a risk that individuals may experience 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, psychological distress, difficulties recruiting and retaining staff, staff health and well-being, reputational damage, increased costs, increased legal and financial claims.</p>			
Mitigations/Controls in place		Additional Controls required	
<ol style="list-style-type: none"> <li>1. Management of bed base through assessment of clinical risk in place.</li> <li>2. Optimising and streamlining management of inpatients and ensuring clear communication across site to ensure timely transfer and repatriation</li> <li>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</li> <li>4. Weekly case-note audits in place to monitor standards of record keeping, with results discussed at clinical governance meetings</li> <li>5. Pathways are co-designed with an extensive group of delivery partners across the 3 sites</li> <li>6. Local Vascular Delivery Groups in place for 2/3 IHCs (West and Central) in order to proactively identify performance concerns and manage risk</li> <li>7. Development of Abdominal Aortic Aneurism (AAA) Quality Improvement programme.</li> <li>8. Consultant vascular surgeon is picking up IR sessions</li> <li>9. Weekly Multi-Disciplinary Team meeting to allocate patients onto the waiting list and ensuring consultants are aware of patients that need</li> </ol>		<ol style="list-style-type: none"> <li>a. Development of Vascular Intranet pages to help share information, including clinical pathways, with staff, in a way that is simple and accessible</li> <li>b. Local vascular delivery groups to be operational across each IHC.</li> <li>c. Review of AAA surveillance protocol / pathway, to include management of persons turned down for AAA repair</li> <li>d. Implementation of deep-dive audit tool to enable quality audit of case notes</li> <li>e. Workforce and resource review to support development of Phase 2 Business Case</li> <li>f. Development of vascular workforce strategy aimed at improving recruitment.</li> <li>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</li> <li>h. Development of Quality dashboard, to support improved use of service and outcome data</li> </ol>	



<p>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</p>				
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	31/03/2026	Progressing		
Build pan-BCU and local quality dashboard to support improved use of service and outcome data	30/03/2026	Progressing		
		Impact	Likelihood	Score



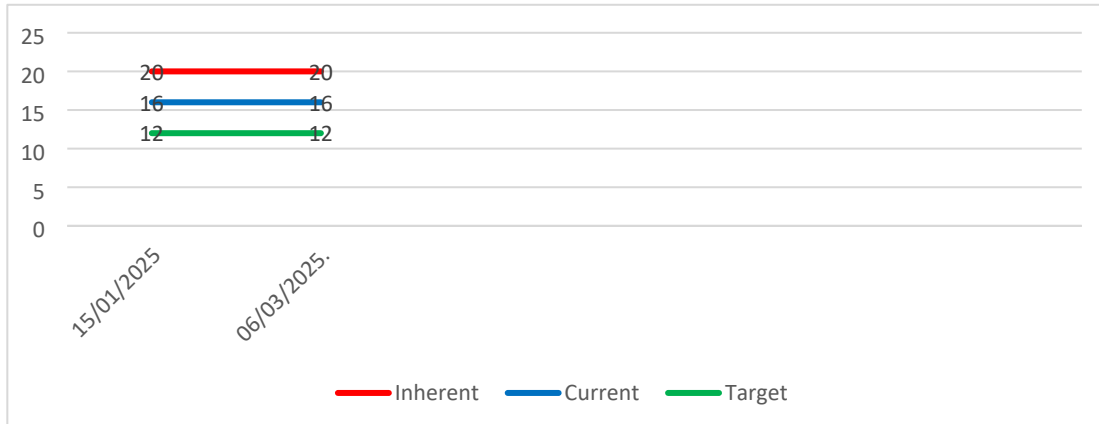
Inherent Risk Rating	4	5	20
Current Risk Rating	4	4	16
Target Risk Score	4	3	12
Risk Appetite	Quality		<16

**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	<b>Risk Title:</b> Renal Services		<b>Date Opened:</b> November 2024	
	<b>Assuring Committee:</b> Quality, Safety and Experience Committee		<b>Date Last Committee Review:</b> 20/02/2025	
<b>Date Last Reviewed:</b> 06/03/2025	<b>Director Lead:</b> Chief Operating Officer	<b>Link to BAF:</b> BAF24-07	<b>Target Risk Date:</b> 31/03/2026	
There is a risk that individuals may experience 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, psychological distress, reputational damage, increased costs, legal costs and financial claims.				
<b>Mitigations/Controls in place</b>			<b>Additional Controls required</b>	
<ol style="list-style-type: none"> <li>1. Close regular scrutiny of waiting lists at a vascular and renal network level.</li> <li>2. Informal management of waiting lists on a networked basis to support prioritisation of cases, where possible</li> <li>3. Additional capacity provided by Locum Consultant.</li> </ol>			<ol style="list-style-type: none"> <li>a. Formal agreement to the establishment of a single Pan-BCU list, rather than 3 separate Integrated Health Community (IHC) Clinic and Theatre lists.</li> <li>b. Additional capacity to support reduction of current waiting list in the East, to a more manageable position.</li> <li>c. Recruitment to 2x vacant Consultant posts</li> <li>d. Re-allocation of resources across the Network, to enable equitable access to interventions locally.</li> </ol>	
<b>Actions</b>			<b>Due Date</b>	<b>Progression Analysis</b>
Submit Waiting List Initiative request to facilitate additional theatre lists, in order to reduce current backlog			01/04/2025	Progressing (revised date from 30/12/2024)
2 requests submitted, one declined due to lack of Theatre staff availability, and awaiting confirmation on 2 <sup>nd</sup> request				
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
Work with new Locum consultants to ensure cover for any vacant theatre lists and clinic sessions	30/05/2025	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		<16

### 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:

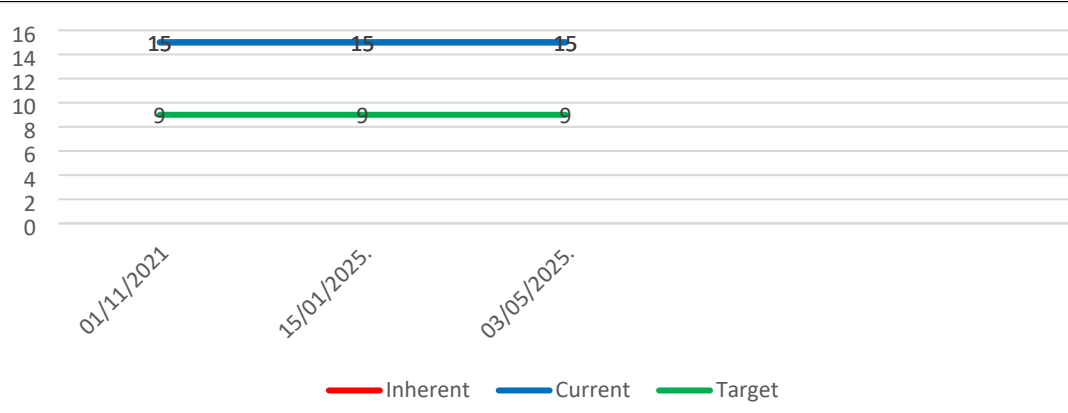
- a. Higher **demand** in the East due to its larger population size, together with the fact that it has the largest dialysis unit.
- b. An inequity in **capacity** across the three IHCs to support renal access – the East having the fewest number of clinics sessions and theatre lists.

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:

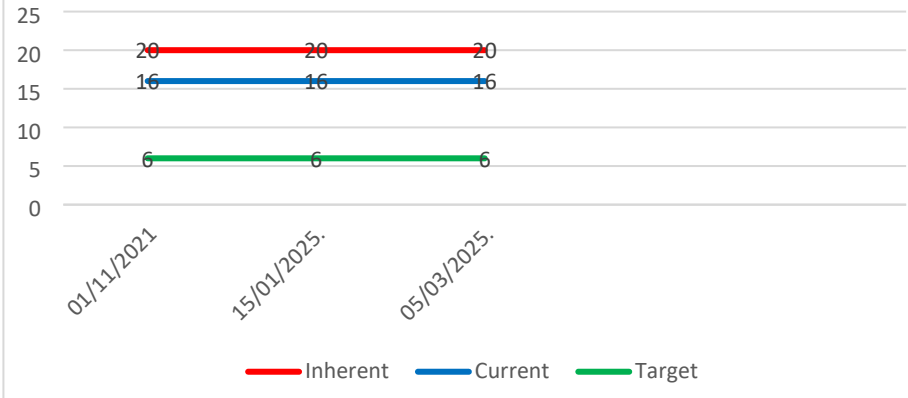
- Ensure a dedicate group of Vascular Surgeons to complete renal access procedures – with flexibility to move across sites
- Dedicated Clinics for Renal VANS alongside surgeons (on each site)
- Dedicated Theatre lists on each site – reflecting the demand of each site's renal population

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

CRR 24-25	<b>Risk Title:</b> Dermatology and Plastic Surgery Services		<b>Date Opened:</b> November 2024	
	<b>Assuring Committee:</b> Quality, Safety and Experience Committee		<b>Date Last Committee Review:</b> 20/02/2025	
<b>Date Last Reviewed:</b> 08/01/2025	<b>Director Lead:</b> Executive Medical Director	<b>Link to BAF:</b> BAF24-07	<b>Target Risk Date:</b> 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.				
<b>Mitigations/Controls in place</b>			<b>Additional Controls required</b>	
<ol style="list-style-type: none"> <li>1. Prioritisation of urgent suspected cancer to mitigate clinical risk</li> <li>2. Provision of Waiting List Initiative activity to provide short term additionality</li> <li>3. Development of insourced arrangements to provide interim additional capacity for a 12-18 month period</li> <li>4. Appointment of clinical leads to support service redesign</li> <li>5. Introduction of Teledermoscopy with a commensurate increase in treatment capacity (minor operating procedures)</li> </ol>			<ol style="list-style-type: none"> <li>a. Appoint a specialty managerial lead to take forward service redesign.</li> <li>b. Approve and implement increased treatment capacity.</li> </ol>	
<b>Actions</b>			<b>Due Date</b>	<b>Progression Analysis</b>
Dermatology - Maintain support for the Clinical Leads in Dermatology as part of a single Dermatology Service for North Wales. Monitoring BAU.			30/06/2025	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	
 <p>Legend: <span style="color: red;">—</span> Inherent <span style="color: blue;">—</span> Current <span style="color: green;">—</span> Target</p>	<b>Impact</b>	<b>Likelihood</b>	<b>Score</b>	
	Inherent Risk Rating	3	5	15
	Current Risk Rating	3	5	15
	Target Risk Score	3	3	9
	Risk Appetite	Quality		<16
	<b>Position &amp; Intended Outcome for Risk</b>			
	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.			

CRR 24-26	<b>Risk Title:</b> Urology Services		<b>Date Opened:</b> November 2024
	<b>Assuring Committee:</b> Quality, Safety and Experience Committee		<b>Date Last Committee Review:</b> 20/02/2025
<b>Date Last Reviewed:</b> 05/03/2025	<b>Director Lead:</b> Executive Medical Director	<b>Link to BAF:</b> BAF24-07	<b>Target Risk Date:</b> 31/12/2025
<p>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 network clinical leadership. This may lead to the inability of the Health Board to deliver timely and appropriate care on a pan-North Wales level. 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.</p> <p>If the actions within the Urology Improvement Plan are not achieved, the ability to mitigate 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 reputation of the Health Board.</p>			
<b>Mitigations/Controls in place</b>		<b>Additional Controls required</b>	
<ol style="list-style-type: none"> <li>1. High use of locum provision</li> <li>2. Outsource of service, case by case, whilst commissioning discussions take place.</li> <li>3. Annual commissioning of service in place</li> <li>4. Commission of Robotic Assisted Surgery prostates to UCL</li> <li>5. Office of the Medical Director currently supporting with Clinical Lead input</li> <li>6. Monthly meeting with Welsh Government and NHSE to provide assurance and update on the risks currently identified and actions within the Improvement Group.</li> </ol>		<ol style="list-style-type: none"> <li>a. Agree mitigation to move to 2 site model if staff becomes unsafe at 1 site.</li> <li>b. Review purchase of an appropriate Robotic Assisted Surgery platform for prostatectomies</li> <li>c. Clinical facilities and equipment investment identified in the Urology Improvement Plan under the Planned care theme not yet in place</li> </ol>	
<b>Actions</b>			<b>Due Date</b>
Scoping, development and implementation of a revised network model of care for on call.			01/04/2025
			<b>Progression Analysis</b>
			Progressing

<p>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. <a href="#">New arrangements being onboarded with Arrowe Park</a></p>	01/12/2024	Complete																																			
<p>Cancer services with support from the OMD to advertise for a Urology Cancer lead.</p>	01/11/2025	Progressing																																			
<p>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.</p>	01/04/2025	Progressing																																			
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<p align="center"><b>Rationale for Corporate Risk</b></p>																																					
<p>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:</p> <ul style="list-style-type: none"> <li>• Increased financial expenditure due to locum provision on the on call rota</li> <li>• Fragile Out Of Hours on-call rota across BCU</li> <li>• Delay in patient care with an inability to meet targets for cancer diagnosis and treatment.</li> <li>• Failure to deliver care closer to home.</li> <li>• Difficulty in recruiting to provide a sustainable cancer service</li> </ul>																																					

CRR 24-27	<b>Risk Title:</b> Neurodevelopment Waiting List		<b>Date Opened:</b> 02/05/2024
	<b>Assuring Committee:</b> Quality, Safety and Experience Committee		<b>Date Last Committee Review:</b> New Risk
<b>Date Last Reviewed:</b> 11/03/2025	<b>Executive Lead:</b> Chief Operating Officer	<b>Link to BAF:</b>	<b>Target Risk Date:</b> 02/05/2027
<p>There is a risk that the Health Board may not meet the target set by the Welsh Government (WG) for Neurodevelopment (ND) services which requires that 80% of assessments commence within 26 weeks of the date of referral. Currently Children and young people referred into the service now will not be seen (not assessed) before their 18th birthday. This could be caused by an increase in demand on the service without the support and funding to increase capacity within the team. This may lead to children and young people not being assessed in a timely manner.</p>			
<b>Mitigations/Controls in place</b>		<b>Additional Controls required</b>	
<ol style="list-style-type: none"> <li>1. BCUHB transformation programme commenced, and a full programme of work has been developed to support the move to a needs led service.</li> <li>2. Welsh Government have issued short term funding to support longest waiters on the list, the service are looking to staff overtime, Agency staff and waiting list validation.</li> </ol>		<ol style="list-style-type: none"> <li>1. Programme Manager essential for delivery of revised service model – only approved until end June 25.</li> <li>2. Support from external stakeholders (Schools, Local Authority and Third sector) for a new service model to implement significant change.</li> <li>3. The National work programme needs to be implemented at pace with the recognised changes required in BCUHB.</li> <li>4. Profile of Needs Training has commenced with Conwy and Denbighshire Local Authorities to support Children on the waiting list and will be rolled out to all local authorities as their capacity allows.</li> <li>5. Recurrent funding is required to allow the team to recruit to substantive posts and funding often given with short notice/time limited with specific aim, such constraints become difficult to navigate.</li> <li>6. Approval of a Business case to support additional staffing structures, and support the improvement programme.</li> <li>7. Greater engagement with external stakeholders such as schools and upskilling staff.</li> </ol>	

	<ol style="list-style-type: none"> <li>8. An agreed current plan to address the backlog waiting list, excessive backlog would require £20m* investment based on current model (e.g. if outsourced).</li> <li>9. A consistent Executive Director to lead on ND challenges</li> <li>10. The Regional Partnership Board workshop in March 2025 will produce short, mid and long term actions with regards to providing support, information and advice for those both on the waiting list and those at early identification. This will include support from Third Sector, Local Authority and Education colleagues.</li> <li>11. Agree a transfer policy for Children and young people approaching 18 - to Adult Mental Health Services/Integrated Autism Service .</li> <li>12. Development of a new prudent assessment to standardise the process and align to best practice. The prudent assessment process will allow all assessment processes to be streamlined and aligned across the Region and reduce inequity.</li> <li>13. The ND services across the Region have an approximate workforce of 70 staff including Clinical and Non-clinical which is in adequate to support the demand on the service. However, additional staffing would not be supported by the current Health Board Estate.</li> <li>14. A single digital information system in place to support the sharing of information across teams eg ND teams, CAMHS, Therapies, Education, Social care</li> <li>15. The Health Board compliance against the Welsh Government 26 week target currently stands at 11% against the target of 80 %</li> </ol>		
<b>Actions</b>		<b>Due Date</b>	<b>Progression Analysis</b>
<p>The Regional Partnership Board have agreed to prioritise ND services for 2025-2026 as part of their work plan. The ND programme team are working with the Regional Partnership Board and wider stakeholders eg schools, Local authorities and Third Sector to agree a cohesive way of working to support Children and Young People on the waiting list</p>		<p><b>31/03/2026</b></p>	<p>Progressing</p>

Work with one Local Authority to train staff to undertake profiling for children on the waiting list. This will provide support for Children, young people and their families whilst waiting for assessment. This will be a pilot project with Ynys Mon and further roll out with other local authorities as they have capacity to support the process. The aim would be for all local authorities to be trained in profiling by March 2026.	30/06/2025 (pilot)  March 2026	Progressing		
Agreement and production of a new draft service model with key partners to promote a whole system approach embedded within a social model of disability that focuses on changing attitudes, environments and systems in collaboration with all stakeholders..	April 2026	Progressing		
Commence implementation of a new service model to support CYP with early support and intervention. This should reduce referral numbers	31/03/2028	Progressing		
Development of agreed Transfer policies between Child and Adult Services to provide support and timely assessment for those moving into adulthood.	31/03/2026	Progressing		
Maintain close working relationships with the National Programme of work and the Regional Partnership Board to ensure a consistent approach to whole system approach.	31/03/2026	Progressing		
Ensure recommendations from the National event in Lampeter are reviewed and implemented as necessary following their release from Welsh Government. Actions will be measured and reviewed	31/12/2025	Progressing		
Submission of Business case to support key roles including the programme and operational staffing (Clinical Lead). Approval will be required by the Health Board	30/07/2025	Progressing		
Validation of current waiting list (waiters over 3 years) to ensure all patients wish to remain on the list. Currently 600 patients on the long waiters list.	30/06/2025	Progressing		
Identification of an Executive Lead for the service to support the programme of work	31/05/2025	Progressing		
Implement new prudent assessment process to decrease the length of the process and provide a more streamlined process for CYP and their families. Revised assessment processes are currently being identified by our Clinical Leads	31/07/2025	Progressing		
Stratification of the waiting list to identify those at greater risk and agree their prioritisation. It is envisaged that this work will support those most in need and allow a more timely assessment.	30/09/2025	Progressing		
Approval of waiting list options paper by ND Strategic Improvement and Development Group. Prudent assessment (streamlined processes aligned to NICE guidance) options will be measured during the monthly performance meeting.	30/05/2025  Ongoing	Progressing		
Funding is being used from Welsh Government to support pilot projects, with the aim to develop new ways of working, increase capacity/support for Children and Young People on the waiting lists. All projects are currently undergoing evaluation via the Regional Partnership Board and findings are expected by the end of April for approval to continue funding in 2025/2026	30/04/2025	Progressing		
<b>To be completed following escalation approval</b>	<b>Impact</b>	<b>Likelihood</b>	<b>Score</b>	
	Inherent Risk Rating	5	4	20
	Current Risk Rating	5	4	20

	Target Risk Score	5	3	15
	Risk Appetite	Quality		<16
<b>Rationale for Corporate Risk</b>				
<p>Waiting list time approaching 20 years for new referrals based on current capacity, with an average monthly capacity gap of approximately 200 assessments. A key ministerial priority for 2025/26 is to deliver an improvement in the target compliance rate to 15% by Q4, for which additional investment will be required. The pressures on the ND waiting list are national with no Health Board in Wales meeting the WG 26-week target, BCUHB are currently the second worst performer against the target.</p> <p>There was a significant increase in demand during the Covid pandemic with accepted referrals rising by 130% from 20/21 to 22/23, and a further increase of 43% in accepted referrals from 22/23 to 23/24. – Year to date in 24/25 accepted referrals are 10% lower partially due to demand management initiatives implemented</p> <p>The ND waiting list is forecast to be over 7,000 by the end of March 25.</p> <p>Whilst the target date for this risk is identified as 2027, it must be noted that delivery of a supported and sustainable service will not be achievable within this timescale due to current capacity, funding and support required from external partner organisations. The above actions have been identified to support the mitigation of the current risk.</p>				

CRR 24-28	<b>Risk Title: Managing External Recommendations and Response Plans</b>		<b>Date Opened: 03/03/2025</b>
	<b>Assuring Committee: Audit Committee</b>		<b>Date Last Committee Review: New Risk</b>
<b>Date Last Reviewed: 03/03/2025</b>	<b>Executive Lead: Director of Corporate Governance</b>	<b>Link to BAF:</b>	<b>Target Risk Date: 30/12/2025</b>
<p>There is a risk that the Health Board may face enforcement, legal action or reputational damage due to the inability to adequately and timely respond to recommendations and action plans issued by external bodies, including regulatory, statutory and professional advisory institutions such as Health Inspectorate Wales (HIW), Care Inspectorate Wales (CIW), Public Services Ombudsman for Wales (PSOW), Coroners, Royal College of Psychiatrists, Royal College of Surgeons, and other specialty reviews. This is due to devolved management, lack of digital capability, resource constraints, and competing priorities potentially impacting compliance, public trust, and operational stability.</p>			
<b>Mitigations/Controls in place</b>		<b>Additional Controls required</b>	
<ol style="list-style-type: none"> <li>1. Regulatory Assurance Group monitors external recommendations from HIW, CIW and PSOW and escalates any risks such as high-priority or delays to the Executive Committee with individual controls and plans in place.</li> <li>2. Integrated governance structures ensure regular updates on progress against action plans.</li> <li>3. Regular updates provided to external bodies on the progress of recommendations to maintain transparency in some areas such as HIW and PSOW.</li> <li>4. All regulatory body review recommendations and updates on progress are currently entered onto the regulatory software system, and reports on progress produced from this information.</li> </ol>		<ol style="list-style-type: none"> <li>a. Prioritisation matrix: A risk-based prioritisation matrix to focus on recommendations with the highest potential impact on patient safety and compliance</li> <li>b. Stakeholder engagement: Engagement with stakeholders around the prioritisation of recommendations based on risk and resource availability.</li> <li>c. Responsible leads: Identify responsible leads for external recommendations, ensuring oversight and approval of work completed</li> <li>d. Reporting lines and escalation: Strengthen all group terms of reference to include clear reporting lines and escalation to executive leadership as required.</li> <li>e. Electronic system: improvements required around a centralised system to better consolidate, triangulate and track action plans and timelines</li> <li>f. Progress reporting: Standardisation of progress reporting across all reviews to ensure consistency, enabling issues to be easily identified and escalated</li> </ol>	

	<p>g. Demand management: Review the options around a flexible pool of resources or temporary taskforces to manage demands.</p> <p>h. Training: Targeted training to staff on effectively managing external reviews and action plans.</p> <p>i. Gap analysis: Undertake a gap analysis of all regulatory, statutory and professional advisory institutions to identify relationship management arrangements, procedures for handling reviews/inspections and recommendations/actions, and internal oversight/reporting arrangements.</p>	
Actions	Due Date	Progression Analysis
<p>i. Undertake a review and mapping exercise of regulatory bodies, and a gap analysis for each showing:</p> <ul style="list-style-type: none"> <li>• who/how manages the relationship with the regulatory body</li> <li>• how data is recorded</li> <li>• how issues are reported and escalated</li> <li>• options around a flexible pool of resources or temporary taskforces to manage demands</li> <li>• training requirements for staff to effectively managing external reviews and action plans</li> <li>• reporting lines and escalation.</li> </ul>	31/04/2025	Progressing
<p>c/d. Table a report for the Executive Committee setting out recommendations to strengthen governance including development of a new policy setting out relationship management arrangements, procedures for handling reviews/inspections and recommendations/actions and internal oversight/reporting arrangements.</p>	30/05/2025	Progressing
<p>a. Develop a risk-based prioritisation matrix to focus on recommendations with the highest potential impact on patient safety and compliance.</p>	30/04/2025	Progressing
<p>b. Engagement with stakeholders around the prioritisation of recommendations based on risk and resource availability.</p>	30/04/2025	Progressing
<p>c. Identify responsible leads for external review recommendations, ensuring oversight and approval of work completed</p>	30/04/2025	Progressing
<p>d. Ensure that all existing group terms of reference include clear reporting lines and escalation to executive leadership as required.</p>	30/04/2025	Progressing

d. Standardisation of progress reporting across all reviews to ensure consistency, enabling issues to be easily identified and escalated	30/04/2025	Progressing
h. Provide targeted training to staff on effectively managing external reviews and action plans.	31/12/2025	Progressing
d. Develop a process to ensure a clear and consistent management approach for regulatory bodies across the Health Board to include the role of specialist functions, and a corporate governance oversight role	31/05/2025	Progressing
e. Develop a single Regulatory Database to log regulatory reviews, inspections, action plans and evidence	31/03/2026	Progressing
d. Develop a strategic group under the Executive Committee to have oversight of the arrangements and management of regulatory, statutory and professional advisory institutions which will include oversight of performance/escalations/risks from relationship managers	30/04/2025	Progressing
d. Develop a new Regulatory Report for Executive Committee / Board to ensure consistency of reporting	31/03/2025	Progressing
d. Once the actions have been implemented, undertake a review of processes after 12 months to ensure good governance arrangements	30/06/2026	Progressing

<b>To be completed following escalation approval</b>		<b>Impact</b>	<b>Likelihood</b>	<b>Score</b>
	Inherent Risk Rating	4	4	16
	Current Risk Rating	4	4	16
	Target Risk Score	3	2	6
	Risk Appetite	Regulatory		20-25
	<b>Rationale for Corporate Risk</b>			
<p>The current arrangements for managing regulatory, statutory and professional advisory institutions review recommendations is variable with good practice in some areas (HIW) and underdeveloped practice in others – this needs standardisation for the Health Board. Royal College Psychiatrists operational risk escalated and broader risk formulated.</p> <p>Audit Wales Structured assessment 2023 recommendation:  “Currently, there is insufficient committee oversight to monitor progress made against recommendations made by non-audit bodies. The Health Board should introduce effective committee oversight for monitoring progress made against recommendations of regulators, including, but not limited to, Healthcare Inspectorate Wales, the</p>				



GIG  
CYMRU  
NHS  
WALES

Bwrdd Iechyd Prifysgol  
Betsi Cadwaladr  
University Health Board

	<p>Coroner, the Welsh Language Commissioner, the Health and Safety Executive, and the Public Services Ombudsman for Wales”.</p>
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Bwrdd Iechyd Prifysgol  
Betsi Cadwaladr  
University Health Board



<b>Teitl adroddiad:</b> <i>Report title:</i>	Board Assurance Framework			
<b>Adrodd i:</b> <i>Report to:</i>	Audit Committee			
<b>Dyddiad y Cyfarfod:</b> <i>Date of Meeting:</i>	Thursday, 08 May 2025			
<b>Crynodeb Gweithredol:</b> <i>Executive Summary:</i>	<p>The purpose of this paper is to seek the Committee's agreement on the proposed assurance ratings for each of the Board Assurance Framework (BAF) risks, ahead of submission to the Board.</p> <p>The proposed assurance ratings have been approved by individual committees responsible for the risk.</p> <p>The Board Assurance Framework will be submitted to the Board in May 2025.</p>			
<b>Argymhellion:</b> <i>Recommendations:</i>	<p>The Committee is asked to:</p> <ul style="list-style-type: none"><li>To <b>receive</b> and <b>consider</b> the contents and assurance rating of the Board Assurance Framework.</li></ul>			
<b>Arweinydd Gweithredol:</b> <i>Executive Lead:</i>	Pam Wenger, Director of Corporate Governance			
<b>Awdur yr Adroddiad:</b> <i>Report Author:</i>	Nesta Collingridge Head of Risk Management			
<b>Pwrpas yr adroddiad:</b> <i>Purpose of report:</i>	I'w Nodi <i>For Noting</i> <input type="checkbox"/>	I Benderfynu arno <i>For Decision</i> <input checked="" type="checkbox"/>	Am sicrwydd <i>For Assurance</i> <input type="checkbox"/>	
<b>Lefel sicrwydd:</b> <i>Assurance level:</i>	<b>Arwyddocaol</b> <i>Significant</i> <input type="checkbox"/> Lefel uchel o hyder/tystiolaeth o ran darparu'r mecanweithiau / amcanion presennol  <i>High level of confidence/evidence in delivery of existing mechanisms/objectives</i>	<b>Derbyniol</b> <i>Acceptable</i> <input checked="" type="checkbox"/> Lefel gyffredinol o hyder/tystiolaeth o ran darparu'r mecanweithiau / amcanion presennol  <i>General confidence / evidence in delivery of existing mechanisms / objectives</i>	<b>Rhannol</b> <i>Partial</i> <input type="checkbox"/> Rhywfaint o hyder/tystiolaeth o ran darparu'r mecanweithiau / amcanion presennol  <i>Some confidence / evidence in delivery of existing mechanisms / objectives</i>	<b>Dim Sicrwydd</b> <i>No Assurance</i> <input type="checkbox"/> Dim hyder/tystiolaeth o ran y ddarpariaeth  <i>No confidence / evidence in delivery</i>
<b>Cyfiawnhad dros y gyfradd sicrwydd uchod. Lle bo sicrwydd 'Rhannol' neu 'Dim Sicrwydd' wedi'i nodi uchod, nodwch gamau i gyflawni sicrwydd 'Derbyniol' uchod, a'r terfyn amser ar gyfer cyflawni hyn:</b>  <b><i>Justification for the above assurance rating. Where 'Partial' or 'No' assurance has been indicated above, please indicate steps to achieve 'Acceptable' assurance or above, and the timeframe for achieving this: N/A</i></b>				

<p><b>Cyswllt ag Amcan/Amcanion Strategol:</b></p> <p><i>Link to Strategic Objective(s):</i></p>	<p>Detailed in the BAF report and how the CRR aligns to the revised BAF</p>
<p><b>Goblygiadau rheoleiddio a lleol:</b></p> <p><i>Regulatory and legal implications:</i></p>	<p>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.</p>
<p><b>Yn unol â WP7, a oedd EqlA yn angenrheidiol ac a gafodd ei gynnal?</b></p> <p><i>In accordance with WP7 has an EqlA been identified as necessary and undertaken?</i></p>	<p>Not applicable for this report</p>
<p><b>Yn unol â WP68, a oedd SEIA yn angenrheidiol ac a gafodd ei gynnal?</b></p> <p><i>In accordance with WP68, has an SEIA identified as necessary ben undertaken?</i></p>	<p>Not applicable for this report</p>
<p><b>Manylion am risgiau sy'n gysylltiedig â phwnc a chwmpas y papur hwn, gan gynnwys risgiau newydd (croesgyfeirio at y BAF a'r CRR)</b></p> <p><i>Details of risks associated with the subject and scope of this paper, including new risks( cross reference to the BAF and CRR)</i></p>	<p>Board Assurance Framework paper</p>
<p><b>Goblygiadau ariannol o ganlyniad i roi'r argymhellion ar waith</b></p> <p><i>Financial implications as a result of implementing the recommendations</i></p>	<p>The effective and efficient mitigation and management of risks has the potential to leverage a positive financial dividend for the Health Board through better integration of risk management into business planning, decision-making and in shaping how care is delivered to our patients thus leading to enhanced quality, less waste and no claims.</p>
<p><b>Goblygiadau gweithlu o ganlyniad i roi'r argymhellion ar waith</b></p> <p><i>Workforce implications as a result of implementing the recommendations</i></p>	<p>Failure to capture, assess and mitigate risks can impact adversely on the workforce.</p>
<p><b>Adborth, ymateb a chrynodeb dilynol ar ôl ymgynghori</b></p> <p><i>Feedback, response, and follow up summary following consultation</i></p>	<p>Executive Committee feedback 26/03/2025 informed this version of the BAF and suggested ratings agreed. P&amp;C (10/04/25) agreed with ratings suggested and the following committees are being concurrently presented with the report while this report is prepared for Audit Committee. The Board report will reflect any further feedback.</p>
<p><b>Cysylltiadau â risgiau BAF:</b> (neu gysylltiadau â'r Gofrestr Risg Gorfforaethol)</p> <p><i>Links to BAF risks:</i> (or links to the Corporate Risk Register)</p>	<p>Board Assurance Framework risks linked to corporate risks</p>
<p><b>Rheswm dros gyflwyno adroddiad i fwrdd cyfrinachol (lle bo'n berthnasol)</b></p>	

***Reason for submission of report to confidential board (where relevant)***

**Camau Nesaf:**

***Next Steps:***

1. Assurance ratings to be presented to the Board for agreement.
2. Business as usual reporting and monitoring: Bi-monthly Review at Risk Scrutiny Group and Executive Team meeting, monitoring of actions within risks. Reporting to Committee quarterly and Board bi-annually as per Risk Management Framework.

**Rhestr o Atodiadau:**

***List of Appendices:***

Appendix 1 – Full Board Assurance Framework



# Board Assurance Framework





# Board Assurance Framework Report

## Purpose

The Board Assurance Framework (BAF) serves as a strategic tool, designed to support the Health Board (BCUHB) in achieving its overarching goals and objectives. The BAF provides a structured approach for identifying, managing, and mitigating risks that may impact the successful delivery of our strategic priorities. Through clear alignment with our organisational strategy and key initiatives, the BAF enables us to maintain an accountable, transparent, and proactive approach to risk management.

The purpose of this BAF is threefold:

- To provide assurance that effective controls are in place to manage risks to our strategic objectives.
- To support informed decision-making by presenting clear, current risk insights to the Board and stakeholders.
- To align risk management efforts across the organisation, ensuring consistency with our vision of delivering high-quality, accessible healthcare services.

By integrating the BAF with our strategic priorities and operational plans, we can ensure that our risk management efforts directly support our mission to improve health outcomes, enhance patient safety, and foster a culture of accountability within BCUHB.

The purpose of this paper is to seek the Committee's agreement on the proposed assurance ratings for each of the Board Assurance Framework (BAF) risks, ahead of submission to the Board.

## Introduction

Board Assurance risks were developed by the Executive Team based on the Health Board's 5 strategic objectives. The report has been approved by the Board 30 Jan 2025 and will be subsequently updated by action handlers and Executives on an on-going basis.

## What is Assurance in Relation to Board Assurance Risks?

In the context of the Board Assurance Framework, **assurance** refers to the level of confidence the Committee can place in the effectiveness of the current risk treatment strategies to mitigate identified threats to strategic objectives. It is based on the extent of evidence available—internal or external—that demonstrates that key controls are in place and working effectively, and that actions to address gaps are progressing as intended.

Assurance levels help the Board determine whether risks are being managed effectively and inform decisions about resource allocation, priority areas, and potential escalations.

The four levels of assurance used are as noted in the key on page 6 of this report.

## Proposal from the Executive Committee

Following its review, the Executive Committee proposes that the majority of the risks on the Board Assurance Framework are currently suggested to be rated as having *Limited Assurance*.

### **Rationale for Proposed Rating**

The recommendation of **Limited Assurance** reflects a realistic and cautious assessment of the current position. Specifically:

- While some progress has been made on risk treatment strategies, there remain to be identified **key gaps in controls** that remain unresolved.
- More **evidence is required** particularly external or independent validation that controls are fully effective.
- Several actions remain as progressing and not yet complete before the risk scores can be confidently reduced.
- As such, the **likelihood of these risks materialising remains**, and further assurance is required before a higher assurance rating can be justified.

This rating encourages focused attention and targeted action in key areas while recognising that progress is underway.

### **Recommendation**

The Committee is asked to **review and agree** the proposed assurance ratings on behalf of the Board for each risk on the Board Assurance Framework. If agreed, these ratings will be presented to the Board for agreement.

### **Next Steps**

- Committees will be asked to score level of assurance in relation to risks.
- The Board Assurance Framework will be maintained and reported to the Risk Scrutiny Group; Executive Team (bi-monthly) and Committees (quarterly) and Board (quarterly) as per the Risk Management Framework on an on-going basis.

The key elements of the BAF are:

- A description of each Principal (strategic) Risk, that forms the basis of the HBs risk framework (with corresponding corporate and operational risks)
- Risk ratings – current (residual), tolerable and target levels. Risks are scored in line with the HB approved scoring matrix.
- Clear identification of strategic threats and opportunities that are considered likely to increase or reduce the Strategic Risk, within which they are expected to materialise
- A statement of risk appetite for each threat and opportunity, to be defined by the Lead Committee on behalf of the Board (Averse = aim to avoid the risk entirely; Minimal = insistence on low-risk options; Cautious = preference for low risk options; Open = prepared to accept a higher level of residual risk than usual, in pursuit of potential benefits)
- Key elements of the risk treatment identified for each threat and opportunity, each assigned to an Risk Lead and individually rated by the lead committee for the level of assurance they can take that the strategy will be effective in treating the risk (see below for key)
- Sources of assurance incorporate: (1) Management (those responsible for the area reported on); (2) Risk and compliance functions (internal but independent of the area reported on); and (3) Independent assurance (Internal audit and other external assurance providers).
- Unlike corporate risks where target dates are key for mitigation, risks will remain reported as the Board seeks assurance accordingly until the risk is sufficiently mitigated. Actions are based on quarters for the year.
- Board committees should review the BAF with particular reference to comparing the tolerable risk level to the current exposure risk rating.
- The RACI clarifies roles and responsibilities for tasks and deliverables and is utilised for sub-risks however the responsibility of the overall BAF risks of the lies with the **Executive Team** and accountability lies with the lead committee.

Likelihood score and descriptor					
	Very unlikely 1	Unlikely 2	Possible 3	Somewhat likely 4	Very likely 5
<b>Frequency</b> How often might/does it happen	This will probably never happen/recur	Do not expect it to happen/recur but it is possible it may do so	Might happen or recur occasionally or there are a significant number of near misses / incidents at a lower consequence level	Will probably happen/recur, but it is not a persisting issue/ circumstances	Will undoubtedly happen/recur, possibly frequently
<b>Probability</b> Will it happen or not?	Less than 1 chance in 1,000 (< 0.1%)	Between 1 chance in 1,000 and 1 in 100 (0.1 - 1%)	Between 1 chance in 100 and 1 in 10 (1- 10%)	Between 1 chance in 10 and 1 in 2 (10 - 50%)	Greater than 1 chance in 2 (>50%)

Key to lead committee assurance ratings:



**Substantial Assurance**

The Committee is satisfied that there is reliable evidence supporting the effectiveness of the current risk treatment strategy in mitigating the threat, with minimal gaps in control. While the majority of actions have been addressed, some minor actions may still require completion before the risk score is reduced. However, the Committee has good assurance regarding action progress. Likelihood of risk materialising: Low.



**Reasonable Assurance**

The Committee has seen sufficient evidence that the most significant actions to reduce the risk have been completed. There is assurance that the planned actions within the current risk treatment strategy are appropriate, with the majority of control and assurance gaps having been addressed. Likelihood of risk materialising: Low to moderate.



**Limited Assurance**

The Committee does not have sufficient evidence for assurance that the current risk treatment strategy is effectively mitigating the threat. There remains to be some key gaps in controls that require management attention, and further external validation is needed. Until further controls are in place, there remains a number of actions to reduce the score. Likelihood of risk materialising: Moderate.



**Unsatisfactory Assurance**

The Committee has no/little evidence for assurance that the current risk treatment strategy is effectively managing the threat. There remains to be several key gaps in controls that require management attention, and further external validation is needed. Until further controls are in place, there remains a number of actions to reduce the score. Likelihood of risk materialising: High

This BAF includes the following Risks to the HBs strategic priorities:

Reference	Principal risk: There is a risk of...	Lead Executive	Lead Committee	Initial date of assessment	Last reviewed by Executive Team	Previous risk score (at previous review/update) C x L	Current risk score C x L	Target risk score C x L
BAF24-01	Not Fully Building an Effective and Accountable Organisation	Director of Corporate Governance and Executive Team oversight	Performance, Finance and Information Governance	20/10/2024	19/03/2025	4x 3= 12	<b>4x 3= 12</b>	2x 2= 4
BAF24-02	Not Delivering Strategic Development and Digital Transformation	Executive Director of Transformation and Strategic Planning & Chief Digital & Information Officer	Planning, Population Health & Partnership	20/10/2024	19/03/2025	5x 4= 20	<b>5x 4= 20</b>	3x 3= 9
BAF24-03	Not Achieving Long Term Financial Sustainable	Executive Director of Finance	Performance, Finance and Information Governance	20/10/2024	19/03/2025	5x 4= 20	<b>5x 4= 20</b>	3x 3= 9
BAF24-04	Not Establishing a Compassionate Culture, Leadership, Engagement and workforce capacity and capability	Deputy Director of People Services	People & Culture	20/10/2024	19/03/2025	4x 4= 16	<b>4x 4= 16</b>	3x 3= 9
BAF24-05	Not Engaging with Citizens, Partners and Communities	Director of Partnerships/Communications and Engagement	Planning, Population Health & Partnership	20/10/2024	19/03/2025	2x 3= 6	<b>2x 3= 6</b>	2x 2= 4
BAF24-06	Not Delivering the Required Improvements to Transform Care and Enhance Outcomes	Executive Director of Nursing Executive Director of Public Health Executive Medical Director Executive Director of Allied Health Professionals and Health Science	Quality, Safety and Experience / Planning, Population Health & Partnership	20/10/2024	19/03/2025	5x 4= 20	<b>5x 4= 20</b>	5x 2= 10
BAF24-07	Not Delivering Timely Access to Care Resulting In Potential Clinical Harm, Poor Delivery of Performance Targets and Reputational Risk	Chief Operating Officer	Performance, Finance and Information Governance	20/10/2024	19/03/2025	4x 4= 16	<b>4x 4= 16</b>	4x 2= 8
BAF24-08	Not Implementing Evidenced Based Improvement and Innovation	Executive Medical Director & Chief Digital & Information Officer	Planning, Population Health & Partnership	20/10/2024	19/03/2025	4x 3= 12	<b>4x 3= 12</b>	3x 2= 6

## 1: Building an effective organisation

Objective area 1 recognises the importance of governance and effective procedures and decision making in high functioning Healthcare organisations. This will better ensure that decisions are made in a timely way, using appropriate information, and that the right people have been involved to ensure the right decisions are made first time.

