Bundle Audit Committee 12 September 2024

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

Betsi Cadwaladr University Health Board (BCUHB)
==UNCONFIRMED== Minutes of the Extra Ordinary Audit Committee held in PUBLIC on 9 July 2024 via Teams

Committee Members Present	
Name	**Title**
Karen Balmer	Independent Member (Chair)
Dyfed Jones	Independent Member
Rhian Watcyn Jones	Independent Member
Urtha Felda	Independent Member
In Attendance	
Russell Caldicott	Interim Executive Director of Finance
Dyfed Edwards	Health Board Chairman
Carol Shillabeer	Chief Executive
Pam Wenger	Director of Corporate Governance
Andrea Hughes	Interim Finance Director, Operational Finance
Phil Meakin	Associate Director of Governance
Matt Edwards	Director – Financial Audit Lead, Audit Wales
Michelle Phoenix	Audit Lead, Audit Wales
Dave Harries	Head of Internal Audit
Nicola Jones	Deputy Head of Internal Audit
Simon Weaver	Head of Financial Control
Sjef Molmans	Local Counter Fraud Specialist
Committee Support	
Jody Evans	Corporate Governance Officer
Philippa Peake Jones	Head of Corporate Affairs

Agenda Item	Action
OPENING BUSINESS	
AC24.78 Welcome and apologies for absence **AC24.78.1** There were no Apologies received.	
AC24.79 Declarations of interest on current agenda **AC24.79.1** There were no declarations of interest received.	
AC24.80 - Financial Annual Accounts 2023/24 **AC24.80.1** The Interim Executive Director of Finance presented the Financial Annual Accounts for 2023/2024, highlighting the Health Board's statutory requirements for preparing and producing financial statements. It was noted that the draft accounts had been submitted to the previous Audit Committee and shared with Welsh Government and Audit Wales.	

AC24.80.2 The Interim Executive Director highlighted the deficit of 24 million in the 2023/2024 financial year. The Audit Committee noted the findings and unqualified audit opinion, and acknowledged the Health Board's first unqualified opinion since 2020/21. The Interim Executive Director informed the Committee of the fantastic result and expressed his sincere thanks to the Team (both internally and externally) for the work undertaken and production of the reports.

AC24.80.3 The Interim Executive Director also addressed the regulatory opinion and non-delivery of key financial duties within the 3-year plan to break even, whilst highlighting similar issues consistent across other Health Boards. The Director also referred to an appointment issue, which followed to the 2023/2024 period.

AC24.80.4 The approval process was explained to the Committee confirming that the accounts would be presented at the Extraordinary Health Board Session on the 19th July for approval, and presented to Welsh Government on the 15th July 2024.

AC24.80.5 The Interim Executive Director and Chair of the Audit Committee congratulated the Teams on their impressive achievement, and expressed gratitude to Audit Wales for their contributions.

AC24.80.6 The Chair of the committee opened up questions to the Committee Members.

AC24.80.6 An Independent Member (RWJ) expressed concern with regards to potential journalistic scrutiny, in relation to service provision. The Chief Executive then spoke about financial governance and controls, whilst acknowledging the disappointing carryover issue. Progress was also raised regarding rapid patient access within the short-term plan, highlighting both internal and external provisions.

AC24.80.7 The Chair requested clarification around the publication of the Accounts. The Director of Corporate Governance clarified that the *draft* accounts had been published in the public domain (as part of the draft process), and the support and preparation of the Communications Team was in place. The Committee discussed and predicted media interest. A discussion ensued and it was confirmed that the Director of Corporate Governance intended to provide support to the Communications Team in order to share the thoughts of the Committee.

PW

AC24.80.8 The Interim Executive Director highlighted the massive rate of positivity from the financial perspective, along with the credibility of the finance teams. The difficult period over the last two years was raised, and it was noted that the progress was to be built into external communications.

AC24.80.9 The Chair closed the item and thanked the Finance Team for the presentation.

AC24.80.10 RESOLVED

The Audit Committee recommend the Board approval of the 2023-24 Annual Accounts to the Health Board, following consideration of Audit Wales findings on their review of the Financial Statements.

AC24.82 - Response to Audit Enquiries Letter

AC24.82.1 The Interim Executive Director of Finance presented the Audit Enquiries Letter to the Committee, and provided a brief overview in relation to the focus and responses of the Health Board and Audit Committee Chair.