<b>Principal risk</b> (what could prevent us achieving this strategic objective)	<b>BAF24-01: Not Fully Building an Effective and Accountable Organisation</b>			<b>Strategic objective</b>	1. To Build an Effective Organisation (1A & 1B: Governance (Board Effectiveness / Risk Management) 1C Operating Model; 1D Performance and Accountability Framework; 1F: Legislative Improvements)
<b>Lead Committee</b>	Performance, Finance and Information Governance Committee	<b>Risk type</b>	Compliance/Regulatory		
<b>Risk Lead</b>	Director of Corporate Governance/Executive Team Oversight	<b>Risk appetite</b>	Open 15-19		
<b>Related Corporate Risks:</b>	CRR24-15 Health and Safety				
<b>Risk rating</b>	<b>Current exposure</b>	<b>Tolerable</b>	<b>Target</b>		
<b>Consequence</b>	4. Major	2. Minor	2. Minor	<b>Initial date of assessment</b>	20/10/2024
<b>Likelihood</b>	3. Possible	2. Unlikely	2. Unlikely	<b>Last reviewed by Committee:</b>	23/12/2024 (Private)
<b>Risk rating</b>	12. Moderate	4. Low	4. Low	<b>Last updated by Executive:</b>	07/03/2024
<b>N.B. Tolerable and Target score lines stacked as both are 4.</b>					

<b>Strategic threat</b> (what might cause this to happen)	<b>Primary risk controls</b> (what controls/ systems & processes do we <b>already</b> have in place to assist us in managing the risk and reducing the likelihood/ impact of the threat)	<b>Gaps in control</b> (are further controls possible in order to reduce risk exposure within tolerable range?)	<b>Sources of assurance (and date)</b> ( <b>Evidence</b> that the controls/ systems which we are placing reliance on are effective)	<b>Gaps in assurance / actions to address gaps and issues</b>	<b>Assurance rating</b>
<b>Responsible:</b>	Head of Covid-19 Inquiry and Thirlwall Inquiry/Assistant Director of Occupational Health, Safety And Security/ EPRR Lead	<b>Accountable:</b>	Executive Team		

Strategic threat (what might cause this to happen)	Primary risk controls (what controls/ systems & processes do we <b>already</b> have in place to assist us in managing the risk and reducing the likelihood/ impact of the threat)	Gaps in control (are further controls possible in order to reduce risk exposure within tolerable range?)	Sources of assurance (and date) ( <b>Evidence</b> that the controls/ systems which we are placing reliance on are effective)	Gaps in assurance / actions to address gaps and issues	Assurance rating
<p><b>Threat:</b> the HB may not be compliant. This could lead to poor decision-making, unaddressed performance gaps, and a lack of ownership over key outcomes, ultimately reducing the Health Board's ability to deliver its strategic goals effectively.</p>	<ul style="list-style-type: none"> <li>Health and Safety Policy</li> <li>HS03 General Risk Assessment Procedure</li> <li>HSG65 Plan, Do, Check, Act process for continuous improvement</li> <li>Service Sector Health and Safety Self-Assessment and Health and Safety Reviews</li> <li>Security Assessment of Premises</li> <li>Some Civil Contingencies and Emergency Preparedness plans</li> <li>Annual emergency preparedness evaluations improvement</li> </ul>	<ul style="list-style-type: none"> <li>Remaining gaps in civil contingency planning post-pandemic</li> <li>Incomplete integration of HSE recommendations into operational plans</li> <li>Incomplete integration of HSE recommendations into operational plans</li> </ul>	<p><b>Management:</b> Health and Safety compliance reporting to Strategic Occupational Safety and Health Group (SOSHG) and People and Culture Committee</p> <p>Monthly reviews of Health, Safety and Security KPIs</p> <p><b>Risk and compliance:</b> Risk Register reporting but noted gap on the Gap analysis reporting for compliance and gaps of general legislative gap analysis</p> <p><b>Independent assurance:</b> HSE audit and compliance checks</p> <ul style="list-style-type: none"> <li>Civil Contingencies Act compliance review</li> </ul>	<ul style="list-style-type: none"> <li>Gap analysis reporting general legislative gap analysis</li> <li>Limited Assurance Internal Audit report for Health and Safety &amp; Corporate Legislative Compliance. Improvement action plan in place and monitored at SOSHG.</li> </ul>	<b>Limited Assurance</b>

↑	Plans to improve control (are further controls possible in order to reduce risk exposure within tolerable range?)		Action Handler	Status of Actions	Date when action will be completed
	Approval and progression of the gap analysis for health and safety measures as set out in the updated Health and Safety Strategy and Plan 2024-2026 dated September 2024.		Lynne Bushell	Complete	30/09/2024
	New approach for Health and Safety Management System being developed aligned to NHS Employers Health and Safety Standards, to include Violence Prevention and Reduction Standards		Lynne Bushell	Progressing	31/03/2025

Responsible:	Director of Performance and Commissioning	Accountable:	Director of Corporate Governance/CEO
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Strategic threat (what might cause this to happen)	Primary risk controls (what controls/ systems & processes do we <b>already</b> have in place to assist us in managing the risk and reducing the likelihood/ impact of the threat)	Gaps in control (are further controls possible in order to reduce risk exposure within tolerable range?)	Sources of assurance (and date) ( <b>Evidence</b> that the controls/ systems which we are placing reliance on are effective)	Gaps in assurance / actions to address gaps and issues	Assurance rating
<p><b>Threat:</b> the Performance and Accountability Framework may not be effectively establish clear lines of accountability and provide consistent, real-time performance monitoring. This could lead to poor decision-making, unaddressed performance gaps, and a lack of ownership over key outcomes, ultimately reducing the Health Board's ability to deliver its strategic goals effectively.</p>	<ul style="list-style-type: none"> <li>Integrated Performance Framework</li> <li>Integrated Performance reports aligned</li> <li>Clear accountability matrix and escalation for senior and mid-level management</li> <li>Performance scorecards for service delivery units</li> </ul>	<ul style="list-style-type: none"> <li>Inconsistent application of performance tools across departments</li> <li>Review Integrated Performance Framework to re-align with new strategic objectives Triangulation with risk management</li> </ul>	<p><b>Management:</b></p> <ul style="list-style-type: none"> <li>Reviews of performance metrics at Executive Team level</li> <li>Regular reporting to Committees</li> </ul> <p><b>Risk and compliance:</b></p> <ul style="list-style-type: none"> <li>Monthly accountability reviews if in escalation for services SLT</li> <li>Performance Reviews held by the CEO</li> <li>Monthly performance reviews by Welsh Government</li> </ul> <p><b>Independent assurance:</b></p> <ul style="list-style-type: none"> <li>External NHS Wales and Health Boards performance benchmarking and NHS benchmarking network</li> </ul>	<p>Reports on performance at IHC</p> <p>Commissioning reports on out of area</p>	<b>Limited Assurance</b>

↑	Plans to improve control (are further controls possible in order to reduce risk exposure within tolerable range?)		Action Handler	Status of Actions	Date when action will be completed
	Finalise the redesign of reporting structures/timings to enhance transparency		Stephen Powell	Progressing	30/06/2025
	Improved Risk triangulation with concerning trajectories		Nesta Collingridge	Progressing	31/09/2025

Responsible:	Director of Corporate Governance	Accountable:	CEO
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<p><b>Threat:</b> the Health Board's operating model may become inefficient or fragmented, leading to unclear roles, duplication of efforts, and siloed working. This could result in reduced operational effectiveness, slower decision-making, and diminished quality of care,</p>	<ul style="list-style-type: none"> <li>• Current definitions of operating model roles and structures in place</li> <li>• Business Partnering approach for clinical and corporate leadership</li> <li>• Staff co-producing a new Operating Model</li> </ul>	<ul style="list-style-type: none"> <li>• Delays in decision-making due to leadership duplication</li> <li>• Lack of integrated systems reducing efficiency</li> <li>• Service reconfiguration plans based on population health needs</li> <li>• Digital tools (Microsoft 365) to streamline operations</li> </ul>	<p><b>Management:</b></p> <ul style="list-style-type: none"> <li>• Service-level performance audits</li> </ul> <p><b>Risk and compliance:</b></p> <ul style="list-style-type: none"> <li>• Assessments of operating model efficiency and insight reports</li> </ul> <p><b>Independent assurance:</b></p> <ul style="list-style-type: none"> <li>• Operating model effectiveness review by internal and external stakeholders</li> <li>• Internal Audit report on duplication of roles and decision-making timelines</li> </ul>	<ul style="list-style-type: none"> <li>• Limited Assurance Internal Audit report for Operating Model &amp; Effective Governance (IHC) Central</li> </ul>	<p><b>Limited Assurance</b></p>
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↑	Plans to improve control (are further controls possible in order to reduce risk exposure within tolerable range?)	Action Handler	Status of Actions	Date when action will be completed
	Completion of the discovery phase reviewing of the operating model based on stakeholder feedback	Julie Parry	Complete	30/11/2024
	Implement a streamlined decision-making protocol by Q3 and looking a re-design phase	Pam Wenger	Progressing	31/10/2025
	Review of the Scheme of Delegation and establishment of a formal Executive Committee with reporting groups with clear delegations. <a href="#">Scheduled to for presentation at the next Audit Committee 04/03/2025 - Formal Executive Committee approved as part of the CEO report by Board 30/01/2025. For approval May Board.</a>	Philippa Peak Jones	Progressing	31/05/2025

Responsible:	Head Of Corporate Affairs/Head of Risk Management	Accountable:	Director of Corporate Governance
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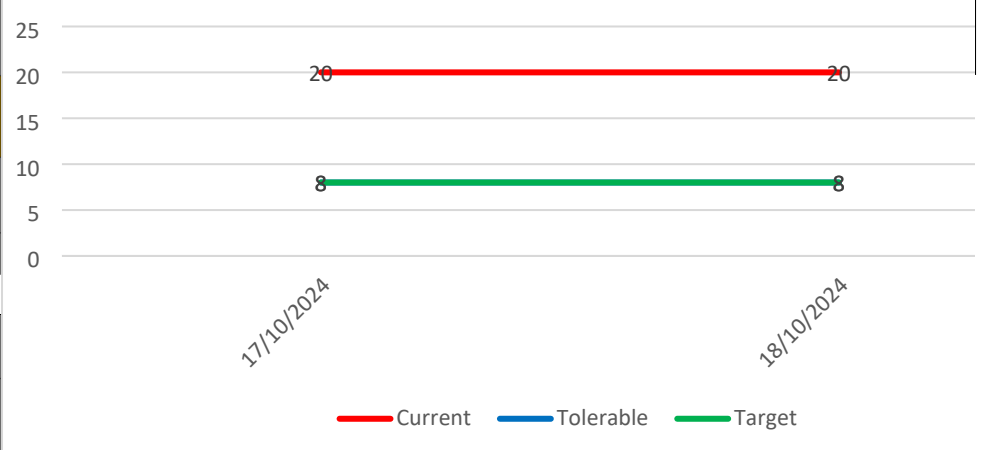
<p><b>Threat:</b> the Health Board's has weak Governance and Ineffective Risk Management Practices</p>	<ul style="list-style-type: none"> <li>• Risk Management Framework updated for improved escalation pathway to Risk Scrutiny Group.</li> <li>• Risk Appetite set 24/25</li> <li>• Board Development Programme</li> <li>• Internal Audit Tracking of Recommendations</li> <li>• Board committee structure now all in place</li> </ul>	<ul style="list-style-type: none"> <li>• Gaps in risk governance maturity, with some areas requiring support and more training to integrate the Risk Framework and Procedures.</li> <li>• Policy Management system and overdue policies.</li> <li>• Self-assessment of board effectiveness</li> <li>• Robust Internal Audit Tracking software and systems.</li> <li>• Incomplete recruitment of executive roles.</li> <li>• Equality Impact Assessment Process integrated within Impact Assessment Impact Screening Tool to ensure compliance</li> </ul>	<p><b>Management:</b></p> <ul style="list-style-type: none"> <li>• Risk reporting at local level and strategic level.</li> </ul> <p><b>Risk and compliance:</b></p> <ul style="list-style-type: none"> <li>• Risk reporting to the Executive Team and Committees Key Performance Indicators (KPIs) on risk management performance to Audit Committee</li> <li>• Internal Audit Reporting to Audit Committee</li> </ul> <p><b>Independent assurance:</b></p> <ul style="list-style-type: none"> <li>• Audit Wales Structured Assessment Report and other Audit Wales Reports</li> </ul>	<ul style="list-style-type: none"> <li>• Limited Assurance Internal Audit reports for: Review of Board Effectiveness &amp; Standards of Business Conduct - Declarations of Interest, Gifts and Hospitality &amp; Risk Management</li> <li>• Audit Wales governance recommendations</li> </ul>	<p><b>Limited Assurance</b></p>
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↑	Plans to improve control (are further controls possible in order to reduce risk exposure within tolerable range?)	Action Handler	Status of Actions	Date when action will be completed
	Improved Scrutiny of Corporate Risks. & Development of the BAF	Nesta Collingridge	Complete	30/01/2025
	Improved Data Analytics of Governance around Risk (Dashboard) and driving improvement of metrics. <a href="#">N.B This work will be ongoing now to ensure the KPIs remain in tolerance (risks being updated) and reported to Audit Committee quarterly.</a>	Nesta Collingridge	Complete	30/01/2025
	Review of the current system once progress has been made on the overdue policies. <a href="#">System approved for procurement which will support automated tracking.</a>	Glesni Driver	Progressing	30/09/2025
	Reviewing current systems to have a more effective way of tracking and reporting audit recommendations. <a href="#">Corporate Governance (policies/tracking) /Risk Management and System approved for procurement 22/01/25, new software in place by 30/09/25 but piloted in 2026 which will support automated tracking. This will not be embedded until 2026-2027.</a>	Glesni Driver	Progressing	30/09/2026
	Executive Team recruitment ongoing with some progress made on appointments.	Georgina Roberts	Progressing	31/03/2026

## 2: Developing strategy and long-lasting change

Objective area 2 draws upon the need for the Health Board to be clear about population needs in North Wales and that services are configured in a way to get the highest value from the resources available to us. In this way the Health Board can provide services that are reliable, more cost-effective, and that make the best use of healthcare professionals.

<b>Principal risk</b> (what could prevent us achieving this strategic objective)	<b>BAF24-02: Not Delivering Strategic Development and Digital Transformation</b>			<b>Strategic objective</b>	2. Developing strategy and long-lasting change (2A 10-year Strategy & 2H Strengthening Planning; 2E Digital, Data, and Technology;)
	Ineffective strategy development, robust planning processes, and a forward-looking approach to digital technology to ensure long-lasting organisational change.				
<b>Lead Committee</b>	Planning, Population Health & Partnership Committee		<b>Risk type</b>	Quality	
<b>Risk Lead</b>	Executive Director Transformation and Strategic Planning / Chief Digital & Information Officer		<b>Risk appetite</b>	Open 15-19	
<b>Related Corporate Risks:</b>	CRR24-07 Fragmented Patient Care Record/CRR24-17 ICT Failure and Cyber				
<b>Risk rating</b>				<b>Review Dates</b>	
	<b>Current exposure</b>	<b>Tolerable</b>	<b>Target</b>		
<b>Consequence</b>	5. Catastrophic	4. Major	4. Major	<b>Initial date of assessment</b>	20/10/2024
<b>Likelihood</b>	4. Somewhat likely	2. Unlikely	2. Unlikely	<b>Last reviewed by Committee:</b>	10/12/2024 (Private)
<b>Risk rating</b>	20. High	8. Medium	8. Medium	<b>Last updated by Executive:</b>	07/04/2025

**N.B. Tolerable and Target score lines stacked as both are 8.**


Strategic threat (what might cause this to happen)	Primary risk controls (what controls/ systems & processes do we <b>already</b> have in place to assist us in managing the risk and reducing the likelihood/ impact of the threat)	Gaps in control (are further controls possible in order to reduce risk exposure within tolerable range?)	Sources of assurance (and date) ( <b>Evidence</b> that the controls/ systems which we are placing reliance on are effective)	Gaps in assurance / actions to address gaps and issues	Assurance rating						
<p><b>Threat:</b> the organisation may struggle to keep pace with the rapid evolution of digital, data, and technology innovations and have outdated systems, inefficiencies, and an inability to fully harness data for informed decision-making and personalised patient care by lack of investment in DDaT infrastructure due to competing priorities</p>	<ul style="list-style-type: none"> <li>• Cyber Security Plan (and evidenced of reasonable assurance through recent internal audit)</li> <li>• Plans to recruit key skills and capabilities gaps</li> <li>• Business case developed for Mental Health and Acute and Community EHR</li> <li>• Clear benchmarking with Gartner IT Score to assess and guide us on what we need to do.</li> <li>• Skills and capabilities augmentation contracts in place with third party companies to support the internal teams in delivering what is required</li> </ul>	<ul style="list-style-type: none"> <li>• Lack of recurrent funding and support the recruitment of critical roles</li> <li>• Lack of support to procure flexible augmentation contracts</li> </ul>	<p><b>Management:</b></p> <ul style="list-style-type: none"> <li>• Quarterly reviews of digital objectives including projects at service level to Senior Leadership Team</li> <li>• Performance and accountability meetings for Annual Plan objectives</li> </ul> <p><b>Risk and compliance:</b></p> <ul style="list-style-type: none"> <li>• Annual audit of data governance and cyber security measures</li> </ul> <p><b>Independent assurance:</b></p> <ul style="list-style-type: none"> <li>• Internal and external audits of data governance and technology</li> <li>• Information Commissioners office</li> <li>• Audit Committee Reporting and Corporate Risk in place</li> <li>• Continual Benchmarking from Gartner Group and Service Desk Institute against best practice</li> </ul>		<p><b>Limited Assurance</b></p>						
<p><b>↑</b></p> <p><b>Plans to improve control</b> (are further controls possible in order to reduce risk exposure within tolerable range?)</p>	<p><b>Action Handler</b>    <b>Status of Actions</b>    <b>Date when action will be completed</b></p>	<p>Senior Posts for reviewing Digital architecture and EHR. Funding for Architecture and EHR Teams is temporary and has been sourced from various non-recurrent budgets. Teams likely to have to stand down from April 2025 onwards and therefore progress halted (subject to budget setting process). NB. This is a 3-to-5-year piece of work. Activity which is required by 31<sup>st</sup> March 2025 will be completed.</p>	<p>Sion Jones    Delayed    31/03/2025</p>	<p>Roll-out of key priority digital transformation projects. No funding from April 2025 onwards, to progress EHR Programme and other augmentation projects to improve the current digital environment. NB. This is a 3-to-5-year piece of work. Activity which is required by 31<sup>st</sup> March 2025 will be completed.</p>	<p>Andrea Williams    Delayed    31/03/2025</p>	<p>System integration – This action needs removing as there is limited system integration work being carried out due to the complexities of the technologies and the lack of integration skills.</p>	<p>Justine Parry    Delayed    31/03/2025</p>	<p>Transformation of the DDaT Operating Model. Lack of available recurrent funding has hampered this piece of work.</p>	<p>Justine Parry    Delayed    31/03/2025</p>	<p>Proposals, (repeated from previous years) for 2025/26 onwards are being progressed for consideration.</p>	<p>Justine Parry    Delayed    31/03/2025</p>


Strategic threat (what might cause this to happen)	Primary risk controls (what controls/ systems & processes do we <b>already</b> have in place to assist us in managing the risk and reducing the likelihood/ impact of the threat)	Gaps in control (are further controls possible in order to reduce risk exposure within tolerable range?)	Sources of assurance (and date) ( <b>Evidence</b> that the controls/ systems which we are placing reliance on are effective)	Gaps in assurance / actions to address gaps and issues	Assurance rating
Responsible: Assistant Director of Health Strategy & Planning		Accountable: Executive Director of Strategy and Transformation			
<b>Threat:</b> Lack of Long-Term Strategic development and implementation of the 10-year strategy and alignment with short term plans	<ul style="list-style-type: none"> <li>Strategic alignment with population needs assessments</li> <li>Comprehensive stakeholder engagement framework</li> <li>Integrated planning framework with multi-year objectives</li> <li>Regular planning reviews aligned with financial and performance data</li> <li>Collaboration and coproduction with external stakeholders to inform planning decisions</li> </ul>	<ul style="list-style-type: none"> <li>Limited public consultation and stakeholder input at early stages.</li> <li>Unclear prioritisation of strategic initiatives.</li> <li>Delayed integration of planning with performance data.</li> </ul> <p>Gaps in external stakeholder engagement in the planning process also includes diverse and inclusive stakeholders</p>	<b>Management:</b> <ul style="list-style-type: none"> <li>Annual planning reviews</li> <li>Progress reports on strategy development milestones</li> <li>Annual planning reviews by the Executive Team</li> </ul> <b>Risk and compliance:</b> <ul style="list-style-type: none"> <li>External benchmarking of planning effectiveness</li> </ul> <b>Independent assurance:</b> <ul style="list-style-type: none"> <li>Annual external audit of strategic alignment with population needs</li> <li>External validation of strategic priorities by key stakeholders</li> <li>Independent review apart of special measures</li> </ul>	<ul style="list-style-type: none"> <li>Public consultation and external engagement</li> </ul>	<b>Limited Assurance</b>

↑	Plans to improve control (are further controls possible in order to reduce risk exposure within tolerable range?)	Action Handler	Status of Actions	Date when action will be completed
	Strategic intent for North Wales to be developed with Partners in order to develop and deliver the 10-Year Strategy which aligns to strategic intent for North Wales. A review of capacity in the planning team in order to deliver effectively once the IMPT is submitted to Board and WG.	Dylan Williams	Regressing	30/12/2026
	Implement phase 1 of Clinical Services Plans in relation to the Challenged Services	Dylan Williams	Progressing	30/03/2026
	Develop phase 2 of the Clinical Services Plan for implementation - a blueprint for services across North Wales	Dylan Williams	Not started	30/03/2027

<b>Principal risk</b> (what could prevent us achieving this strategic objective)	<b>BAF24-03: Not Achieving Long Term Financial Sustainability</b>			<b>Strategic objective</b>	2. Developing strategy and long-lasting change (2I Finance Governance Environment; 2D Capital Priorities: Supporting Change)
<b>Lead Committee</b>	Performance, Finance and Information Governance Committee		<b>Risk type</b>	Finance	
<b>Risk Lead</b>	Executive Director of Finance		<b>Risk appetite</b>	Open 15-19	
<b>Related Corporate Risks:</b>	CRR24-05 Financial Sustainability /CRR24-06 Suitability and Safety of Sites				
<b>Risk rating</b>				<b>Review Dates</b>	
	<b>Current exposure</b>	<b>Tolerable</b>	<b>Target</b>	<b>Initial date of assessment</b>	20/10/2024
<b>Consequence</b>	5. Catastrophic	3. Moderate	3. Moderate		

Likelihood	4. Somewhat likely	3. Possible	3. Possible	Last reviewed by Committee:	23/12/2024 (Private)	 <p>25 20 15 10 5 0</p> <p>17/10/2024 18/10/2024</p> <p>— Current — Tolerable — Target</p>
Risk rating	20. High	9. Medium	9. Medium	Last updated by Executive:	01/04/2025	


Strategic threat (what might cause this to happen)	Primary risk controls (what controls/ systems & processes do we already have in place to assist us in managing the risk and reducing the likelihood/ impact of the threat)	Gaps in control (are further controls possible in order to reduce risk exposure within tolerable range?)	Sources of assurance (and date) (Evidence that the controls/ systems which we are placing reliance on are effective)	Gaps in assurance / actions to address gaps	Assurance rating	
<b>Responsible:</b>		Interim Director of Finance	<b>Accountable:</b>	Executive Director of Finance		
<p><b>Threat:</b> Health Board key financial duty is to attain a break-even financial position. Failure to achieve the key duty results in cash depletion and a lack of ability to pay employees and suppliers of goods and services.</p> <p>A reduction in funding or change in financial trajectory or unexpected event resulting in an increased Financial Improvement Plan (FIP) requirement to reduce the scale of the financial deficit, without having an adverse impact on quality and safety</p>	<ul style="list-style-type: none"> <li>Annual Plan details requirements for further controls and required controls detailed in 'Gaps in controls'</li> <li>Monthly reporting of financial performance, articulating risk to delivery, drivers of any financial risk and suggested actions in place to mitigate risk</li> <li>Monthly reporting to Welsh Government financial performance each month, again articulating drivers of risk to delivery and mitigating actions</li> <li>Corporate risk for shorter term sustainability in place</li> </ul>	<ul style="list-style-type: none"> <li>Financial governance framework aligned with the organisation's strategic priorities.</li> <li>An endorsed Clinical Strategy that articulates demand and capacity modelling by speciality.</li> <li>Financial capital resource availability</li> <li>Integration of financial planning with performance and risk management processes</li> <li>The Health Board has a planned deficit in year, not achieving the key 1st duty to attain break-even. This presents a current unmitigated risk to balancing financial allocations with spending in year. Inconsistent alignment between financial planning and strategic service goals</li> </ul>	<p><b>Management:</b></p> <ul style="list-style-type: none"> <li>Monthly financial reporting and budgetary controls</li> </ul> <p><b>Risk and compliance:</b></p> <ul style="list-style-type: none"> <li>Oversight by Audit Committee</li> <li>Annual audit of financial governance effectiveness</li> <li>Regular financial performance reviews</li> </ul> <p><b>Independent assurance:</b></p> <ul style="list-style-type: none"> <li>Internal and external audit reports on financial controls</li> <li>Annual review of compliance with Welsh Government financial guidelines</li> <li>Monthly oversight of financial performance by Welsh Government</li> </ul>	<ul style="list-style-type: none"> <li>Limited Assurance Internal Audit report for Delivery of Health Board Transformational Savings &amp; Budgetary Control</li> <li>Limited assurance report on budgetary control environment</li> <li>Head of Internal Control Opinion articulating limited assurance over systems of internal control</li> <li>Qualification of accounts 2022/23 and Qualification for regulatory breach 2024/25 All containing actions to address gaps</li> </ul>	<b>Limited Assurance</b>	
	<b>Plans to improve control</b> (are further controls possible in order to reduce risk exposure within tolerable range?)			<b>Action Handler</b>	<b>Status of Actions</b>	<b>Date when action will be completed</b>
	Implementation of Value Based Healthcare and a Value and Sustainability approach to savings development. Implemented and principle approach agreed, savings will be developed through Executive leads through transactional and transformational schemes.			Joanna Garrigan	Progressing	31/03/2026
	Strengthen financial forecasting and integrate financial risks into operational planning. Progressing through IMTP production.			Joanna Garrigan	Progressing	30/09/2025

Develop further the control environment for addressing planned position and implementation of any corrective actions. <b>Additional control actions have been implemented to support the HB to achieve the planned deficit as agreed with WG.</b>		Joanna Garrigan	Complete	31/03/2025	
Enhanced Accountability & Performance framework to hold officers to account for delivery. Areas for escalation have been identified and separate meetings held with services chaired by CEO.		Joanna Garrigan	Complete	27/12/2025	
Responsible:		Head Of Capital Development	Accountable: Executive Director of Finance		
<b>Threat:</b> Inadequate Capital Investment to Support Organisational Change	<ul style="list-style-type: none"> <li>Estates Strategy</li> <li>Capital prioritisation programme aligned with strategic objectives that involves operational and clinical teams in prioritisation of limited resources</li> <li>Project management for capital investments, the Health Board having substantial material schemes in train</li> <li>Prioritisation of investments in infrastructure to support clinical services and statutory requirements</li> <li>Capital Manual</li> <li>Capital prioritisation for urgent projects</li> <li>Six facet survey being completed for all provider infrastructure</li> </ul>	<ul style="list-style-type: none"> <li>Delays in capital project approvals and implementation.</li> <li>End of year wrap up report on overheads and programme progress.</li> <li>Implement stronger project management controls to track capital investments.</li> <li>Discretionary capital use in prioritisation between medical equipment, IM&amp;T and Estates works (relative prioritisation between asset classes not undertaken)</li> <li>Prioritisation of substantial business cases within the plans of the Health Board that aligns to Clinical Strategy</li> </ul>	<b>Management:</b> <ul style="list-style-type: none"> <li>Monthly financial reporting of plan verse actual expenditure and budgetary controls</li> </ul> <b>Risk and compliance:</b> <ul style="list-style-type: none"> <li>Oversight by Audit Committee</li> <li>Some reviews to assess the alignment of capital investments with strategic goals Board</li> </ul> <b>Independent assurance:</b> <ul style="list-style-type: none"> <li>Internal Governance of capital project progress and expenditure and reporting up to Committee and Welsh Government.</li> <li>Welsh Government monthly reviews of plans for expenditure in year verse allocated resources.</li> </ul>	<ul style="list-style-type: none"> <li>Reports on alignment of capital investments with strategic goals Board</li> <li>Prioritisation plans being endorsed through Executive for inclusion within the IMTP endorsed through Health Board and Committees.</li> <li>External support secured to service major capital developments.</li> <li>Capital Investment Group formed, reporting into Executive on Capital works.</li> </ul>	<b>Limited Assurance</b>
	<b>Plans to improve control</b> (are further controls possible in order to reduce risk exposure within tolerable range?)		<b>Action Handler</b>	<b>Status of Actions</b>	<b>Date when action will be completed</b>
	Decarbonisation Board reporting of key objectives through to Committee (PPHP) <b>completed</b> , articulating goals and objectives through to Health Board. <b>Revised NHS Wales decarb plan due for review in 2025, once finalised the HB will produce and action plan.</b>		Stuart Keen	Progressing	31/03/2026
	Ongoing development of Estates strategy to be informed by completion of six facet survey (review of estates which will take 12* months)		Stuart Keen	Progressing	31/03/2026
	Monthly reporting of this year's expenditure verse plans in order to ensure delivery of this year's capital programme, fully embedded and forms new control.		Executive Director of Finance	Complete	31/03/2026
	Prioritisation of major capital works within the strategy for the Health Board in completion of the three-year IMTP. <b>Schemes and priorities discussed at Execs.</b>		Ian Howard	Progressing	31/03/2026


### 3: Creating compassionate culture, leadership and engagement

Objective area 3 capitalises upon the huge body of evidence that demonstrates how culture, leadership and engagement with residents, staff, communities and partners significantly impact upon the quality of services and patient experience provided. The Health Board has identified opportunities to make improvements in these areas that would then in turn lead to better outcomes.

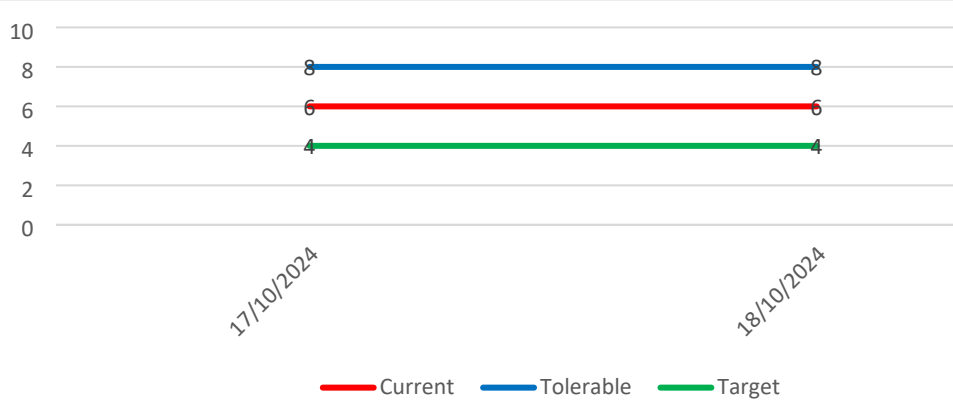
<b>Principal risk</b> (what could prevent us achieving this strategic objective)	<b>BAF24-04: Not Establishing a Compassionate Culture, Leadership, Engagement and workforce capacity and capability</b> A risk that the Health Board may inadequately foster a compassionate culture and strong leadership, resulting in disengaged staff, low morale, and high turnover.			<b>Strategic objective</b>	3: To have a compassionate culture, leadership & engagement (3A Compassionate Leadership and Organisational Development & 1G Workforce Planning)
<b>Lead Committee</b>	People & Culture Committee		<b>Risk type</b>	Quality	
<b>Risk Lead</b>	Deputy Director of People's Services		<b>Risk appetite</b>	Seek 15-19	
<b>Related Corporate Risks:</b>	CRR24-01 People, Culture and Wellbeing /CRR24-16 Leadership/Special Measures				
<b>Risk rating</b>				<b>Review Dates</b>	
	<b>Current exposure</b>	<b>Tolerable</b>	<b>Target</b>		
<b>Consequence</b>	4. Major	3. Moderate	3. Moderate	<b>Initial date of assessment</b>	20/10/2024
<b>Likelihood</b>	4. Somewhat likely	3. Possible	3. Possible	<b>Last reviewed by Committee:</b>	19/12/2024 (Private)
<b>Risk rating</b>	16. High	9. Medium	9. Medium	<b>Last updated by Executive:</b>	11/03/2025

N.B. Tolerable and Target score lines stacked as both are 9.

Strategic threat (what might cause this to happen)	Primary risk controls (what controls/ systems & processes do we <b>already</b> have in place to assist us in managing the risk and reducing the likelihood/ impact of the threat)	Gaps in control (Specific areas / issues where further work is required to manage the risk to accepted appetite/ tolerance level)	Sources of assurance (and date) ( <b>Evidence</b> that the controls/ systems which we are placing reliance on are effective)	Gaps in assurance / actions to address gaps and issues	Assurance rating	
Responsible:		Head Of Policy, Practice & Compliance-WOD	Accountable:		Deputy Director of People's Services	
<p><b>Threat:</b> that the Health Board may inadequately foster a compassionate culture and strong leadership, resulting in disengaged staff, low morale, and high turnover.</p>	<ul style="list-style-type: none"> <li>• Workforce Planning Framework in collaboration with HEIW</li> <li>• Skill-mix review and capacity-building programmes</li> <li>• Strategic partnership with Bangor University</li> <li>• Integrated Leadership Development Framework</li> <li>• Staff Engagement Plan</li> <li>• Continuous feedback loops for leadership performance</li> <li>• All Wales International Recruitment programme for nurses and doctors.</li> <li>• Improved Internal Audit Assurance with recruitment of senior and interim staff</li> <li>• Staff counselling / Occupational Health support</li> <li>• Strategic Equality Plan key driver in the culture change required for a compassionate and inclusive culture.</li> </ul>	<ul style="list-style-type: none"> <li>• Critical vacancies, particularly in clinical and leadership roles</li> <li>• Underdeveloped retention and progression pathways</li> <li>• Further embedding of Integrated Leadership Development Framework</li> <li>• Further leadership development initiatives</li> <li>• Current Equality governance arrangements require strengthening</li> </ul>	<p><b>Management:</b></p> <ul style="list-style-type: none"> <li>• Service Led skill-mix efficiency and commissioning requirements</li> <li>• Annual staff engagement surveys and reports to Committee and Board</li> <li>• People &amp; Culture Dashboard to Committee</li> </ul> <p><b>Risk and compliance:</b></p> <ul style="list-style-type: none"> <li>• Corporate risks CRR24-01 People, Culture and Wellbeing CRR24-16 Leadership/Special Measures reported to committee.</li> <li>• Review of all Organisational Development risks reported. Local Workforce and Organisational Development risk meeting.</li> <li>• Quarterly performance reviews to CEO of Directorates/ Divisions</li> <li>• Freedom to Speak Up Guardian report</li> </ul> <p><b>Independent assurance:</b></p> <ul style="list-style-type: none"> <li>• Annual workforce plan reviews with HEIW</li> <li>• Internal Audit reports</li> </ul>	<ul style="list-style-type: none"> <li>• Limited Assurance Internal Audit report for Review of Workforce Planning Arrangements</li> </ul>	<p><b>Limited Assurance</b></p>	
	<p><b>Plans to improve control</b> (are further controls possible in order to reduce risk exposure within tolerable range?)</p>			<b>Action Handler</b>	<b>Status of Actions</b>	<b>Date when action will be completed</b>
Prioritise workforce plans for 'challenged services'		Georgina Roberts/ Nick Graham		Progressing	31/03/2026	
Continue reducing agency usage and improve value and sustainability of workforce		Georgina Roberts/ Nick Graham		Progressing	31/03/2026	
Implementing Values and Behaviours Framework		Georgina Roberts		Progressing	31/03/2026	
Embedding Integrated Leadership Development Framework		Georgina Roberts		Progressing	31/03/2026	

<b>Principal risk</b> <small>(what could prevent us achieving this strategic objective)</small>	<b>BAF24-05: Not Engaging with Citizens, Partners and Communities</b> Risk of ineffective engagement with citizens, partners and communities may result in a lack of public trust, poor service user experience, and a disconnect between the Health Board's services and the needs of the population.			<b>Strategic objective</b>	3: To have a compassionate culture, leadership & engagement encompassing 3B: Citizen Engagement & 3C: Being a Good Partner
<b>Lead Committee</b>	Planning, Population Health & Partnership Committee		<b>Risk type</b>	Reputation	
<b>Risk Lead</b>	Director of Partnerships/Communications and Engagement		<b>Risk appetite</b>	Seek 20-25	
<b>Related Corporate Risks:</b>					
<b>Risk rating</b>				<b>Review Dates</b>	
	<b>Current exposure</b>	<b>Tolerable</b>	<b>Target</b>		
<b>Consequence</b>	2. Minor	2. Minor	2. Minor	<b>Initial date of assessment</b>	20/10/2024
<b>Likelihood</b>	3. Possible	4. Possible	2. Unlikely	<b>Last reviewed by Committee:</b>	10/12/2024 (Private)
<b>Risk rating</b>	6. Low	8. Medium	4. Low	<b>Last updated by Executive:</b>	01/04/2025



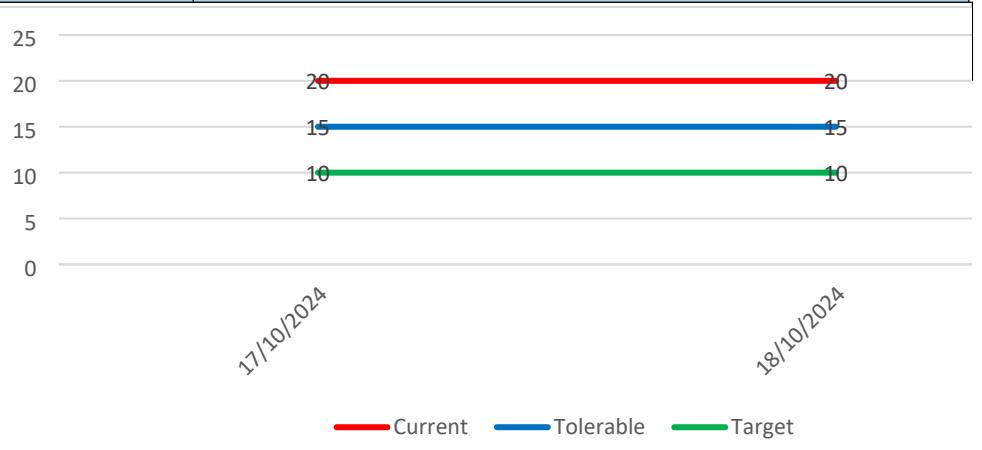
<b>Strategic threat</b> <small>(what might cause this to happen)</small>	<b>Primary risk controls</b> <small>(what controls/ systems &amp; processes do we already have in place to assist us in managing the risk and reducing the likelihood/ impact of the threat)</small>	<b>Gaps in control</b> <small>(are further controls possible in order to reduce risk exposure within tolerable range?)</small>	<b>Sources of assurance (and date)</b> <small>(Evidence that the controls/ systems which we are placing reliance on are effective)</small>	<b>Gaps in assurance / actions to address gaps and issues</b>	<b>Assurance rating</b>
Responsible:	Director Of Partnerships/communications And Engagement		Accountable:	Director Of Partnerships/communications And Engagement	
<b>Threat:</b> of ineffective engagement with citizens and communities may result in a lack of public trust, poor service user experience, and a disconnect between the Health Board's services and the needs of the population.	<ul style="list-style-type: none"> <li>• Collaboration with key stakeholders</li> <li>• Strategic partnerships with local authorities and community organisations</li> <li>• Partnership governance frameworks</li> <li>• Comprehensive inclusive and diverse citizen engagement strategy</li> <li>• Accessible feedback mechanisms such as surveys and public engagement activity</li> <li>• Regular updates to the public on strategic priorities</li> <li>• Survey of engagement across the Health Board</li> <li>• Collaboration on complaint's process</li> </ul>	<ul style="list-style-type: none"> <li>• Communication back to the public on their influence from feedback</li> <li>• Lack of structured feedback from key partners</li> <li>• Limited cross-sector collaboration in specific service areas</li> <li>• Anchor Institute Framework</li> </ul>	<b>Management:</b> <ul style="list-style-type: none"> <li>• Citizen experience reports to Board</li> <li>• Feedback from engagement and where required public consultations.</li> </ul> <b>Risk and compliance:</b> <ul style="list-style-type: none"> <li>• Partnership feedback sessions</li> <li>• Forward Plan and oversight of Regional Partnership Board by the Planning, Population Health &amp; Partnership Committee</li> </ul> <b>Independent assurance:</b> <ul style="list-style-type: none"> <li>• Perception survey with partners</li> <li>• Independent Advisor for external perspective on engagement approach</li> </ul>	Risk Register for Partnerships/Communications and Engagement.	<b>Limited Assurance</b>

↑	<b>Plans to improve control</b> (are further controls possible in order to reduce risk exposure within tolerable range?)	<b>Action Handler</b>	<b>Status of Actions</b>	<b>Date when action will be completed</b>
	Perception Survey completed, Survey findings to now go to Executive Committee and PPHP Committee	Helen Stevens-Jones	Complete	31/03/2025
	Developing Anchor Institute Framework – ongoing, with paper to Executives by 31/05/25 outlining approach and next steps	Helen Stevens-Jones	Progressing	31/03/2026
	Citizen Engagement Plan being reviewed – the draft principles and framework developed - now with the engagement group for comments	Helen Stevens-Jones	Progressing	30/06/2026


	Improve the feedback loop to ensure timely action on public input – ongoing, with review of Board actions against key themes by 31/01/25. January Citizen's Engagement report as evidence	Helen Stevens-Jones	Complete	31/01/2025
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## 4: Improving quality, outcomes and experience


Objective area 4 covers a large thematic area where improvements are required to improve clinical performance across a number of key areas. The Health Board wishes to build further upon good work commenced that takes a pathway focused approach to this.

<b>Principal risk</b> (what could prevent us achieving this strategic objective)	<b>BAF24-06: Not Delivering the Required Improvements to Transform Care and Enhance Outcomes</b>			<b>Strategic objective</b>	4. To Improve Quality, Outcomes and Experience (4A Patient Experience; 4B Prevention; 4I Adult Mental Health, Learning Disability)
	Risk of ineffectively delivering consistent high quality of patient care across the HB resulting in incidents of avoidable harm and poor clinical unmet patient needs, regulatory non-compliance, and reputational harm.				
<b>Lead Committee</b>	Quality, Safety and Experience Committee / Planning, Population Health & Partnership Committee		<b>Risk type</b>	Quality	 <p>25 20 15 10 5 0</p> <p>17/10/2024 18/10/2024</p> <p>— Current — Tolerable — Target</p>
<b>Risk Lead</b>	Executive Director of Nursing Executive Director of Public Health Executive Medical Director Executive Director of Allied Health Professionals and Health Science		<b>Risk appetite</b>	Open 15-19	
<b>Related Corporate Risks:</b>	CRR24-02 Patient Safety / CRR24-04 Failure to Embed Learning/ CRR24-08 Delivering a population health approach to health and wellbeing/ CRR24-18 Managing Outbreaks				
<b>Risk rating</b>				<b>Review Dates</b>	
	<b>Current exposure</b>	<b>Tolerable</b>	<b>Target</b>	<b>Initial date of assessment</b>	20/10/2024
<b>Consequence</b>	5. Catastrophic	5. Catastrophic	5. Catastrophic	<b>Last reviewed by Committee:</b>	17/12/2024 (Private)
<b>Likelihood</b>	4. Somewhat likely	3. Possible	2. Unlikely	<b>Last updated by Executive:</b>	04/04/2025
<b>Risk rating</b>	20. High	15. High	10. Medium		


Strategic threat (what might cause this to happen)	Primary risk controls (what controls/ systems & processes do we <b>already</b> have in place to assist us in managing the risk and reducing the likelihood/ impact of the threat)	Gaps in control (Specific areas / issues where further work is required to manage the risk to accepted appetite/tolerance level)	Sources of assurance (and date) ( <b>Evidence</b> that the controls/ systems which we are placing reliance on are effective)	Gaps in assurance / actions to address gaps and issues (Insufficient evidence as to effectiveness of the controls or negative assurance)	Assurance rating
Responsible:	Deputy Executive Director of Nursing	Accountable:	Executive Director of Nursing	Responsible Committee	Quality, Safety and Experience Committee
<p><b>Threat:</b> A loss of organisational focus on patient safety and quality of care leading to increased incidence of avoidable harm, exposure to 'Never Events', higher than expected mortality, and significant reduction in patient satisfaction</p>	<ul style="list-style-type: none"> <li>• Patient incident/feedback systems and policies</li> <li>• Data analysis and learning at service level</li> <li>• Datix Reporting</li> <li>• Staff training - falls, HAPU, etc</li> <li>• Quality governance arrangements at Health Board, IHC/division &amp; service levels including:                             <ul style="list-style-type: none"> <li>○ Local and Exec PSE Groups</li> <li>○ Local and Exec Quality Delivery Groups</li> <li>○ Clinical audit programme &amp; monitoring arrangements</li> <li>○ Ward accreditation/ metrics and programme</li> </ul> </li> <li>• Integrated Concerns Policy and Toolkit</li> <li>• Concerns Hub</li> <li>• 72 hr incident reviews</li> <li>• Sign-off process for incidents and Nationally Reported Incidents</li> <li>• Executive Led Oversight Group</li> <li>• Quality assurance visits</li> <li>• Internal Reviews against External National Reports</li> <li>• Getting it Right First Time (GIRFT)</li> <li>• Localised deep dives, reports and action plans</li> <li>• Operational grip on workforce gaps</li> <li>• Patient Advice and Liaison Service Activity</li> <li>• Comprehensive Cultural Competence training and awareness</li> </ul>	<ul style="list-style-type: none"> <li>• Inconsistent collection of real-time patient feedback</li> <li>• Delays in addressing patient concerns or complaints.</li> <li>• Operational oversight of sustainable change, evidence of learning and improvement measures</li> </ul>	<p><b>Management:</b></p> <ul style="list-style-type: none"> <li>• Learning from deaths Report to QC and Board</li> <li>• Quarterly Strategic Priority Report to Board;</li> <li>• Divisional risk reports to SRG bi-annually;</li> <li>• Guardian of Safe Working report to Board</li> <li>• Quality and Governance Reporting Pathway; Quality Safety and Experience Committee reports include:                             <ul style="list-style-type: none"> <li>○ Safeguarding Annual Report to QSE</li> <li>○ Infection Control Annual Report</li> <li>○ Health and Safety Annual Report</li> <li>○ Bi monthly Quality Report</li> <li>○ Deep dive Reports</li> <li>○ Risk Management Report</li> <li>○ Integrated Performance Report</li> </ul> </li> </ul> <p><b>Risk and compliance:</b></p> <ul style="list-style-type: none"> <li>• Quality Dashboard</li> <li>• Annual Quality Report &amp; Duty of Candour</li> <li>• Corporate Risks</li> <li>• Ombudsman Annual Letter</li> </ul> <p><b>Independent assurance:</b></p> <ul style="list-style-type: none"> <li>• Health Inspectorate Wales Reports</li> <li>• Care Inspectorate Wales Reports</li> <li>• Coroners reports:</li> <li>• Internal Audit reports.</li> <li>• Royal College Reports</li> <li>• Llais Reports</li> </ul> <p>Screening Quality Assurance Services assessments and reports of:</p> <ul style="list-style-type: none"> <li>• Antenatal and New-born screening</li> <li>• Breast Cancer Screening Services</li> <li>• Bowel Cancer Screening Services</li> <li>• Cervical Screening Services</li> </ul> <p>External Accreditation/Regulation annual assessments and reports of;</p> <ul style="list-style-type: none"> <li>• Pathology (UKAS)</li> <li>• Endoscopy Services (JAG)</li> <li>• Medical Equipment and Medical Devices (BSI)</li> <li>• Blood Transfusion Annual Compliance Report (MHRA)</li> </ul>	<p>Limited Assurance Internal Audit report for Limited Assurance: Lessons Learnt, Falls, Deprivation of Liberty</p> <p>Ombudsman recommendations to be managed.</p> <p>Services maintaining a proactive for complaint management and strategic oversight.</p> <ul style="list-style-type: none"> <li>• Nursing &amp; Midwifery Vision</li> <li>• Allied Health Professional Strategy</li> <li>• Clinical services plan</li> </ul>	<p><b>Limited Assurance</b></p>

		• Ionising Radiation (Medical Exposure) Regulations				
	<b>Plans to improve control</b> (are further controls possible in order to reduce risk exposure within tolerable range?)			<b>Action Handler</b>	<b>Status of Actions</b>	<b>Date when action will be completed</b>
	Civica mapping of services to improve consistency of levels of feedback			Chris Lynes	Complete	31/03/2025
	Expand real-time feedback systems across all services (SMS texting for priority areas e.g. ED)			Chris Lynes	Complete	31/12/2024
	Quality Management System in development. – pilots in urology and vascular			Chris Lynes	Complete	31/03/2025
	Reduced response times for addressing patient complaints.			Chris Lynes	Complete	31/03/2025
	Learning Repository Development – Delayed due to Digital Team capacity, Digital lead now allocated time to complete and progressing with a revised completion date from 31/12/2024 to 31/06/25			Chris Lynes	Delayed	30/06/2025

Strategic threat (what might cause this to happen)	Primary risk controls (what controls/ systems & processes do we already have in place to assist us in managing the risk and reducing the likelihood/ impact of the threat)	Gaps in control (Specific areas / issues where further work is required to manage the risk to accepted appetite/tolerance level)	Sources of assurance (and date) (Evidence that the controls/ systems which we are placing reliance on are effective)	Gaps in assurance / actions to address gaps and issues (Insufficient evidence as to effectiveness of the controls or negative assurance)	Assurance rating
Responsible:	Head Of Public Health Assurance & Development	Accountable:	Executive Director of Public Health	Responsible Committee	Population Health & Partnership Committee
<b>Threat:</b> A widespread loss of organisational focus on investment and support to improve integrated prevention to better population health and wellbeing	<ul style="list-style-type: none"> <li>Public Health team and other teams across the HB, working on evidenced based programmes of work which link to National and local priorities</li> <li>Integrated prevention strategies focused on population health and wellbeing to reduce health inequalities</li> <li>Continuation of Grant funding confirmed 25/26</li> <li>Ministerial Priorities include Prevention and Population Health</li> </ul>	<ul style="list-style-type: none"> <li>Limited access to timely integrated data supporting prevention activity.</li> <li>Insufficient integration between prevention and clinical services</li> <li>Services fail to prioritise prevention as part of the delivery of effective services and outcomes.</li> <li>Large proportion of budget is non-recurrent grant funding</li> <li>Diabetes Pathway Programme delivery plans (service level) - dependent on options for change agreement</li> </ul>	<p><b>Management:</b></p> <ul style="list-style-type: none"> <li>Regular reports against a range of outcomes from the public health outcomes framework to Planning, Population Health &amp; Partnership Committee</li> </ul> <p><b>Risk and compliance:</b></p> <ul style="list-style-type: none"> <li>CRR24-08 Delivering a population health approach to health and wellbeing and CRR24-18 Outbreak Management reported to Planning, Population Health &amp; Partnership Committee.</li> <li>Operational Risk Register maintained.</li> </ul> <p><b>Independent assurance:</b></p> <ul style="list-style-type: none"> <li>Regular reports against a range of outcomes from the public health outcomes framework to Regional Partnership Board Public Service Boards &amp; Welsh Government</li> </ul>	<ul style="list-style-type: none"> <li>Limited assurance of effective models - based on availability of data, intelligence, evidence and evaluation of impact of current prevention approaches within the Health Board and wider partner networks.</li> </ul>	<b>Limited Assurance</b>

	<b>Plans to improve control</b> (are further controls possible in order to reduce risk exposure within tolerable range?)			<b>Action Handler</b>	<b>Status of Actions</b>	<b>Date when action will be completed</b>
	Increase collaboration with community partners			Brian Laing	Complete	31/03/2025
	Strengthen the integration of prevention into service and Health Board planning.			Gwyneth Page	Complete	31/03/2025
	DDAT/Public Health Integrated approach to population health and clinical data and intelligence			Kathryn Lang / Rob Atenstaedt	Progressing	30/09/2025
	Diabetes Pathway Programme – options for change approval			Jane Moore	Progressing	30/07/2025
	Service delivery plans to respond to Diabetes pathway changes			Service Leads	Progressing	30/10/2025
	Grant funded Programme plans approved by Welsh Government and Public Health Wales			Gwyneth Page	Progressing	30/04/2025

Strategic threat (what might cause this to happen)	Primary risk controls (what controls/ systems & processes do we already have in place to assist us in managing the risk and reducing the likelihood/ impact of the threat)	Gaps in control (Specific areas / issues where further work is required to manage the risk to accepted appetite/tolerance level)		Sources of assurance (and date) (Evidence that the controls/ systems which we are placing reliance on are effective)	Gaps in assurance / actions to address gaps and issues (Insufficient evidence as to effectiveness of the controls or negative assurance)	Assurance rating
Responsible:	Director of Mental Health & Learning Disabilities	Accountable:	Executive Director of Allied Health Professionals and Health Science	Responsible Committee	Quality, Safety and Experience Committee	
<p><b>Threat:</b> Risk of insufficient focus on Mental Health, wellbeing and Learning Disabilities in the Health Board strategy, planning and operations leading to sub optimal patient outcomes, lack of an holistic approach, regulatory non-compliance and reputational harm.</p>	<ul style="list-style-type: none"> <li>Alignment with Welsh Government National strategies for Mental Health and wellbeing, Learning Disabilities and Substance Misuse</li> <li>Adherence to Royal College and Clinical standards</li> <li>National NHS Executive Mental Health and Learning Disabilities (MHLD) Strategic Improvement Programme</li> <li>Established Royal College Psychiatry Improvement programme with Health Board wide reporting and governance</li> <li>Established reporting through existing HB Governance Frameworks, Oversight committees and routine audits to ensure compliance and monitor progress.</li> <li>Inclusion in Health Board Annual Plan and monitoring mechanisms</li> <li>Inclusion in organisational Major change programme, oversight and reporting</li> <li>Clinically led Physical health work stream in MHLD</li> <li>Primary care pathways</li> <li>Crisis Care Concordat in place</li> </ul>	<ul style="list-style-type: none"> <li>Recruitment and Retention challenges impacting on workforce including interim posts</li> <li>Engagement and collaboration with physical health services</li> <li>'Foundations for the Future' programme maturity</li> <li>Insufficient focus on health inequalities</li> <li>Lack of integrated Electronic Health Record and other digital systems</li> <li>Limited visibility of Mental health and Learning disabilities data at Board level</li> <li>Current risk to balanced financial position</li> <li>Greater focus on community and earlier intervention services</li> </ul>		<p><b>Management:</b></p> <ul style="list-style-type: none"> <li>External reviews in 2023-24, undertaken as part of Special Measures all recommendations completed and managed.</li> <li>Performance Management and reporting</li> <li>Civica and patient reporting metrics</li> </ul> <p><b>Risk and compliance:</b></p> <ul style="list-style-type: none"> <li>Compliance with Royal College Standards</li> <li>Audit Reports</li> <li>Committee reports e.g. QSE</li> </ul> <p><b>Independent assurance:</b></p> <ul style="list-style-type: none"> <li>Development of co-produced Patient Carer engagement work</li> <li>Expert advisory group</li> <li>External reviews</li> <li>National and Local performance reporting</li> <li>Together 4 Mental Health Partnership Board in place</li> </ul>	<ul style="list-style-type: none"> <li>Lack of integrated patient care records impacting on care, planning and reporting</li> <li>Increasing the scope of performance reviews focusing on patient pathways.</li> <li>Improving our real time patient data</li> <li>Visibility of community mental health activity</li> </ul>	<p><b>Limited Assurance</b></p>
<b>Plans to improve control</b> (are further controls possible in order to reduce risk exposure within tolerable range?)				<b>Action Handler</b>	<b>Status of Actions</b>	<b>Date when action will be completed</b>
Recruitment plans for substantive workforce				Carole Evanson	Progressing	31/09/2025
Increased pathways with Primary care				Alberto Salmoiraghi	Progressing	31/12/2025
Active engagement with the Foundations for the future programme				Carole Evanson	Progressing	31/10/2025
Electronic Health Record programme with MHLD as early adopter				Iain Wilkie	Progressing	31/03/2026
Enhanced Savings plans				Nicola Hyde	Progressing	31/03/2026
Responsive annual plan				Vicky Jones	Complete	31/03/2025
Implementation of Communication strategy, will remain dynamic and developmental				Vicky Jones	Complete	31/12/2025
Alignment with Learning Disabilities national programme- Improving Care Improving lives review				Carole Evanson	Progressing	31/03/2026

<b>Principal risk</b> (what could prevent us achieving this strategic objective)	<b>BAF24-07: Not Delivering Timely Access to Care Resulting In Potential Clinical Harm, Poor Delivery of Performance Targets and Reputational Risk</b>			<b>Strategic objective</b>	4. To Improve Quality, Outcomes and Experience 4E: Planned Care; 4F: Cancer Care; 4G: Urgent and Emergency Care; 4H: Diagnostics; 4ICAMHS and Neurodevelopment)
	Risk of ineffectively delivering timely access to care resulting in potential clinical harm, poor delivery of performance targets and reputational risk				
<b>Lead Committee</b>	Performance, Finance and Information Governance Committee	<b>Risk type</b>	Quality		
<b>Risk Lead</b>	Interim Chief Operating Officer	<b>Risk appetite</b>	Open 15-19		
<b>Related Corporate Risks:</b>	CRR24-10 Urgent Emergency Care/ CRR24-11 Planned Care/ CRR24-12 Areas of Clinical Concern /CRR24-13 Timely Diagnostics				
<b>Risk rating</b>	<b>Current exposure</b>	<b>Tolerable</b>	<b>Target</b>		
<b>Consequence</b>	4. Major	4. Major	4. Major	<b>Review Dates</b>	
				<b>Initial date of assessment</b>	20/10/2024
<b>Likelihood</b>	4. Somewhat likely	2. Unlikely	2. Unlikely	<b>Last reviewed by Committee:</b>	23/12/2024 (Private)
<b>Risk rating</b>	16. High	8. Medium	8. Medium	<b>Last updated by Executive:</b>	01/04/2025
<b>N.B. Tolerable and Target score lines stacked as both are 8.</b>					

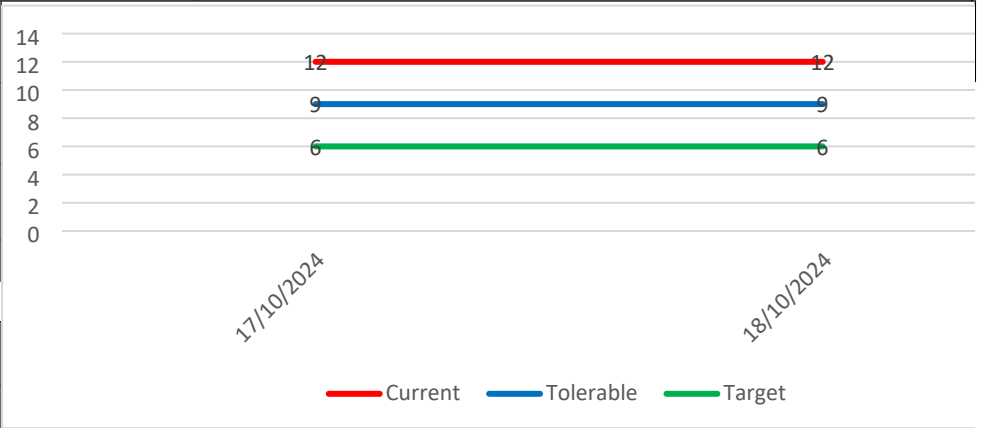
<b>Strategic threat</b> (what might cause this to happen)	<b>Primary risk controls</b> (what controls/ systems & processes do we <b>already</b> have in place to assist us in managing the risk and reducing the likelihood/ impact of the threat)	<b>Gaps in control</b> (Specific areas / issues where further work is required to manage the risk to accepted appetite/tolerance level)	<b>Sources of assurance (and date)</b> ( <b>Evidence</b> that the controls/ systems which we are placing reliance on are effective)	<b>Gaps in assurance / actions to address gaps and issues</b> (Insufficient evidence as to effectiveness of the controls or negative assurance)	<b>Assurance rating</b>
<b>Responsible:</b>	Interim Associate Director for Emergency Care/ Associate Director of Planned Care/ Professional Service Manager Radiography/ Assistant Area Director – Children	<b>Accountable:</b>	Interim Chief Operating Officer	Responsible Committee	Performance, Finance and Information Governance Committee
<b>Threat:</b> The Health Board faces significant risks related to the ability to meet national and local performance targets related to access to timely care. The increased patient acuity, backlog of long waiting times, lack of standardised processes and robust demand and capacity planning at service level may negatively impact the delivery of consistent quality of care. Without strategic planning and robust controls, these risks could lead to reduced public confidence, increased colleague fatigue, ineffective use of resources and failure to achieve regulatory compliance or national standards.	<ul style="list-style-type: none"> <li>Initiation of demand capacity plans at specialty/service level</li> <li>Improved planning including the Winter Resilience Plan with clear principles to protect urgent and planned care pathways</li> <li>Major change programmes for Urgent and Emergency Care (UEC) and Planned Care</li> <li>Strengthening preventative support through integrating services such as SICAT and GP out of hours with active community pathways</li> <li>Strengthening capability and capacity to lead and deliver services with clear executive Senior Responsible Officers (SRO) in place supported by clinical and operational leads</li> <li>Cancer recovery plan</li> <li>Planned care delivery plan against the agreed trajectories supported with resource allocations</li> <li>Diagnostics delivery plan against the agreed trajectories supported with resource allocations</li> <li>Governance framework for accountability including weekly executive led progress reviews for UEC and Planned Care</li> <li>Chief Operating Officer and Director of Performance and commissioning collective leadership oversight for operational performance with support from the executive team</li> <li>Clear workstreams (4) for UEC incorporated into operational planning and delivery as a framework aligned to the national 6 goals for UEC</li> <li>Optimised hospital flow through SAFER programmes and discharge protocols ensuring resilience to protect planned care pathways</li> </ul>	<ul style="list-style-type: none"> <li>Clinical variations and lack of standardised operational processes across the Health Board</li> <li>Limited integration of pathways and care processes between primary, community and secondary care</li> <li>Insufficient capacity in challenged services and Neurodevelopment</li> <li>Strategic approach for equipment replacement scheme to ensure service efficiency and sustainability</li> <li>Estates strategy to address service needs</li> <li>Challenges in workforce retention and gaps in critical roles affecting service delivery</li> <li>Need for enhanced digital infrastructure to support predictive analytics and proactive planning</li> </ul>	<p><b>Management:</b> Integrated Quality Performance Delivery Tracking referrals and waiting times Performance tracking on ambulance handovers Monthly Performance monitoring Strategic Improvement Development Groups. Reviewing consistency in triage processes</p> <p><b>Risk and compliance:</b> Performance reports to Integrated Performance Executive Delivery Group &amp; Board Corporate Risk reporting to Performance and finance committee Patient-reported outcome measures (PROMs) and Patient-reported experience measures (PREMs) data</p> <p><b>Independent assurance:</b> Internal Audit findings demonstrating substantial assurance</p>	<ul style="list-style-type: none"> <li>Independent reviews (focused on areas of concern)</li> <li>Daily Health Board wide oversight grip in control for UEC performance and reporting</li> <li>Health Board resource plan for seven-day UEC care model</li> <li>Health Board workforce plan to align demand and capacity on a seven-day basis</li> <li>Clear structure and delivery for pathways of care delays for North Wales as a system</li> <li>Ensuring compliance with Joint Advisory Group on Gastrointestinal Endoscopy (JAG) accreditation.</li> <li>Lack of consistent and reliable performance data at daily and weekly level.</li> <li>Health Board workforce plan at modality level.</li> </ul>	<b>Unsatisfactory</b>

	<ul style="list-style-type: none"> <li>• Access to care based on clinical urgency and then chronological wait across all programmes of care</li> <li>• Developing close partnership working with the 6 Local Authorities, Welsh Ambulance Service Trust (WAST), third sector and other providers to maximise care outcomes</li> <li>• Effective utilisation through planning and robust governance for use of nationally allocated resources for planned care and UEC</li> <li>• Regional approach in strategic planning through the Regional Partnership Board ensuring a North Wales approach for delivering services for our citizens</li> </ul>		<p>Welsh Government Targets Joint Executive Team WG UEC Programme Board with WG attendance NHS Executive touch points Significant guidance and steer with National Imaging Programme CAMHS &amp; Neurodevelopment National Programme links established. National Specification being worked towards. Regional ND, CAMHS meetings for improvement. CAMHS &amp; Neurodevelopment Enhanced Monthly NHS Exec meeting with performance leads.</p>	<ul style="list-style-type: none"> <li>• Specific diagnostics assurance process to delivery national patient standard for wait levels.</li> <li>• CAMHS &amp; Neurodevelopment Improvement programme reporting to be defined and governance structure</li> </ul>	
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↑	Plans to improve control (are further controls possible in order to reduce risk exposure within tolerable range?)	Action Handler	Status of Actions	Date when action will be completed
	Major change programmes for UEC and planned care aligned to the Six Goals for Urgent and Emergency Care (UEC) framework and national objectives (such as timely access to care and building community capacity). <a href="#">Governance structure completed, all workstreams now all aligned.</a>	Alison Bishop	Complete	31/03/2025
	UEC improvement programme review to ensure the necessary improvements and outcomes are having the required impact on quality and safety of UEC services. <a href="#">Sept midway review.</a>	Alison Bishop	Progressing	30/09/2025
	Use of data analytics to identify high-risk populations (completed) and optimise resource allocation, <a href="#">as a part of workstream one, needs aligning to enhanced community care.</a>	Alison Bishop	Progressing	31/03/2026
	Deployment of live dashboards for real-time monitoring (complete) of performance and governance metrics. Standardise data collection and reporting processes to reduce variability in decision-making. <a href="#">Review of various dashboards to align input criteria and date.</a>	Alison Bishop/ David Hutton	Progressing	31/06/2025
	Strengthen digital capabilities to support service teams (such as e-triage, further roll out of home adaptations particularly rural areas, single patient tracking lists). <a href="#">Align digital plan to UEC plans.</a>	Alison Bishop/Danielle Edwards	Progressing	31/03/2026
	Standardising care pathways across the Health Board. <a href="#">Current mapping exercise.</a> Sits within clinical service strategy, community health pathways being rolled out for development in elective care.	Alison Bishop/Vicky Freeman	Progressing	31/03/2026
	Winter Resilience Plan milestones and adherence to ministerial requirements for capacity building, <a href="#">plan complete evaluation and lessons learnt.</a>	David Hutton	Progressing	31/05/2025
	Revised Access policy to ensure standardised practice across the Health Board	Rhys Blake	Complete	30/01/2025
	Re-enforce specialty level planning cycle through service line demand and capacity plan across the Health Board. <a href="#">Reinforced with services, complete. To be evidenced in April 2026 through Plans</a>	Stephen Powell/Kathryn Lang	Progressing	31/03/2026
	Strengthened workforce planning for key areas linked to challenged services	Tracey Rosco/Paolo	Progressing	31/03/2026
	Telehealth care to strengthen out of hospital care including home systems and video facilitated care forms workstream 1 or 4 for UEC	Alison Bishop	Progressing	TBC
	Continued efforts to further strengthen collaboration with local authorities and voluntary sectors for integrated care delivery models. <a href="#">Milestones to be reported</a>	Chief Operating Officer	Progressing	31/03/2026
	Incorporate public health needs analysis to service planning (such as deprivation links to access for UEC, Planned Care, CAMHS and Womens services)	Chief Operating Officer /Executive Director of Public Health	Progressing	31/03/2026
	Regional approach for services such as Child and Adolescent Mental Health (CAMHS)	Louise Bell	Progressing	31/09/2025

### 5: Establishing an effective environment for Learning

Objective area 5 provides opportunity to learn when things don't go as planned, to teach, and to widely use the many sources of information available to us in order to support decision making and knowledge.

<b>Principal risk</b> (what could prevent us achieving this strategic objective)	<b>BAF24-08: Not Implementing Evidenced Based Improvement and Innovation</b>			<b>Strategic objective</b>	5: Effective Environment for Learning 5A: University Partnership; 5B: Research, Development and Innovation & 5C: Academic Careers)
	Lack of support, capability and agility to optimise strategic and operational opportunities to improve patient care				
<b>Lead Committee</b>	Planning, Population Health & Partnership Committee		<b>Risk type</b>	Quality	
<b>Risk Lead</b>	Executive Medical Director /Chief Digital & Information Officer		<b>Risk appetite</b>	Open 15-19	
<b>Related Corporate Risks:</b>	CRR24-04 Failure to Embed Learning				
<b>Risk rating</b>	<b>Current exposure</b>	<b>Tolerable</b>	<b>Target</b>	<b>Review Dates</b>	
<b>Consequence</b>	4. Major	3. Moderate	3. Moderate	<b>Initial date of assessment</b>	20/10/2024
<b>Likelihood</b>	3. Possible	3. Possible	2. Unlikely	<b>Last reviewed by Committee:</b>	10/12/2024 (Private)
<b>Risk rating</b>	12. Medium	9. Medium	6. Low	<b>Last updated by Executive:</b>	07/04/2025

<b>Strategic threat</b> (what might cause this to happen)	<b>Primary risk controls</b> (what controls/ systems & processes do we <b>already</b> have in place to assist us in managing the risk and reducing the likelihood/ impact of the threat)	<b>Gaps in control</b> (are further controls possible in order to reduce risk exposure within tolerable range?)	<b>Sources of assurance (and date)</b> ( <b>Evidence</b> that the controls/ systems which we are placing reliance on are effective)	<b>Gaps in assurance / actions to address gaps and issues</b>	<b>Assurance rating</b>
Responsible:	Assistant Director Data, Intelligence & Insight		Accountable:	Chief Digital & Information Officer	
<b>Threat:</b> Lack of understanding and agility resulting in reduced efficiency and effectiveness around how we provide care for patients	<ul style="list-style-type: none"> <li>Data collated and available through various systems and software (IRIS/RTT Hub)</li> <li>Information account Managers to ensure data is interpreted correctly</li> <li>Some Integrated data analytics and reporting in place</li> <li>Integrated Leadership Framework &amp; Performance Appraisal and Development</li> </ul>	<ul style="list-style-type: none"> <li>Regular data analytics reviews and intelligence reports for further assurances</li> <li>More Assurance on evidence of being intelligence-led</li> <li>Insufficient integration of data analytics consistently across all service areas</li> <li>Data driven decision-making framework for services</li> <li>Limited use of real-time data in clinical decision-making</li> <li>Inconsistent access to learning opportunities across different service areas</li> <li>Limited evaluation of the impact of training on service delivery</li> <li>Limited collaboration on research projects</li> </ul>	<b>Management:</b> <ul style="list-style-type: none"> <li>Monthly data governance reviews</li> <li>Progress against annual plan to committees</li> </ul> <b>Risk and compliance:</b> <ul style="list-style-type: none"> <li>Annual reviews of the effectiveness of learning initiatives</li> </ul> <b>Independent assurance:</b> <ul style="list-style-type: none"> <li>Clinical body reporting on external evaluations of learning and development programmes</li> </ul>		<b>Limited Assurance</b>

Strategic threat (what might cause this to happen)	Primary risk controls (what controls/ systems & processes do we <b>already</b> have in place to assist us in managing the risk and reducing the likelihood/ impact of the threat)	Gaps in control (are further controls possible in order to reduce risk exposure within tolerable range?)	Sources of assurance (and date) ( <b>Evidence</b> that the controls/ systems which we are placing reliance on are effective)	Gaps in assurance / actions to address gaps and issues	Assurance rating	
	Review (PADR) policy, staff development toolkit. <ul style="list-style-type: none"> <li>Continuous professional development opportunities for staff</li> </ul>					
	<b>Plans to improve control</b> (are further controls possible in order to reduce risk exposure within tolerable range?)		<b>Action Handler</b>	<b>Status of Actions</b>	<b>Date when action will be completed</b>	
	Develop BCU's data warehouse, broadening the range of datasets available. This was a milestone in the Annual Plan 2024/25. Evidence provided on additional datasets created. This now forms business as usual activity as and when new datasets are required.		Kathryn Lang	Complete	31/03/2025	
	Standardise access to learning opportunities for recipient of intelligence products as well as in house team. Additional training provided, with Training Needs Analysis being completed. Once results are returned, a further training programme will be developed.		Kathryn Lang	Complete	31/03/2025	
	Exploring the links with universities on opportunities to work together on data analytics		Kathryn Lang	Progressing	30/09/2025	
Responsible:		Associate Director Research & Development & Programme Director – North Wales Medical School	Accountable:		Executive Director Nursing	
<b>Threat:</b> Ineffective university partnerships, inadequate joint investment in research, and supporting academic career development to sustain a joint effective environment for learning.	<ul style="list-style-type: none"> <li>Some strategic partnerships with academic institutions</li> <li>Memorandum of Understanding in place with Bangor University</li> <li>Dedicated governance structure for North Wales Medical School and related projects</li> <li>Research governance structure</li> <li>Collaboration with external research bodies and innovation hubs</li> <li>All Wales Innovation Pathway deployed</li> </ul>	<ul style="list-style-type: none"> <li>Inconsistent engagement with academic partners across all healthcare services</li> <li>Lack of investment in healthcare innovation projects</li> <li>Limited career progression opportunities in academia for clinical and non-clinical staff</li> <li>No Memorandum of Understanding in place with Wrexham University at present</li> </ul>	<b>Timescale: 2025/26</b> (next update provided will be quarterly milestones based off annual plan)	<b>Management:</b> <ul style="list-style-type: none"> <li>Clinical Effectiveness Group reporting</li> </ul> <b>Risk and compliance:</b> <ul style="list-style-type: none"> <li>Regular joint project reviews and risk register for projects maintained</li> </ul> <b>Independent assurance:</b> <ul style="list-style-type: none"> <li>External evaluations of projects</li> <li>Welsh Government Annual review of university designation criteria</li> </ul>	<ul style="list-style-type: none"> <li>Strategic partnership with Wrexham University to be established with a supporting Memorandum of Understanding</li> <li>Internal governance arrangements and reporting to Clinical Effectiveness Group to be strengthened.</li> <li>Reporting and monitoring of academic career pathways, assessments of joint academic roles and impact on healthcare delivery</li> <li>Commitment to joint investment in research and innovation</li> <li>Partnership reviews with universities.</li> <li>Further review of independent assurance requirements</li> </ul>	<b>Limited Assurance</b>
	<b>Plans to improve control</b> (are further controls possible in order to reduce risk exposure within tolerable range?)		<b>Action Handler</b>	<b>Status of Actions</b>	<b>Date when action will be completed</b>	
	Strengthen collaborative research projects with university partners.		Lynne Grundy & Lea Marsden	Progressing	31/03/2026	
	Strengthen academic career pathways with universities		Lynne Grundy & Lea Marsden	Progressing	31/03/2026	
	Increase R&D collaboration with industry and academic institutions		Lynne Grundy & Lea Marsden	Progressing	31/03/2026	
	Secure additional funding for healthcare innovation projects		Lynne Grundy & Lea Marsden	Progressing	31/03/2026	

Increase the number of joint appointments between the Health Board and academic institutions	Lynne Grundy & Lea Marsden	Progressing	31/03/2026
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## Effective Risk Management

<b>Teitl adroddiad:</b> <i>Report title:</i>	Breaches to the Standing Orders			
<b>Adrodd i:</b> <i>Report to:</i>	Audit Committee			
<b>Dyddiad y Cyfarfod:</b> <i>Date of Meeting:</i>	Thursday, 08 May 2025			
<b>Crynodeb Gweithredol:</b> <i>Executive Summary:</i>	The Audit Committee reviews any breaches to the Standing Orders, this paper summarises the number of breaches in the past 12 months.			
<b>Argymhellion:</b> <i>Recommendations:</i>	<ul style="list-style-type: none"> <li><b>NOTE</b> that the Breaches Paper</li> </ul>			
<b>Arweinydd Gweithredol:</b> <i>Executive Lead:</i>	Pam Wenger, Director of Corporate Governance			
<b>Awdur yr Adroddiad:</b> <i>Report Author:</i>	Philippa Peake-Jones, Head of Corporate Governance			
<b>Pwrpas yr adroddiad:</b> <i>Purpose of report:</i>	I'w Nodi <i>For Noting</i> <input checked="" type="checkbox"/>	I Benderfynu arno <i>For Decision</i> <input checked="" type="checkbox"/>	Am sicrwydd <i>For Assurance</i> <input type="checkbox"/>	
<b>Lefel sicrwydd:</b> <i>Assurance level:</i>	<b>Arwyddocaol Significant</b> <input type="checkbox"/> Lefel uchel o hyder/tystiolaeth o ran darparu'r mecanweithiau / amcanion presennol  <i>High level of confidence/evidence in delivery of existing mechanisms/objectives</i>	<b>Derbyniol Acceptable</b> <input checked="" type="checkbox"/> Lefel gyffredinol o hyder/tystiolaeth o ran darparu'r mecanweithiau / amcanion presennol  <i>General confidence / evidence in delivery of existing mechanisms / objectives</i>	<b>Rhannol Partial</b> <input type="checkbox"/> Rhywfaint o hyder/tystiolaeth o ran darparu'r mecanweithiau / amcanion presennol  <i>Some confidence / evidence in delivery of existing mechanisms / objectives</i>	<b>Dim Sicrwydd No Assurance</b> <input type="checkbox"/> Dim hyder/tystiolaeth o ran y ddarpariaeth  <i>No confidence / evidence in delivery</i>
<b>Cyfiawnhad dros y gyfradd sicrwydd uchod. Lle bo sicrwydd 'Rhannol' neu 'Dim Sicrwydd' wedi'i nodi uchod, nodwch gamau i gyflawni sicrwydd 'Derbyniol' uchod, a'r terfyn amser ar gyfer cyflawni hyn:</b>  <b><i>Justification for the above assurance rating. Where 'Partial' or 'No' assurance has been indicated above, please indicate steps to achieve 'Acceptable' assurance or above, and the timeframe for achieving this:</i></b>				
<b>Cyswllt ag Amcan/Amcanion Strategol:</b> <i>Link to Strategic Objective(s):</i>	1 Building and Effective Organisation			
<b>Goblygiadau rheoleiddio a lleol:</b> <i>Regulatory and legal implications:</i>	The changes as highlighted in this paper are within the legal framework.			
<b>Yn unol â WP7, a oedd EqlA yn angenrheidiol ac a gafodd ei gynnal?</b>	Not required for this change.			

<b><i>In accordance with WP7 has an EqIA been identified as necessary and undertaken?</i></b>	
<b>Yn unol â WP68, a oedd SEIA yn angenrheidiol ac a gafodd ei gynnal?</b>  <b><i>In accordance with WP68, has an SEIA identified as necessary been undertaken?</i></b>	None identified
<b>Manylion am risgiau sy'n gysylltiedig â phwnc a chwmpas y papur hwn, gan gynnwys risgiau newydd (croesgyfeirio at y BAF a'r CRR)</b>  <b><i>Details of risks associated with the subject and scope of this paper, including new risks( cross reference to the BAF and CRR)</i></b>	None identified.
<b>Goblygiadau ariannol o ganlyniad i roi'r argymhellion ar waith</b>  <b><i>Financial implications as a result of implementing the recommendations</i></b>	None identified.
<b>Goblygiadau gweithlu o ganlyniad i roi'r argymhellion ar waith</b>  <b><i>Workforce implications as a result of implementing the recommendations</i></b>	None identified for this report.
<b>Adborth, ymateb a chrynodeb dilynol ar ôl ymgynghori</b>  <b><i>Feedback, response, and follow up summary following consultation</i></b>	
<b>Cysylltiadau â risgiau BAF:</b> (neu gysylltiadau â'r Gofrestr Risg Gorfforaethol)  <b><i>Links to BAF risks:</i></b> (or links to the Corporate Risk Register)	None identified
<b>Rheswm dros gyflwyno adroddiad i fwrdd cyfrinachol (lle bo'n berthnasol)</b>  <b><i>Reason for submission of report to confidential board (where relevant)</i></b>	This paper will be available in public.
<b><i>Next Steps:</i></b> <b><i>Implementation of recommendations</i></b>	
<b><i>List of Appendices:</i></b>  Appendix 1 – Breach Log	

## BREACHES TO THE STANDING ORDERS

### 1. SITUATION

The purpose of this report is to report the Breaches in relation to publication of papers to the Audit Committee

### 2. BACKGROUND

Local health boards and trusts in Wales must agree standing orders for the regulation of their proceedings and business. They are designed to translate the statutory requirements 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, they provide the regulatory framework for the business conduct of the health board. Any breaches or failures to comply with the documents must be reported to the Audit Committee and subsequently included in the annual report.