AC24.82.2 An Independent Member (UF) requested clarification concerning Welsh Risk Pool ongoing cases. The Interim Executive Director of Finance provided an overview of the Welsh Risk Pool (WRP) and the relationship with the Health Board, whilst clarifying that that WRP was underwritten, and further explained the threshold and cost consequences of the charge back proportions.

AC24.82.3 An Audit Wales Lead (MP) conveyed that the expectations had been in line with the review and feedback was adequately received.

RESOLVED
The Audit Committee noted the response to the Audit Enquires Letter and recommended the response detail to the Health Board.

AC24.83 - ISA 260 Audit of Financial Statements - Audit Wales

AC24.83.1 The ISA 260 Audit of Financial Statement was presented to the Committee. The Audit Wales Lead (MP) clarified the timeline and approval of the accounts, along with key improvements and standards of the collaborative work undertaken. Key elements and amendments were highlighted, in particular to thresholds and materiality, in relation to standard practices to specific areas of interest. Ethical standards were also highlighted, whilst drawing attention to the independence and objectivity regarding the mitigated risks and controls in place.

AC24.83.2 The Audit Wales Lead also commented on the considerations of the audit statement by the committee and forthcoming approval of the Board. It was noted of the Auditor General intention in issuing an unqualified statement. The HM Treasuries compliance and accordance was also highlighted, concerning the work undertaken.

AC24.83.3 The Financial duty to break even in relation to a 3 year plan was raised, along with a breach in standing financial instructions. It was clarified that the matters were included therein the report for the attention of the Auditor General and Senedd in further detail.

AC24.83.4 Attention was drawn to the amendments to appendices 4 and 5; whilst acknowledgement to the positivity of the report, and in particular the significant improvements to the quality of the draft statements. The Audit Lead

also made a comparison to the previous year, in terms of challenges and concerns relating to quality. The Audit Lead commended the Committee.

AC24.83.5 The Audit Lead also commented upon the progress and mapping of the financial statements and paid individual thanks to the Head of Financial Control for the support provided.

AC24.83.6 Significant improvement was acknowledged with regards to the quality of the remuneration report. The Committee noted the context in significant changes within the Health Board to date, whilst highlighting the updates made in appendix 5 of the report, along with some sensitivity issues. The recognition was made of the necessity to establish stronger governance arrangements regarding remuneration reporting.

AC24.83.7 An Audit Wales Lead (MP) also raised attention to appendix 4 and 5 amendments and in particular pay disclosures and benefits in relation to remuneration, pensions and salaries. It was raised that the updates and amendments had been brought in line with the requirements for the management of the accounts.

AC24.83.8 The Chair of the Committee requested clarification on the quality process of the report and the Chief Executive referred to the Director of Corporate Governance to update.

AC24.83.9 The Chief Executive also commented upon the challenges and ongoing work, in relation to remuneration, along with the open dialogue and discussions with Audit Wales and forthcoming improvements in relation to the complex and challenging environment. The Chief Executive also relayed her thanks for the work of Colleagues.

AC24.83.10 The Director of Corporate Governance echoed the detail expressed by the Chief Executive and provided an overview of the ongoing work with Audit Wales.

AC24.83.11 The Audit Wales Lead (MP) clarified the detail in relation to post project learning and sharing of reflections along with the commitment to the Health Board to address the issues identified going forwards.

AC24.83.12 The Chair of the Committee queried an inherited matter, in relation to clarification to an interim post in the previous financial year under the previous Board. The Audit Wales Lead (MP) clarified the payment dates and informed the Committee of the quantum payments. A discussion ensued. An IM (RWJ) also referred to an extension approval for the post. IM (UF) referred to preparation and planning going forwards, concerning support and conversations in relation to the remuneration committee. The Interim Executive Director of Finance referred to the irregularities, and that they occurred because of decisions taken, prior to the Health Boards move to Special Measures. It was noted that the issue had been highlight to the external Communications Team.