The Audit Committee and Board approved the below amendments to the Standing Orders in March 2025

*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.*

As part of its Intervention Orders, under Special Measures, the Health Board was given 5 days to publish papers, although where possible it continued to publish within 7 days.

#### **Late Circulation of Board Papers**

Standing orders set out that board papers must be issued to members and published on the health board's website no later than five days before the meeting. Details of papers that have been circulated late and therefore caused a breach in standing orders are listed in this report. The Corporate Governance Directorate have put in additional measures and processes to address the late circulation of papers.

### 3. CONCLUSION

This report gives the Audit Committee a full summary of any breaches of publications over the past twelve months. IMTP "Objective 1A Effective Systems of Governance" highlights ways in which governance will be improved over the coming year and this will support report authors to produce papers and understand reporting timelines.

### 4. RECOMMENDATIONS

The Audit Committee are asked to:

- **NOTE** the Breaches Paper

**Record of Breaches of Publication of Committee Papers 2024 – 2025**

<b>Meeting Date</b>	<b>Body</b>	<b>Standard</b>	<b>Issue/Reason for Breach</b>	<b>Details of papers</b>
30.05.2024	Health Board	Publication of papers 5 days before meeting	Paper published two days before meeting	CEO report
25.07.2024	Health Board	Publication of papers 5 days before meeting	Paper published one day before meeting	Health Board Response to the Royal Psychologist response
25.07.2024	Health Board	Publication of papers 5 days before meeting	Paper published one day before meeting	North Wales Vascular Network Report
26.09.2024	Health Board	Publication of papers 5 days before meeting	Paper published three days before meeting	CEO report
26.09.2024	Health Board	Publication of papers 5 days before meeting	Paper published three days before meeting	Chairs report
26.09.2024	Health Board	Publication of papers 5 days before meeting	Paper published three days before meeting	Culture Leaderships and engagement
28.11.2024	Health Board	Publication of papers 5 days before meeting	Paper published two days before meeting	CEO report
30.01.2025	Health Board	Publication of papers 5 days before meeting	Paper published two days before meeting	Values and Behaviours Framework
30.01.2025	Health Board	Publication of papers 5 days before meeting	Paper published three days before meeting	Vascular Services
04.03.2025	Audit Committee	Publication of papers 5 days before meeting	Paper published one day before meeting	Conformance Report
27.03.2025	Health Board	Publication of papers 5 days before meeting	Paper published two days before meeting	CEO report

Please note no other Committees or Advisory Groups have reported any Breaches during this period



<b>Teitl adroddiad:</b> <i>Report title:</i>	Declarations of Interests/Gifts and Hospitality		
<b>Adrodd i:</b> <i>Report to:</i>	Audit Committee		
<b>Dyddiad y Cyfarfod:</b> <i>Date of Meeting:</i>	Thursday, 08 May 2025		
<b>Crynodeb Gweithredol:</b> <i>Executive Summary:</i>	<p>The Board must ensure that the Health Board establishes and maintains a system for the declaration, recording and handling of Health Board officers' interests in accordance with the Values and Standards of Behaviour Framework.</p> <p>The purpose of this paper is to provide assurance to the Audit Committee.</p> <p>A new electronic system widely used within the NHS was purchased from Civica called 'Declare' to capture all declarations. This was launched at the end of August 2023 and is available in both English and Welsh. This is being promoted to staff and managers to ensure that annual declarations are made and any gifts and hospitality are appropriately declared and Health Board is compliant.</p> <p>Link to Declare: <a href="https://mydeclarations.co.uk">Betsi Cadwaladr University Health Board (mydeclarations.co.uk)</a></p>		
<b>Argymhellion:</b> <i>Recommendations:</i>	<p>Gofynnir i'r Bwrdd</p> <p>The Committee is asked to:</p> <ul style="list-style-type: none"> <li>• <b>RECEIVE</b> assurance on the progress in the compliance with the Standards of Business Conduct Policy noting there will be further improvements to be completed during 2025/26;</li> <li>• <b>NOTE</b> the update against the Internal Audit Limited Assurance Report;</li> <li>• <b>NOTE</b> that Improvement has taken place over the past year that Declarations of Interests and Gifts and Hospitality are being reviewed and monitored within the Health Board and that the new monitoring system functioning; and</li> <li>• <b>AGREE</b> the changes to the monitoring arrangements as set out in the Policy.</li> </ul>		
<b>Arweinydd Gweithredol:</b> <i>Executive Lead:</i>	Pam Wenger – Director of Corporate Governance		
<b>Awdur yr Adroddiad:</b> <i>Report Author:</i>	Philippa Peake-Jones – Head of Corporate Governance		
<b>Pwrpas yr adroddiad:</b> <i>Purpose of report:</i>	I'w Nodi <i>For Noting</i> <input checked="" type="checkbox"/>	I Benderfynu arno <i>For Decision</i> <input type="checkbox"/>	Am sicrwydd <i>For Assurance</i> <input checked="" type="checkbox"/>
<b>Lefel sicrwydd:</b>	Arwyddocaol	Derbyniol	Rhannol Dim Sicrwydd

<b>Assurance level:</b>	<b>Significant</b> <input type="checkbox"/> Lefel uchel o hyder/tystiolaeth o ran darparu'r mecanweithiau / amcanion presennol  <i>High level of confidence/evidence in delivery of existing mechanisms/objectives</i>	<b>Acceptable</b> <input type="checkbox"/> Lefel gyffredinol o hyder/tystiolaeth o ran darparu'r mecanweithiau / amcanion presennol  <i>General confidence / evidence in delivery of existing mechanisms / objectives</i>	<b>Partial</b> <input checked="" type="checkbox"/> Rhywfaint o hyder/tystiolaeth o ran darparu'r mecanweithiau / amcanion presennol  <i>Some confidence / evidence in delivery of existing mechanisms / objectives</i>	<b>No Assurance</b> <input type="checkbox"/> Dim hyder/tystiolaeth o ran y ddarpariaeth  <i>No confidence / evidence in delivery</i>
<p><b>Cyfiawnhad dros y gyfradd sicrwydd uchod. Lle bo sicrwydd 'Rhannol' neu 'Dim Sicrwydd' wedi'i nodi uchod, nodwch gamau i gyflawni sicrwydd 'Derbyniol' uchod, a'r terfyn amser ar gyfer cyflawni hyn:</b></p> <p><b><i>Justification for the above assurance rating. Where 'Partial' or 'No' assurance has been indicated above, please indicate steps to achieve 'Acceptable' assurance or above, and the timeframe for achieving this:</i></b></p> <p><b>Partial assurance has been noted above because the system that has previously been invested in by the Health Board has only just been implemented and there needs to be a continued roll out of Information and engagement with it to ensure it is used effectively.</b></p>				
<b>Cyswllt ag Amcan/Amcanion Strategol:</b>  <b><i>Link to Strategic Objective(s):</i></b>	This report is purely administrative. There are no associated strategy implications.			
<b>Goblygiadau rheoleiddio a lleol:</b>  <b><i>Regulatory and legal implications:</i></b>	This annual update is provided in order to comply with Standing Orders 8.1 – 8.7.			
<b>Yn unol â WP7, a oedd EqIA yn angenrheidiol ac a gafodd ei gynnal?</b>  <b><i>In accordance with WP7 has an EqIA been identified as necessary and undertaken?</i></b>	Do/Naddo Y/N  Os naddo, rhowch esboniad yn ymwneud â'r rheswm pam nad yw'r ddyletswydd yn berthnasol  <i>If no please provide an explanation as to why the duty does not apply</i>  <u>Gweithdrefn ar gyfer Asesu Effaith ar Gydraddoldeb WP7</u>  <u>WP7 Procedure for Equality Impact Assessments</u>			
<b>Yn unol â WP68, a oedd SEIA yn angenrheidiol ac a gafodd ei gynnal?</b>  <b><i>In accordance with WP68, has an SEIA identified as necessary been undertaken?</i></b>	Do/Naddo Y/N  Os naddo, rhowch esboniad yn ymwneud â'r rheswm pam nad yw'r ddyletswydd yn berthnasol  <i>If no please provide an explanation as to why the duty does not apply</i>  <u>Gweithdrefn WP68 ar gyfer Asesu Effaith Economaidd-Gymdeithasol.</u>			

	<u><i>WP68 Procedure for Socio-economic Impact Assessment.</i></u>
<p><b>Manylion am risgiau sy'n gysylltiedig â phwnc a chwmpas y papur hwn, gan gynnwys risgiau newydd (croesgyfeirio at y BAF a'r CRR)</b></p> <p><b><i>Details of risks associated with the subject and scope of this paper, including new risks( cross reference to the BAF and CRR)</i></b></p>	<p>(crynodeb o'r risgiau a rhagor o fanylion yma)</p> <p>This report is purely administrative. There are no associated risks.</p>
<p><b>Goblygiadau ariannol o ganlyniad i roi'r argymhellion ar waith</b></p> <p><b><i>Financial implications as a result of implementing the recommendations</i></b></p>	<p>Scrutiny of this annual return (undertaken by Counter Fraud, Corporate Governance Directorate and the Audit Committee) supports the mitigation of governance/financial risks associated with conflicts of interest and enables the Audit Committee to review and report to the Board upon the adequacy of the LHB's arrangements for dealing with offers of gifts, hospitality and sponsorship.</p>
<p><b>Goblygiadau gweithlu o ganlyniad i roi'r argymhellion ar waith</b></p> <p><b><i>Workforce implications as a result of implementing the recommendations</i></b></p>	<p>Relevant staff are obliged to make declarations of interest and any gifts and hospitality received or declined.</p>
<p><b>Cysylltiadau â risgiau BAF:</b> (neu gysylltiadau â'r Gofrestr Risg Gorfforaethol)</p> <p><b><i>Links to BAF risks:</i></b> <i>(or links to the Corporate Risk Register)</i></p>	
<p><b>Rheswm dros gyflwyno adroddiad i fwrdd cyfrinachol (lle bo'n berthnasol)</b></p> <p><b><i>Reason for submission of report to confidential board (where relevant)</i></b></p>	
<p><b>Camau Nesaf:</b> <b>Gweithredu argymhellion</b></p> <p><b><i>Next Steps:</i></b> <b><i>The continuation to Implement the agreed recommendations.</i></b></p>	
<p><b>Rhestr o Atodiadau:</b></p> <p><b><i>List of Appendices: Appendix 1 Progress against Internal Audit</i></b></p>	

# **ANNUAL DECLARATIONS OF INTERESTS/GIFTS AND HOSPITALITY**

## **1. PURPOSE**

This report sets out how we will manage two registers:

- Gifts, hospitality and sponsorship for the Health Board
- Declared interests

## **2. BACKGROUND**

The Board must adopt a set of values and standards of behaviour for the Health Board (HB) that meets the requirements of the NHS Wales Values and Standards of Behaviour framework.

### **2.1 Establishing and Maintaining the Register of Interests, Gifts, Hospitality, and Sponsorship**

As part of that commitment, and in line with the Standards of Behaviour Policy, the Director of Corporate Governance has established and maintains a register of interests declared by staff and Independent Members. The register includes details of directorships, pecuniary (financial) and non-pecuniary interests in organisations that may have dealings with the NHS and membership of professional committees and third sector bodies. Where relevant it also includes details of interests of spouses, civil partners or close family members.

### **2.2 Publication of the Register of Interests**

The Register of Interests is published on the Health Board website. When making a declaration, staff are able to make representations that information on their interests should not be published. This allows for, in exceptional circumstances, an individual's name and/or other information to be redacted from any publically available registers where the public disclosure of information could give rise to a real risk of harm or is prohibited by law.

An interest remains on the public register for a minimum of 6 months and no more than 12 months after the Director of Corporate Governance has been informed that the interest has expired.

## **3. POLICY REVIEW**

This policy has been reviewed and updated in 2025 in order to incorporate All Wales provisions around the declarations of interests, particularly in relation to gifts and hospitality. The scope of the policy has also been widened to explicitly incorporate agency, locum staff and board members.

The Policy requires the following monitoring to take place:

<b>Area</b>	<b>Frequency</b>
Monitoring of gifts and hospitality monthly	Quarterly
Monitoring of DOI compliance	Monthly
Reporting compliance via Executives	Quarterly
Audit committee reporting – copies of registers and DOI compliance quarterly	Bi-annually

It is proposed that a change to the audit arrangements in this policy be considered to the following:

- The Director of Corporate Governance will arrange for the Declarations of Interest Register and an overview of the gifts, hospitality, honoraria and sponsorship activities within the Health Board to be presented to the Executive Committee twice a year and to the Audit Committee bi-annually.
- The Audit Committee will review and report to the Board upon the adequacy of the arrangements for declaring, registering and handling interests, gifts, hospitality, honoraria and sponsorship at least annually.

**This proposed change would be consistent with other Health Boards.**

#### **4. REPORTING SYSTEM**

Gifts and/or hospitality received with a value of £25 or below were not included as the policy sets the threshold at any gift with an estimated value over £25. This has been amended in the policy and the associated WP6 workforce policy has been updated to match. As part of the review of the policy, additional guidance has been developed to support staff in the declaration of interests in accordance with the Standards of Behaviour Policy.

The electronic system for recording declarations has been rolled out in the Health Board. As outlined in the previous internal audit this system was not implemented fully and therefore during the last 12 months the Corporate Governance Directorate has begun to address this and has made good progress in taking this forward. As the comparison table highlighted below notes improvements have been made but there is further work to do.

The Standards of Behaviour Policy requires mandatory annual declarations of interests are required from Board members, all senior employees (band 8c or equivalent and above), all Consultants and also other employees of any pay band deemed to be undertaking roles where there is potential for a conflict of interest (as determined by a Director). Annual declarations must be submitted even if a nil return (nothing to declare).

In terms of the compliance of all senior employees at 8c or equivalent and above, the compliance will be reported to each Executive Director bi-annually. The reporting systems will need to be developed during 2025-26 and an update on progress will be reported in the next scheduled report. It is proposed that the IHC and Corporate Directorates received quarterly compliance reports and the Corporate Governance Directorate will work with the governance leads in services to progress this.

## **5. INTERNAL AUDIT ON THE STANDARD OF BUSINESS CONDUCT POLICY**

An Internal Audit took place during 2024 and a final Internal Audit Report was received on 20 June 2024. An action plan was produced an update of which can be seen attachment 1 to the report. A review up of this Audit is being undertaken by Internal Audit this year.

## **6. GOVERNANCE ARRANGEMENTS**

Every Board member and HB 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.

Governance Leads are assigned for Directorates and all declarations of interests are approved by line managers.

## **7. PUBLICATION**

The BetsiNet Intranet Pages have been updated and staff can access the portal via links provided as well as find guidance on declarations here:

[\*\*Declarations of interest, gifts and hospitality \(sharepoint.com\)\*\*](#)

In the case of Board Members, submitted declarations of interests are required to be published and documented within the Annual Report in line with the commitment to openness and transparent governance. These are also published on the Health Board website for full transparency which is in line with Standing Orders.

[bcuhb.nhs.wales/about-us/health-board-meetings-and-members/declarations-of-interest/register-of-board-members-declarations-of-interest-2024-25-for-the-website-14032025pdf/](https://bcuhb.nhs.wales/about-us/health-board-meetings-and-members/declarations-of-interest/register-of-board-members-declarations-of-interest-2024-25-for-the-website-14032025pdf/)

**Comparison Table:**

Type of Declaration	Number reported to 31/3/25	Number reported to 28/12/23 (last reported in detail to Audit Committee)
Anrhegion/Gifts	26	8
Buddiannau teyrngarwch/Loyalty Interests	89	31
Cyflogaeth allanol/Outside Employment	271	75
Cyfranddaliadau a buddiannau perchnogaeth eraill/Shareholdings and other ownership interests	36	5
Digwyddiadau a Noddir/Sponsored Events	20	11
Dim buddiannau i'w datgan/Nil Declaration	2436	1780
Lletygarwch/Hospitality	33	10
Patentau/Patents	2	
Rhoddion/Donations	2	
Swyddi a noddir/Sponsored Posts	3	1
Ymarfer Clinigol Preifat/Clinical Private Practice	143	27
Ymchwil a Noddir/Sponsored Research	7	
<b>Total Declarations Reported</b>	<b>3068</b>	<b>1948</b>

**Appendix 1 – Update against Internal Audit Standard of Business Conduct**

Ref.	Recommendation	Agreed Mgmt Response	Deadline / lead	Update	Status
<p>31. We reviewed existing policy OBS02 Standards of Business Conduct and found the following issues and limitations:</p> <ul style="list-style-type: none"> <li>• OBS02 does not reflect current working practice / declaration system. The policy references previous declaration system.</li> <li>• Minor continuity errors.</li> <li>• Lack of clarity regarding mandated declarations of interest by staff that fall outside documented pay band thresholds.</li> </ul>					
1.1	<p>Management:</p> <ul style="list-style-type: none"> <li>• Update policy to reflect current working practice and systems.</li> <li>• Ensure that the requirements regarding mandatory annual declarations of interest for staff that fall outside the documented pay band thresholds are clearly stated.</li> </ul>	<ul style="list-style-type: none"> <li>• Review and update Policy to ensure that it is in line with the rest of Wales</li> <li>• Review Policy to ensure that the pay bands are consistent with the rest of Wales.</li> <li>• Discuss and agree with the Workforce Directorate ways in which the annual declarations of interest can be embedded into existing mechanisms.</li> </ul>	<p>31 July 2024</p> <p>Head of Corporate Affairs</p>	<p>Policy and guidance now updated and live</p>	
1.2	<p>Management:</p> <ul style="list-style-type: none"> <li>• Communicate operational requirements and ensure that relevant staff groups are aware of their responsibilities (e.g. role of line managers and Governance Leads in reviewing, approving,</li> </ul>	<ul style="list-style-type: none"> <li>• Communication briefing to all managers on responsibilities in relation to Declarations of Interest</li> </ul>	<p>30 Sept2024</p> <p>Head of Corporate Affairs</p>	<p>Declare system automatically produces emails to all colleagues reminding them of their responsibilities. There has been information shared in weekly bulletins on this too.</p>	

**Appendix 1 – Update against Internal Audit Standard of Business Conduct**

Ref.	Recommendation	Agreed Mgmt Response	Deadline / lead	Update	Status
	and escalating issues of concern).				
<p>2. In May 2022 the Health Board purchased the Civica Declare system to manage staff declarations. The system was not implemented until August 2023 despite the Health Board incurring implementation fees. We reviewed implementation and noted the following limitations, recognising that some system features were only recently activated:</p> <ul style="list-style-type: none"> <li>Scheduled notifications and management approval activated March 2024 - we were unable to confirm that all scheduled notifications were operating as intended – the recipients of two of the eleven scheduled notifications were marked as “test email”.</li> <li>We were unable to reconcile declaration data published on the Declare portal site to source data. We also noted that the financial year filter was not aligning with the BCU financial year (1 April – 31 March).</li> <li>System embedded guidance documents are all NHS England documentation.</li> </ul>					
2.1	<p>Management:</p> <ul style="list-style-type: none"> <li>Ensure all scheduled notifications are functioning as intended.</li> <li>Ensure published data is accurate and can be reconciled to source data.</li> <li>Ensure published guidance documentation is consistent with NHS Wales requirements and relevant to Health Board staff.</li> </ul>	<ul style="list-style-type: none"> <li>Review monthly scheduled notifications</li> <li>Review monthly published data to ensure that it is accurate and can be reconciled to source data.</li> <li>Review published guidance documentation is consistent with NHS Wales requirements and relevant to Health Board staff. A meeting with Declare has already been arranged for Friday 14 June 2024</li> </ul>	<p>30 June 2024</p> <p>30 June 2025</p> <p>Head of Corporate Affairs</p>	<ul style="list-style-type: none"> <li>Scheduled notices – confirmed that all relevant notices are active and working as intended</li> <li>NHS England logos have been removed – there is one section on the system that we are working with Declare on so that they highlight our guidance</li> </ul>	
<p>3. During 2023/24 the reporting of declarations of interest, gifts and hospitality to the Audit Committee did not meet policy requirements. We reviewed Audit Committee minutes and noted the following:</p> <ul style="list-style-type: none"> <li>OBS02 states that registers should be submitted and reviewed by the Audit Committee bi-annually – however 2024/25 cycle of business limits this to annual review.</li> </ul>					

## Appendix 1 – Update against Internal Audit Standard of Business Conduct

Ref.	Recommendation	Agreed Mgmt Response	Deadline / lead	Update	Status
	<ul style="list-style-type: none"> <li>Declarations of interest and gifts and hospitality registers were scheduled for inclusion in the March 2024 Audit Committee – however, there was no evidence that the registers were submitted or reviewed at the March 2024 Audit Committee.</li> <li>Limited performance / compliance data reported to the Audit Committee for scrutiny.</li> <li>Registers linked in September 2023 Audit Committee (declarations of interest, gifts and hospitality) were limited to Board Member submissions only.</li> </ul>				
3.1	<p>Management:</p> <ul style="list-style-type: none"> <li>Review reporting arrangements and ensure staff declarations are subject to Audit Committee oversight and scrutiny in line with policy requirements.</li> </ul>	<ul style="list-style-type: none"> <li>Update Cycles of business and submit to the Audit Committee twice a year</li> </ul>	<p>18 July 2024</p> <p>30 June 2025</p> <p>Head of Corporate Affairs</p>	<p>Updated cycles of business are currently being worked on to align with the new IMTP. A full table of all declarations will not help give assurance and will be over cumbersome but trends and concerns will be reported going forwards, as per this report.</p>	
	<p>4. We reviewed Board Member declarations of interest, submitted via manual returns, and found the following issues and limitations:</p> <ul style="list-style-type: none"> <li>The due diligence work undertaken by the Office of the Board Secretary identified seven Board Members with undisclosed interests. Six of the seven omissions related to directorship roles within other organisations.</li> <li>The published public register had not been updated with the undisclosed interests at the time of review.</li> <li>Not all published declarations relating to external employment provide sufficient detail of role. We noted two instances whereby Board Member' declarations were limited to “employed by...”, despite their employment relating to senior / Director level positions within the respective organisations.</li> <li>Two previous Board Members in post during 2023/24 were not included in the public register – both individuals left their position in April 2023.</li> </ul>				
4.1	<p>The Director of Corporate Governance:</p> <ul style="list-style-type: none"> <li>Ensures Board Member declarations are accurate and comprehensive</li> </ul>	<ul style="list-style-type: none"> <li>Monitor and review declarations on a weekly basis</li> <li>Produce a targeted communication campaign and implement</li> </ul>	<p>30 June 2024</p> <p>Ongoing</p>	<p>Declarations are being reviewed weekly. Communications are all turned on within the Declare system.</p> <p>A paper system is implemented for Board Members as these are publicly declared. As can be evidenced these are regularly</p>	

**Appendix 1 – Update against Internal Audit Standard of Business Conduct**

Ref.	Recommendation	Agreed Mgnt Response	Deadline / lead	Update	Status
	<p>throughout the year – not limit due diligence work to year-end.</p> <ul style="list-style-type: none"> <li>Reminds Board Members of the requirement to declare all outside employment as part of their mandatory annual declaration of interest, and to notify the Office of the Board Secretary (Corporate Governance Directorate April 2024 onwards) of any changes as and when they arise.</li> <li>Ensures the public register of Board Member interests is maintained and kept up to date.</li> </ul>	<ul style="list-style-type: none"> <li>Any changes to Board Member interests will be uploaded publicly when received. Accurate as of 1 June 2024</li> </ul>	<p>Head of Corporate Affairs</p>	<p>reviewed and updated should any changes be made.</p>	
<p>5. We reviewed Health Board staff declarations of interest data (submitted via Declare) and found the following issues and limitations:</p> <ul style="list-style-type: none"> <li>Low approval rate (9% for all declarations, and 11% for declarations made by Decision Makers) – we acknowledge that the line manager approval feature was only recently activated.</li> <li>A significant number (1,797) of nil declarations have been marked as approval not applicable – adversely impacting the overall approval rate.</li> <li>We found twenty (20) duplicate entries within the source Declare report.</li> <li>We identified a further sixty-one (61) instances where staff had made the same declaration within a short period of time – sixty (60) of these</li> </ul>					

**Appendix 1 – Update against Internal Audit Standard of Business Conduct**

Ref.	Recommendation	Agreed Mgnt Response	Deadline / lead	Update	Status
were resubmissions of nil declarations, all noted as 2023/24. The time between submissions ranged from one day to six months.					
5.1	<p>Management:</p> <ul style="list-style-type: none"> <li>• Ensure line managers are aware of their responsibilities regarding approving declarations of interest (and gifts and hospitality).</li> <li>• Ensure staff understand when, and how often, a declaration should be made.</li> <li>• Establish controls and /or oversight arrangements to manage and escalate non-responses (from Decision Makers) and failure to approve (by line managers).</li> <li>• Ensure data extracted from Declare is reviewed and adjusted appropriately prior to reporting (e.g. to Audit Committee).</li> </ul>	<ul style="list-style-type: none"> <li>• Draft a new communication plan and SOP for Declarations to include flow charts so that Managers are clear about their responsibilities.</li> <li>• Work with the Workforce Directorate on options around including Declarations on PADR templates</li> <li>• Regularly review Declarations and identify and escalate non-responses (from Decision Makers) and failure to approve (by line managers)</li> </ul>	<p>30 Sept2024</p> <p>Head of Corporate Affairs</p>	<ul style="list-style-type: none"> <li>• Completed</li> <li>• Work is ongoing with Workforce in relation to the new PADR templates and making sure that the Declarations are included.</li> <li>• A new weekly report is circulated to all Administrators which highlights these issues for escalation.</li> </ul>	
6. We reviewed gift, hospitality, and sponsored event declarations submitted by staff and found the following issues and limitations:					

**Appendix 1 – Update against Internal Audit Standard of Business Conduct**

Ref.	Recommendation	Agreed Mgmt Response	Deadline / lead	Update	Status
	<ul style="list-style-type: none"> <li>• Not all declarations of hospitality and sponsored events are submitted and approved in accordance with policy requirements.</li> <li>• Only nine (9) of the twenty-six (26) hospitality and sponsored event declarations were subject to Director / Assistant Director approval (a further three (3) were pending approval).</li> <li>• We found five (5) examples of hospitality / sponsored events that had been accepted and attended prior being declared / approved. These findings are limited to declarations whereby staff have included the event date(s) in the interest description field.</li> <li>• All declarations were noted as either approved or pending approval – none were recorded as declined or not approved. We found two submissions that meet the unacceptable hospitality criteria – both were marked pending approval.</li> <li>• None of the declarations marked pending approval were recent submissions – the most recent being declared 23 February 2024.</li> <li>• The date arose field in Declare is not used consistently – some staff have recorded the event date in the field, whilst others have use it to record the offer date.</li> <li>• The provider details for eleven (11) of the twenty-five (25) gift declarations were marked as “Overwritten for Data Protection”. It is not clear whether this was specified in the initial declarations, or if the field was amended for reporting purposes.</li> </ul>				
6.1	<p>Management:</p> <ul style="list-style-type: none"> <li>• Ensure all offers of hospitality and sponsored events are declared, reviewed, and approved prior to attending per policy requirements. All retrospective declarations to be escalated.</li> <li>• All hospitality and sponsored events to be approved by a Director / Assistant Director.</li> <li>• Ensure all declarations pending approval are</li> </ul>	<ul style="list-style-type: none"> <li>• Reviewed gift, hospitality, and sponsored event declarations and produce a SOP and flow chart to ensure clarity.</li> <li>• Produce a communications plan to raise awareness and compliance</li> </ul>	<p>31 Oct 2024</p> <p>Head of Corporate Affairs</p>	<p>New Policy and flow chart now in place – communications being sent directly from Declare.</p> <p>There is further work to be undertaken on gifts and hospitality but the comparison table shared in the paper highlights that there is an improvement.</p>	

**Appendix 1 – Update against Internal Audit Standard of Business Conduct**

Ref.	Recommendation	Agreed Mgnt Response	Deadline / lead	Update	Status
	reviewed and approved / declined. <ul style="list-style-type: none"> <li>• Ensure provider details are recorded to enable effective monitoring per policy requirements.</li> </ul>				

<b>Teitl adroddiad:</b> <b>Report title:</b>	Welsh Health Circulars and Ministerial Directions – update from 1 <sup>st</sup> September 2024 to 31 <sup>st</sup> March 2025			
<b>Adrodd i:</b> <b>Report to:</b>	Audit Committee			
<b>Dyddiad y Cyfarfod:</b> <b>Date of Meeting:</b>	Thursday, 08 May 2025			
<b>Crynodeb Gweithredol:</b> <b>Executive Summary:</b>	<p>The purpose of this report is to provide the Committee with an:</p> <ul style="list-style-type: none"> <li>• update on the current position regarding WHCs received from 1<sup>st</sup> September 2024 to 31<sup>st</sup> March 2025</li> <li>• update on the current position regarding MDs received from 1<sup>st</sup> September 2024 to 31<sup>st</sup> March 2025.</li> </ul>			
<b>Argymhellion:</b> <b>Recommendations:</b>	<p>The Committee is asked to:</p> <ul style="list-style-type: none"> <li>• <b>NOTE</b> the current position regarding WHCs and MHDs received from 1<sup>st</sup> September 2024 to 31<sup>st</sup> March 2025.</li> </ul>			
<b>Arweinydd Gweithredol:</b> <b>Executive Lead:</b>	Pam Wenger, Director of Corporate Governance			
<b>Awdur yr Adroddiad:</b> <b>Report Author:</b>	Glesni Driver, Head of Statutory Compliance and Inquiries			
<b>Pwrpas yr adroddiad:</b> <b>Purpose of report:</b>	I'w Nodi <i>For Noting</i> <input checked="" type="checkbox"/>	I Benderfynu arno <i>For Decision</i> <input type="checkbox"/>	Am sicrwydd <i>For Assurance</i> <input checked="" type="checkbox"/>	
<b>Lefel sicrwydd:</b> <b>Assurance level:</b>	<b>Arwyddocaol Significant</b> <input type="checkbox"/> Lefel uchel o hyder/tystiolaeth o ran darparu'r mecanweithiau / amcanion presennol  <i>High level of confidence/evidence in delivery of existing mechanisms/objectives</i>	<b>Derbyniol Acceptable</b> <input checked="" type="checkbox"/> Lefel gyffredinol o hyder/tystiolaeth o ran darparu'r mecanweithiau / amcanion presennol  <i>General confidence / evidence in delivery of existing mechanisms / objectives</i>	<b>Rhannol Partial</b> <input type="checkbox"/> Rhywfaint o hyder/tystiolaeth o ran darparu'r mecanweithiau / amcanion presennol  <i>Some confidence / evidence in delivery of existing mechanisms / objectives</i>	<b>Dim Sicrwydd No Assurance</b> <input type="checkbox"/> Dim hyder/tystiolaeth o ran y ddarpariaeth  <i>No confidence / evidence in delivery</i>

<p><b>Cyfiawnhad dros y gyfradd sicrwydd uchod. Lle bo sicrwydd 'Rhannol' neu 'Dim Sicrwydd' wedi'i nodi uchod, nodwch gamau i gyflawni sicrwydd 'Derbyniol' uchod, a'r terfyn amser ar gyfer cyflawni hyn:</b></p> <p><i>Justification for the above assurance rating. Where 'Partial' or 'No' assurance has been indicated above, please indicate steps to achieve 'Acceptable' assurance or above, and the timeframe for achieving this: N/A</i></p>	
<p><b>Cyswllt ag Amcan/Amcanion Strategol:</b></p> <p><i>Link to Strategic Objective(s):</i></p>	<p>Building an Effective Organisation</p>
<p><b>Goblygiadau rheoleiddio a lleol:</b></p> <p><i>Regulatory and legal implications:</i></p>	<p>It is essential that the Health Board has robust arrangements in place to assess, capture and provide assurance on actions taken to comply with Welsh Health Circulars (WHCs) and Ministerial Directions (MDs).</p>
<p><b>Yn unol â WP7, a oedd EqIA yn angenrheidiol ac a gafodd ei gynnal?</b></p> <p><i>In accordance with WP7 has an EqIA been identified as necessary and undertaken?</i></p>	<p>The Equality duty is not applicable. This report is purely administrative in nature and submitted for information only. The associated public sector duties are not engaged, and there are no associated impacts on any of the protected groups</p>
<p><b>Yn unol â WP68, a oedd SEIA yn angenrheidiol ac a gafodd ei gynnal?</b></p> <p><i>In accordance with WP68, has a SEIA identified as necessary been undertaken?</i></p>	<p>The Socio-Economic duty is not applicable. This report is purely administrative in nature and submitted for information only. The associated public sector duties are not engaged, and the report does not relate to a decision, strategic or otherwise.</p>
<p><b>Manylion am risgiau sy'n gysylltiedig â phwnc a chwmpas y papur hwn, gan gynnwys risgiau newydd (croesgyfeirio at y BAF a'r CRR)</b></p> <p><i>Details of risks associated with the subject and scope of this paper, including new risks (cross reference to the BAF and CRR)</i></p>	<p>Not applicable, other than those relating to the information contained within the WHCs and MDs</p>
<p><b>Goblygiadau ariannol o ganlyniad i roi'r argymhellion ar waith</b></p> <p><i>Financial implications as a result of implementing the recommendations</i></p>	<p>Not applicable, other than the financial implementations of the WHCs and MDs</p>
<p><b>Goblygiadau gweithlu o ganlyniad i roi'r argymhellion ar waith</b></p> <p><i>Workforce implications as a result of implementing the recommendations</i></p>	<p>Failure to capture, assess and implement WHC and MD can have an adverse impact on the workforce.</p>
<p><b>Adborth, ymateb a chrynodeb dilynol ar ôl ymgynghori</b></p> <p><i>Feedback, response, and follow up summary following consultation</i></p>	<p>Not applicable for this report.</p>

<p><b>Cysylltiadau â risgiau BAF:</b> (neu gysylltiadau â'r Gofrestr Risg Gorfforaethol)</p> <p><b>Links to BAF risks:</b> (or links to the Corporate Risk Register)</p>	<p>Strategic Objective - Failure to Build an Effective Organisation</p> <p>CRR 24 – 16 Leadership - is the key Corporate Risk related to this work.</p>
<p><b>Rheswm dros gyflwyno adroddiad i fwrdd cyfrinachol (lle bo'n berthnasol)</b></p> <p><b>Reason for submission of report to confidential board (where relevant)</b></p>	<p>Not applicable</p>
<p><b>Camau Nesaf:</b></p> <p><b>Next Steps:</b></p> <ol style="list-style-type: none"> <li>1. Ongoing implementation of the process to source and record newly-published WHCs and MDs, and circulation for update to the relevant Executive Director</li> <li>2. Quarterly update report to the Executive Committee on WHCs and MDs</li> <li>3. Six-monthly report to Audit Committee on newly-published WHCs and MDs.</li> </ol>	
<p><b>Rhestr o Atodiadau:</b></p> <p><b>List of Appendices:</b></p> <p>Appendix 1 – List of Welsh Health Circulars received from 1<sup>st</sup> September 2024 to 31<sup>st</sup> March 2025.</p> <p>Appendix 2 – List of Ministerial Directions received from 1<sup>st</sup> September 2024 to 31<sup>st</sup> March 2025.</p>	

# **WELSH HEALTH CIRCULARS AND MINISTERIAL DIRECTIONS – 1<sup>st</sup> SEPTEMBER 2024 TO 31<sup>st</sup> MARCH 2025**

## **1. INTRODUCTION**

The purpose of this report is to provide an update on Welsh Health Circulars (WHCs) and Ministerial Directions (MDs) received and actioned between 1<sup>st</sup> September 2024 and 31<sup>st</sup> March 2025.

## **2. BACKGROUND**

As previously reported, WHCs and MDs contain important information that the Health Board need to review and enact if required. The 2023 'Office of the Board Secretary Review' contained a recommendation to *'Review the management of WHCs and MDs to ensure these are tracked through Committees in terms of the compliance achieved against each for onward assurance to the Board'*.

The Corporate Governance Directorate has responsibility for maintaining a library of all WHCs and MDs received, the name of the identified Executive Director lead, and to capture actions being undertaken to ensure implementation and compliance.

This report follows an update to the Audit Committee on 5<sup>th</sup> November 2025.

## **3. CURRENT POSITION**

### **3.1 Welsh Health Circulars**

A total of 19 WHCs have been received between 1<sup>st</sup> September 2024 and 31<sup>st</sup> March 2025. All these have been shared with the relevant Executive lead, with at least an initial response received.

A copy of the Legislation Library containing the WHCs received from WHCs have been received between 1<sup>st</sup> September 2024 and 31<sup>st</sup> March 2025, together with a summary status update as at 7<sup>th</sup> April 2025 is included in Appendix 1.

### **3.2 Ministerial Directions**

A total of 17 MDs were been received between 1<sup>st</sup> September 2024 and 31<sup>st</sup> March 2025. All these have been shared with the relevant Executive lead, with updates on action required received for the majority.

A copy of the Legislation Library containing the MDs received from 1<sup>st</sup> September 2024 and 31<sup>st</sup> March 2025, together with a summary status update as at 7<sup>th</sup> April 2025 is included in Appendix 2.

## **4. REQUEST FOR PROGRESS UPDATES**

Once the WHCs and MDs are circulated, the Corporate Governance Directorate will request ongoing updates on progress from the Executive Lead and Lead Officer until the necessary actions have been undertaken.

## 5. **REPORTING**

A report on the current position with the WHCs and MDs received by the Health Board, as well as updates on their progress will be continue to be submitted to both the Executive Committee and Audit Committee on a twice-annual basis. The Health Board is required to report compliance against Ministerial Directions and Welsh Health Circulars as part of the Accountability Report.

## 6. **BUDGETARY/FINANCIAL IMPLICATIONS**

There are no budgetary implications associated with this paper.

Resources for progressing the work around the WHCs and MDs lie with the relevant directorate, division, or department as part of business-as-usual functions.

## 7. **RISK MANAGEMENT**

It is essential that the Health Board implements directions received within WHCs and MDs in line with the published implementation dates (where provided) in order to minimise risks associated with those areas of work.

There are risks to the Health Board relating to information contained within the WHCs and MDs as they highlight areas of change or improvement required by the Health Board. Any risks to the Health Board identified from WHCs and MDs should be dealt with in line with our risk management policies and procedures.

## 8. **EQUALITY AND DIVERSITY IMPLICATIONS**

The Equality duty is not applicable to the content of this report as it is purely administrative in nature and submitted for information only.

However, Equality and Diversity compliance should be fully considered when implementing changes to processes and procedures in line with the requirements of the WHCs and MDs.

**APPENDIX 1 – LIST OF WELSH HEALTH CIRCULARS RECEIVED FROM  
1<sup>ST</sup> SEPTEMBER 2024 TO 31<sup>ST</sup> MARCH 2025**

**APPENDIX 2 – LIST OF MINISTERIAL DIRECTIONS RECEIVED FROM  
1<sup>ST</sup> SEPTEMBER 2024 TO 31<sup>ST</sup> MARCH 2025**

WELSH HEALTH CIRCULARS

WHC ID	Publication date	Welsh Health Circular Title	Link to WHC - either WG website or internal folder	Description	Executive Lead	Lead Officer	Action Required by BCUHB (Compliance / Action / For Information)	Date Action Required By (if known)	Circulation:	Confirmation of Initial Action Taken	Details of Action Taken	All action completed Yes/No/Partial
WHC/2024/035	18/09/2024	Standardising the management of acute deterioration	<a href="#">Standardising the management of acute deterioration. (WHC/2024/035)</a>	A national approach for identifying when care should increase if a patient's condition worsens	<del>Angela Wood, Executive Director of Nursing</del> Sree Andole, Interim Exec Medical Director	Sarah Bellis, Resuscitation Lead	Action	N/A	Angela Wood, Nicky Southern	Circulated email	<p><b>18/09/2024</b> Angela Wood confirmed that WHC had been forwarded to the Exec Medical Director deputies and Marie to cascade. AW also confirmed that it was being sent to the Senior Nurses to cascade to their teams.</p> <p><b>13/11/2024</b> Emailed Nicky and Marie requesting update as to whether process has been standardised</p> <p><b>16/12/2024</b> Update rec'd from Jo Shillingford. - will be added to SCEG January agenda.</p> <p><b>02/04/2025</b> Rec'd confirmation from Angela Wood that they have met the deadline for the first section of this WHC - 31.3.25 - by confirming the Exec Sponsor and Implementation Lead. The remaining action for Int. Exec MD.</p> <p><b>02/04/2025</b> Jo Shillingford confirmed that it went to SCEG in January and all information cascaded. Awaiting confirmation from Sree Andole that his actions are complete.</p>	Partial
WHC/2024/036	20/09/2024	Oxygen cylinders: regulation 28 report and patient safety notice 041 reminder	<a href="#">Oxygen cylinders: regulation 28 report and patient safety notice 041 reminder. (WHC/2024/036)</a>	Directions to local health boards and NHS trusts following a regulation 28 prevention of future deaths report and oxygen cylinders patient safety notice (PSN) about oxygen cylinder	Angela Wood, Executive Director of Nursing		Action	30/09/2024	Angela Wood, Chris Lynes, Teresa Owen and Tracey Radcliffe	Circulated email	<p><b>29/08/2024</b> Chris Lynes confirmed that this WHC had been received by Andrew Merriman, chair of the Medical Gases Group, who will action the alert through that group and feed up to the patient safety group.</p> <p><b>30/08/2024</b> Angela confirmed that she will be lead exec for this.</p> <p><b>30/08/2024</b> Andrew Merriman, interim chair of Medical Gases Group (MGG), stated that any actions or escalations noted at the MGG, including action owners can be shared within the appropriate governance as well as at PSG.</p> <p><b>11/09/2024</b> AM confirmed that this was on the agenda for the Medical Gas Group (MGG) to discuss on 12/09/24.</p> <p><b>23/09/2024</b> Update received from AM. WHC was discussed at the MGG. The patient safety team are chelating all of the information across the HB and will use this information to populate and submit the compliance return response. Any outstanding actions will be managed through the medical gas group as a standing agenda item.</p> <p><b>13/11/2024</b> Emailed Andy Merriman to request update as to whether all actions from WHC are complete. Tracey Radcliffe confirmed that actions submitted and complete.</p> <p><b>NO FURTHER ACTION REQUIRED.</b></p>	Yes
WHC/2024/037	24/09/2024	Winter respiratory framework 2024 to 2025	<a href="#">Winter respiratory framework 2024 to 2025. (WHC/2024/037)</a>	Our plans for the NHS, social care and communities for managing respiratory viruses.	Imran Devji, Interim Chief Operating Officer		Action				<p><b>24/09/2024</b> Cascaded by the Medical Directorate. FL awaiting response from Imran Devji as to who should be the Exec lead.</p> <p><b>25/09/2024</b> Chased Imran for answer.</p> <p><b>09/10/2024</b> following approval of the WHC and MDs paper at ET on 09/10/2024, request for outstanding updates sent to Imran Devji and Sandra Ingham - deadline 16/10/2024.</p> <p><b>17/10/2024</b> Sandra Ingham confirmed that the information has been circulated to IHC Directors for wider distribution, Sharon Scott will ensure it is referred to in the Winter Plan, due to its reference to Health Protection. Info also sent to Sam Lauder, Public Health, and Jane Trowman for distribution to Care Homes.</p> <p><b>17/10/2024</b> Lois Lloyd confirmed the allocations:</p> <ul style="list-style-type: none"> <li>- Vaccination element lies with me as SRD with Jane Moore as Exec DPH.</li> <li>- Antiviral distribution and community pharmacy access as well with her.</li> <li>- Process: <ul style="list-style-type: none"> <li>- Vaccination - Strategic Immunisation Group noted actions and delivery oversight via area operational immunisation group.</li> <li>- Antiviral access for care homes operationalised via her office and linked with Sharon as EPRR and oversight by Primary Care Board</li> <li>- Community Pharmacy access via her office aligned to UEC in annual plan.</li> </ul> </li> </ul> <p><b>18/10/24</b> Received confirmation from West and East IHCs that they actioned the WHC.</p> <p><b>14/11/24</b> Central IHC confirmed that they have actioned WHC.</p> <p><b>NO FURTHER ACTION REQUIRED</b></p>	Yes
WHC/2024/038	04/10/2024	Healthcare associated infections and antimicrobial resistance goals 2024 to 2025	<a href="#">Healthcare associated infections and antimicrobial resistance goals 2024 to 2025. (WHC/2024/038)</a>	Our expectations for health boards and trusts to reduce care related illness and resistance to antibiotic	Angela Wood, Executive Director of Nursing (previously assigned to Jane Moore, Acting Executive Director of Public Health)		Action/Information	Immediate	Jane Moore, Rhian Baker	Circulated email	<p><b>09/10/2024</b> Update rec'd from ET - lead for this is Angela Wood, not Jane Moore. Information to be circulated to Angela Wood.</p> <p><b>10/10/2024</b> As per note above, details sent to Angela Wood</p> <p><b>11/10/2024</b> Meeting arranged with Mandy Jones/Andrea Ledgerton to discuss</p> <p><b>17/10/2024</b> Angela Wood forwarded request to Andrea Ledgerton asking her to identify what plans are for each goal, for it then to be presented to the next IPG and EQDG.</p> <p><b>13/11/2024</b> Requested updated from Andrea Ledgerton</p> <p><b>14/11/2024</b> Comprehensive update rec'd from Andrea L, confirming Key HCAI and AMR, E Coli bacteraemia, pseudomonas aeruginosa bacteraemia, klebsiella spp. bacteraemia, clostridioides difficile, staphylococcus aureus bacteraemia, total antimicrobial usage plus additional key recommendations and improvement goals for 2025-26 - full details in file. All these recommendations were presented to SiPG 31/10/24 and to QDG 11/11/24.</p> <p><b>03/01/2025</b> Update received from Andrea L - The actions are actions in progress and part of the IP programme of work. Also many of the actions sit with the IHCs and form part of their improvement plans which are monitored and reported through the Local and Strategic Infection Prevention Groups.</p> <p><b>04/04/2025</b> Update received from Andrea Ledgerton. All actions have or are being progressed, with some being carried over into the 2025/2026 infection prevention programme of work. Progress and outcomes are being monitored through the Local Infection Prevention Groups and the Strategic Infection Prevention Group. East IHC have recently had their 6-month IPC Learning review to measure outcomes with improvement observed in many areas. Centrals are due to have their review in May and West in June.</p> <p>Business as usual and the promotion of best practice is ongoing to support a reduction in Healthcare Associated Infection.</p>	Partial
WHC/2024/039	04/10/2024	Pre-Transfusion Sample taking Compliance with the confirmatory sample rule	<a href="#">Pre-transfusion sample taking. (WHC/2024/039)   GOV.WALES</a>	Risk raised by the Blood Health National Oversight Group in Wales relating to pre-transfusion sample taking and the erroneous practice of taking two samples from a patient at the same phlebotomy episode.	Jane Moore, Acting Executive Director of Public Health; James Risley, Deputy Executive Medical Director; Angela Wood, Executive Director of Nursing		Action	Immediate	Jane Moore, James Risley, Angela Wood	circulated email	<p><b>10/10/2024</b> Advised by Jane Moore that as this relates to the taking of samples, it falls under Nursing &amp; Medical Directorates. Await update.</p> <p><b>21/10/2024</b> Advised by Angela Wood that to ensure we comply with their policies and procedures in relation to -pre-transfusion sample taking, to ensure that risk assessment, policies and procedures are being reviewed, updated and appropriate applied, Angela has asked that this would be the Office of the Medical Director to oversee, track and ensure compliance.</p> <p><b>13/11/2024</b> Forwarded to Office of the Medical Director.</p> <p><b>16/12/2024</b> Update rec'd from Jo Shillingford. WHC had not gone through CEG and would be put on January agenda.</p> <p><b>02/04/2025</b> Jo Shillingford confirmed that WHC was taken to SCEG in January and all info was cascaded to the various teams.</p> <p><b>NO FURTHER ACTION REQUIRED.</b></p>	Yes
WHC/2024/040	29/10/2024	Adopting a patient and family-initiated escalation approach	<a href="#">Adopting a patient and family-initiated escalation approach. (WHC/2024/040).   HTML   GOV.WALES</a>	Letter to health professionals about enabling patients and families to escalate their concerns.	Angela Wood, Executive Director of Nursing	Angela Wood, Executive Director of Nursing	Action	Immediate	Angela Wood, Nicky Southern, Pam Wenger	Circulated email	<p><b>17/10/2024</b> Angela Wood provided update - for SNT and Business meeting to identify what the plans are across sites and level of implementation</p> <p><b>07/01/2025</b> Update received from Angela/Nicky - The WHC was circulated the Senior Nursing and Midwifery team for their information and was also an agenda item at the Nursing and Midwifery Business meeting on 4th November 2024. It was noted that the monitoring and reporting would be undertaken by the STEAR group and then via the Clinical Effectiveness Group (CEG). A short took place to seek assurance of awareness and implementation. All DoNs were aware and confirmed the requirements were being actioned.</p> <p>It was noted that this was more straight forward to implement within acute settings. Whilst further clarification is required as to whether there is a requirement to implement within community settings all agreed to continue to consider how to implement within community settings to ensure equity for patients.</p> <p><b>08/04/2025</b> Advised by Chris Lynes that this is now being led by OMD. Jo Shillingford advised that Sarah Bellis, Implementation Lead for BCUHB for the work to standardise early warning scores and the management of acute deterioration. Awaiting update.</p>	Partial

WHC/2024/041	04/11/2024	Ambulance patient handover guidance	<a href="#">Ambulance patient handover guidance</a> <a href="#">(WHC/2024/041)</a> <a href="#">HTML   GOV.WALES</a>	This guidance is intended to set a statement of intent for health boards to deliver when managing the ambulance patient handover process, and to set out key actions for consistent delivery to support optimal outcomes and experience. It has been developed with clinical and operational input and should be read as a second iteration of the original document released in May 2016.	Imran Devji, Interim Chief Operating Officer		Compliance	Immediate	Imran Devji, Sandra Ingham	Circulated Email	<b>30/10/2024</b> Confirmation received from Imran Devji that this has been actioned. <b>NO FURTHER ACTION REQUIRED.</b>	Yes
WHC/2024/042	05/11/2024	Introduction of the 'Dictionary of medicines and devices	<a href="#">Welsh Health Circulars/Letters/2024</a> <a href="#">W/HC 2024 042</a>	The Digital and data strategy for health and social care in Wales, published in 2023, recognises the central importance of standards-based rules governing access to a shared health and social care record for different uses including clinical care, planning, and managing health services, research, and innovation. To achieve this Welsh Government requires the adoption of four guiding principles for health and social care data; data should be Findable, Accessible, Interoperable and Reusable (FAIR).	Teresa Owen		Compliance	Immediate	Dylan Roberts, Jacqui Pendleton	Circulated Email	<b>06/11/2024</b> Dylan confirmed receipt and forwarded to Teresa advising it may be for her, but will give consideration. <b>13/11/2024</b> Chased Teresa Owen & Dylan Roberts for update. <b>14/11/2024</b> Dylan confirmed that Mike Greenhalgh and a couple of other members of DdaT have had an initial look at this and they are meeting w/c 18/11 to draw some conclusions. Following that meeting, they will provide a more detailed update. <b>26/11/2024</b> chased Jacqui/Dylan for an update. <b>Mike Greenhalgh advised that his understanding is that this WHC has been withdrawn, pending re-release. The WHC itself calls for all data transfers between systems to be dm+d compliant and of all systems, ePMA is the only dm+d compliant.</b> <b>13/12/2024</b> STILL AWAITING OFFICIAL CONFIRMATION THIS WHC HAS BEEN WITHDRAWN. <b>08/01/2025</b> Update from Mike Greenhalgh 'it was our understanding that the WHC had been withdrawn, due to an issue with the wording – not sure if it has been re-issued since. The only system we have currently on the road map (undergoing implementation at the moment) that will share medication data is ePMA and this will use FHIR as the transfer mechanism and is dm+d compliant so would fall within the WHC. Any future interactions involving medications would specify this as a pre-condition. <b>22/01/2025</b> Policy & strategy document received and forwarded to Mike Greenhalgh. Awaiting update from Mike G. <b>07/04/2025</b> Update rec'd from Ceri Harris & Rebecca Hubbard - discussions have taken place around the implementation of the Anti-Racism E-Learning training to mandate, as well as with other Welsh Health Boards and a Welsh Government lead to see if there is a national approach, to which end we have discovered there isn't a standardised national plan. We will now start the process to mandate locally for BCUHB. Concerns re the quality of training has been fed back to WG - advised that this would be picked up in future reviews of the training. Have asked members of BCUnity to review, so feedback includes lived experiences. The new post of Culture, Education and Training lead – Equality will be filled in the next few weeks, their role will be supporting mandated training as well as developing our own cultural competence training that will reflect the experiences of staff, patients and the wider population of North Wales.	Partial
WHC/2024/043	14/11/2024	Pertussis Vaccine Offer for Healthcare Workers	<a href="#">Welsh Health Circulars/Letters/2024</a> <a href="#">W/HC 2024 043</a>	To provide clarity on the occupational offer of pertussis vaccine to NHS Wales Healthcare workers (HCWs).	Jane Moore, Interim Executive Director of Public Health	Jane Moore, Interim Executive Director of Public Health	Compliance / Action	Immediate	Jane Moore, Pam Wenger, Jason Brannan	circulated email	<b>16/11/2024</b> Update from David Maslen-Jones rec'd. Current position on Pertussis vaccination - there are 1794 members of staff in the high risk groups, of which 166 have had Pertussis in last 5 yrs and the numbers currently requiring immunisation is 1,794. This requires a major look back and the plan is : •Check data. Again we are unsure whether previous data held on the old software system has transferred across, •Send emails to all Managers of the At risk areas areas, inform the new WHC and request they double check the information they hold/ask staff and return back to our Imms co-ordinator. •Blanned for Jan/Feb OH clinics across all sites. •Create poster for all area managers and do joint Comms with James for BN to inform the WHC update •Email staff direct of their history and updated WHC advice, as we did with MMR we can update those who've had while pregnant etc. Actions are therefore ongoing, of note, The UK National guidance only recommends boosters for those in Priority group 1: HCWs with regular and close clinical contact with severely ill young infants (under 3 months) and women in the last month of pregnancy, This includes clinical staff working with women in the last month of pregnancy (for example, in midwifery, obstetrics and maternity settings) and neonatal and paediatric intensive care staff who are likely to have close and/or prolonged clinical contact with severely ill young infants (under 3 months of age). Main focus will be targeted on this group <b>07/04/2025</b> Update rec'd from Jilly Beattie: Work continues on the 5 year audit for Pertussis, with the first wave of employees contacted, including those working in Womens and Maternity, Paediatrics, GP practice and GP Out of Hours. • 170 Managers / Supervisors were emailed on 25/02/2025 informing of the recent WHC, the recall audit plan, and information to advise that employees may be contacted if our records held in Occupational Health & Wellbeing show they haven't received a Pertussis containing vaccine within the last five years. • 1,182 employees were then emailed informing that records show they were advised an Occupational vaccination for Pertussis, reasons for the recall, a copy of the WHC, and details how to access a vaccine or update the department to inform given elsewhere or declined. • 25 employees have attended for vaccination. • 4 employees contacted to inform given elsewhere, usually whilst pregnant. • 5 employees declined. • 1,146 employees haven't responded. <b>(MORE DETAIL IN FILE)</b>	Partial
WHC/2024/044	18/11/2024	Mandatory E-Learning Module – Anti-Racism	<a href="#">W/HC/2024/044 - Mandatory E-Learning Module – Anti-Racism</a>	The ARWAP outlines the vision for becoming an anti-racist nation by 2030. This includes ensuring that - <b>Service Delivery: Public sector providers are culturally aware and competent in delivering services to Black, Asian, and Minority Ethnic (BAME) people, recognizing the differences among ethnic minority groups.</b> <b>Workplace Equality:</b> All staff in public sector and funded bodies receive mandatory training in anti-racism	Jason Brannan, Deputy Director of People	Jason Brannan, Deputy Director of People	Compliance/Action	Dec-25	Jason Brannan, Sue Dallimore, Gill Querci	Circulated Email	<b>06/11/2024</b> Pam Wenger asked Jason Brannan for suitable training for the IMs. <b>13/11/2024</b> Jason Brannan asked Rebecca Testa to identify which mandate retraining is set up on the IM profiles. Once this info available, JB and PW to review to ensure it is picked up, however JB believed that through the equality diversity training IMs have already rec'd it should have been included. Awaiting update. <b>20/11/2024</b> Received confirmation from Gill Querci that a meeting has been arranged between Jason Brannan, Pam Wenger, Llinos Roberts and Becky Testa to discuss mandatory training for the IMs. <b>13/12/2024</b> Update rec'd from Sue Dallimore - 'a meeting has been provisionally rescheduled for 20.1.25 (original mtg cancelled due to Jason's sickness). Mtg to include Jason, Pam, Becky and Llinos'. <b>15/12/2024</b> Work ongoing with NWSP to ensure alignment with competencies - currently it is not. Have also raised some concerns regarding the quality and content of the training within the ELG, which was in breach of Welsh measure 97 as was only available in English. This was amended 12/12/2024. Jason Brannan has been to do a video for briefing for this and the WRFS payroll messages in Jan to encourage staff to do both. (Again currently not aligned to competencies) <b>19/12/2024</b> Update rec'd from Rebecca Hubbard - 'OD team are working on creating an E-Learning guide on how to complete the module in ESR, hopefully this will assist with locating the module in the system. Have also requested of our All Wales WFIS colleagues to see if there is a national approach to including the module in other E-Learning modules. We will also ensure the Workforce Systems team are aware of the WHC and the requirement to mandate so they can prepare work in attaching the competency in ESR. <b>04/04/25</b> Update rec'd from Ceri Harris & Rebecca Hubbard. BCU has fed back to WG some of the concerns on the quality of the training - told that this would be picked up in future reviews of the training. Members of BCUnity had been asked to review to ensure feedback included lived experiences. Discussions have taken place	Partial
WHC/2024/045	26/11/2024	Spotting Sepsis in Children Awareness Leaflet	<a href="#">Welsh Health Circulars/Letters/2024</a> <a href="#">W/HC 2024 045</a>	To raise further awareness in the community about the signs and symptoms of sepsis in children.	Jim McGuigan, Deputy Medical Director	Jim McGuigan, Deputy Medical Director	Action	Immediate	Jim McGuigan, Lois Lloyd, Angela Wood, Pam Wenger	Circulated Email	<b>18/11/2024</b> Confirmation received from Angela Wood, that WHC had been circulated to the Senior Nursing Team <b>18/11/2024</b> Confirmation received from Jim McGuigan that WHC circulated to IHC MDs, Hospital and PC MDs for circulation locally. Jim also asked Dafydd Bulman to circulate to all GP practices and community pharmacies via PC Comms. <b>26/11/2024</b> Dafydd B confirmed that leaflet was cascaded to GP PMS, GPOOH, Sessional GPs, Pharmacists and technicians, Dental practices, HB Primary Care Managers, HB Pharmacy & prescribing advisors, Medical Committees, Pharmacy Committees and Dental Committees. <b>NO FURTHER ACTION REQUIRED.</b>	Yes

WHC/2024/046	05/12/2024	Influenza (flu) Vaccination Programme deployment 'mop up' 2024-2025	<a href="#">Welsh Health Circulars/Letters/2024/WHC 2024 046</a>	To ensure everyone who is eligible for a flu vaccination can receive one, health boards are expected to support Primary Care Services with targeted fly 'mop up'. The intention is to maximise uptake in all adult groups, particularly those in a clinical risk group. With additional health board support, alongside ongoing planned GP and Community Pharmacy flu vaccination, it is hoped that this will boost uptake whilst relieving pressure on Primary Care services during this challenging period.	Jane Moore, Interim Executive Director of Public Health	Katie Spruce	Action	Immediate	Jane Moore, Katie Spruce, Pam Wenger	Circulated Email	<b>05/12/2024</b> Update received from Katie Spruce <b>13/12/2024</b> Update received from Katie S. A written response of interventions has been submitted to VPW, as per request, and actions are ongoing. Teams continue to engage at both cluster and practice level to offer support and direction. <b>03/01/2025</b> Katie Spruce updated - As of 24/12/2024, 159,621 adult flu vaccinations administered this is 59% of 270,140 eligible patients. Ongoing. More detailed info in file. <b>02/04/2025</b> Update requested.	Partial
WHC/2024/047	18/12/2024	COVID-19 spring vaccination programme 2025	<a href="#">Welsh Health Circulars/Letters/2024/WHC 2024 047</a>	WfG has accepted the latest advice from the Joint Ctte on Vaccination and Immunisation (JCVI) which has advised a spring COVID-19 vaccination should be offered to our most vulnerable citizens in 2025. Eligible cohorts: - adults 75 and over, residents in care home for older adults and individuals aged 65+ who are immunosuppressed (as defined in tables 3 or 4 in the COVID-19 chapter of the Green Book).	Jane Moore, Interim Executive Director of Public Health	Katie Spruce	Action	Immediate	Jane Moore, Katie Spruce, Pam Wenger and Philippa Peake-Jones	Circulated email	<b>03/01/2025</b> Katie Spruce advised that for an update - see WHC/2024/046, which supersedes. <b>NO FURTHER ACTION REQUIRED.</b>	Yes
WHC/2024/050	19/12/2024	Infected Blood Inquiry: Implementation of Recommendation 8a and 8b	<a href="#">Welsh Health Circulars/Letters/2024/WHC 2024 050</a>	Following the IBI report in May, this WHC is in relation to a recommendation within the report that focuses on finding undiagnosed patients. Two specific recommendations for patients who may have had a blood transfusion.	Imran Devji, Interim Chief Operating Officer	Imran Devji, Interim Chief Operating Officer	Action	Immediate	Imran Devji, Shellee Jones, Angela Wood, Nicki Southern, Sree Andole, Marie Davies, Jane Moore, Rhian Baker.	Email circulated	<b>03/01/2025</b> Imran Devji advised in hand and will provide more details when possible. David Fletcher chasing for an update. <b>06/01/2025</b> Jane Moore confirmed that as part of the initial response, her team set up a pathway for people who contacted the health board if they were concerned they might have had a transfusion - this Rob Atenstaedt and colleagues pulled together. RA able to provide the details to Imran Devji, if required. <b>13/01/2025</b> Received confirmation from Imran Devji that recommendations regarding 8a and 8b were circulated to Rachel Page and the 3 IHCs. <b>NO FURTHER ACTION REQUIRED.</b>	Yes
WHC/2024/051	27/01/2025	Health board allocations: 2025 to 2026 (WHC/2024/051)	<a href="#">Health board allocations: 2025 to 2026 (WHC/2024/051)   GOV.WALES</a>	This letter notes health boards' funding arrangements for the coming financial year.	Russell Caldicott, Executive Director of Finance	Russell Caldicott, Executive Director of Finance	Compliance	Immediate	Russell Caldicott, Natalie Morris-Evans, Pam Wenger	Email Circulated	<b>03/01/2025</b> Natalie confirmed that the WHC had already been received and shared. No actions as such; the Team is using the documents as part of its financial planning. <b>NO FURTHER ACTION REQUIRED.</b>	Yes
WHC/2025/001	04/03/2025	NHS Wales Sustainability Conference and Awards 2025	<a href="#">Welsh Health Circulars/Letters/2025/WHC 2025 001/Welsh Health Circular - NHS Wales Sustainability Awards - ENG.pdf</a>	Invitation to the NHS Wales Sustainability Conference and Awards 2025 - originally set up to promote the principles of sustainable healthcare and support the incorporation of sustainable practices into the clinical area.	Stuart Keen, Director of Environment and Estates	Stuart Keen, Director of Environment and Estates	Action	Immediate	Stuart Keen, Director of Environment and Estates	Email forwarded to Stuart Keen	<b>07/04/2025</b> Update requested	No
WHC/2025/002	06/03/2025	Timelines and responsibilities for the implementation of Early Warning Scores (EWS) to identify acute deterioration	<a href="#">Welsh Health Circulars/Letters/2025/WHC 2025 002/WHC (2025) 002.pdf</a>	This WHC identifies the implementation timelines and organisational responsibilities for implementing the NEWS2, PEWS, MEWTT2 and MEWS early warning scores.	Angela Wood, Executive Director of Nursing & Midwifery	Angela Wood, Executive Director of Nursing & Midwifery	Action	30/09/2025	Angela Wood, Nicky Southern, Pam Wenger, Sreeman Andole, Marie Davies	Email circulated.	<b>27/03/2025</b> <b>Chris Hancock</b> /Angela Wood confirmed that there are two parts to this WHC; the first part is to confirm the Exec Sponsor and Implementation Lead by 31/03/25, which was done.	Partial
WHC/2025/005	12/03/2025	Climate emergency leadership day and adaptation	<a href="#">Welsh Health Circulars/Letters/2025/WHC 2025 005/Welsh Health Circular - Climate Emergency Spread &amp; Scale Leadership Day &amp; Adaptation - ENG.pdf</a>	In line with 'A Healthier Wales' refreshed actions, NHS organisations must embed action on the climate emergency in decision making and plans. All organisations are expected to have completed scoping, current and future risk assessment (sections 1-3) outlined in the toolkit and have plans in place prioritising what short and longer term actions will be taken (sections 5.7 and page 57). To support implementation of the strategy, a Health and Social Care toolkit has been published to help organisations identify the climate risks and opportunities most relevant to them and which should then inform work on plan development.	Stuart Keen, Director of Environment and Estates	Stuart Keen, Director of Environment and Estates	Action	Immediate	Stuart Keen, Director of Environment and Estates	Email circulated	<b>07/04/2025</b> Update requested	No
WHC/2025/007	12/03/2025	Changes to standing orders for health organisations	<a href="#">Welsh Health Circulars/Letters/2025/WHC 2025 007</a>	There are updates to the standing orders. These follow changes to the regulations for health boards, trusts and special health authorities.	Pam Wenger, Director of Corporate Governance	Pam Wenger, Director of Corporate Governance	Action	01/10/2025		Email circulated	<b>07/03/2025</b> Philippa Peake-Jones confirmed that the changes were taken through Audit Committee 04/03/2025. <b>NO FURTHER ACTION REQUIRED.</b>	Yes

## MINISTERIAL DIRECTIONS

MD ID	Publication date	Ministerial Direction title	Link to Ministerial Direction	Description	Executive Lead	Lead Officer	Action required Yes/No/Unknown at present	Update on action	All action completed Yes/No/Partial
WG24-42	30/09/2024	THE NATIONAL HEALTH SERVICE (WALES) ACT 2006 The Pharmaceutical Services (Clinical Services) (Wales) (Amendment) Directions 2024	<a href="#">Pharmaceutical Services (Clinical Services) (Wales) (Amendment) Directions 2024   GOV.WALES</a>	The Directions set out amendments to the requirements for the provision of clinical pharmaceutical services in Wales.	Nick Lyons, Executive Medical Director, now reassigned to Sreeman Andole, Interim Executive Medical Director	Lois Lloyd, Chief Pharmacist	Yes	<p><b>17/01/2025</b> - circulated to Executive Lead and Lead Officer, requested update</p> <p><b>22/01/2025</b> - Lois Lloyd confirmed that she had received the MD and all actions complete, which included:</p> <p><b>10/03/2025</b> - Lois confirmed the following:                      In practice, there were no required actions for the health board, as the directions did not impact our commissioning approach. The changes primarily affected:</p> <ul style="list-style-type: none"> <li>• Training eligibility, which was managed by HEIW.</li> <li>• Pharmacy access rights, handled by DHCW.</li> <li>• All Wales Pharmacy Database (AWPD) entries, where NWSSP Shared Services managed the link between the two.</li> </ul> <p>That said, any updates to the national service specification aligning with these directions would have been shared through the Community Pharmacy Group and the Primary Care Contracts Management Group for awareness and approval.</p>	Yes
WG24-43	10/10/2024	THE NATIONAL HEALTH SERVICE (WALES) ACT 2006 Directions to Local Health Boards as to the Statement of Financial Entitlements (Amendment) (No. 3) Directions 2024	<a href="#">THE NATIONAL HEALTH SERVICE (WALES) ACT 2006 Directions to Local Health Boards as to the Statement of Financial Entitlements (Amendment) (No. 3) Directions 2024</a>	The Welsh Ministers, in exercise of the powers conferred on them by sections, 12, 45, 203(9) and (10) and 204(1) of the National Health Service (Wales) Act 2006(a) and after consulting in accordance with section 45(4) of that Act with the bodies appearing to them to be representative of persons to whose remuneration these Directions relate, give the following Directions.	Russell Caldicott, Interim Executive Director of Finance	Andrea Hughes, Interim Director of Finance	No	<b>20/12/24</b> Update requested. 15/01/2025 - The Amendment has been shared and relevant staff are aware of the changes, there are no actions from the update.	Yes
No MD ref	11/11/2024	The Betsi Cadwaladr University Local Health Board Intervention (Amendment) Order: March 2023	<a href="#">The Betsi Cadwaladr University Local Health Board Intervention (Amendment) Order 2023</a>	The Welsh Ministers make the following Order in exercise of the powers conferred by sections 26 and 27 of the National Health Service (Wales) Act 2006(1).	Carol Shillabeer, Chief Executive Pam Wenger, Director of Corporate Governance	Elin Gwynedd, Chief of Staff	No	<p><b>07/01/2025</b> Sent to Elin Gwynedd, Carol Shillabeer and Emma Hughes. Update from Pam Wenger 14/01/2025 - all have been actioned, and an update provided to Board in November. Update 15/01/2025 - 3 intervention orders have now been made (Feb, March 23 and No 24). The first 2 intervention orders were made to enable effective governance of the Health Board whilst it was in special measures, and following the resignation of the Chair, Vice-Chair and Independent Members of the Board. The most recent intervention order has been made in recognition of the improvements the Health Board has made to its governance arrangements, meaning the provision made by the first two intervention orders is no longer required. This includes the appointment of a full set of independent members, a permanent Chair and Vice-Chair; the appointment of a permanent Chief Executive and Director of Corporate Governance; and all board committees are now established and operating. Unfortunately the making of the most recent order does not change the escalation status of Betsi Cadwaladr University Local Health Board which remains in special measures.</p> <p><b>01/04/2025</b> Requested an update.</p>	Yes

No MD ref	11/11/2024	Betsi Cadwaladr University Local Health Board Intervention Order: February 2023	<a href="#">Betsi Cadwaladr University Local Health Board Intervention Order 2023</a>	The Welsh Ministers make the following Order in exercise of the powers conferred by sections 26 and 27 of the National Health Service (Wales) Act 2006(1).	Carol Shillabeer, Chief Executive Pam Wenger, Director of Corporate Governance	Elin Gwynedd, Chief of Staff	No	07/01/2025 Sent to Elin Gwynedd, Carol Shillabeer and Emma Hughes. Update from Pam Wenger 14/01/2025 - all have been actioned, and an update provided to Board in November. Update 15/01/2025 - 3 intervention orders have now been made (Feb, March 23 and No 24). The first 2 intervention orders were made to enable effective governance of the Health Board whilst it was in special measures, and following the resignation of the Chair, Vice-Chair and Independent Members of the Board. The most recent intervention order has been made in recognition of the improvements the Health Board has made to its governance arrangements, meaning the provision made by the first two intervention orders is no longer required. This includes the appointment of a full set of independent members, a permanent Chair and Vice-Chair; the appointment of a permanent Chief Executive and Director of Corporate Governance; and all board committees are now established and operating. Unfortunately the making of the most recent order does not change the escalation status of Betsi Cadwaladr University Local Health Board which remains in special measures.	Yes
WG24-45	11/11/2024	The Betsi Cadwaladr University Health Board Intervention (Revocation) Order: November 2024	<a href="#">The Betsi Cadwaladr University Health Board Intervention (Revocation) Order: November 2024   GOV.WALES</a>	his order revokes the health board's February 2023 intervention order and the March 2023 amendment order	Carol Shillabeer, Chief Executive Pam Wenger, Director of Corporate Governance	Elin Gwynedd, Chief of Staff	No	07/01/2025 Sent to Elin Gwynedd, Carol Shillabeer and Emma Hughes. Update from Pam Wenger 14/01/2025 - all have been actioned, and an update provided to Board in November. Update 15/01/2025 - 3 intervention orders have now been made (Feb, March 23 and No 24). The first 2 intervention orders were made to enable effective governance of the Health Board whilst it was in special measures, and following the resignation of the Chair, Vice-Chair and Independent Members of the Board. The most recent intervention order has been made in recognition of the improvements the Health Board has made to its governance arrangements, meaning the provision made by the first two intervention orders is no longer required. This includes the appointment of a full set of independent members, a permanent Chair and Vice-Chair; the appointment of a permanent Chief Executive and Director of Corporate Governance; and all board committees are now established and operating. Unfortunately the making of the most recent order does not change the escalation status of Betsi Cadwaladr University Local Health Board which remains in special measures.	Yes
WG24-26	28/11/2024	Directions to Local Health Boards as to the Statement of Financial Entitlements (Amendment) (No. 4) Directions 2024	<a href="#">Directions to Local Health Boards as to the Statement of Financial Entitlements (Amendment) (No. 4) Directions 2024   GOV.WALES</a>	Fee scales for dispensing doctors from 1 October 2024 to 31 March 2025 and from 1 April 2025	Russell Caldicott, Interim Executive Director of Finance		No	07/01/2025 Sent to Russell Caldicott. 15/01/2025 - The Amendment has been shared and relevant staff are aware of the changes, there are no actions from the update.	Yes
WG24-49 (WG 2024 No. 49)	03/12/2024	The Local Health Board Medical Services (Wales) Directions 2024	<a href="#">The Local Health Board Medical Services (Wales) Directions 2024   GOV.WALES</a>	The directions state requirements for local health boards providing primary medical services themselves	<del>Sreeman Andole, Interim Executive Medical Director; Chris Stockport, Executive Director Transformation and Strategic Planning; Imran Devji, Interim Chief Operating Officer</del> Paolo Tardivel, Interim Executive Director Transformation and Strategic Planning Tehmeena Ajmal, COO	Tehmeena Ajmal, COO	Yes	07/01/2025 Sent to Sree Andole and Chris Stockport. 09/01/2025 - Response from Chris Stockport - These are the Directions that cover any HB provided GMS services – this would include Managed Practices. There is work ongoing to develop practice statement for managed practices in line with these Directions, however, that will take a couple of months. They will also then be our reference point for any other services we may wish to directly provide. 02/04/2025 Advised that this has now been transferred to Tehmeena Ajmal. 04/04/2025 Update rec'd from Lynne Joannou - the plan is to have the generic Board practice statements ready by the end of Q1.	Partial
WG24-53	19/12/2024	The directed supplementary services directions and specification for complex multi-morbidity and frailty 2024	<a href="#">The directed supplementary services directions and specification for complex multi-morbidity and frailty 2024   GOV.WALES</a>	GPs can support the management and ongoing monitoring of patients at high risk of admission or re-admission to hospital		Tehmeena Ajmal, COO	Yes	07/01/2025 Sent to Sree Andole, Chris Stockport and Imran Devji. 09/01/2025 - Response from Chris Stockport - We are currently inviting expressions of interest from practices to deliver the service and will be commissioning it once these have been received. 2.4.25 Advised that this has now been transferred to Tehmeena Ajmal. Update expected from Lynne Joannou. 04/04/2025 Lynne Joannou confirmed that practices that expressed an interest were commissioned to provide this service. This was a short-lived service which ended on 31st March 2025.	Yes

WG25-03	10/02/2025	Directions to Local Health Boards as to the Personal Dental Services Statement of Financial Entitlements (Amendment) Directions 2025.	<a href="#">The Directions to Local Health Boards as to the Personal Dental Services Statement of Financial Entitlements (Amendment) Directions 2025   GOV.WALES</a>	These directions raise payments to dental foundation trainees and trainers for 2022 to 2023	Russell Caldicott, Executive Finance Director	Russell Caldicott, Executive Finance Director	No	25/02/2025 Forwarded to Russell Caldicott, cc Natalie 05/03/2025 Confirmation received from russell that no action required and information shared with the team.	Yes
WG25-04	10/02/2025	Directions to Local Health Boards as to the General Dental Services Statement of Financial Entitlements (Amendment) (No. 2) Directions 2025	<a href="#">The Directions to Local Health Boards as to the General Dental Services Statement of Financial Entitlements (Amendment) (No.2) Directions 2025   GOV.WALES</a>	Rises in NHS dental contract payments and payments to dental foundation trainees and trainers for 2023 to 2024	Russell Caldicott, Executive Finance Director	Russell Caldicott, Executive Finance Director	No	25/02/2025 Forwarded to Russell Caldicott, cc Natalie 05/03/2025 Confirmation received from Russell that no action required and information shared with the team.	Yes
WG25-05	10/02/2025	Directions to Local Health Boards as to the Personal Dental Services Statement of Financial Entitlements (Amendment) (No.2) Directions 2025	<a href="#">The Directions to Local Health Boards as to the Personal Dental Services Statement of Financial Entitlements (Amendment) (No.2) Directions 2025   GOV.WALES</a>	Rises in NHS dental contract payments and payments to dental foundation trainees and trainers for 2023 to 2024	Russell Caldicott, Executive Finance Director	Russell Caldicott, Executive Finance Director	No	25/02/2025 Forwarded to Russell Caldicott, cc Natalie 05/03/2025 Confirmation received from russell that no action required and information shared with the team.	Yes
WG25-06	11/02/2025	Directions to Local Health Boards as to the Statement of Financial Entitlements (Amendment) (Directions 2025	<a href="#">Directions to Local Health Boards as to the Statement of Financial Entitlements (Amendment) Directions 2025   GOV.WALES</a>	Directions to local health boards on amendments to the general medical services contrac	Russell Caldicott, Executive Finance Director	Russell Caldicott, Executive Finance Director	No	25/02/2025 Forwarded to Russell Caldicott, cc Natalie 05/03/2025 Confirmation received from russell that no action required and information shared with the team.	Yes
WG25-08	18/02/2025	Directions to Local Health Boards as to the Personal Dental Services Statement of Financial Entitlements (Amendment) (No. 3) Directions 2025	<a href="#">The Directions to Local Health Boards as to the Personal Dental Services Statement of Financial Entitlements (Amendment) (No.3) Directions 2025   GOV.WALES</a>	Rises in NHS dental contract payments and payments to dental foundation trainees and trainers for 2024 to 2025	Russell Caldicott, Executive Finance Director	Russell Caldicott, Executive Finance Director	No	25/02/2025 Forwarded to Russell Caldicott, cc Natalie 05/03/2025 Confirmation received from russell that no action required and information shared with the team.	Yes
WG25-07	18/02/2025	Directions to Local Health Boards as to the General Dental Services Statement of Financial Entitlements (Amendment) (No. 3) Directions 2025.	<a href="#">The Directions to Local Health Boards as to the General Dental Services Statement of Financial Entitlements (Amendment) (No.3) Directions 2025   GOV.WALES</a>	Rises in NHS dental contract payments and payments to dental foundation trainees and trainers for 2024 to 2025	Russell Caldicott, Executive Finance Director	Russell Caldicott, Executive Finance Director	No	25/02/2025 Forwarded to Russell Caldicott, cc Natalie 05/03/2025 Confirmation received from russell that no action required and information shared with the team.	Yes
No MD ref	21/02/2025	Statement of General Ophthalmic Services Remuneration and Fee Directions: 2025	<a href="#">Statement of general ophthalmic services remuneration and fee directions: 2025   GOV.WALES</a>	The statement provides for the normal general ophthalmic services payments and claims process.	Russell Caldicott, Executive Finance Director	Russell Caldicott, Executive Finance Director	No	25/02/2025 Forwarded to Russell Caldicott, cc Natalie 05/03/2025 Confirmation received from russell that no action required and information shared with the team.	Yes
WG25-02	21/02/2025	Directions to Local Health Boards as to the General Dental Services Statement of Financial Entitlements (Amendment) Directions 2025	<a href="#">The Directions to Local Health Boards as to the General Dental Services Statement of Financial Entitlements (Amendment) Directions 2025   GOV.WALES</a>	These directions raise payments to dental foundation trainees and trainers for 2022 to 2023	Russell Caldicott, Executive Finance Director	Russell Caldicott, Executive Finance Director	No	25/02/2025 Forwarded to Russell Caldicott, cc Natalie 05/03/2025 Confirmation received from Russell that no action required and information shared with the team.	Yes
WG25-12	28/03/2025	The Wales Infected Blood Support Scheme (amendment) Directions 2025	<a href="https://www.gov.wales/wales-infected-blood-support-scheme-amendment-directions-2025">https://www.gov.wales/wales-infected-blood-support-scheme-amendment-directions-2025</a>	Directions provide amendments regarding annual payments for the financial year 2025-26.	Russell Caldicott, Executive Finance Director	Russell Caldicott, Executive Finance Director	Unknown	02/04/2025 Forwarded to Russell Caldicott. Awaiting update.	