RESOLVED The Audit Committee noted the report and recommended the report to the Health Board.	
AC24.84 - Local Counter Fraud 2023/2024 Annual Report **AC24.84.1** The Interim Executive Lead introduced the report and informed the Committee of activities undertaken along with regular performance and proactive updates being received. **AC24.84.2** The Interim Director of Finance informed the Committee of the Team being within budget for the year, along with headlines of proactive and reactive work undertaken by the Counter Fraud Team, The Committee noted that the Counter Fraud Policy was also under review. The Committee also received an update on the positivity of the counter fraud standards return. The retirement of the Head of Counter Fraud was also noted, which was in the process of being recruited to. **AC24.84.3** It was confirmed that the Deputy Head of Local Counter Fraud had successfully completed the Data Analytics Course and had won an award, (which also included a member within the Finance Team). The Committee acknowledged the new skill set, which were to be utilised within a number of forthcoming projects. **AC24.84.4** The Committee acknowledged the significant engagement with staff, with regards to regular presentations, and sharing of fraud awareness articles. Shared working links were also reported upon, along with links to the Post Payment Verification Team. Details in relation to the Risk Management Teams involvement and ongoing/new referral cases were also shared in the report. **AC24.84.5** A refresh and update of the report template had also been confirmed, in relation to future Committee Reporting via public and private sessions. The Chair thanked and congratulated the Counter Fraud Team for the report. Questions were then invited. **AC24.84.6** An IM (RWJ) commented upon the huge amount of work undertaken and queried as to how the Health Board quantify financial savings. Whilst unable to clarify; it was reported that the Deputy Head of Local Counter Fraud Service had been in discussions with the Central Intelligence Team and referred to a new module being under development for future reporting. A discussion took place, in relation to financial savings and ongoing cost benefits. The Interim Executive Director of Finance also commented upon direct interventions along with recovery and reporting through to Committee Level. It was noted that continued fraud awareness was intended, along with ongoing consistent approaches and progress. **AC24.84.7** The Deputy Head of Local Counter Fraud Service also emphasised that the Health Board were the 1st in Wales to roll out a Mandatory Fraud Awareness eLearning Module and reported the positive steps to date. The	

Committee acknowledged and gave thanks to progress and update of the training module.

RESOLVED:
The Audit Committee considered and noted the Local Counter Fraud Annual Report for 2023/24.

AC24.85 - Head of Internal Audit Opinion and Annual Report 2023/2024

AC24.85.1 The Chief Executive and Accountable Officer opened the item and provided thanks to the Internal Audit Team, along with the flexibility and support provided throughout the year whilst noting the system of internal control and levels of considerable challenge therein the organisation. The Chief Executive also expressed and gave thanks to the recently appointed Director of Corporate Governance, whilst noting the systems, and process challenges that the Health Board had been faced with.

AC24.85.2 The Head of Internal Audit presented the report to the Committee, whilst commenting on areas and points of focus and confirmed a limited assurance opinion for the year 2023/2024.

AC24.85.3 The Committee were guided to the synopsis to the reviews and the assurances applied throughout the year. The deteriorating picture of compliance was presented. The similarities to other NHS organisations had been recognised, as the picture was not unique to BCUHB.

AC24.85.4 The Head of Internal Audit also drew attention to governance, risk, and regulatory compliance; in being the top risks areas along with quality and safety being under concern in relation to limited assurances. Noncompliance with regards to operational policies and procedures was also commented upon, along with controls and management of risks relating to achieving corporate objectives.

AC24.85.5 The Committee were assured that Internal Audit had complied with the public sector standards and clarification was received confirming of there being no impairment to independence in relation to any member of the Team. The Head of Internal Audit also confirmed access levels within the Health Board in the event of raising concerns (via the Accountable Officer, Chair of Audit Committee and Health Board Chair).

AC24.85.6 The Head of Internal Audit also commented upon Key Performance Indicators and a slight decline in relation to management report turnaround responses.

AC24.85.7 On behalf of the Internal Audit Team, the Head of Internal gave thanks to the Corporate Governance Directorate, Chair of the Audit Committee, Committee Members, Health Board Chair and all Executives for the ongoing support provided throughout 2023/2024.