<b>Teitl adroddiad:</b>	Response to Audit Enquiries Letter
<b>Report title:</b>	
<b>Adrodd i:</b>	Audit Committee
<b>Report to:</b>	
<b>Dyddiad y Cyfarfod:</b>	Thursday, 08 May 2025
<b>Date of Meeting:</b>	
<b>Crynodeb Gweithredol:</b>	The purpose of this report is :
<b>Executive Summary:</b>	<p><b>to provide the Audit Committee with the response to the Audit Enquiries letter</b></p> <p>The Auditor General’s <a href="#">Statement of Responsibilities</a> sets out that he is responsible for obtaining reasonable assurance that the financial statements taken as a whole are free from material misstatement, whether caused by fraud or error. It also sets out the respective responsibilities of auditors, management and those charged with governance.</p> <p>The letter formally seeks documented consideration and understanding on a number of governance areas that impact on Audit Wales audit of the Health Board’s financial statements. These considerations are relevant to both the management of Betsi Cadwaladr University Health Board and ‘those charged with governance’. (The Audit Committee)</p> <p>The areas of governance that they are seeking the Health Board views on are:</p> <ol style="list-style-type: none"> <li>1. Matters in relation to fraud</li> <li>2. Matters in relation to laws and regulations</li> <li>3. Matters in relation to related parties</li> </ol> <p>The information provided will inform their understanding of the Health Board and its business processes and support their work in providing an audit opinion on the 2024-25 financial statements.</p> <p>The ask from Audit Wales is to update the attached tables in Appendix 1 to Appendix 3. This has been drafted by the Directorate of Corporate Governance with support from Health Board Teams and overview from Executive Director of Finance. The response has been considered by the Executive Committee on 30 April 2025 and by the Chair of the Audit Committee via email following this.</p>
<b>Argymhellion:</b>	The Audit Committee is asked to;
<b>Recommendations:</b>	<ol style="list-style-type: none"> <li>1. <b>Note and endorse</b> the response to the Audit Enquiries Letter</li> </ol>

<b>Arweinydd Gweithredol:</b> <i>Executive Lead:</i>	Pam Wenger, Director of Corporate Governance			
<b>Awdur yr Adroddiad:</b> <i>Report Author:</i>	Phil Meakin, Associate Director of Governance			
<b>Pwrpas yr adroddiad:</b> <i>Purpose of report:</i>	I'w Nodi <i>For Noting</i> <input checked="" type="checkbox"/>	I Benderfynu arno <i>For Decision</i> <input type="checkbox"/>	Am sicrwydd <i>For Assurance</i> <input checked="" type="checkbox"/>	
<b>Lefel sicrwydd:</b> <i>Assurance level:</i>	<b>Arwyddocaol</b> <i>Significant</i> <input type="checkbox"/> Lefel uchel o hyder/tystiolaeth o ran darparu'r mecanweithiau / amcanion presennol  <i>High level of confidence/evidence in delivery of existing mechanisms/objectives</i>	<b>Derbyniol</b> <i>Acceptable</i> <input checked="" type="checkbox"/> Lefel gyffredinol o hyder/tystiolaeth o ran darparu'r mecanweithiau / amcanion presennol  <i>General confidence / evidence in delivery of existing mechanisms / objectives</i>	<b>Rhannol</b> <i>Partial</i> <input type="checkbox"/> Rhywfaint o hyder/tystiolaeth o ran darparu'r mecanweithiau / amcanion presennol  <i>Some confidence / evidence in delivery of existing mechanisms / objectives</i>	<b>Dim Sicrwydd</b> <i>No Assurance</i> <input type="checkbox"/> Dim hyder/tystiolaeth o ran y ddarpariaeth  <i>No confidence / evidence in delivery</i>
<b>Cyfiawnhad dros y gyfradd sicrwydd uchod. Lle bo sicrwydd 'Rhannol' neu 'Dim Sicrwydd' wedi'i nodi uchod, nodwch gamau i gyflawni sicrwydd 'Derbyniol' uchod, a'r terfyn amser ar gyfer cyflawni hyn:</b> <b><i>Justification for the above assurance rating. Where 'Partial' or 'No' assurance has been indicated above, please indicate steps to achieve 'Acceptable' assurance or above, and the timeframe for achieving this:N/A</i></b>				
<b>Cyswllt ag Amcan/Amcanion Strategol:</b> <i>Link to Strategic Objective(s):</i>	This work links to all strategic objectives of the Health Board as the Annual Governance Statement encompasses reporting of them all.			
<b>Goblygiadau rheoleiddio a lleol:</b> <i>Regulatory and legal implications:</i>	<p>It is essential that the Health Board is able to produce an Annual Report and Accounts that meets the requirements of Welsh Government and financial regulations</p> <p>The Health Board is required to act according to its Standing Orders. This report contains information to allow the Health Board to conform to this. It is essential that the Board has robust arrangements in place for Corporate Governance and failure to do so could have legal implications for the Health Board.</p>			
<b>Yn unol â WP7, a oedd EqIA yn angenrheidiol ac a gafodd ei gynnal?</b> <b><i>In accordance with WP7 has an EqIA been identified as necessary and undertaken?</i></b>	N/A			
<b>Yn unol â WP68, a oedd SEIA yn angenrheidiol ac a gafodd ei gynnal?</b> <b><i>In accordance with WP68, has an SEIA identified as necessary ben undertaken?</i></b>	N/A			
<b>Manylion am risgiau sy'n gysylltiedig â phwnc a chwmpas y papur hwn, gan</b>	The nature of this paper has an impact on the way the Annual Report and Accounts are reported and managed in the Health Board.			

<p><b>gynnwys risgiau newydd (croesgyfeirio at y BAF a'r CRR)</b></p> <p><i>Details of risks associated with the subject and scope of this paper, including new risks( cross reference to the BAF and CRR)</i></p>	
<p><b>Goblygiadau ariannol o ganlyniad i roi'r argymhellion ar waith</b></p> <p><i>Financial implications as a result of implementing the recommendations</i></p>	<p>The effective and efficient management of governance and finance has the potential to leverage a positive financial dividend for the Health Board through better integration of risk management into business planning, decision-making and in shaping how care is delivered to our patients thus leading to enhanced quality, less waste and no claims.</p>
<p><b>Goblygiadau gweithlu o ganlyniad i roi'r argymhellion ar waith</b></p> <p><i>Workforce implications as a result of implementing the recommendations</i></p>	<p>N/A</p>
<p><b>Adborth, ymateb a chrynodeb dilynol ar ôl ymgynghori</b></p> <p><i>Feedback, response, and follow up summary following consultation</i></p>	<p>N/A</p>
<p><b>Cysylltiadau â risgiau BAF:</b> (neu gysylltiadau â'r Gofrestr Risg Gorfforaethol)</p> <p><i>Links to BAF risks: (or links to the Corporate Risk Register)</i></p>	<p>BAF 24-01 – Not fully building and effective and accountable organisation</p>
<p><b>Rheswm dros gyflwyno adroddiad i fwrdd cyfrinachol (lle bo'n berthnasol)</b></p> <p><i>Reason for submission of report to confidential board (where relevant)</i></p>	<p>.</p>
<p><b>Camau Nesaf:</b> <b>Next Steps:</b></p> <ol style="list-style-type: none"> <li>1. To confirm that the Audit Committee has noted and endorsed the Audit Enquiries letter response with Audit Wales</li> </ol>	
<p><b>Rhestr o Atodiadau:</b> <b>List of Appendices:</b></p> <p>Appendix 1 - Response to the Audit Enquiries Letter</p>	



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Pam Wenger, Director of Corporate Governance  
Russell Caldicott, Interim Executive Director of Finance  
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St Asaph  
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**Reference:** AW/BCUHB/AEL/2024-25

**Date issued:** 20/03/2025

Dear Pam & Russell,

### **Audit enquiries to those charged with governance and management**

The Auditor General's Statement of Responsibilities sets out that he is responsible for obtaining reasonable assurance that the financial statements taken as a whole are free from material misstatement, whether caused by fraud or error. It also sets out the respective responsibilities of auditors, management and those charged with governance.

This letter formally seeks documented consideration and understanding on a number of governance areas that impact on our audit of your financial statements. These considerations are relevant to both the management of Betsi Cadwaladr University Health Board and 'those charged with governance'.

I have set out below the areas of governance on which I am seeking your views:

1. Matters in relation to fraud

Audit enquiries to those charges with governance and management. Please contact us in Welsh or English / cysylltwch â ni'n Gymraeg neu'n Saesneg.

2. Matters in relation to laws and regulations
3. Matters in relation to related parties

The information you provide will inform our understanding of the Health Board and its business processes and support our work in providing an audit opinion on your 2024-25 financial statements.

I would be grateful if you could update the attached table in [Appendix 1 to Appendix 3](#) for 2024-25. I have provided a copy of the responses you made for 2023-24 for your reference.

The completed [Appendix 1 to Appendix 3](#) should be formally considered and communicated to us on behalf of both management and those charged with governance by **30 April 2025**. In the meantime, if you have queries, please contact me on 02920 320660 or [Michelle.Phoenix@audit.wales](mailto:Michelle.Phoenix@audit.wales).

Yours sincerely



Michelle Phoenix

Audit Manager

## Appendix 1

### Matters in relation to fraud

International Standard for Auditing (UK) 240 covers auditors' responsibilities relating to fraud in an audit of financial statements.

The primary responsibility to prevent and detect fraud rests with both management and 'those charged with governance', which for the Health Board is the Audit Committee. Management, with the oversight of those charged with governance, should ensure there is a strong emphasis on fraud prevention and deterrence and create a culture of honest and ethical behaviour, reinforced by active oversight by those charged with governance.

As external auditors, we are responsible for obtaining reasonable assurance that the financial statements are free from material misstatement due to fraud or error. We are required to maintain professional scepticism throughout the audit, considering the potential for management override of controls.

### What are we required to do?

As part of our risk assessment procedures we are required to consider the risks of material misstatement due to fraud. This includes understanding the arrangements management has put in place in respect of fraud risks. The ISA views fraud as either:

- The intentional misappropriation of assets (cash, property, etc); or
- The intentional manipulation or misstatement of the financial statements.

We also need to understand how those charged with governance exercises oversight of management's processes. We are also required to make enquiries of both management and those charged with governance as to their knowledge of any actual, suspected or alleged fraud, management's process for identifying and responding to the risks and the internal controls established to mitigate them.

## Enquiries of management – in relation to fraud

Question	2024-25 Response
<p>1. What is management's assessment of the risk that the financial statements may be materially misstated due to fraud? What is the nature, extent and frequency of management's assessment?</p>	<p>The Auditor General for Wales issued an unqualified true and fair opinion on the Health Board's 2023-24 accounts (a clean bill of health). However, a qualified regularity opinion for 2023-24 was issued in regards to:</p> <ul style="list-style-type: none"><li>• Not attaining the key financial duty to break-even for three years</li><li>• Payment to an interim Executive member of the Board above delegated limits.</li></ul> <p>Audit Wales 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</p> <p>Audit Wales stated the balance sheet closing position for 2023/24 represented a true and fair view (clean bill of health) management's assessment is that material risk of misstatement in the 2023/24 financial statements due to fraud is <b>low</b> for the following reasons:</p> <ul style="list-style-type: none"><li>• Principal assurance provided through conduct and performance of a professional finance function, design and implementation of extensive financial systems providing Health Board's financial data</li><li>• The financial systems have been designed to satisfy the requirements of the Standing Orders, Scheme of Delegation, Standing Financial Instructions and BCU Finance policies and procedures</li><li>• Financial statements compiled from information from the financial systems, which comply with requirements of the relevant accounting concepts and conventions, International Accounting Standards, Welsh Government Manual of Accounts and HM Treasury's Financial Reporting Manual.</li><li>• The year-end financial statements are produced using the same data and transactions that have been used for management reporting and accounting throughout the year, including submissions to Welsh Government.</li></ul>

## Enquiries of management – in relation to fraud

Question	2024-25 Response
	<p>There is ongoing review and monitoring of the financial position throughout the 2024/25 year. Reports are produced by senior members of the Finance Department and these are reviewed by the Finance Director and Executive Director of Finance. Regular Finance Reports are produced for the Performance, Finance and Information Governance Committee and Health Board.</p> <ul style="list-style-type: none"><li>• Internal Audit undertakes regular audits of key financial systems each year. A programme delivered in accordance with public sector internal audit standards by the NHS Wales Shared Services Partnership. The scope of this work is agreed with the Audit Committee and is focussed on significant risk areas and local improvement priorities;</li><li>• There is an active counter-fraud department. The Internal Audit report confirmed reasonable assurance.</li></ul> <p>Audit Wales completed a review of Effectiveness of Counter-Fraud Arrangements in the Wales Public Sector in September 2020, and identified that the Health Board demonstrates a commitment to counter-fraud, has suitable arrangements to support the prevention and detection of fraud and is able to respond appropriately where fraud occurs.</p> <p>Further, the Health Board has implemented recommendations made by Internal Audit, the Fraud e-learning module is included within the Health Board’s mandatory training for staff and fraud risk assessments used as a live resource, now integrated within the general risk management framework to ensure that these risks are appropriately managed and escalated as necessary.</p>

## Enquiries of management – in relation to fraud

Question	2024-25 Response
2. Do you have knowledge of any actual, suspected or alleged fraud affecting the audited body?	<p>The Health Board actively encourages officers to report suspected fraud and regularly undertakes fraud prevention activities, investigating suspected fraudulent activity in year. A total of 40 new cases were reported during 2024/25 with 35 cases under investigation concluded at close of the financial year. No cases had been transferred during the year to Counter Fraud Service Wales and the residual number of cases under investigation at the Health Board increased to 28. The outcome of these cases ranged from no fraud found to one instance where the potential value of the fraud is in the region of over £80k with a case file for CPS being prepared.</p> <p>A non-fraud loss of £12k had been reported in a concluded salary overpayment case now pursued through the debt recovery process in place. In addition, 242 fraud prevention activities were conducted including the publication of prevention and deterrence articles, newsletters and assistance in fraud proofing Health Board policies and procedures. The Local Counter Fraud, Bribery and Corruption policy had been updated and is implemented. None of the individual identified cases considered material relative to the Annual Accounts.</p> <p>All instances or referrals of actual, suspected or alleged fraud affecting the Health Board are investigated by the Health Board's Local Counter Fraud team. Investigations are recorded on the NHS Counter Fraud Authority (NHSCFA) Case Management System.</p> <p>All investigation outcomes, progress and sanctions are reviewed by the Head of the Counter Fraud Service Wales (CFSW) team. The Health Board provides a quarterly statistical return to CFSW which is used to collate the information for the Counter Fraud Steering Group and Welsh Government.</p>

## Enquiries of management – in relation to fraud

Question	2024-25 Response
	<p>All Counter Fraud work is reported both prospectively (agreeing the workplan) and retrospectively (reporting back quarterly and annually findings and progress against planned and new reactive activity) to the Audit Committee.</p>
<p>3. What is management's process for identifying and responding to the risks of fraud in the audited body, including any specific risks of fraud that management has identified or that have been brought to its attention?</p>	<p>The Health Board endorses policies and procedures designed to assure the Board on governance and fraud prevention. The policies and procedures reviewed by NHS Wales Internal Audit team and the Audit Committee (the Committee charged with governance) receiving independent assurances over the System of Internal Control in place throughout the Health Board.</p> <p>The Internal Audit function reports findings to the Audit Committee, engaging management to identify areas for improvement. Agreed actions are reviewed for completeness by the Audit Committee through oversight of the outstanding recommendations (Audit Committee recommendations tracker tool).</p> <p>A total of 27 audit reports were received by the Health Board during 2024/25, 23 from Internal Audit and 4 from Audit Wales, and these recommendations are being progressed, with updates provided at each Audit Committee.</p> <p>There has also been considerable work undertaken to review and approve historical internal and external audit recommendations for closure, and all historical recommendations are now closed. This resulted in the closure of 407 historical Internal Audit recommendations, and 227 External Audit recommendations.</p> <p>There is an active and dedicated Local Counter Fraud department within the Health Board. The team having access to wider technical expertise and intelligence available for tackling fraud across NHS Wales should that be required</p>

## Enquiries of management – in relation to fraud

Question	2024-25 Response
	<p>in individual cases. Transactions and balances most at risk of fraud are flagged in the reporting to Board and include:</p> <ul style="list-style-type: none"><li>• Recruitment, employment and payroll-related fraud (immaterial to the Annual Accounts)</li><li>• Potential conflicts and management of interests (in the context of good practice over procurement and other decision-making which can have a significant financial effect, and disclosure of related party transactions required in the Annual Accounts)</li><li>• Primary Care provider-related fraud (immaterial to Accounts)</li><li>• Patient fraud to avoid prescription charges and/or obtain NHS medication by deceit (immaterial to Accounts)</li><li>• Involving desirable assets, e.g., Cash, patient monies and valuables (immaterial to Accounts).</li></ul>
4. What classes of transactions, account balances and disclosures have you identified as most at risk of fraud?	<p>Transactions and balances most at risk of fraud are flagged in the reporting to Board and include:</p> <ul style="list-style-type: none"><li>• recruitment, employment and payroll-related fraud (immaterial to the Annual Accounts)</li><li>• potential conflicts and management of interests (in the context of good practice over procurement and other decision-making which can have a significant financial effect, and disclosure of related party transactions required in the Annual Accounts)</li><li>• Primary Care provider-related fraud (immaterial to Accounts)</li><li>• patient fraud to avoid prescription charges and/or obtain NHS medication by deceit (immaterial to Accounts)</li></ul>

## Enquiries of management – in relation to fraud

Question	2024-25 Response
	<ul style="list-style-type: none"><li>• and those involving desirable assets, e.g., cash, patient monies and valuables (immaterial to Accounts).</li></ul> <p>In relation to the management and disclosure of interests, all relevant staff are required to disclose interests and the offer/receipt of gifts and hospitality etc. The Health Board has a system 'Declare' for staff to record Declarations of Interest. The Audit Committee monitored uptake in 2024/25.</p> <p>Board and other members are required to declare any ongoing and ad-hoc potential conflicts of interest pertaining to any meeting agenda, and these are recorded in the minutes. Guidance issued to members requests officers make a declaration if uncertainty exists as to whether a declaration is required or not.</p> <p>The Health Board has an approved set of Standing Financial Instructions, Scheme of Delegation and Standing Orders to ensure processes are in place for appropriate decision-making. The Contract Award process involves a structured approach to evaluation, declarations of independence by evaluators and an independent sign off prior to contract award.</p> <p>The Health Board developed (in conjunction with Welsh Government) a specification and Commissioned an Independent Review into Contract Procurement Management in 2023. The findings put forward 24 actions (for the Health Board, NWSSP and WG). The HB has completing 19 of 24 actions, strengthening processes and compliance, training provided in conjunction with NWSSP and eWaiver System updates.</p> <p>Further work to embed Financial Policies and establish Local Contract Registers and embed Contract Management principles, is ongoing.</p>

## Enquiries of management – in relation to fraud

Question	2024-25 Response
5. Are you aware of any whistleblowing or complaints by potential whistle blowers? If so, what has been the audited body's response?	<p>The former and current Head of Local Counter Fraud for the Health Board are not aware of any whistleblowing disclosures made locally relating to fraud, bribery or corruption during 2024/25, which have been made under the provisions of Whistleblowing Legislation – the Public Interest Disclosure Act 1998 (PIDA).</p> <p>Finance colleagues from the Healthcare Contracting team had sought and were provided with advice from LCFS on PIDA and the interpretation of the whistleblowing policy against when complaints or concerns are raised by individuals.</p>
6. What is management's communication, if any, to those charged with governance regarding their processes for identifying and responding to risks of fraud?	<p>The Head of Local Counter Fraud meets regularly with the Executive Director of Finance on progress and operational matters. Access to meet and discuss in private fraud issues and risks with the Chair of the Audit Committee is in place. The Head of Local Counter Fraud also regularly meets with the Executive Director of Corporate Governance who is the Health Board's Counter Fraud Champion.</p> <p>An annual Local Counter Fraud Workplan is produced and endorsed by the Audit Committee. Regular progress reports on the Counter Fraud activities are produced and discussed at the Audit Committee and at the Board via the Audit Committee Chair's Assurance Report.</p>
7. What is management's communication, if any, to employees regarding their views on business practices and ethical behaviour?	<p>Health Board policies and related procedures are published on its intranet and are accessible to staff. These include the Anti-Fraud, Bribery and Corruption Policy that has been approved by the Audit Committee and is publicised and promoted in the electronic staff newsletter.</p>

## Enquiries of management – in relation to fraud

Question	2024-25 Response
	<p>Since April 2021, the Health Board has included Counter Fraud training in its Mandatory Training Programme for all staff, via the completion of a Counter Fraud eLearning module. The Health Board promotes the mandatory programme of Fraud Awareness training for staff. Also, from the 1st of October 2023 there is an additional e-learning competency in place, changing from a mandatory training package with No Renewal date to a 3-year cycle. BCU was the first Health Board in Wales to implement this.</p> <p>The Health Board publishes on its intranet, an Executive Counter Fraud message from the Chief Executive Officer, which draws attention the Health Board's stance on fraud and its specific policy on Local Counter Fraud, Bribery and Corruption.</p> <p>Also signposts route for staff to raise concerns with the counter fraud team. Staff are able to report fraud anonymously via the NHSCFA Protect Fraud and Corruption Reporting Line or an On-Line Fraud Reporting Tool and Local Counter Fraud messages are regularly included in staff payslips, with regular reports and news articles are also reported in the Health Board's electronic staff bulletins.</p>
8. For service organisations, have you reported any fraud to the user entity?	The Health Board does not operate as a service organisation.

## Enquiries of those charged with governance – in relation to fraud

Question	2024-25 Response
1. Do you have any knowledge of actual, suspected or alleged fraud affecting the audited body?	<p>In responding to this question, within my role of Audit Committee Chair I seek assurance from the evidence provided by management through the investigations undertaken by the Counter Fraud team.</p> <p>In addition, external assurance reports are provided by Audit Wales and Internal Audit and based on the completion of this work and reported findings and support the response given by management to the question asked.</p> <p>At time of writing this report, I am not aware of any actual, suspected or alleged fraud. In last year's report I did note that investigations continue into the matters raised by Ernst and Young. North Wales Police and Counter fraud services have concluded their investigations and found no matters of fraud.</p>
2. What is your assessment of the risk of fraud within the audited body, including those risks that are specific to the audited body's business sector?	<p>The Health Board has received the conclusions from the Structured Assessment 2024 by Audit Wales, with the assessment evidencing many improvements now enacted, not least the embedding of the Audit Committee (the Committee charged with governance). This was formally received by the Board in March 2025.</p> <p>During 2024-25 The Health Board has taken some steps to increase the oversight by the Audit Committee of Standards of Business Conduct, updating its Standards of Business Conduct Policy and clearly documenting the processes for staff to follow to declare interests and gifts, which it will communicate with staff across the organisation.</p>

## Enquiries of those charged with governance – in relation to fraud

Question	2024-25 Response
	<p>This work is a recognised priority for the Corporate Governance directorate and further work is scheduled into 2025-26 with progress to be overseen by the Audit Committee.</p> <p>Committee has met regularly throughout the 2024/25 financial year, and is operating in accordance with the HFMA good practice handbook, receiving information aligned to its business cycle.</p> <p>A key continuation for Committee has been the timely receipt of;</p> <ul style="list-style-type: none"><li>• Approval of the annual Local Counter Fraud Workplan</li><li>• Ability to review and amend the program of work within the financial year</li><li>• Annual report in the process of submission by the 31st of May 2025 deadline</li></ul> <p>I have continued to meet regularly with the Head of Local Counter Fraud Services for private 1 to 1 meeting throughout the year following the Committees re-instatement in 2023/24.</p> <p>In addition, the Audit Committee now receives a detailed conformance report, which details areas of non-compliance with Health Board Standing Financial Instructions, Scheme of Reservations and Delegations and Standing Orders.</p> <p>I would conclude by stating I align with management’s assessment as to their being a low risk of fraud within the audited body</p>

## Enquiries of those charged with governance – in relation to fraud

Question	2024-25 Response
<p>3. How do you exercise oversight of:</p> <ul style="list-style-type: none"><li>• management's processes for identifying and responding to the risk of fraud in the audited body, and</li><li>• the controls that management has established to mitigate these risks?</li></ul>	<p>I have remained Audit Chair for the 2024/25 financial year, and would reference statements made previously, in that;</p> <ul style="list-style-type: none"><li>• The HB has an established counter fraud team that does remain visible throughout the organisation. Findings are reported regularly to members of the Audit Committee and private session of the Audit Chair.</li><li>• Audit Wales and Internal Audit have reported on assessments undertaken during the financial year, with reporting against prevention of these risks contained within the assessment and rating of reports presented to Audit Committee</li></ul> <p>The full review and endorsement with oversight of Welsh Government for implementation of revised Standing Orders, Scheme of Reservation and Delegation and Standing Orders, with conformance reporting undertaken by management and findings reported through to Audit Committee.</p> <p>In addition, the Audit Committee and Health Board have maintained oversight of the improvements made within the control environment, through examples of progress in the enhancement of and training in awareness of the enhanced controls. This has been evidenced through the conformance report, in that;</p> <ul style="list-style-type: none"><li>• Single Source Waivers have continued to reduce</li><li>• The number of invoices received without orders received has halved in 2024/25 when compared to a comparative period in 2023/24.</li></ul>



## **Appendix 2**

### **Matters in relation to laws and regulations**

International Standard for Auditing (UK and Ireland) 250 covers auditors' responsibilities to consider the impact of laws and regulations in an audit of financial statements.

Management, with the oversight of those charged with governance, is responsible for ensuring that the Health Board's operations are conducted in accordance with laws and regulations, including compliance with those that determine the reported amounts and disclosures in the financial statements.

As external auditors, we are responsible for obtaining reasonable assurance that the financial statements are free from material misstatement due to fraud or error, taking into account the appropriate legal and regulatory framework. The ISA distinguishes two different categories of laws and regulations:

- laws and regulations that have a direct effect on determining material amounts and disclosures in the financial statements;
- other laws and regulations where compliance may be fundamental to the continuance of operations, or to avoid material penalties.

### **What are we required to do?**

As part of our risk assessment procedures we are required to make enquiries of management and those charged with governance as to whether the Health Board is in compliance with relevant laws and regulations. Where we become aware of information of non-compliance or suspected non-compliance we need to gain an understanding of the non-compliance and the possible effect on the financial statements.

## Enquiries of management – in relation to laws and regulations

Question	2024-25 Response
<ul style="list-style-type: none"><li>Is the audited body in compliance with relevant laws and regulations? How have you gained assurance that all relevant laws and regulations have been complied with? Are there any policies or procedures in place?</li></ul>	<p>The Health Board's performance against its statutory financial duties is disclosed in the Annual Accounts that are subject to external Audit. The Health Board gaining assurance from the Health Board endorsed set of Standing Orders, Standing Financial Instructions and Scheme of Delegation to provide a business framework for ensuring the operation of services are within relevant legislative requirements, with additional policies and procedures produced to support delivery.</p> <p>Compliance over operation of, and adherence to, these policies and procedures is assured through independent review by the Internal Audit service reporting to the Audit Committee, Audit Committee Chair and Executive Director of Finance on findings. Action plans are agreed with key officers within the Health Board to strengthen areas as required, these findings are reported to Health Board members.</p> <p>The Health Board gains assurance over compliance with relevant law and regulations (both directly related to financial reporting and also more broadly from the perspective of the Health Board's medical/clinical/ healthcare business perspective) through a variety of sources. These include:</p> <ul style="list-style-type: none"><li>In 2024/25, a fully revised, detailed and comprehensive Financial Conformance Report was established and submitted to the Audit Committee.</li><li>An Annual Procurement Assurance Report is to be presented to the Audit Committee during 2024/25 including established systems within its departments, policies, self-assessments, network of groups and Executive performance and accountability reviews</li><li>internal and external audit reviews</li></ul>

## Enquiries of management – in relation to laws and regulations

Question	2024-25 Response
	<ul style="list-style-type: none"> <li>• feedback from inspections and external reports e.g., Health Inspectorate Wales, Royal Colleges and Llais Reports.</li> <li>• the Corporate Governance Office monitoring Board business to ensure compliance with Standing Orders (NHS Wales Act 2006)</li> </ul> <p>Introduction of a monitoring system in 2024/25 in relation to the progress against Ministerial Directions and Welsh Health Circulars. This process requires confirmation from the relevant Director that action has been taken to ensure compliance with the requirements.</p>
<ul style="list-style-type: none"> <li>• Have there been any instances of non-compliance or suspected non-compliance with relevant laws and regulations in the financial year, or earlier with an ongoing impact on this year's audited financial statements?</li> </ul>	<p>During 2024-25 the Health Board received formal notice of prosecution by the Health and Safety Executive for failure to discharge a general health and safety duty to persons other than employees. The court hearing was held on 1<sup>st</sup> April 2025 with the Health Board being fined £0.3m. This was accounted for in the 2024-25 financial year and discharged in April 2025.</p> <p>The Health Board's year-end close down procedures include consideration of potential liabilities that are uncertain in nature, including formal litigation claims arising from alleged negligence (clinical and non-clinical).</p> <p>These are accounted for in accordance with the relevant reporting standard with losses being approved by the Audit Committee on a quarterly basis. The Health Board also follows national guidance in relation to the accounting for potential liabilities arising from retrospective claims for Funded Nursing Care and Continuing Healthcare.</p>

## Enquiries of management – in relation to laws and regulations

Question	2024-25 Response
<ul style="list-style-type: none"><li>Are there any potential litigations or claims that would affect the financial statements?</li></ul>	<p>The Health Board is aware that the Health and Safety Executive is undertaking a formal investigation following an inpatient suicide in December 2024. This investigation is in the early stages.</p> <p>The Health Board is in discussion with the Local Authority in regards to invoicing for section 117 care. However, the level debated sits below the materiality of the Health Board.</p>
<ul style="list-style-type: none"><li>Have there been any reports from other regulatory bodies, such as HM Revenues and Customs which indicate non-compliance?</li></ul>	<p>The Health Board did not have any non-compliance reports in 2024/25</p> <p>During the year HMRC assessed the Health Board as low risk on the basis of its track record of compliance with tax law and regulation as a major organisation.</p>
<ul style="list-style-type: none"><li>Are you aware of any non-compliance with laws and regulations within any service organisation since 1 April of the financial year?</li></ul>	<p>To be confirmed</p>

## Enquiries of those charged with governance – in relation to laws and regulations

Question	2024-25 Response
<p>1. Are you aware of any non-compliance with laws and regulations that may be expected to have a fundamental effect on the operations of the entity?</p>	<p>During 2024-25 the Health Board received formal notice of prosecution by the Health and Safety Executive for failure to discharge a general health and safety duty to persons other than employees. The court hearing was held on 1st April 2025 with the Health Board being fined £0.3m. This was accounted for in the 2024-25 financial year and discharged in April 2025.</p> <p>The Health Board set a deficit plan for 2024/25 of £19.8m which reduced to £8.6m following the receipt of additional in-year funding of £11.15m from Welsh Government to reflect the continuing pressures experienced. The final outturn (subject to Audit) totals a £7.6m deficit.</p> <p>Whilst the outturn will be below the control target of a £8.6m deficit for 2024/25, the Health Board will not achieve the regulatory requirement to break even over a three-year period (which for 2023/24 resulted in a regulatory qualification).</p> <p>The Health Board is not aware of any further non-compliance with relevant laws and regulations of a fundamental nature.</p>

## **Appendix 3**

### **Matters in relation to related parties**

International Standard for Auditing (UK) 550 covers auditors' responsibilities relating to related party relationships and transactions.

The nature of related party relationships and transactions may, in some circumstances, give rise to higher risks of material misstatement of the financial statements than transactions with unrelated parties.

Because related parties are not independent of each other, many financial reporting frameworks establish specific accounting and disclosure requirements for related party relationships, transactions and balances to enable users of the financial statements to understand their nature and actual or potential effects on the financial statements. An understanding of the entity's related party relationships and transactions is relevant to the auditor's evaluation of whether one or more fraud risk factors are present as required by ISA (UK and Ireland) 240, because fraud may be more easily committed through related parties.

### **What are we required to do?**

As part of our risk assessment procedures, we are required to perform audit procedures to identify, assess and respond to the risks of material misstatement arising from the entity's failure to appropriately account for or disclose related party relationships, transactions or balances in accordance with the requirements of the framework.

## Enquiries of management – in relation to related parties

Question	2024-25 Response
1. Have there been any changes to related parties from the prior year? If so, what is the identity of the related parties and the nature of those relationships? Confirm these have been disclosed to the auditor.	Yes.  Disclosable related parties, their nature and any changes are disclosed in the Annual Accounts.
2. What transactions have been entered into with related parties during the period? What is the purpose of these transactions? Confirm these have been disclosed to the auditor.	The notes to the 2024/25 Accounts disclose each declared interest and the value of the Health Board's transactions with those parties during the financial year.
3. What controls are in place to identify, account for and disclose related party transactions and relationships?	All staff have access to the forms for Declarations of Interest and offers of Gifts and Hospitality. An e-system 'Declare' is in place  During meetings, Board members are obliged to declare any ongoing and ad-hoc potential conflicts of interest pertaining to the Agenda as and when they arise, and these are recorded in the minutes. Whilst disclosure is the responsibility of individuals, examples of what might be considered relevant areas for disclosure are provided within the guidance and Board Members are advised that if in doubt to disclosure any potential interest.

## Enquiries of management – in relation to related parties

Question	2024-25 Response
	<p>The Health Board requires all Senior Managers and Finance Staff to disclose interests and to complete a declaration of interests form or use the 'Declare' electronic system, which records all relevant related parties.</p> <p>When preparing the Annual Accounts, the information disclosed for Executives and Independent Members is cross-referenced to known sources (Companies House and Charity Commission etc) to ensure completeness. Where individuals are identified with potential further disclosable interests these are approached individually by the Directorate of Corporate Governance and asked to confirm the relevant details. Registers of Directors' Interests are also uploaded to the Health Board's external web-site.</p>
<p>4. What controls are in place to authorise and approve significant transactions and arrangements:</p> <ul style="list-style-type: none"><li>• with related parties, and</li><li>• outside the normal course of business?</li></ul>	<p>Arrangements and Transactions with related parties, including significant and outside the normal course of business are subject to the requirements of the Health Board's Standing Orders, Standing Financial Instructions and Scheme of Reservation and Delegation of Powers.</p> <p>Where potential conflicts are identified, staff are expected to step aside from decision-making and their line-managers are required to put alternative arrangements in place. During meetings, Board members are obliged to declare any ongoing and ad-hoc potential conflicts of interest pertaining to the Agenda as and when they arise, and these are recorded in the minutes.</p>

## Enquiries of those charged with governance – in relation to related parties

Question	2024-25 Response
<p>5. How does the Audit Committee, in its role as those charged with governance, exercise oversight of management's processes to identify, authorise, approve, account for and disclose related party transactions and relationships?</p>	<p>The Audit Committee has sought and received updates from management on disclosures undertaken and training implemented throughout the 2024/25 financial year.</p> <p>In addition, members have received declarations of interest reporting through Committee, with the governance teams of the Health Board providing oversight and assurance in chasing up any subsequent declarations and approvals / appropriate authorisation and declarations.</p> <p>The Directorate of Corporate Governance produces a report indicating compliance with declarations of interest policy. This was reviewed throughout 2024/25 by members of Audit Committee, monitoring use and reinforcing use of the new system now in place.</p> <p>The Audit Committee will seek ongoing discussion of compliance with the Declarations of Interest policy throughout 2025/26.</p>



<b>Teitl adroddiad:</b> <i>Report title:</i>	Internal Audit Progress Report 18 February – 23 April 2025			
<b>Adrodd i:</b> <i>Report to:</i>	Audit Committee			
<b>Dyddiad y Cyfarfod:</b> <i>Date of Meeting:</i>	8 May 2025			
<b>Crynodeb Gweithredol:</b> <i>Executive Summary:</i>	<p><u>Progress report</u></p> <p>The progress report is produced in accordance with:</p> <ul style="list-style-type: none"> <li>the requirements as set out within the Public Sector Internal Audit Standards: Standard 2060 – Reporting to Senior Management.</li> <li>the Welsh Government NHS Wales Audit Committee Handbook – Section 4.5 Reviewing internal audit assignment reports.</li> </ul> <p>The progress report summarises four reviews finalised since the last Committee meeting in March 2025, with the recorded assurance as follows:</p> <ul style="list-style-type: none"> <li>Reasonable assurance – two</li> <li>Limited assurance – one</li> <li>Assurance rating not applied – one</li> </ul> <p>The report also includes information on draft reports issued and work in progress as well as a request for the Committee to approve an addition to the 2025/26 internal audit plan.</p>			
<b>Argymhellion:</b> <i>Recommendations:</i>	<p>The Committee is asked to:</p> <p><b>Progress report</b></p> <ul style="list-style-type: none"> <li>Receive the progress report.</li> </ul> <p><b>Plan</b></p> <ul style="list-style-type: none"> <li>Approve the addition of a review ‘<i>Contract management and procurement review – Digital, Data and Technology Directorate</i>’ to the 2025/26 Internal Audit Plan.</li> </ul>			
<b>Arweinydd Gweithredol:</b> <i>Executive Lead:</i>	Director of Corporate Governance			
<b>Awdur yr Adroddiad:</b> <i>Report Author:</i>	Dave Harries, Head of Internal Audit, CMIIA Nicola Jones, Deputy Head of Internal Audit, CMIIA			
<b>Pwrpas yr adroddiad:</b> <i>Purpose of report:</i>	I’w Nodi <i>For Noting</i> <input checked="" type="checkbox"/>	I Benderfynu arno <i>For Decision</i> <input checked="" type="checkbox"/>	Am sicrwydd <i>For Assurance</i> <input checked="" type="checkbox"/>	
<b>Lefel sicrwydd:</b> <i>Assurance level:</i>	<p>Arwyddocaol <i>Significant</i> <input type="checkbox"/></p> <p>Lefel uchel o hyder/tystiolaeth o ran darparu'r mecanweithiau / amcanion presennol</p> <p><i>High level of confidence/evidence in delivery of existing mechanisms/objectives</i></p>	<p>Derbyniol <i>Acceptable</i> <input type="checkbox"/></p> <p>Lefel gyffredinol o hyder/tystiolaeth o ran darparu'r mecanweithiau / amcanion presennol</p> <p><i>General confidence / evidence in delivery of</i></p>	<p>Rhannol <i>Partial</i> <input type="checkbox"/></p> <p>Rhywfaint o hyder/tystiolaeth o ran darparu'r mecanweithiau / amcanion presennol</p> <p><i>Some confidence / evidence in delivery of</i></p>	<p>Dim Sicrwydd <i>No Assurance</i> <input type="checkbox"/></p> <p>Dim hyder/tystiolaeth o ran y ddarpariaeth</p> <p><i>No confidence / evidence in delivery</i></p>

	existing mechanisms / objectives	existing mechanisms / objectives
<p><b>Cyfiawnhad dros y gyfradd sicrwydd uchod. Lle bo sicrwydd 'Rhannol' neu 'Dim Sicrwydd' wedi'i nodi uchod, nodwch gamau i gyflawni sicrwydd 'Derbyniol' uchod, a'r terfyn amser ar gyfer cyflawni hyn:</b></p> <p><b><i>Justification for the above assurance rating. Where 'Partial' or 'No' assurance has been indicated above, please indicate steps to achieve 'Acceptable' assurance or above, and the timeframe for achieving this:</i></b></p>		
<p>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.</p>		
<p><b>Cyswllt ag Amcan/Amcanion Strategol:</b></p> <p><b><i>Link to Strategic Objective(s):</i></b></p>	<p>N/A other than those relating to individual audit reviews / recommendations.</p>	
<p><b>Goblygiadau rheoleiddio a lleol:</b></p> <p><b><i>Regulatory and legal implications:</i></b></p>	<p>The progress report is required per the Welsh Government NHS Wales Audit Committee Handbook – Section 4.5 Reviewing internal audit assignment reports.</p>	
<p><b>Yn unol â WP7, a oedd EqlA yn angenrheidiol ac a gafodd ei gynnal?</b></p> <p><b><i>In accordance with WP7 has an EqlA been identified as necessary and undertaken?</i></b></p>	<p>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).</p>	
<p><b>Yn unol â WP68, a oedd SEIA yn angenrheidiol ac a gafodd ei gynnal?</b></p> <p><b><i>In accordance with WP68, has an SEIA identified as necessary been undertaken?</i></b></p>	<p>The Socio-Economic 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.</p>	
<p><b>Manylion am risgiau sy'n gysylltiedig â phwnc a chwmpas y papur hwn, gan gynnwys risgiau newydd (croesgyfeirio at y BAF a'r CRR)</b></p> <p><b><i>Details of risks associated with the subject and scope of this paper, including new risks (cross reference to the BAF and CRR)</i></b></p>	<p>N/A other than those relating to individual audit reviews/recommendations.</p>	
<p><b>Goblygiadau ariannol o ganlyniad i roi'r argymhellion ar waith</b></p> <p><b><i>Financial implications as a result of implementing the recommendations</i></b></p>	<p>The progress report may record issues/risks, identified as part of a specific review, which has financial implications for the Health Board.</p>	
<p><b>Goblygiadau gweithlu o ganlyniad i roi'r argymhellion ar waith</b></p> <p><b><i>Workforce implications as a result of implementing the recommendations</i></b></p>	<p>N/A other than those relating to individual audit reviews/recommendations.</p>	
<p><b>Adborth, ymateb a chrynodeb dilynol ar ôl ymgynghori</b></p> <p><b><i>Feedback, response, and follow up summary following consultation</i></b></p>	<p>The Progress Report is produced independently of management. The Progress report shared with the Director of Corporate Governance.</p>	

<p><b>Cysylltiadau â risgiau BAF:</b> (neu gysylltiadau â'r Gofrestr Risg Gorfforaethol)</p> <p><b>Links to BAF risks:</b> (or links to the Corporate Risk Register)</p>	<p>N/A other than those relating to individual audit reviews.</p>
<p><b>Rheswm dros gyflwyno adroddiad i fwrdd cyfrinachol (lle bo'n berthnasol)</b></p> <p><b>Reason for submission of report to confidential board (where relevant)</b></p>	<p>N/A</p>
<p><b>Camau Nesaf:</b> <b>Gweithredu argymhellion</b></p> <p><b>Next Steps:</b> <b>Implementation of recommendations</b></p> <p>The 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.</p>	
<p><b>Rhestr o Atodiadau:</b></p> <p><b>List of Appendices:</b></p> <ul style="list-style-type: none"> <li>• Appendix 1: Progress report</li> <li>• Appendix 2: Final Internal Audit Report – Clinical Audit</li> <li>• Appendix 3: Final Internal Audit Report – Contracted Patient Services – Quality and Safety arrangements – Follow up</li> </ul>	

# Internal Audit Progress Report

## Audit Committee

18 February to 23 April 2025

Betsi Cadwaladr University Health Board

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# Introduction

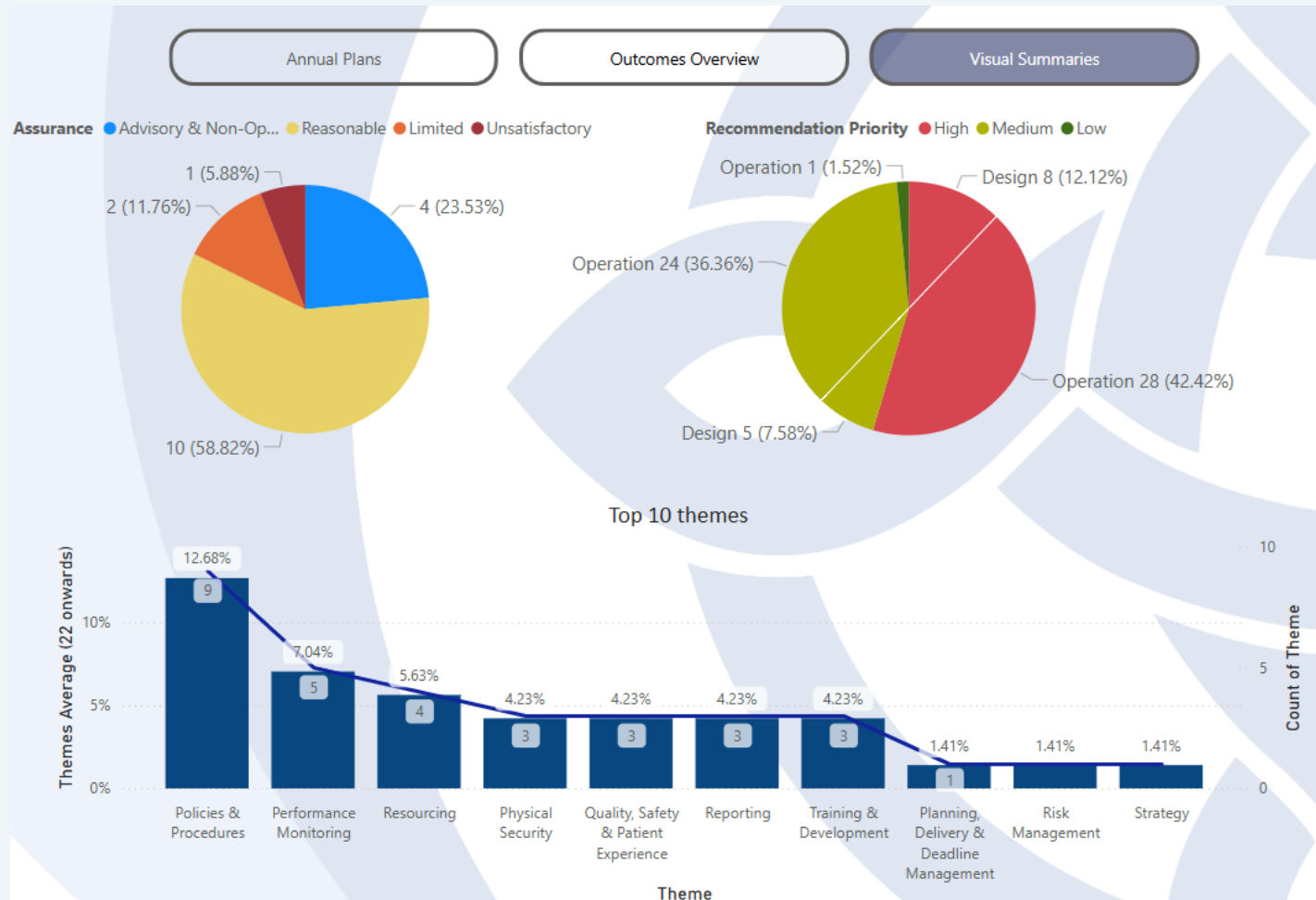
This progress report provides an update to the Audit Committee in respect of the assurances, key issues, and progress against the Internal Audit (IA) Plan for 2024/25.