AC24.85.8 The Chair thanked the Head of Internal Audit whilst acknowledging the detail and overview provided, in relation to the progress to date, and improvements concerning risk and regulatory compliance envisaged going forwards.	
AC24.85.9 The Director of Corporate Governance expressed her gratitude to the support of the Internal Audit Team, along with the complexities to the management of audit processes. It was confirmed that traction and delivery of improvements were being made, in relation to the update of internal and external recommendations identified via the Structured Assessment. It was noted that historic recommendations were also being reviewed to ensure all actions were adequately closed.	
AC24.85.10 The Interim Executive Director of Finance commented on the limited assurances, along with the reductions in compliance and referred to the processes in place, for tracking audit recommendations going forwards. Delivery and accountability was also raised.	
AC24.85.11 An IM (RWJ) requested that Internal Audit Reports be collated for IMs to view for ease in 1 location. It was confirmed by the Director of Corporate Governance that a system had recently been set up. The IM then referred to the Operating Model and tracking of recommendations, in relation to previous concerns raised with regards to tracking of updates.	
AC24.85.12 IM (UF) expressed the usefulness of the report, in relation to collating thoughts and discussions relating to audit tracking and assurances. The IM thanked the Head of Internal audit. The Chair then summarised the ongoing work of the Audit Committee and also in relation to management responses	
RESOLVED: The Audit Committee received the Head of Internal Audit opinion and annual report for 2023/24. The level of 'limited assurance' was reported, as anticipated. It was clarified that improvements to internal controls are a key priority for the Executive team.	
AC24.86 - Annual Report 2023/2024 **AC24.86.1** The Director of Corporate Governance presented the Annual Report 2023/2024, and explained that the 3 sections of the documentation which in combination, would provide the finalised report for submission to Audit Wales and Welsh Government. **AC24.86.2** The Committee were informed of the iterative process and thanks was given to the Associate Director of Governance (PM) and the wider team, in relation to the check and challenge compliance. **AC24.86.3** The Director of Corporate Governance referred to 3 minor updates to the report, which would be made prior to presentation to the Health Board. It was proposed to work with Audit Wales, to finalise the points, to address the specific issues raised.	**PW**

AC24.86.4 The Director of Corporate Governance expressed that the report was a true and fair position of the activities of the Health Board throughout the year, along with been compliant with the manual for accounts, as set by Welsh Government. The significant period of changes was noted by the Committee and was also noted as being reflected within the report.

AC24.86.5 Progress in relation to Special Measures was also highlighted along with ongoing work in relation to governance, risk and assurance.

AC24.86.6 The Limited Internal Audit Opinion was also noted therein the annual governance statement. Attention was also drawn to the Operating Model, along with specific areas of concern.

AC24.86.7 Audit Wales Reporting was also noted in relation to levels of assurances, within the period of challenge. The ongoing work to strengthen the corporate governance and assurances processes was highlighted. Breaches of statutory planning duties was also raised.

AC24.86.8 The Director of Corporate Governance then invited questions.

AC24.86.9 An IM (RWJ) commented upon the Chief Executives tone as being very appropriate within the report. A discussion took place and the IM also commented on the proof reading progress of the report. The Director of Corporate Governance confirmed that substantive proof reading had been undertaken.

AC24.86.10 The Chief Executive commented on the suggested improvements, in relation to report specifics and terminology, which would be included in future iterations.

AC24.86.11 An IM (UF) queried as to how the Committee linked to the Quality Safety Experience Committee in dealing with clinical audits. It was confirmed that the issues were to be dealt with via the Integrated Chairs Meeting. It was noted that the Director of Corporate Governance and IM would discuss outside of the meeting.

AC24.86.12 Statute requirements and obligations in reporting were also raised and the Director of Corporate Governance and Interim Executive Director provided the overview in terms of compliance with guidance and prescribed time frames. It was also noted that the Health Board Annual General Meeting (AGM) would receive a summary version of the report in September, along with the Communications Team providing an overview summary. Following a discussion, with regards to the AGM, it was also confirmed that the public were able to engage. The Chief Executive also expressed the importance of engagement and also referred to a recent stakeholders brief in relation to special measures which was very well received.

AC24.86.13 Subject to minor updates, the committee formally recorded that the committee; • Received and consider the Annual Report 2023-24, Part 1 and 2 and Annual Governance Statement. • Recommend to Board at its meeting on 10 July 2024 the approval and signature of the Annual Report and Financial Accounts for year ended 31st March 2024. **RESOLVED** Subject to minor updates, the committee; formally recorded, received and considered the Annual Report 2023-24, The Committee recommend to the Board the approval of the Report for onward submission to Welsh Government, following the incorporation of the accounts, subject to the Board approval.	
AC24.86 - Review of Meeting Effectiveness **AC24.86.1** The Members agreed that the meeting was informative and positive discussions arose.	
AC24.87 Date of next meeting **AC24.87.1** The Chair reiterated her thanks and commended the Finance Team and all involved in producing the reports taken at the Audit Committee Meeting. It was confirmed that the date of the next meeting would be Thursday 18th July 2024, 9.30-13.30pm.	

Betsi Cadwaladr University Health Board (BCUHB)
UNCONFIRMED Minutes of the Audit Committee held in PUBLIC
on 18 July 2024
in the Boardroom, Carlton Court, St Asaph and via Teams

Committee Members Present	
Name	**Title**
Karen Balmer	Independent Member (Chair)
Urtha Felda	Independent Member
Dyfed Jones	Independent Member (via Teams)
Rhian Watcyn Jones	Independent Member (via Teams)
In Attendance	
Russell Caldicott	Interim Executive Director of Finance *(part meeting)*
Dyfed Edwards	Health Board Chairman *(part meeting)*
Pam Wenger	Director of Corporate Governance
Andrea Hughes	Interim Finance Director, Operational Finance
Andrew Doughton	Audit Manager, Audit Wales
Fflur Jones	Performance Audit Lead, Audit Wales
Matt Edwards	Director – Financial Audit Lead, Audit Wales
Dave Harries	Head of Internal Audit
Nicola Jones	Deputy Head of Internal Audit
Libby Ryan Davies	Integrated Health Community Director (Central)
Nesta Collingridge	Head of Risk Management *(part meeting)*
Amanda Legge	All Wales Post Payment Verification (PPV) Manager (NWSSP) *(part meeting)*
Wyn Owens	Head of Operational Procurement & National Sourcing NWSSP *(part meeting)*
Committee Support	
Jody Evans	Corporate Governance Officer
Philippa Peake Jones	Head of Corporate Affairs

Agenda Item	Action
PRELIMINARY MATTERS	
AC24.88 Welcome, introductions and apologies for absence **AC24.88.1** The Chair of the Committee welcomed everyone to the meeting and apologies were received from Nick Lyons – Executive Medical Director, Sjef Molmans - Local Counter Fraud Specialist, Finance and Carol Shillabeer - Chief Executive.	
AC24.89 Declarations of interest on current agenda **AC24.89.1** No declarations of interest were made at the meeting.	

AC24.90 Minutes of previous meeting for accuracy **AC24.90.1** AC24.57.3.1 ***RESOLVED***: The Minutes from the meeting held on May 7th were confirmed as accurate, with amendments to the language concerning item AC24.57.7.7 and a correction to the job title of the External Audit Manager. **AC24.90.2** It was agreed that items on the action log that were closed by the Committee would be noted in the minutes of the meeting going forward.	**JE**
AC24.91 Action Log and matters arising not covered on the agenda **AC24.91.1** Members received the action log and noted that it did not appear to be a clear record of the actions that were closed the previous meeting. Following a discussion between the Chair and the Head of Internal Audit about the resolution of closed items on the action log, it was agreed that a review of the actions from the previous meeting be reviewed and an update provided to the Chair to ensure that there were no actions missing. It was noted that the column advising of the revised deadline date was missing which was an oversight and would be reinstated. In reviewing the action log, the Committee agreed to close the following actions: AC23.93, AC24.57.7.7, AC24.57.7.10, AC24.57.8.4, AC24.58.5, AC24.16.1 & 2, AC24.57.3.1, AC24.57.6.2, AC24.57.6.3, AC24.58.7.1, AC24.58.9, AC24.59.2.7, AC24.59.2.14, AC24.59.3.2, AC24.59.3.3, AC24.60.1.6, AC24.61.1.6, AC24.61.2.3, AC24.61.2.6, AC24.61.5.2, AC24.62.1.7 and AC24.63.1.1. **RESOLVED**: That; updates to the summary action log be recorded therein.	**KB/PW**
AC24.92 Notification of matters referred from other Committees **AC24.92.1** There were no matters referred from other Committees noted at the meeting.	
AC24.93 To note the items considered in the In-committee Audit Committee **AC24.93.1** The Committee noted the items that were considered in the In-committee Audit Committee, held on the 7th May 2024; · Details of Breaches of SFIs, Scheme of Delegation and Standing Orders. · Independent Review Management Response (Contract Procurement Review). · Local Counter Fraud Report. · Development of the Annual Governance Statement 2023/24. **RESOLVED;** that the items were noted.	

AC24.94 Effective Governance – Integrated Health Community (IHC) Central - Final Internal Audit Report

AC24.94.1 The Integrated Health Community Director (Central) presented the Limited Assurance Report to the Committee, along with a summary of the *Limite*d status recommendations and management action plan.

AC24.94.2 It was noted that the management plan had been reviewed at the 19th June 2024 Executive Team Meeting, and was subsequently submitted to Internal Audit.

AC24.94.3 The IHC Director thanked the Internal Audit Team for their patience with regard to the accuracy of comments, which had been included in the final report.

AC24.94.4 The Committee noted that a number of key actions had been completed to date, and that work was ongoing to progress recommended actions with the support of the Corporate Governance Team, in terms of completion of the review of the Governance arrangements.