# Reports Issued

Since the last progress report, four reviews have been issued as final.

The image below details final report ratings to date, recommendations by priority and themes identified. This shows the key themes of recommendations to date relate to policies & procedures, performance monitoring, and resourcing. Please refer to table 7 for theme definitions.

Image 1: Extract from the NHS Wales tracker for Betsi Cadwaladr University Health Board as of 23 April 2025 – 2024/25 overview



## Executive Summaries

Clinical Audit	BCU-2425-29	March 2025
Report opinion:	Limited	

### Purpose

To review operational compliance with Health Board Policy for Clinical Audit, review and sharing of audit findings and delivery of National (Tier 1), Organisational Priority (Tier 2) and Local (Tier 3) clinical audits.

### Overview

We have concluded limited assurance on this area. Whilst there has been progress in addressing issues with clinical audit since our previous reviews in 2022 and 2023, there are still several areas where further improvements are needed. The significant matters requiring management attention include:

- It is unclear how the Tier 2 clinical audit plan for the Health Board has been developed. The audits should be based on Health Board risks and priorities, however there is no formal assessment that has been undertaken that provides a rationale for the areas on the plan.
- There is a lack of evidence to demonstrate oversight and collation of data on lessons learnt and where these are shared, and in developing action plans to address areas of risk.
- A high percentage (75%) of Tier 3 audits have not been undertaken by the agreed completion date. Whilst the Clinical Effectiveness Team are starting to enquire about these, this is a recent process that has not yet resulted in an increase in compliance with audit completion.

Full details of matters arising are detailed within the Findings & Agreed Action Plan.

## Scope & Assurance Summary

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

Related Findings

Assurance

1	There is appropriate guidance and documentation in place for the undertaking of Clinical Audit within the Health Board.	1	<b>Reasonable</b>
2	There is an approved Clinical Audit Plan in place, which includes National (Tier 1) audits and Local (Tier 2) audits, and resource is identified to progress and complete audits.	2	<b>Limited</b>
3	Progress against delivery of the clinical audit plan is reviewed regularly by an appropriate forum.	-	<b>Reasonable</b>
4	Learning from clinical audits is documented in line with Health Board guidance and shared at appropriate forum(s) across the Health Board.	3,4,5	<b>Limited</b>
5	Local (Tier 3) audits are registered with the Clinical Effectiveness Team, are progressed in line with timescales stated, and appropriate documentation completed.	6	<b>Limited</b>

## Management Actions



High Priority



Medium Priority

## Themes

- Lessons Learnt
- Policies & Procedures
- Quality, Safety & Patient Experience

## Risk Types

- Quality or Safety Issues
- Legal & Regulatory Non-Compliance

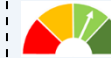
Board Assurance Framework and Risk Management

BCU-2425-21

April 2025

Report opinion:

Reasonable



### Purpose

To review the efficacy of the Health Board's Risk Management and Board Assurance processes.

### Overview

We have concluded reasonable assurance on this area. The significant matters requiring management attention include:

- No Level 1 risk management training is happening across the Health Board at the time of this review, although we recognise the plan to upload a training video to address this gap. There are no clear metrics available that determine the number of staff who require Level 2 and/or Level 3 risk management training, thus contributing to embedding the principles of risk management throughout the Health Board.
- The quality of operational risk registers continues to be an issue across some services - risk owners must take responsibility to address overdue risk review and target dates coupled with development of SMART action plans.

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 and are highlighted for management information:

- In October 2024, three operational workstreams subject to a risk audit were assessed as basic for their maturity profile. In March 2025 they remain at this level and Corporate Risk Management may wish to provide support to ensure these areas progress. [Objective 2]
- The Mental Health and Learning Disabilities Division have 50% of their live risks out of date – Corporate Risk Management and the responsible Executive Director may wish to provide focused support to ensure they address this. [Objective 2]
- Whilst noting a small number of BAF actions are recorded as 'delayed' due to funding, the lack of funding should not be used as a barrier to not progress mitigating actions; Corporate Risk Management may wish to consider a risk workshop with officers and Executive Directors to help identify and support progress of alternate actions to ensure the BAF risk does not materialise/is lessened. [Objective 3]

- The Corporate Risk Register (CRR) has many progressing actions noted although we found 34% have revised implementation dates which could undermine effective risk mitigation – Corporate Risk Management may wish to consider enhancing reporting to include a focus for the Risk Scrutiny Group/Committee on this area, with respective risk leads providing assurance as to alternative mitigation where dates prolong the action. [Objective 4]

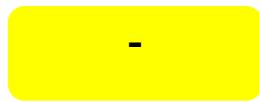
## Scope & Assurance Summary

Objectives	The objectives and associated assurance ratings are not necessarily given equal weighting when formulating the overall audit opinion.	Related Findings	Assurance
1	Risk Management and Assurance arrangements are defined within an up-to-date Strategy and Framework and associated procedures, aligned to the Health Board’s objectives and strategic direction. Procedures include guidance for the identification, classification, scoring and recording of risks throughout IHCs / directorates / divisions.	-	<b>Substantial</b>
2	Comprehensive risk registers are in place for IHCs / directorates / divisions, and are actively monitored and scrutinised, with effective escalation of risks.	-	<b>Reasonable</b>
3	Key operational risks from the IHC / directorate / division risk registers are escalated to the CRR and principal risks to the achievement of the Health Board’s strategic objectives are recorded in the BAF.	-	<b>Reasonable</b>
4	Processes are in place to support the monitoring and review of key risks and assurance mechanisms, including the CRR and BAF, across the Health Board, including at Committee and Board level.	-	<b>Substantial</b>
5	There is targeted risk management training available to staff throughout the Health Board, with completion / compliance monitored.	1	<b>Limited</b>
6	There has been progress in implementing the internal audit recommendations raised in the 2023/24 audit of Risk Management (BCUHB-2324-19).	2	<b>Reasonable</b>

### Management Actions



High Priority



Medium Priority

### Themes

- Training & Development
- Communication & Engagement
- Contractual

### Risk Types

Quality or Safety Issues

Discretionary Capital Funding Allocation	BCU-2425-08	April 2025
Report opinion:	Reasonable	

### Purpose

To assess the risk-based approach and scrutiny applied to the allocation of discretionary funds, and in addition where there is slippage or new funding, how this has been managed.

### Overview

We have concluded reasonable assurance on this area. The matters requiring management attention include:

- The 'Procedure Manual for Managing Capital Projects' and associated Addendum, were last updated in December 2020. Whilst not necessarily dedicated to Discretionary Capital, both require updating to reflect current working practices and changes in governance / Committee arrangements.
- Sample testing of approved business cases identified some that were lacking management and finance approvals. We are advised the business case template is under review, and the process has changed.
- From information provided, we have been unable to establish justification as to why some potential investments have taken priority over others.

## Scope & Assurance Summary

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

Related Findings

Assurance

1	There is a documented process in place for discretionary capital funding bids. This includes clear guidance on the timescales for submission of bids, and the information required by areas to support these.	1	<b>Reasonable</b>
2	A risk-based approach is taken to review, scrutinise and prioritise bids for funding.	2,3	<b>Limited</b>
3	Progress of the agreed capital programme is reviewed regularly. Where there is slippage or additional funding made available, changes to the plan are managed appropriately.	-	<b>Substantial</b>
4	There are effective governance arrangements in place for reporting on status, progress and issues relating to the capital programme.	-	<b>Substantial</b>

### Management Actions

### Themes

### Risk Types



High Priority



Medium Priority

■ Approvals

■ Finance Management & Control  
■ Policies & Procedures

Financial Loss

Legal & Regulatory Non-Compliance

Contracted Patient Services: Quality and Safety arrangements – Follow up

BCU-2425-

April 2025

Report opinion:

Not Applicable

## Purpose

The overall objective of this audit was to review implementation that the agreed management action has been applied to address risks identified and reported in the 2022/23 *Contracted Patient Services: Quality and Safety Arrangements (BCU-2223-19)* audit report which concluded unsatisfactory (no) assurance.

## Overview

None of the agreed actions have been closed as per table below:

	High	Medium	Low	<b>Total</b>
Closed	-	-	-	-
Partially Implemented	-	-	-	-
Outstanding	4	-	-	<b>4</b>
<b>Total</b>	<b>4</b>	-	-	<b>4</b>

Further details on each recommendation are provided below.

Our follow-up review has identified that both posts responsible for implementation of all the agreed actions are no longer present.

On 28 February 2025, we were advised that executive leadership for this review had transferred to the Director of Performance and Commissioning, however it must be noted that all agreed actions had implementation dates pre-dating the appointment of the Director and should, in our view, already have progressed.

In identifying a sample of contracts for review, of the fourteen NHS England providers the Health Board commissions services from directly, totalling £78,988,225 (excluding those services facilitated by the NHS Wales Joint Commissioning Committee) we were advised that seven (50%) had been signed by the provider and the Chief Executive/Director of Finance.

The delegation for signing all healthcare contracts is set out in the Scheme of Reservation and Delegation (SoRD) whereby the Health Board under the *Contracts between NHS Bodies (annual value)* delegation value states it must receive the "Initial contract schedule approved via annual budget approval process. New contracts /variations £1m+ to be retrospectively reported with £10m+ approved in advance". We have found no evidence the initial contract schedule has been presented to the Health Board in 2024/25 as part of the annual budget approval process or any subsequent presentation of this information for the Board to consider – consequently there is no delegated approval for Executive officers to sign and agree contracts on behalf of the Health Board.

We note the SoRD is subject to review as clarity is required surrounding *Delegated Matter 13a Primary Care Patient Services/ Healthcare Agreements* that state *Contract negotiation and provision of service agreements* is operationally delegated to *System Oversight* – we are unclear to what post(s) *System Oversight* refers.

## Work in Progress Summary

The following draft reports have been issued:

Table 1: Draft Reports issued

Review	Status	Date draft report issued	Date management response due
Standing Financial Instructions: Procurement	Draft report issued – awaiting management response.	24 March 2025	23 April 2025
Waiting List Initiative payments – IHC Centre	Draft report issued – awaiting management response.	2 April 2025	2 May 2025
Effective Governance: Cancer Services	Draft report issued – awaiting management response.	23 April 2025	22 May 2025

The following reviews are currently in progress:

Table 2: Reviews in progress

Review	Status	Draft report due
Effective Governance: Integrated Health Community – East	Fieldwork complete – file and report for QA.	April 2025
Partnerships, Engagement and Communications	Fieldwork complete – file and report for QA.	April 2025
Performance Management	Fieldwork complete – file and report for QA.	April 2025
Integrated Assurance and Approval Plans (IAAP): Llandudno Hospital Orthopaedic Hub	Fieldwork complete – file and report for QA.	April 2025

Review	Status	Draft report due
Duty of Quality	Fieldwork nearing completion.	April 2025
Standards of Business Conduct – Follow-up	Fieldwork nearing completion.	May 2025
Budgetary Control	Fieldwork nearing completion.	May 2025
Waste Management	Fieldwork nearing completion.	May 2025
Grievance Management	Fieldwork nearing completion.	May 2025
Falls Management – Follow-up (2025/26)	Fieldwork started.	May 2025
Contract management and procurement review – Digital, Data and Technology Directorate (2025/26)	Fieldwork started.	June/July 2025

## Follow-up

The Corporate Governance Directorate provide Internal Audit with details of actions agreed as closed by Executives and provide relevant evidence to support closure. We have not received or reviewed specific follow-up actions this reporting period except for those reviews identified in the plan.

Table 3 below provides a summary of the number of recommendations reviewed by Internal Audit during 2024/25. These are classified as closed if there is sufficient evidence to support closure; partially closed if there is some progress / evidence; and outstanding if there is either no evidence provided or evidence does not support closure.

Table 3: Summary of follow-up reviewed in 2024/25

Date recommendations provided to Internal Audit	Total number of recommendations reviewed	Closed	Partially Closed	Outstanding
17 May 2024	47	29 (62%)	11 (23%)	7 (15%)
21 June 2024	21	7 (33%)	5 (24%)	9 (43%)
17 September 2024	28	13 (46%)	7 (25%)	8 (29%)

Date recommendations provided to Internal Audit	Total number of recommendations reviewed	Closed	Partially Closed	Outstanding
3 January 2025	49	16 (33%)	22 (45%)	11 (22%)
<b>TOTAL</b>	<b>145</b>	<b>65 (45%)</b>	<b>45 (31%)</b>	<b>35 (24%)</b>

## Contingency/Health Board support/Advice

Internal Audit supports the Health Board through providing advice and guidance on areas of control, new systems, and processes.

We meet regularly with Audit Wales to discuss recent issues and areas of emerging risks to the Health Board.

We attend and observe the Risk Scrutiny Group and Executive Policy Oversight Group in this reporting period coupled with observing Health Board Committees.

## Delivering the plan

The additional support provided to the Health Board with focused reviews is channelled through contingency. As new risks are identified in year, the Director of Corporate Governance and Internal Audit will consider the planned reviews against the emerging high-level risks.

The Audit Committee is requested to agree to the following changes to the audit plan:

Table 4: Changes to the internal audit plan 2025/26

Review Title	Reason for requesting deferral/removal from plan/adding to the plan
Contract management and procurement review – Digital, Data and Technology Directorate	<p>We have been advised of a risk relating to the procurement of digital contracts. Internal Audit have been requested by the Executive Director of Finance and Director of Corporate Governance to undertake a review to ensure compliance with Standing Financial Instructions regarding procurement and contract management within the Digital, Data and Technology Directorate (DDaT).</p> <p><b>Recommendation: This review is added to the internal audit plan for 2025/26</b></p>

The following tables detail the planned performance indicators (Table 5) captured by Internal Audit in delivering the service and the planned delivery of the core internal audit plan (Table 6).

Table 5 is reporting a positive status across all indicators. Figures are based on seventeen reports issued as final for 2024/25.

Table 5: Performance Indicators

Indicator	Status	Actual	Target	Red	Amber	Green
Report turnaround: time from fieldwork completion to draft reporting [10 days]	Green	95%	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	88%	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 6: 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 – September)	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
Value Based Healthcare	June / July 2024	Final report issued.	Reasonable
Discretionary Capital Funding Allocation (previously Capital Business Cases)	July / August 2024	Final report issued.	Reasonable
Corporate Legislative Compliance: Health and Social Care (Quality and Engagement) (Wales) Act 2020 (Duty of Candour and Duty of Quality) – Duty of Quality	March / April 2025	Review in progress.	

Planned output	Outline timing	Status	Assurance (including draft report assurance opinions)
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	Final report issued.	Reasonable
Standards of Business Conduct - Declarations of interest, gifts, and hospitality – Follow up	February / March 2025	Review in progress.	
Follow-Up of Internal Audit recommendations (October - March)	October 2024 – March 2025	Completed – reported through progress report.	Not applicable
Contracted Patient Services: Quality and Safety arrangements - Follow up (Deferred from 2023/24)	February 2025	Final report issued.	Not applicable
Performance Management Framework & Reporting	January / February 2025	Review in progress.	
Partnerships, Engagement and Communications	January / February 2025	Review in progress.	
Budgetary Control & Financial reporting	February / March 2025	Review in progress.	
Standing Financial Instructions – Procurement	December 2024 / January 2025	Draft report issued.	Reasonable
Clinical Audit	December 2024 / January 2025	Final report issued.	Limited

Planned output	Outline timing	Status	Assurance (including draft report assurance opinions)
Effective Governance: Integrated Health Community – East	January / February 2025	Review in progress.	
Effective Governance: Cancer Services	December 2024 / January 2025	Draft report issued.	Limited
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	Review in progress.	
Waiting List Initiative – IHC Centre	December 2024 / January 2025	Draft report issued.	Limited
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 Contingencies Act 2004	June / July 2024	Deferred.	
Contracted Patient Services: Quality and Safety arrangements - Follow up (Deferred from 2023/24)	April to September 2024	Deferred.	

## Themes and definitions

Table 7 – Themes and Definitions assigned reviews as detailed in Image 1

Reference	Theme	Definition / Examples
1	Approvals	The internal control framework for securing approvals is ineffective.

Reference	Theme	Definition / Examples
		Appropriate approvals have not been sought/ obtained prior to key decisions.
2	Communication Engagement	<p>&amp; There is no clear communication strategy and/ or stakeholder identification arrangements.</p> <p>Information is not communicated clearly internally within teams, or externally with partners, for a or wider stakeholders.</p> <p>Lack of engagement with staff, partners and wider stakeholders. Engagement with external providers is not consistent, resulting in contracts or agreements not being monitored.</p>
3	Contractual	<p>The form of contract is not appropriate and does not adequately protect the interests of the organisation.</p> <p>Contractual documentation has not been executed in a timely manner.</p> <p>The contract is not being applied as intended.</p>
4	Cyber Security	<p>There is no strategy for maintaining cyber security and/ or it is deficient.</p> <p>The strategy/ plans are not implemented as intended and are therefore ineffective.</p>
5	Financial Management & Control	<p>Financial controls and management information requirements have not been properly considered.</p> <p>The financial controls or management arrangements are inadequate and/ or poorly applied, impacting the exposure to risk.</p>
6	Governance	<p>Inadequate / ineffective governance and oversight structures in place, which may include:</p> <ul style="list-style-type: none"> <li>• Absence of key roles and associated responsibilities to provide good governance.</li> <li>• Ineffective accountability and reporting structures with the absence of key scrutiny groups/ committees.</li> </ul> <p>General weaknesses in the internal control framework that are sufficient to impact the overall governance of the area audited.</p>
7	Information & Data Quality / Accuracy	<p>Systems, processes and procedures that support data accuracy/ quality are poorly designed or are not operating as intended, resulting in poor data quality.</p> <p>There is limited/ no guidance on the expected arrangements for data and information management.</p> <p>Insufficient records are maintained and/ or there are key gaps that would impact decision making.</p> <p>Information and/ or data is of an insufficient quality for monitoring, reporting and decision making.</p>

Reference	Theme	Definition / Examples
8	Lessons Learnt	<p>There are inadequate or no systems and processes in place to capture lessons learnt.</p> <p>Lessons learnt are not regularly shared/ reviewed within the organisation.</p> <p>There is clear evidence that the organisation has not learnt from prior experiences.</p>
9	Performance Monitoring	<p>There are no/ limited systems in place to capture performance information.</p> <p>The systems are ineffective in capturing the required information to manage performance.</p> <p>Performance information is not monitored and/ or shared.</p> <p>Corrective action to address performance issues is not determined or is ineffective.</p>
10	Physical Security	<p>There is no strategy/ plan to maintain physical security.</p> <p>There is a lack of consideration of physical security needs (either current and/or future)</p>
11	Planning, Delivery & Deadline Management	<p>A lack of timescales or deadlines being set.</p> <p>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.</p>
12	Policies & Procedures	<p>There are no policies or procedures in place, or they are inadequate to manage the risk.</p> <p>Policies or procedures are overdue for review or do not reflect current operational and/or best practice.</p>
13	Reporting	<p>Reporting and escalation requirements not clearly defined, including what gets reported where and when.</p> <p>Defined reporting does not provide adequate information to support robust assurance, escalation and risk management.</p> <p>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.</p>
14	Resourcing	<p>Organisational planning and management approaches do not incorporate consideration of demand and capacity.</p> <p>Demand and capacity inadequately considered.</p> <p>Lack of proactive review of resource to deliver plans or business-as-usual activities.</p>

Reference	Theme	Definition / Examples
15	Risk Management	<p>Inadequate/ ineffective risk strategy, appetite and/or management arrangements.</p> <p>The approach to risk management and/ or arrangements applied are not operating as intended.</p>
16	Strategy	<p>An appropriate strategy has not been developed to outline the vision of the organisation.</p> <p>The strategy is not an effective tool in achieving organisational objectives.</p>
17	Training & Development	<p>There is no defined strategy for training and development.</p> <p>Training needs have not been identified.</p> <p>There is no plan in place to address identified training needs.</p>

# Appendix A

## Assurance Opinion

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

## Prioritisation of Findings

Priority	Explanation
<b>High</b>	Significant risk to achievement of a system objective OR evidence present of material loss, error, or misstatement. Poor system design OR widespread non-compliance.
<b>Medium</b>	Some risk to achievement of a system objective. Minor weakness in system design OR limited non-compliance.

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# Clinical Audit

## Final Internal Audit Report 2024/25

Betsi Cadwaladr University Health Board



Limited Assurance

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### Review Reference

BCU-2425-29

### Fieldwork

January 2025 – February 2025

### Executive Sign Off

March 2025

### Audit Committee

April 2025

### Executive Lead

Sreeman Andole, Interim Executive Medical Director

### Audit Team

Dave Harries, Head of Internal Audit  
Nicola Jones, Deputy Head of Internal Audit  
Patrick Williams, Principal Auditor

# Executive Summary

## Purpose

To review operational compliance with Health Board Policy for Clinical Audit, review and sharing of audit findings and delivery of National (Tier 1), Organisational Priority (Tier 2) and Local (Tier 3) clinical audits.

## Overview

We have concluded **limited** assurance on this area. Whilst there has been progress in addressing issues with clinical audit since our previous reviews in 2022 and 2023, there are still several areas where further improvements are needed. The significant matters requiring management attention include:

- It is unclear how the Tier 2 clinical audit plan for the Health Board has been developed. The audits should be based on Health Board risks and priorities, however there is no formal assessment that has been undertaken that provides a rationale for the areas on the plan.
- There is a lack of evidence to demonstrate oversight and collation of data on lessons learnt and where these are shared, and in developing action plans to address areas of risk.
- A high percentage (75%) of Tier 3 audits have not been undertaken by the agreed completion date. Whilst the Clinical Effectiveness Team are starting to enquire about these, this is a recent process that has not yet resulted in an increase in compliance with audit completion.

Full details of matters arising are detailed within the Findings & Agreed Action Plan.

## Scope & Assurance Summary

Objectives <small>The objectives and associated assurance ratings are not necessarily given equal weighting when formulating the overall audit opinion.</small>	Related Findings	Assurance
1 There is appropriate guidance and documentation in place for the undertaking of Clinical Audit within the Health Board.	1	<b>Reasonable</b>
2 There is an approved Clinical Audit Plan in place, which includes National (Tier 1) audits and Local (Tier 2) audits, and resource is identified to progress and complete audits.	2	<b>Limited</b>
3 Progress against delivery of the clinical audit plan is reviewed regularly by an appropriate forum.	-	<b>Reasonable</b>
4 Learning from clinical audits is documented in line with Health Board guidance and shared at appropriate forum(s) across the Health Board.	3,4,5	<b>Limited</b>
5 Local (Tier 3) audits are registered with the Clinical Effectiveness Team, are progressed in line with timescales stated, and appropriate documentation completed.	6	<b>Limited</b>

## Management Actions

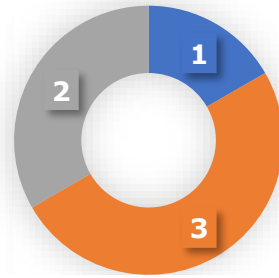


High Priority



Medium Priority

## Themes



- Lessons Learnt
- Policies & Procedures
- Quality, Safety & Patient Experience

## Risk Types

Quality or Safety Issues  
Legal & Regulatory Non-Compliance

# Findings & Agreed Action Plan

**Objective 1:** There is appropriate guidance and documentation in place for the undertaking of Clinical Audit within the Health Board.

**Reasonable**

The Clinical Audit intranet page on BetsiNet provides resource for staff, which includes materials such as policies, guidelines, training resources and annual reports. It also features Tier 1 publications of service assessments related to national compliance findings, Tier 2 proformas, and Tier 3 guidance, which includes a registration tool and guidance for writing reports.

The Clinical Audit Policy & Procedure document (MD22) was reviewed and updated in July 2023 and is available on the intranet page; this sets out the process for undertaking clinical audits, encompassing the Welsh Government mandated audits (Tier 1), local priority audits based on Health Board priorities and risks (Tier 2) and arrangements in place for local (Tier 3) audits. Additionally, it includes roles and responsibilities, organisational structures and training information.

The policy states the Audit Committee is the approving committee for the annual audit plan. We are advised this is no longer the process and approval of the plan is via the Executive Quality Delivery Group (EQDG), with the plan and progress provided to the Quality, Safety & Experience (QSE) Committee. The Audit Committee terms of reference states the committee will "seek assurance on an overall Clinical Audit plan, its fitness for purpose and its delivery". This requirement is not reflected in the guidance.

Key Findings	Risk & Impact	Agreed Management Action
<p>1 <b>Guidance and documentation</b></p> <p>Section 7.3 of the MD22 - Clinical Audit Policy &amp; Procedure document does not accurately represent the current process for approval of the annual clinical audit plan. It states the Audit Committee are responsible for approval, however we are advised the Executive Quality Delivery Group approves the plan.</p> <p>The requirements for the Audit Committee to receive assurance on clinical audit are not reflected in the policy and procedure.</p>	<p>Procedures do not reflect the current process, which could lead the incorrect scrutiny and approval for the clinical audit plan.</p>	<p><b>Agreed Action:</b></p> <p>This has recently changed and has been confirmed that the principle is that the Executive Quality Deliver Group does the "approving" and Quality Safety Experience Committee does the "assuring". The policy will be reviewed and updated to reflect the recent changes in these procedures.</p> <p><b>Expected Evidence of Implementation:</b></p> <p>Revised policy clarifying roles and responsibilities in relation to approval of the plan and assurance provided to committees. <i>All completed and copied to Policies department changes approved for updating on Betsinet. (This has now been completed and revised policy approved and uploaded)</i></p>
<p><b>Theme:</b> Policies &amp; Procedures</p>	<p><b>Medium Priority</b></p> <p>Control Design</p>	<p><b>Officer: Head of Clinical Effectiveness</b> <b>Date: 14/3/2025</b></p>

**Objective 2:** There is an approved Clinical Audit Plan in place, which includes National (Tier 1) audits and Local (Tier 2) audits, and resource is identified to progress and complete audits.

**Limited**

The Annual Clinical Audit Plan was presented and approved at the Executive Quality Delivery Group (EQDG) on 10 June 2024. The Plan includes Tier 1 audits, presented for information and confirmation to the group, and Tier 2 audits for approval.

The Tier 1 audit plan for 2024/25 lists forty-five national programme audits that the Health Board is required to complete. A further five national audits were not included in the plan, as four were not applicable to the Health Board due to services being commissioned elsewhere, and one the Health Board is not participating in due to there being no service (Falls & Fragility Fractures Audit Programme (FFFAP): Fracture Liaison Service).

Each national audit requires a Health Board lead and project leads for each area (East, Central and West). Out of these forty-five national audits, 28 (62%) had a Health Board lead assigned, while 17 (38%) had not been appointed at the time of writing this report. All audits had area projects leads assigned.

The Tier 2 clinical audit plan includes nine audits, each with an appointed accountable lead. This is a reduction from previous years, we were advised that this is following scrutiny by the Head of Clinical Effectiveness and Deputy Executive Medical Director, which determined that many audits did not meet the necessary criteria (those considered necessary at a corporate level).

Six of the nine audits were carried over from the last year's plan, with the addition of three new audits. We were advised that the Clinical Effectiveness Team contacted those who completed Tier 2 audits the previous year to confirm if they were re-auditing the same areas this year (annual audits). We have not seen any evidence of a formal assessment or risk-based approach that justifies the rationale for these reviews or the other tier 2 audits included in the plan. We note the following, taken from the Strategic Clinical Effectiveness Group (SCEG) Chair's report dated 10 January 2025, to be presented at the Executive Quality Delivery Group on 10 February 2025. *'Tier 2 Audit plan for 2025/2026 needs to develop noting the continuous audits that remain on the plan and new Tier 2 audits identified from specific local risks, strategic interests and concerns. The Group were asked to consider these and come back to February meeting with recommendations that could be discussed further.'*

Key Findings	Risk & Impact	Agreed Management Action
<p>2 <b>Development of Tier 2 audit plan</b></p> <p>We have been unable to evidence standardised formal assessments being undertaken for the Tier 2 audit plan and it is unclear how the plan has been developed. The audits should be based on Health Board risks and priorities, however there is no formal assessment that has been undertaken that provides rationale for the areas on the plan. <i>This issue was also raised as a high priority within the 2022 audit review.</i></p>	<p>Tier 2 audits are not based on risks to the Health Board, resulting in an increased risk exposure, with resource not focused on areas required.</p>	<p><b>Agreed Action:</b> Through Strategic Clinical Effectiveness Group there has been process where the current Tier 2 audit was reviewed and discussions on which audits needed to be carried over into the new audit plan for 2025-2026. Also as noted above, the group was asked to consider and identify from specific local risk, strategic interest and concerns. In order to capture this a new table for the audit plan has been developed which will provide details needed to provide assurance of the rational.</p>

		<p><b>Expected Evidence of Implementation:</b></p> <p>Evidence that the 2025/26 Tier 2 clinical audit plan is based on an assessment of risks to the Health Board/priorities. This is being discussed further around risks and reasons for decisions made for those on the plan at Strategic Clinical Effectiveness meeting 11<sup>th</sup> March 2025, and will then go to EQDG in April for discussion and approval.</p>
<p><b>Theme:</b> Quality, Safety &amp; Patient Experience</p>	<p>Control Design</p>	<p><b>High Priority</b></p> <p><b>Officer: Head of Clinical Effectiveness</b></p> <p><b>Date: 11/4/2025</b></p>

**Objective 3:** Progress against delivery of the clinical audit plan is reviewed regularly by an appropriate forum. **Reasonable**

There is evidence of regular reporting on clinical audit activity to the Strategic Clinical effectiveness Group (SCEG), Executive Quality Delivery Group (EQDG) and Quality, Safety & Experience Committee (QSE).

The QSE receives assurance through an integrated quality report, which includes details on Tier one audits. Consideration should be given to including Tier two audits in the report, as these are necessary at a corporate level due to their risk profile or the need for improvement. We note that an update on the development of the Tier 2 audits is to be presented at the QSE on 20 February 2025.

As noted in Objective 1, the Audit Committee terms of reference states the committee will “seek assurance on an overall Clinical Audit plan, its fitness for purpose and its delivery”. There has not been regular reporting of the Clinical Audit Plan and progress to the Audit Committee. *A key finding relating to this is raised in objective 1.*

The progression of Tier 1, 2, and 3 audits is monitored in detail through quarterly and annual reports. These reports ensure accountability and provide any necessary assistance to meet agreed timelines. They are submitted to the SCEG for discussion and review, as well as the EQDG.

Monthly clinical effectiveness assurance reports are also provided to the Integrated Health Communities (IHCs) and services, outlining the achievements as well as issues relating to participation, named leads and completion of the service assessment of compliance proformas.

Tier 1

Service Assessment of Compliance (SAoC) proformas are required to be completed for Tier 1 audits, which capture details of National Audit findings, recommendations, local continuous quality improvement, and where the data was shared within the service. The forms are to be returned within 8 weeks of the audit date of publication.

As of January 6, 2025, 40 SAoCs should have been completed. A review of data provided by the clinical effectiveness team shows that 72.5% have been completed or are going through the approval process, with 27.5% yet to be completed.

We reviewed three of the twelve completed audits to verify that the forms were fully completed and submitted correctly. All three audits had been returned and had the necessary approvals.

Escalation emails are to be sent to the Clinical Directors and Integrated Health Community (IHC) Medical Directors for overdue forms. We reviewed a sample of overdue audits to confirm whether emails were sent. An email was sent for one audit; however, no emails were sent for the other two audits.

The Audit Management and Tracking database (AMaT) has been implemented across the Health Board and now includes the monitoring process for all Tier 1 audits. Additionally, it is used for three selected Tier 2 audits to collate information required for the audits. Evidence was provided showing the entry of the SAoC data into the system and the creation of action plans for each audit. Weekly emails are sent to the owners of overdue actions; however, we are advised that there is no process / escalation where the owner does not respond to these emails.

Tier 2

While we observed monitoring and updates on Tier 2 audits being presented to the SCEG and EQDG within the organisational structure, we have not been able to demonstrate oversight in collecting data on lessons learned/shared and developing action plans to address issues.

Tier 3

Tier 3 audits are recorded via an E-Tool on the intranet site. We reviewed ten out of 95 completed audits from 2024 to verify that completed audit reports were uploaded. All audits reviewed had completed reports, which includes details on performance, outcomes, and learning, as well as information on how these would or have been shared within the departments.

Key Findings	Risk & Impact	Agreed Management Action
<p>3 <b>Overdue Service Assessment of Compliance proformas</b> We were unable to observe evidence of escalation emails for overdue SAoCs being sent for two of the three overdue audits we sampled.</p>	<p>Non-compliance with requirements for National mandated audits.</p>	<p><b>Agreed Action:</b> The Clinical Effectiveness Facilitator (CEF) will as part of the SOP ensure the following will be required:                      * Evidence of email escalations to be saved to the project folder by the CEF team and an update of the SOP to ensure this is part of the process                      * Schedule regular departmental audits of project folders to confirm that evidence is there – on quarterly basis to be captured with reports produced                      * Document evidence of escalations in The Audit Management</p>

			and Tracking (AMaT) to make the process transparent – this will show which areas have not replied and ensure that this information is captured by the CEF and monitored properly or escalated as necessary
			<b>Expected Evidence of Implementation:</b> Email evidence demonstrating overdue Service Assessment of Compliance proformas are being progressed. This has now been set up by the team and will be scheduled as part of our process from 1 <sup>st</sup> April 2025
		<b>Medium Priority</b>	<b>Officer: Head of Clinical Effectiveness</b> <b>Date: 1/4/2025</b>
	<b>Theme:</b> Policies & Procedures	Control Operation	
4	<b>Escalation process for overdue action plans</b> For Tier 1 audits, when an action becomes overdue, weekly reminder emails are sent to the action owner generated from the AMaT system. If the owner does not respond, there is no escalation process in place to ensure the action is completed.	Potential for non-compliance with regulatory standards.	<b>Agreed Action:</b> We will develop a process for this, to ensure that moving forward that progress is included with Tier 1 improvement actions and included in the Monthly Assurance report that is sent out to IHCs and Divisions. Need to ensure tighter controls are incorporated in our SOPs and that monitored on regular basis to raise and escalate with actions that are overdue
			<b>Expected Evidence of Implementation:</b> Evidence of escalation where owners have not responded to chaser emails for overdue actions, i.e. escalation process, emails. This is being developed now as part of our process and will be in place by 1 <sup>st</sup> April 2025
		<b>High Priority</b>	<b>Officer: Head of Clinical Effectiveness</b> <b>Date:1/4/2025</b>
	<b>Theme:</b> Policies & Procedures	Control Design	
5	<b>Lessons learnt shared to appropriate forum</b> We have not been able to demonstrate oversight in collecting data on lessons learned/shared and in developing action plans to address issues from Tier 2 audits.	Audit findings are not shared with relevant areas / staff, leading to ongoing inefficiencies and potential harm.	<b>Agreed Action:</b> Tier 2 audit details have been captured through Strategic CEG updates and within quarterly reports, however going forward there needs to be a more robust process, similar to Tier 1 and Tier 3. A form will be development to roll out from April 2025 to capture learning, where shared and development of actions plans.

		<p><b>Expected Evidence of Implementation:</b></p> <p>Evidence of information on lessons learnt form Tier 2 audits where this has been shared (Minutes of meetings, presentations etc.</p> <p>Action plans for Tier 2 audits. (Comparable to the Tier 1 procedure). Will be in place by 1<sup>st</sup> April 2025</p>
<p><b>Theme:</b> Lessons Learnt</p>	<p>Control Operation</p>	<p><b>High Priority</b></p> <p><b>Officer: Head of Clinical Effectiveness</b></p> <p><b>Date: 1/4/2025</b></p>

**Objective 5:** Local (Tier 3) audits are registered with the Clinical Effectiveness Team, are progressed in line with timescales stated, and appropriate documentation completed. **Limited**

Tier 3 audits are registered via the online E-tool available on the clinical audit intranet page. There are mandatory fields that are required to be completed before audits can progress, including related guidance (i.e. NICE guidance), associated risks, project description and details of where findings and results will be presented.

We were provided with details of Tier 3 audits registered between April 2024 and December 2024.