AC24.94.5.1 The audit report had contained a management action that related to the re-establishment of a Financial Control Group. The purpose of these Groups will be to oversee the planning and delivery of financial targets whilst understanding the impacts of the necessary change to deliver a reduction in financial spend. The IHC Director reported that the IHC were aligning the Terms of Reference. It was also noted in the meeting that there was a management action in the audit report that the Central IHC Clinical Effectiveness Group (CEG) will be the responsible forum for ensuring that required clinical audit is completed and assurance would then be overseen by the Quality Operational Delivery Group (QODG). It was noted by the Committee that the ToR will be reviewed to ensure that this is reflected and that the ToR would relate to Tier 1, 2 and 3 audits.

AC24.94.5.2 Significant focus was given to improvements to performance and monitoring against concerns, complaints and incidents. It was noted that a huge amount of work had been undertaken to address the backlog with support and scrutiny from the Director of Nursing and Chief Executive. It was reported that a significant improvement had been recognised.

AC24.94.5.3 Risk Management was also commented upon by the Director, including the ongoing evaluation of service-related risks. It was affirmed that Risk Management was an integral part of the process; particularly in relation to the periodic updates of service risk reviews, and updates to the risk register. It was also raised that the updates were consistently featured on the agendas of the key Governance Groups within the IHC and recognised within the Terms of Reference. It was also noted that attendance issues at the Risk Management Group meetings had been a concern for the IHC. It was confirmed that the Director was optimistic that the recent updates to the terms of reference would lead to enhanced participation and overall improvement in attendance.

AC24.94.5.4 The Committee noted the update and questions were invited.

AC24.94.6 Independent Member (DJ) raised a question, regarding the revision of the current implementation to evaluate improvements. The Head of Internal Audit stated that a follow-up would be conducted within the year. He also mentioned that discussions with the Director of Corporate Governance would take place to review the progress of follow-ups. Additionally, the Head of Internal Audit indicated that focus testing would be implemented, to aid in the formal closure of the actions.

AC24.94.7 Independent Member (RWJ) sought assurances from the Director, in relation to the development of trajectories and how these would clear the backlog of complaints, with a target completion date set for the end of July. RWJ queried what was the plan with regard to getting a grip on the overspend incurred by the IHC. The Director emphasised that establishing trajectories was not solely about planning, but also about ensuring swift resolution of issues. The Director clarified the range of ongoing work around expenditure and key drivers. It was also noted that Senior Management was reviewing bed escalations and the reduction of bed escalations and variances in pay spend as a result of agency usage as a key focus of cost pressures. RWJ expressed her disappointment that the measures re financial control had not enabled the IHC to manage its budgets and that all budget holders should be looking at how they can reduce costs.

AC24.94.8 Independent Member (RWJ) furthermore commented upon the number of complaints and actions and queried as to why the work had not been undertaken previously. The Director explained the legacy of the situation along with additional resource and measures, in relation to pilots being undertaken to meet the demand. The IM also questioned the budget holders role with regards to the report highlighting the IHC being the biggest over spender; the Director clarified the budget holders were working hard to review opportunities in working differently, in order to reduce expenditure.

AC24.94.9 The Chair of the Committee referred to the number of open complaints since April, and questioned the position at the end of June. The Director agreed to forward the detail to the Chair following the meeting, it was noted that overdue complaints had significantly reduced. It was also agreed to provide a future update on the impact of the actions being taken, with regards to the reduction of outstanding complaints responses at a future meeting.

AC24.94.10 The Interim Executive Director of Finance also expressed his disappointment, along with concerns in relation to the management of cost pressures and risk compared to others. It was noted that there was a huge amount of work to be undertaken within the IHC. The Interim Executive Director of Finance also confirmed that specific support had been provided to the IHC by the Chief Finance Officer and that work was being undertaken in the background. The Committee Chair then reflected on the distinctiveness of the three separate IHCs. The necessity for mutual learning, in terms of financial