Table 1 Tier 3 registered audits

Total April – December 2024	Complete	Ongoing	Withdrawn
340	95 (27.5%)	243 (71.5%)	2 (0.6%)

Of the 243 ongoing Tier 3 audits, 183 (75.3%) were overdue based on the proposed completion dates. It is recognised by the team that a large number of audits are overdue, and they have recently implemented a new process of contacting areas by email to confirm the reasons for overdue audits, proposed completion dates and the completion of conclusion and impact forms. We are not yet able to determine whether this will have an impact on the overall completion figures going forward.

Tier 3 Local audit registrations and activity are discussed within the monthly clinical effectiveness assurance reports that are also sent to the IHCs and services, as well being monitored through the SCEG and EQDG.

Following a completed audit, the team request a 'conclusion and impact' form, allowing them to better understand the assurance gained and risks identified from this project as well as the learning and where it has been shared. As stated in objective 4 above, all completed audits had submitted the required documentation.

Key Findings	Risk & Impact	Agreed Management Action
6 <b>Overdue Tier 3 audits</b>	Tier 3 audits are completed in the	<b>Agreed Action:</b> Prior to the internal audit, we had already development and were getting these steps in place:

<p>A large number of Tier 3 audits (183) are overdue with no revised dates of completion.</p> <p>We recognise the clinical effectiveness team have introduced a process to improve completion rates, however Integrated Health Communities (IHCs) and Services are responsible for monitoring their Tier 3 audits, and ensuring the E-tool system is up to date with expected time scales.</p>	<p>appropriate timescale leading to ongoing inefficiencies and potential harm.</p>	<p>The Clinical Effectiveness Department emails auditors that have overdue projects, to ask them to update the e-tool (either with an updated completion date, mark as complete by uploading report or mark as abandoned).</p> <p>This has been agreed within the team that once this has been requested 3 times non-progress will be reported through departmental Clinical Effectiveness NICE/Audit Group (CENAG) and will then be raised within IHC/Divisions/Services</p> <p><b>Expected Evidence of Implementation:</b></p> <p>Reminder to IHCs and Services on their responsibilities relating to Tier 3 audits and the need to ensure timescales etc. are up to date in the E-tool system.</p> <p>Evidence that overdue audits have been followed up by the Clinical Effectiveness team i.e. through email or reporting and the impact this has made on completion rates (i.e. reduction in number of audits overdue). This is being rolled out and will be in place 1<sup>st</sup> April 2025</p>
<p><b>Theme:</b> Quality, Safety &amp; Patient Experience</p>	<p><b>High Priority</b></p> <p>Control Operation</p>	<p><b>Officer: Head of Clinical Effectiveness</b></p> <p><b>Date: 1/4/2025</b></p>

# Appendix A

## Assurance Opinion

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

## Prioritisation of Findings

Priority	Explanation
<b>High</b>	Significant risk to achievement of a system objective OR evidence present of material loss, error, or misstatement. Poor system design OR widespread non-compliance.
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# Follow-up: Contracted Patient Services: Quality and Safety Arrangements Final Internal Audit Report 2024/25

Betsi Cadwaladr University Health Board

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BCU-2425-24

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March 2025

**Executive Sign Off**

15 April 2025

**Audit Committee**

April 2025

**Executive Lead**

Stephen Powell, Director of Performance and Commissioning

**Audit Team**

Dave Harries, Head of Internal Audit  
Nicola Jones, Deputy Head of Internal Audit

# Executive Summary

## Purpose

This audit originates from the 2024/25 internal audit plan, agreed with management, and approved by the Audit Committee. The overall objective of this audit is to review implementation that the agreed management action has been applied to address risks identified and reported in the 2022/23 *Contracted Patient Services: Quality and Safety Arrangements (BCU-2223-19)* audit report which concluded unsatisfactory (no) assurance

## Overview

None of the agreed actions have been closed as per table below:

	High	Medium	Low	Total
Closed	-	-	-	-
Partially Implemented	-	-	-	-
Outstanding	4	-	-	4
<b>Total</b>	<b>4</b>	<b>-</b>	<b>-</b>	<b>4</b>

Further details on each recommendation are provided below.

Our follow-up review has identified that both posts responsible for implementation of all the agreed actions are no longer present.

On 28 February 2025, we were advised that executive leadership for this review had transferred to the Director of Performance and Commissioning, however it must be noted that all agreed actions had implementation dates pre-dating the appointment of the Director and should, in our view, already have progressed.

In identifying a sample of contracts for review, of the fourteen NHS England providers the Health Board commissions services from directly, totalling £78,988,225 (excluding those services facilitated by the NHS Wales Joint Commissioning Committee) we were advised that seven (50%) had been signed by the provider and the Chief Executive/Director of Finance.

The delegation for signing all healthcare contracts is set out in the Scheme of Reservation and Delegation (SoRD) whereby the Health Board under the *Contracts between NHS Bodies (annual value)* delegation value states it must receive the "Initial contract schedule approved via annual budget approval process. New contracts /variations £1m+ to be retrospectively reported with £10m+ approved in advance". We have found no evidence the initial contract schedule has been presented to the Health Board in 2024/25 as part of the annual budget approval process or any subsequent presentation of this information for the Board to consider – consequently there is no delegated approval for Executive officers to sign and agree contracts on behalf of the Health Board.

We note the SoRD is subject to review as clarity is required surrounding *Delegated Matter 13a Primary Care Patient Services/ Healthcare Agreements* that state *Contract negotiation and provision of service agreements* is operationally delegated to *System Oversight* – we are unclear to what post(s) *System Oversight* refers.

# Status of Previously Agreed Recommendation

Ref	Recommendation	Original Responsibility & Timescale	Priority Rating	Status, Updated Responsibility and Timescale
<b>1. Process Management</b>				
1.1	<p>Management establish robust overarching Commissioning Assurance Framework, Policy, or relevant Standard Operating Procedure (SOP) to support the healthcare commissioning / contracting process. This should ensure that lines of escalation, roles, responsibilities, and requirements regarding the management and oversight of the quality aspect of services provided are clearly defined.</p>	<p>Associate Director of Healthcare Contracting. Deputy Director of Quality. 31 August 2023</p>	<p><b>High</b></p>	<p><b>Not Implemented Finding</b></p> <p>We received a copy of a draft Commissioning Assurance Framework (CAF), dated July 2024, which was prepared by Healthcare Contracting leads, however this has not been progressed within the Health Board. This was due to the pending start date of a newly appointed Director of Performance and Commissioning.</p> <p>We met with officers from the Healthcare Contracting Team and Director of Performance and Commissioning (DP&amp;C) on the 18 March 2025 and were advised that:</p> <p>The DP&amp;C acknowledged receipt of the draft CAF from Healthcare contracting but had agreed that the focus in the immediate term was on planned care and whilst the review area was a risk for the Health Board, the long waits for patients was deemed a higher risk and priority.</p> <p>The DP&amp;C does not believe the development of the CAF is now the correct tool for the Health Board and contracted services should be subject to the same rigour as the Health Board's own services.</p> <p>The DP&amp;C stated that the intention is to amend the current Integrated Performance and Quality Framework and include a specific section on the expected standards and assurance for commissioned services. This will ensure that all contracted services will be subject to the same rigour and process as in-house provide care.</p>






Ref	Recommendation	Original Responsibility & Timescale	Priority Rating	Status, Updated Responsibility and Timescale
				<p><b>Revised Action, Responsibility and Timescale</b></p> <p>Recommendation accepted. The Director of Performance and Commissioning will ensure this is completed during Quarter 1 of 2025/26.</p>
<b>2. Contractual Obligations</b>				
2.1	<p>Management establish controls to ensure that all commissioned providers adhere to agreed contractual agreements and assess current contract review meeting arrangements to ensure appropriate levels of oversight and engagement.</p>	<p>Associate Director of Healthcare Contracting. Deputy Director of Quality. 31 August 2023</p>	<b>High</b>	<p><b>Not Implemented</b></p> <p><b>Finding</b></p> <p>We selected a sample of six NHS England providers with which the Health Board has contracts in place. A review of the Care Quality Commission (CQC) website has identified all six providers as amber rated <i>Requires Improvement</i>.</p> <p>We received evidence of regular meetings being held between the Health Board and the Countess of Chester NHS Foundation Trust (CoCH) but no evidence for the remaining five in our sample. Agenda items with the CoCH focus on finance and performance; we found no evidence that quality and safety issues were being shared by the CoCH or anyone with a quality remit attending from the Health Board.</p> <p>Through reviewing recent Board papers for the NHS England providers, we have noted matters relating to patient safety/quality being reported and are unsighted whether any of these relate to Health Board patients.</p> <p><b>Revised Action, Responsibility and Timescale</b></p> <p>Recommendation accepted. The Director of Performance and Commissioning will ensure this is completed during Quarter 1 of 2025/26.</p>
<b>3. Quality Measures</b>				

Ref	Recommendation	Original Responsibility & Timescale	Priority Rating	Status, Updated Responsibility and Timescale
3.1	Management to review contractual quality measures to ensure they are robust, effective, and appropriate.	Associate Director of Healthcare Contracting. 31 March 2024	High	<p><b>Not Implemented</b></p> <p>As noted in 2.1 above, a Commissioning Assurance Framework has not been implemented, and quality measures of contracts have not been reviewed.</p> <p><b>Revised Action, Responsibility and Timescale</b></p> <p>Recommendation accepted. The Director of Performance and Commissioning will ensure this is completed during Quarter 1 of 2025/26.</p>
3.2	Management to ensure procedures have provision for addressing and escalating quality issues that fall outside the agreed measures.	Associate Director of Healthcare Contracting. Deputy Director of Quality. 31 October 2023	High	<p><b>Not Implemented</b></p> <p>As noted in 2.1 above, a Commissioning Assurance Framework has not been implemented and procedures for addressing and escalating issues have not been developed (beyond those already in place during our previous review).</p> <p><b>Revised Action, Responsibility and Timescale</b></p> <p>Recommendation accepted. The Director of Performance and Commissioning will ensure this is completed during Quarter 1 of 2025/26.</p>
<b>4. Board Assurance</b>				
4.1	Management to review governance and reporting arrangements to ensure English NHS provider quality and performance data is subject to Health Board review and scrutiny.	Associate Director of Healthcare Contracting. Deputy Director of Quality. 31 October 2023	High	<p><b>Not Implemented</b></p> <p>We can find no evidence that a six-monthly report has been provided to the Quality, Safety and Experience Committee (QSE) as detailed within the agreed management response.</p> <p>We have found no reference to contracted services within the standard agenda item titled <i>Integrated Quality Report</i> presented by the Executive Director of Nursing and Midwifery to QSE.</p>

Ref	Recommendation	Original Responsibility & Timescale	Priority Rating	Status, Updated Responsibility and Timescale
				<p><b>Revised Action, Responsibility and Timescale</b></p> <p>Recommendation accepted. The Director of Performance and Commissioning will ensure this is completed during Quarter 1 of 2025/26.</p>

# Appendix A

## Assurance Opinion

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

## Prioritisation of Findings

Priority	Explanation
<b>High</b>	Significant risk to achievement of a system objective OR evidence present of material loss, error, or misstatement. Poor system design OR widespread non-compliance.
<b>Medium</b>	Some risk to achievement of a system objective. Minor weakness in system design OR limited non-compliance.

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



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

## Public Sector Internal Audit Standards

Audit work undertaken by NHS Wales Audit and Assurance Services conforms with the International Standards for the Professional Practice of Internal Auditing and associated Public Sector Internal Audit Standards as validated through the external quality assessment undertaken by the Chartered Institute of Public Finance & Accountancy in April 2023.



## Audit Committee Update – Betsi Cadwaladr University Health Board

Date issued: April 2025

Document reference: 4866A2025

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

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## About this document

- 1 This document provides the Audit Committee with an update on our current and planned accounts and performance audit work at Betsi Cadwaladr University Health Board. We presented our most recent Audit Plan to the committee on 3 March 2025.
- 2 We also provide additional information on:
  - Other relevant examinations and studies published by the Audit General.
  - Relevant corporate documents published by Audit Wales (e.g. fee schemes, annual plans, annual reports), as well as details of any consultations underway.
- 3 Details of future and past Good Practice Exchange (GPX) events are available on our [website](#).

## Accounts audit update

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

### Exhibit 1 – Accounts audit work

Area of work	Executive Lead	Focus of the work	Current status	Planned date for consideration
<b>Audit of Accounts 2024-25</b>	Russell Caldicott, Executive Director of Finance	We will follow the audit approach designed as part of our planning work and undertake appropriate audit testing to enable the Auditor General to provide his opinions on the financial statements of the Health Board.	Audit to commence 6 May 2025.	Audit Committee and Board June 2025.
<b>Audit of Awyr Las charity Accounts 2023-24</b>	Russell Caldicott, Executive Director of Finance	The audit of Awyr Las accounts is complete.  The Auditor General signed the audit opinion on 31 January 2025.	Complete	Not applicable

## Performance audit update

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

### Exhibit 2 – Performance audit work

Area of work	Executive Lead	Focus of the work	Current status	Planned date for consideration
<b>All Wales thematic work on Urgent and Emergency Care</b>	Chief Operating Officer	<p>This work examines different aspects of the urgent and emergency care system in three parts:</p> <ul style="list-style-type: none"> <li>• Part One: Flow out of hospital.</li> <li>• Part Two: accessing urgent and emergency care.</li> </ul>	Part One: Completed	July 2024
			Part Two: Report drafting	June 2025
<b>Planned Care</b>	Executive Medical Director	<p>This work will follow on from the national <a href="#">report on tackling the planned care backlog</a>. It considers:</p> <ul style="list-style-type: none"> <li>• The extent that health boards have achieved Welsh Government targets for recovering planned care services;</li> <li>• The efficacy of local plans and activity to recover waiting lists; and</li> <li>• Use of the additional Welsh Government financial allocations to improve waiting lists.</li> </ul>	Drafting	June 2025

Area of work	Executive Lead	Focus of the work	Current status	Planned date for consideration
<p><b>Use of the strategic financial assistance provided by the Welsh Government for the 3.5-year period October 2020 onwards</b></p>	<p>Executive Director of Finance and Corporate Resources</p>	<p>This audit will encompass a high-level examination of the Health Board's use of the additional £297m financial assistance provided by the Welsh Government as part of the targeted intervention package announced in October 2020.</p>	<p>Drafting</p>	<p>June 2025</p>
<p><b>Structured Assessment - deep dive review of investment in digital systems to support service resilience and transformation</b></p>	<p>Director of Digital Services</p>	<p>This audit will examine digital arrangements, with a particular focus on how NHS bodies are investing in digital technologies, solutions, and capabilities to support the workforce, transform patient care, meet demand, and improve productivity and efficiency.</p>	<p>Fieldwork</p>	<p>October 2025</p>

Area of work	Executive Lead	Focus of the work	Current status	Planned date for consideration
<b>Structured Assessment 2025 - core</b>	Director of Corporate Governance / Board Secretary	<p>This work will review the following core areas:</p> <ul style="list-style-type: none"> <li>• Board and committee effectiveness, cohesion, and transparency.</li> <li>• Corporate systems of assurance.</li> <li>• Corporate planning arrangements.</li> <li>• Corporate financial planning arrangements.</li> </ul> <p>This work will also seek to provide an update on the Health Board's progress in addressing audit recommendations made in previous structured assessment reports.</p>	Planning	October 2025
<b>Structured Assessment - deep dive review of the arrangements to manage estates</b>	Executive Director of Finance and Corporate Resources	<p>This work will examine the effectiveness of corporate arrangements to manage the Health Board's estate with a particular focus on how NHS bodies are prioritising resources to meet strategic priorities whilst also ensuring the current estate remains fit for purpose.</p>	Planning	December 2025
<b>Review of quality governance arrangements</b>	Executive Director of Nursing	<p>This audit will examine progress in addressing issues identified in previous audit work. The scope of the work will be</p>	Planning	October 2025

Area of work	Executive Lead	Focus of the work	Current status	Planned date for consideration
		determined during the audit planning process.		
<b>Thematic review of cancer services</b>	To be confirmed	<p>Following on from our recent review of the national leadership arrangements for cancer services, this work will consider:</p> <ul style="list-style-type: none"> <li>• The progress NHS bodies are making towards achieving Welsh Government targets and quality standards for cancer services;</li> <li>• The efficacy of local plans and associated actions to recover cancer waiting lists; and</li> <li>• Use of the additional Welsh Government financial allocations to improve cancer services.</li> </ul>	Not yet started	April 2026

## Other relevant publications

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

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

Title	Publication Date
<a href="#"><u>No time to lose: Lessons from our work under the Well-being of Future Generations Act</u></a>	April 2025
<a href="#"><u>The Biodiversity and Resilience of Ecosystems Duty</u></a>	March 2025
<a href="#"><u>Addressing workforce challenges in NHS Wales</u></a>	February 2025
<a href="#"><u>Cancer services in Wales</u></a>	January 2025

## Additional information

- 7 **Exhibit 4** provides information on corporate documents published by Audit Wales since the last committee update. Links to the documents on our website are provided. There are no relevant Audit Wales consultations currently underway.

### Exhibit 4 – Audit Wales corporate documents

Title	Publication Date
<a href="#"><u>Annual Plan 2025-26</u></a>	April 2025
<a href="#"><u>Fee Scheme</u></a>	January 2025

Title	Publication Date
<u>Audit Quality Report 2024: Strengthening trust in audit</u>	January 2025



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# Management response form

**Report title:** Cancer Services in Wales: A review of the strategic approach to improving the timeliness of diagnosis and treatment

**Completion date:** 14/01/25

Ref	Recommendation	Management response Please set out here relevant commentary on the planned actions in response to the recommendations	Completion date Please set out by when the planned actions will be complete	Responsible officer (title)
R1	The Welsh Government should publicly clarify the status of the Cancer Improvement Plan and its links to the National Cancer Recovery Programme and the Cancer: Improving Outcomes initiative. As part of this the Welsh Government should clarify how it intends to hold NHS bodies to account for delivery of the Cancer Improvement Plan.	Accept.  The Welsh Government will update the Quality Statement for Cancer to clarify the respective roles of the Cancer Recovery Programme, Cancer improvement Plan, and other important national work streams such as the Making it Happen initiative. This will include a description of accountability arrangements.	End quarter 1 2025-26	Sue Tranka  Chief Nursing Officer
R2	The Welsh Government should set out a coherent model for system leadership in respect of cancer services that clarifies its own role and that of the NHS Executive and sets out how it will bring on board clinicians and other key stakeholders to build a common view of	Accept.  The Welsh Government is in the process of finalising a revised governance and leadership model for cancer service development. This will include the introduction of a National Cancer Leadership Board	End quarter 4 2024-25	Nick Wood  Deputy Chief Executive, NHS Wales

Ref	Recommendation	<b>Management response</b> Please set out here relevant commentary on the planned actions in response to the recommendations	<b>Completion date</b> Please set out by when the planned actions will be complete	<b>Responsible officer (title)</b>
	cancer service performance, quality and opportunities for improvement.	that will coordinate or lead on national actions. The NHS Executive will provide the clinical, third sector, and private sector input to its work. This model will continue to develop in response to the feedback of those directly involved and those involved through related leadership groups. These arrangements will be described in the updated Quality Statement for Cancer.		
R3	The Welsh Government should review its oversight and performance framework in respect of cancer services to focus on a broader range of issues, including a more explicit alignment to the ambitions and quality attributes set out in the Quality Statement for Cancer.	Accept.  The NHS Performance Framework only includes the top-level strategic metrics for the NHS; it does not include all the metrics that are routinely applied in accountability processes. There are a broader set of metrics which sit outside the Framework. This includes component waits in the cancer pathway, access to treatment measures, data on care quality and outcome, screening and immunisation uptake, and patient outcomes. The broader set of metrics	End quarter 1 2025-26	Jeremy Griffith  Director of Operations

Ref	Recommendation	Management response Please set out here relevant commentary on the planned actions in response to the recommendations	Completion date Please set out by when the planned actions will be complete	Responsible officer (title)
		are used as part of routine accountability process as required. The updated Quality Statement for Cancer will include additional detail to explain how cancer service delivery will be measured.		
R4	The Welsh Government should develop a more coherent approach to population health improvement by setting out how it intends to use its Science Evidence Advice: NHS in 10+ Years to harness the opportunities associated with prevention to reduce the incidence of cancer and other major conditions.	<p>The Welsh Government pursues an evidence-led approach to prevention and to reducing population-level risk for cancer and major conditions. There are established programmes for smoking prevention through the Smoke Free Wales Strategy and Tobacco Control Delivery Plan (with additional supportive legislation imminent) and on tackling overweight and obesity, through the Healthy Weight Healthy Wales strategy and delivery plan, including through the facilitation of physical activity. These programmes are under constant review and development as new evidence and technologies emerge.</p> <p>The NHS Planning Framework for 2025-28 has population health and prevention as one of the five</p>	Establishment of preventing ill-health advisory group by end quarter 1 2025-26	<p>Sioned Rees</p> <p>Director for Public Health Protection</p>

Ref	Recommendation	<b>Management response</b> Please set out here relevant commentary on the planned actions in response to the recommendations	<b>Completion date</b> Please set out by when the planned actions will be complete	<b>Responsible officer (title)</b>
		<p>priority areas and this will support a further drive and focus on primary, secondary and tertiary prevention interventions in the plans of NHS organisations.</p> <p>We are also in the process of establishing a preventing ill-health advisory group under the Chief Medical Officer to support and harness opportunities to implement sustainable, evidence informed policies that focus on preventing ill-health and related inequalities. The initial focus will be on securing and measuring funding of ill-health prevention, strengthening the current architecture, progressing work on data, and supporting the cross-government role in prevention of ill-health. The establishment of this group will assist in providing sustained engagement and a coherent, coordinated approach to the development of appropriate policy and system responses.</p>		

Ref	Recommendation	Management response Please set out here relevant commentary on the planned actions in response to the recommendations	Completion date Please set out by when the planned actions will be complete	Responsible officer (title)
R5	The Welsh Government should work with Public Health Wales to accelerate decision making for a national lung screening programme. It should clarify as soon as possible whether it will fund national lung screening for Wales and the timescale for implementing such a programme.	Accept.  The Welsh Government has asked Public Health Wales to accelerate its work on scoping lung screening to permit a decision by Welsh Ministers on its introduction and funding. Public Health Wales is due to provide an interim report by end of March and a final report by end of September to permit Welsh Ministers to make a decision on introducing a national lung screening programme.	End quarter 2 2025-26	Sioned Rees  Director for Public Health Protection
R6	As part of a wider approach to encourage greater regional working between health boards, the Welsh Government and the NHS Executive should work with the service to understand and help address any key barriers to delivering regional services. This should include working with DHCW to identify digital solutions to support shared waiting lists for	Accept.  The Welsh Government will work with NHS organisations to support regional working for services, where appropriate, to address service fragility. This will include working with Digital Health and Care Wales on the development of digital solutions to permit shared waiting lists.	Ongoing	Mike Emery  Chief Digital Officer

Ref	Recommendation	Management response Please set out here relevant commentary on the planned actions in response to the recommendations	Completion date Please set out by when the planned actions will be complete	Responsible officer (title)
	cancer diagnosis and treatment, where it is appropriate to do so.			
R7	The Welsh Government should work with the NHS Executive, HEIW and other NHS bodies to ensure there are employment opportunities for radiologists who have been trained in the National Imaging Academy.	Accept.  The Welsh Government will work with health boards in Wales, which are responsible for planning their workforce, to enable employment of Imaging Academy graduates in line with local or regional workforce needs.	Quarter 2 2025-26	Helen Arthur  Director of Workforce and Government Business
R8	The Welsh Government should clarify national roles and responsibilities for monitoring and ensuring compliance with its data standards including how it will hold NHS bodies to account for poor compliance.	Accept.  Digital Health and Care Wales develop and design data standards, including minimum data sets for NHS Wales. DHCW advises the Welsh Government on what should be included and how they should be collected. Only the Welsh Government can mandate	Quarter 3 2025-26	Mike Emery  Chief Digital Officer

Ref	Recommendation	<b>Management response</b> Please set out here relevant commentary on the planned actions in response to the recommendations	<b>Completion date</b> Please set out by when the planned actions will be complete	<b>Responsible officer (title)</b>
		<p>requirements through national policy, planning guidance or Welsh Health Circulars. To ensure compliance, the Welsh Government expects organisations to audit themselves against the standards and DHCW to deliver a quality assurance and review process. Regulatory bodies such as Audit Wales and Healthcare Inspectorate Wales also have a role in auditing organisations against national standards. DHCW and regulatory bodies should report to the Welsh Government any significant failure to comply with national data requirements, so that these can be addressed with NHS organisations through accountability processes and meetings.</p>		
R9	<p>The Welsh Government should work with the NHS Executive (particularly the Cancer Network), DHCW and Public Health Wales NHS Trust to develop a more comprehensive set of publicly available data on cancer services, which as a minimum should include:</p>	<p>Accept in principle.</p> <p>The Welsh Government will develop a cancer data road map to improve the available data on cancer service delivery for use by the NHS, the Welsh Government, and the public. However, it may not be</p>	Quarter 3 2025-26	<p>Mike Emery</p> <p>Chief Digital Officer</p>

Ref	Recommendation	Management response Please set out here relevant commentary on the planned actions in response to the recommendations	Completion date Please set out by when the planned actions will be complete	Responsible officer (title)
	<ul style="list-style-type: none"> <li>• the number of people currently waiting for cancer diagnosis or treatment (open pathway data);</li> <li>• Performance against the 62-day target for the health board providing diagnosis and treatment and health board of residence, including people living Powys Teaching Health Board area;</li> <li>• Performance across the patient pathways including timeliness of diagnostic reporting across different tumour sites; timeliness from the decision to treat a patient to the start of that treatment (including surgery, radiotherapy and Systemic Anti-Cancer Therapy); and diagnosis and treatment of recurrent disease. Performance information should be provided at cancer sub-tumour level where possible;</li> <li>• Timeliness of diagnosis and treatment for patients referred from the breast and cervical screening programmes; and</li> </ul>	<p>possible to provide all of this data to the public for reasons of data accuracy, reporting burden on NHS services, and patient confidentiality. In addition, the barriers to providing data on treatment in England must first be understood before commitments can be made to publishing this data, but we support the principle of doing so, subject to their further analysis.</p>		

Ref	Recommendation	Management response Please set out here relevant commentary on the planned actions in response to the recommendations	Completion date Please set out by when the planned actions will be complete	Responsible officer (title)
	<ul style="list-style-type: none"> <li>accurate information on equity of access, including ethnicity of cancer patients as well as the experiences of different patient groups (this should include children and young people).</li> </ul>			
R10	The Welsh Government should work with DHCW and NHS England to share regular and consistent data on the timeliness of diagnosis and treatment for Welsh cancer patients treated by NHS England.	<p>Accept.</p> <p>The Welsh Government will work with health boards, NHS England, and Digital Health and Care Wales to ensure relevant data on the diagnosis and treatment of Welsh residents seen in England is appropriately shared.</p>	Quarter 4 2025-26	<p>Mike Emery</p> <p>Chief Digital Officer</p>



<b>Teitl adroddiad:</b> <i>Report title:</i>	Local Counter Fraud Service Q4 Report 2024/2025 - PUBLIC			
<b>Adrodd i:</b> <i>Report to:</i>	Audit Committee			
<b>Dyddiad y Cyfarfod:</b> <i>Date of Meeting:</i>	Thursday, 08 May 2025			
<b>Crynodeb Gweithredol:</b> <i>Executive Summary:</i>	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.			
<b>Argymhellion:</b> <i>Recommendations:</i>	The Audit Committee is asked to consider and note the contents of the Q4 report.			
<b>Arweinydd Gweithredol:</b> <i>Executive Lead:</i>	Mr. Russell Caldicott – Interim Executive Director of Finance			
<b>Awdur yr Adroddiad:</b> <i>Report Author:</i>	Ms Danielle Kerr-Timmins – Head of Local Counter Fraud Service			
<b>Pwrpas yr adroddiad:</b> <i>Purpose of report:</i>	I'w Nodi <i>For Noting</i> <input checked="" type="checkbox"/>	I Benderfynu arno <i>For Decision</i> <input type="checkbox"/>	Am sicrwydd <i>For Assurance</i> <input checked="" type="checkbox"/>	
<b>Lefel sicrwydd:</b> <i>Assurance level:</i>	Arwyddocaol <i>Significant</i> <input checked="" type="checkbox"/> <small>Lefel uchel o hyder/tystiolaeth o ran darparu'r mecanweithiau / amcanion presennol  <i>High level of confidence/evidence in delivery of existing mechanisms/objectives</i></small>	Derbyniol <i>Acceptable</i> <input type="checkbox"/> <small>Lefel gyffredinol o hyder/tystiolaeth o ran darparu'r mecanweithiau / amcanion presennol  <i>General confidence / evidence in delivery of existing mechanisms / objectives</i></small>	Rhannol <i>Partial</i> <input type="checkbox"/> <small>Rhywfaint o hyder/tystiolaeth o ran darparu'r mecanweithiau / amcanion presennol  <i>Some confidence / evidence in delivery of existing mechanisms / objectives</i></small>	Dim Sicrwydd <i>No Assurance</i> <input type="checkbox"/> <small>Dim hyder/tystiolaeth o ran y ddarpariaeth  <i>No confidence / evidence in delivery</i></small>
<b>Cyfiawnhad dros y gyfradd sicrwydd uchod. Lle bo sicrwydd 'Rhannol' neu 'Dim Sicrwydd' wedi'i nodi uchod, nodwch gamau i gyflawni sicrwydd 'Derbyniol' uchod, a'r terfyn amser ar gyfer cyflawni hyn:</b>  <b><i>Justification for the above assurance rating. Where 'Partial' or 'No' assurance has been indicated above, please indicate steps to achieve 'Acceptable' assurance or above, and the timeframe for achieving this:</i></b>				
<b>Cyswllt ag Amcan/Amcanion Strategol:</b> <i>Link to Strategic Objective(s):</i>	The previous Local Counter Fraud Service Workplan for 2024/25 was approved by the Audit Committee on 7 May 2024			
<b>Goblygiadau rheoleiddio a lleol:</b> <i>Regulatory and legal implications:</i>	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.
<p><b>Yn unol â WP7, a oedd EqIA yn angenrheidiol ac a gafodd ei gynnal?</b></p> <p><i>In accordance with WP7 has an EqIA been identified as necessary and undertaken?</i></p>	<p>No</p> <p>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.</p> <p><a href="#"><u>Gweithdrefn ar gyfer Asesu Effaith ar Gydraddoldeb WP7</u></a></p> <p><a href="#"><u>WP7 Procedure for Equality Impact Assessments</u></a></p>
<p><b>Yn unol â WP68, a oedd SEIA yn angenrheidiol ac a gafodd ei gynnal?</b></p> <p><i>In accordance with WP68, has an SEIA identified as necessary been undertaken?</i></p>	<p>No</p> <p>Socio-economic Impact Assessment is not required to be carried out, as this report does not deal with Health Board's strategic decisions.</p> <p><a href="#"><u>Gweithdrefn WP68 ar gyfer Asesu Effaith Economaidd-Gymdeithasol.</u></a></p> <p><a href="#"><u>WP68 Procedure for Socio-economic Impact Assessment.</u></a></p>
<p><b>Manylion am risgiau sy'n gysylltiedig â phwnc a chwmpas y papur hwn, gan gynnwys risgiau newydd (croesgyfeirio at y BAF a'r CRR)</b></p> <p><i>Details of risks associated with the subject and scope of this paper, including new risks( cross reference to the BAF and CRR)</i></p>	<p>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.</p>
<p><b>Goblygiadau ariannol o ganlyniad i roi'r argymhellion ar waith</b></p> <p><i>Financial implications as a result of implementing the recommendations</i></p>	<p>No recommendations</p>
<p><b>Goblygiadau gweithlu o ganlyniad i roi'r argymhellion ar waith</b></p> <p><i>Workforce implications as a result of implementing the recommendations</i></p>	<p>No recommendations</p>
<p><b>Adborth, ymateb a chrynodeb dilynol ar ôl ymgynghori</b></p> <p><i>Feedback, response, and follow up summary following consultation</i></p>	<p>The paper has been subject to Executive review and sign off.</p>
<p><b>Cysylltiadau â risgiau BAF:</b> (neu gysylltiadau â'r Gofrestr Risg Gorfforaethol)</p>	<p>1. Risk of significant financial loss due to Salary Overpayments (Risk Register 2601)</p>

<p><b>Links to BAF risks:</b> (or links to the Corporate Risk Register)</p>	<ol style="list-style-type: none"> <li>2. Potential Loss of income to Overseas Visitor Patients (Risk Register 3058)</li> <li>3. General Medical Services - Capitation /Patient Registration Fees (Risk register 3061)</li> <li>4. Pharmaceutical Fraud (Risk Register 3064)</li> <li>5. Private Patients (Risk Register 3060)</li> <li>6. Cyber Enabled Salary Diversion (Risk Register 4165)</li> <li>7. Continence Services (Risk Register 4170)</li> <li>8. Payroll Fraud – Misrepresentation of Qualifications, Skills and Experience (Risk Register 4171)</li> <li>9. Hospital Mortality Services (Risk Register 4172)</li> </ol>
<p><b>Rheswm dros gyflwyno adroddiad i fwrdd cyfrinachol (Ile bo'n berthnasol)</b></p> <p><b>Reason for submission of report to confidential board (where relevant)</b></p>	<p>N/A</p>
<p><b>Next Steps:</b></p> <p>The Committee is required to note the contents of the Q4 Local Counter Fraud Service Progress Report.</p>	
<p><b>List of Appendices:</b></p> <p>N/A</p>	

## **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, and any other relevant developments. The Committee is invited to review and note the contents of this report.

### **2. Updates**

#### **2.1 Cases**

	<b>Q3 24/25</b>	<b>Q4 24/25</b>
<b>Open Cases at close of Q</b>	38	22
<b>Ready for Closure at close of Q</b>	16	8

#### **2.2 Training**

Training is primarily delivered through e-learning modules, with workbooks available as an alternative for staff without computer access. This mandatory training must be renewed every three years, and compliance remains strong at 91.92%.

4 presentations were delivered to 78 staff members during the quarter.

#### **2.3 Policy**

The finalised F03 Counter Fraud, Bribery, and Corruption Policy is now available on Betsi Net. As part of the 2025/2026 Annual Workplan, a structured publication program will be implemented throughout the next financial year to promote awareness of the policy and clarify roles and responsibilities.

#### **2.4 Proactive Work**

- There were 18 media reports or news articles / fraud deterrence activities published in Q4.
- The Q4 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 managers, workforce colleagues and external Primary Care Contractors.

## 2.5 Annual Counter Fraud Staff Survey 2024/2025

In March 2025, the Annual Counter Fraud Survey was conducted to assess staff awareness of counter fraud practices, policies, and procedures. The survey also included questions on Declarations of Interest, Gifts, and Hospitality to meet Requirement 12 of the Counter Fraud Functional Standard Return, which received an Amber rating in 2023/2024. Notably, no survey was conducted in 2023/2024.

Although the response rate was low (64 responses), the overall results were positive.

Topic	% of respondents
Are aware that BCUHB has a Local Counter Fraud Team	91%
Understand what the BCUHB Local Counter Fraud Team do	73%
Know how to make contact with the BCUHB Counter Fraud Team	70%
Know that they can report suspicions of Fraud, Bribery or Corruption anonymously to NHS Counter Fraud Authority	80%
Have completed the Fraud Awareness E-Learning in the past 3 years	89%
Are aware of the Counter Fraud, Bribery and Corruption Policy	80%
Know what their responsibilities are according to the Counter Fraud, Bribery and Corruption Policy	77%
Know that BCUHB has a Standards of Business Conduct Policy	63%
Know their responsibilities are under the Standards of Business Conduct Policy	63%
Know how to find a Policy on Betsi Net if they want to read it	92%
Know whether they need to submit a Declaration of Interest	92%
Know when they needed to declare receiving a gift	80%

Insights from the survey will be used to shape publications and fraud clinics for the 2025/2026 financial year, aiming to enhance staff awareness. To assess the impact, the survey will be conducted again toward the end of the 2025/2026 financial year. Additionally, efforts will be made to broaden its reach, ensuring a more representative response.

## 2.6 Counter Fraud Functional Standard Return and Annual Report

The 2024/2025 submission for the Counter Fraud Functional Standard Return is now live until the 30<sup>th</sup> May 2025. The Counter Fraud Team are in the process of completing the self-assessment submission and the declaration will be signed by both the Executive Director of Finance and Chair of the Audit Committee prior to submission to ensure complete transparency.

The 2023/2024 submission for BCUHB received an overall Green rating, with eleven of the twelve requirements achieving a Green rating and one receiving an Amber rating. Early indications suggest that the 2024/2025 submission should also receive an overall Green rating, though it is likely that four of the twelve requirements will score amber or red.

NHS Counter Fraud Authority require that the full submission report is provided to the Audit Committee as part of the Local Counter Fraud Annual Report, therefore the Annual Report will be presented to the Committee on the 30<sup>th</sup> of June 2025.

## **2.7 Public website update**

Following concerns relating to ease of reporting of fraud within the Health Board for members of the public, work has been undertaken between the Counter Fraud Team and Corporate Communications to develop a reporting route guide for the BCUHB public website which is now live.

## **2.8 Other**

Graham Jones (Band 6 Local Counter Fraud Specialist) has formally submitted notice of his intention to retire, with his final working day being 15 May 2025. The Band 6 position will be advertised in due course. We extend our sincere thanks to Graham for his valuable contributions to the team and wish him all the very best in his retirement.

## **3. Budgetary / Financial Implications**

There are no budgetary implications associated with this paper.

## **4. 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



<b>Cyfarfod a dyddiad:</b> <b>Meeting and date:</b>	Audit Committee				
<b>Cyhoeddus neu Breifat:</b> <b>Public or Private:</b>	Public				
<b>Teitl yr Adroddiad</b> <b>Report Title:</b>	Summary of business considered in private session to be reported in public				
<b>Cyfarwyddwr Cyfrifol:</b> <b>Responsible Director:</b>	Pam Wenger, Director of Corporate Governance				
<b>Awdur yr Adroddiad</b> <b>Report Author:</b>	Philippa Peake-Jones, Head of Corporate Affairs				
<b>Craffu blaenorol:</b> <b>Prior Scrutiny:</b>	None				
<b>Atodiadau</b> <b>Appendices:</b>	None				
<b>Y/N to indicate whether the Equality/SED duty is applicable</b>					<b>N</b>
<b>Argymhelliad / Recommendation:</b>					
The Committee is asked to note the report.					
<b>Ar gyfer penderfyniad /cymeradwyaeth For Decision/ Approval</b>		<b>Ar gyfer Trafodaeth For Discussion</b>		<b>Ar gyfer sicrwydd For Assurance</b>	<b>Er gwybodaeth For Information</b> ✓
<b>Sefyllfa / Situation:</b>					
To report in public session on matters previously considered in private session.					
<b>Cefndir / Background:</b>					
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.					
<b>Asesiad / Assessment</b>					
The Committee considered the following matters in private session:					
<b>4 March 2025</b>					
<ul style="list-style-type: none"> <li>Local Counter Fraud Service Progress Report</li> <li>Job Planning as part of Consultant Contracts</li> </ul>					

### 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
04.03.25	Suggested as part of discussion at meeting 04.03.25	Pam Wenger	Standing Orders Reservation and Delegation of Powers	Full review of Standing Orders Reservation and Delegation of Powers	Philippa Peake-Jones	Pam Wenger	20.05.25 Private AC	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
12.09.24	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
31.03.25	Email from Danielle Timmins 31.03.25	Danielle Timmins	Counter Fraud Annual Report	Counter Fraud Annual Report to go to Audit Committee in June 25.	Danielle Timmins	Russ Caldicott	24.06.25	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
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	<b>CLOSED</b> Went to Comm in May 25
16.01.25	Action AC25/10.1 from Audit Committee	Audit Committee / Pam Wenger	Health Board Policies  Report on overdue policies (not WCDs)	An update on HB Policies and WCDs went to the January meeting. A report focussing on overdue policies to go to the Committee in April.	Glesni Driver	Pam Wenger	30.04.25	<b>CLOSED</b> Went to Comm in May 25
25.02.25	Discussion with PW and PPJ re: March 25 agenda	PW & PPJ	Annual Report Compliance with the Corporate Governance Code	PPJ agreed with PW to put this forward from March 25	Philippa Peake-Jones	Pam Wenger	30.04.25	<b>CLOSED</b> Went to Comm in May 25
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.	<ul style="list-style-type: none"> <li>Counter Fraud Policy to go to Committee.</li> <li>Draft Policy in development and being progressed by Head of Counter Fraud.</li> </ul> Action AC24/166.1 to be addressed in the policy.	Danielle Timmins	Russell Caldicott	04.03.25	<b>CLOSED</b> 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	<b>CLOSED</b> 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	<b>CLOSED</b> 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	<b>CLOSED</b> 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	<b>CLOSED</b> 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	<b>CLOSED</b> 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	<b>CLOSED</b> 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	<b>CLOSED</b> 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	<b>CLOSED</b> This is included on the AC Development Plan