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management or complaint resolution was emphasised as a crucial element of the integrated approach. Cost effectiveness was referred to by the Interim Executive Director of Finance along with mitigations of risk and additional capacity. It was agreed to share the report with the Performance, Finance and Information Governance Committee. **RESOLVED**: The Committee *noted* the update and requested an update on the impact of the actions being taken, with regards to the reduction of outstanding complaints responses at a future meeting with the report being shared with PFIG.	**PPJ**
AC24.95 To receive a Report from NHS Shared Services Partnership on 23/24 Annual Procurement Assurance **AC24.95.1** The Head of Operational Procurement & National Sourcing NWSSP (WO) provided the Committee with an inaugural report and presentation, which included key updates on National Procurement initiatives and outcomes that had a direct bearing on the Health Board, the update also provided the summary of procurement activity undertaken. **AC24.95.2** The Chair of the Committee commented upon the inaugural report and frequency of the reporting, the Head of Operational Procurement and National sourcing clarified the internal restructuring of the service, and referred to the refreshed standard of reporting. The Interim Director of Operational Finance confirmed the reporting pattern, which was reviewed in incorporation into the Health Boards Conformance reporting. Chair then queried the delivery and carriage costs in the report. It was clarified that the savings opportunities concerning carriage, delivery and bulk buys were part of the Health Boards savings Workplan. **AC24.95.3** The Interim Executive Director of Finance also explained to the Committee of the Health Boards membership and attendance at the National Workstream reporting on Value Sustainability, whilst ensuring oversight and opportunities to target saving gaps. The Director of Corporate Governance also acknowledged the update in terms of feeding into the Audit Committee. **AC24.95.4** The Chair of the Committee questioned as to whether or not the audit recommendations had been completed. It was confirmed that the recommendations had been completed, however Internal Audit had not yet followed up and closed the recommendations. It was noted that the actions relating to the closure would not take place until the second part of the financial year, it was clarified that a full deep dive would be undertaken. **AC24.95.5** The Chair also addressed the Committee regarding the log of Tenders. Particular emphasis was placed on the discrepancies observed in the names of suppliers listed, and the Chair questioned the potential enhancements to ensure accuracy in future records. The Head of Operational Procurement & National Sourcing confirmed that the data was taken from a manual spreadsheet, not extracted from the Tender Management System. He also	

clarified that the Team would standardise suppliers across the data sheet in future reporting. Chair then requested that The Head of Internal follow up to test the point made. The Head of Internal Audit confirmed that the point would be picked up on an All Wales Basis. A discussion ensued following a similar point made by IM (RWJ) regarding inconsistencies across the system in relation to streamlining. It was explained that the suppliers would be combined where possible.

AC24.95.6 The Head of Internal Audit acknowledged the report's comprehensive detail and the Committee noted a comparable report to be introduced across Wales. The Head of Internal Audit also remarked on the adherence to NWSSP standard operating procedures; the need for broader assurances concerning payroll, and the necessity for additional detail regarding these aspects be incorporated into the reporting going forwards.

AC24.95.7 The Director of Corporate Governance delineated the distinct governance processes pertaining to shared services; along with the involvement of the Health Board, being part of the All Wales Partnership Committee, and the process of governance reporting to Velindre NHS Trust as the host body. The Committee acknowledged the Director's remarks, recognising the importance of clear boundaries and assurances. It was noted to arrange a future session with Board Members, to further discuss the role and operations of Shared Services. A further discussion took place with a dialogue on financial matters and the adherence to NWSSP internal Standard Operating Procedures, which would be included in future internal audits.

AC24.95.8 The Chair discussed the provision of branded merchandise for North Wales Child and Adolescent Services, emphasising the importance of the products' compliance with ethical standards. Confirmation was given that all merchandise procured through the Health Board's processes meets environmental standards. Additionally, it was noted that there is a process for sourcing from Welsh suppliers whenever feasible.

AC24.95.9 The Committee expressed gratitude to the Head of Operational Procurement & National Sourcing for presenting the report. The Head of Operational Procurement also invited suggestions for improvements to the reporting template for consideration in future iterations.

RESOLVED: The Committee *noted* the inaugural Annual Assurance Report (Procurement) for 2023/24

PW

AC24.99 To receive an annual report from NHS Shared Services Partnership on Post Payment Verification 2023/2024

AC24.99.1 The NWSSP Lead (AL) presented the briefing, in relation to the Post Payment Verification (PPV) Annual Assurance Report for 2023/24, which provided an overview of the verification work for claims from General Medical Services (GMS), General Ophthalmic Services (GOS), and General Pharmaceutical Services (GPS).

AC24.99.2 It was reported that the team completed 48 of 49 GMS planned visits and one extended visit within BCUHB. The next year would prioritise revisits, with extended visits for routine and revisit cases.

AC24.99.3 The Lead summarised that GOS had moved towards remote access, including virtual visits, amidst the ongoing shift to electronic records, with continued physical visits as necessary.

AC24.99.4 In relation to the GPS, it was noted that a new service check system was implemented in 2023/24, with all visits completed. It was summarised that the upcoming year would see collaborative scheme verification and expanded remote working, alongside quarterly reporting across Wales.

AC24.99.5 The Committee noted that technical issues with dispensing data checks had been resolved, allowing for quarterly reporting.

AC24.99.6 It was reported that the Clinical Waste Self Assessments were also successfully piloted and were ongoing whilst highlighting the fresh approaches that could lead to financial savings for the NHS in the domain of clinical waste management. Plans were also in place to pilot self-assessments for pharmacies.

AC24.99.7 It was explained that meetings were being held throughout Wales and with the audit team. Additionally, explorations into further potential cost-saving measures were underway. Correspondingly, a visual guide concerning PPV had been developed for GOS contractors, akin to the GMS.

AC24.99.8 The Committee Chair requested details on the availability of comparative trend analysis, including geographical data (in relation to East, Central and West IHC areas). It was explained that a new business information team in primary care was currently creating a data dashboard, and confirmed that plans were in place to improve this data moving forward.

AL

AC24.99.9 The Director of Corporate Governance questioned if any particular themes had been raised upon the visits in terms of learning, and of the resolutions or progress and (where applicable) to counter fraud. The NWSSP Lead provided an overview of the current actions taken and it was agreed to include any anonymised common themes within future reports to the Committee. The Interim Executive Director of Finance commented on the establishment of benchmarks and provided explanations regarding the scope and guarantees involved in recuperating and collaborating with newly integrated practices.

AL

AC24.99.10 The Chair inquired about the proportion of electronic versus paper-based systems. It was confirmed that, owing to a large contractor, the ratio stands at an even 50/50. A discussion ensued over manual paper checks compared to electronic verification methods.

RESOLVED: The Committee *reviewed, noted* and were *assured* that the PPV cycle was being managed appropriately but requested prior year/prior period comparative data going forward.

AC24.96 Risk Management

AC24.96.1 The Committee received an update from the Head of Risk Management in relation to the position on the, Limited Internal Audit Report, Corporate Risk Register, Risk Management arrangements, and the proposal to the role of Risk Management Group.

AC24.96.2 Internal Audit Report - The Head of Risk Management expressed gratitude to the Internal Audit Team in the production of the limited assurance report. The Committee then received an update on the four recommendations and the advancements achieved to date.

AC24.96.2.1 A significant improvement in quality assurance rates was highlighted, rising from 23% to 56%, and the establishment of a business cycle designed for the quarterly review of risk registers. Attention was also drawn to the insufficient examination of the corporate risk register, and suggestions had been made for revising the risk management group.

AC24.96.2.2 The Head of Risk Management indicated that the growing scope and attendance of the Risk Management Group meetings had hindered thorough analysis of the corporate risk register. Consequently, it was proposed to the Audit Committee to the establishment of a risk scrutiny group with fewer members to enable dedicated scrutiny, and to adjust the meeting schedule to provide ample opportunity for addressing risk escalation.

AC24.96.3 Risk Management Framework - The Committee noted that the Risk Management Framework had also been updated in line with the report recommendations and inclusion of the details in relation to the Health Boards Risk appetite and tolerance levels.

AC24.96.3.1 The Director of Corporate Governance also acknowledged the disappointment of receiving a limited assurance report, but also expressed appreciation for the risk team's efforts over the past year. The necessity for continued dedication to risk management and the vigilant monitoring of risks by the scrutiny group was emphasised.

AC24.96.3.2 The Committee Chair acknowledged and appreciated the progress made and the Committee recognised the foundation laid for future enhancements.

AC24.96.3.3 The Chair of the Health Board attended the meeting at this point.

AC24.96.3.4 IM (RWJ) inquired about the integration of the risk appetite and how it fed into the scoring system. The Head of Risk Management affirmed that

going forward, the tolerance scoring level would be incorporated into the risk matrix and reflected in upcoming Committee reports.

AC24.96.3.5 The Committee observed that 9 out of the 17 risks listed in the Corporate Risk Register exceeded the Health Board's tolerance levels. It was confirmed that the risks are set to be reviewed by the Risk Scrutiny Group, then discussed further by the Executive Team and relevant Committees to ensure prioritisation. Additionally, attention was noted to aligning risk management and actions with the Health Board's Annual Plan.

AC24.96.4 Corporate Risk Register - The Head of Risk Management then presented the Corporate Risk Register, offering a summary of its contents. There were no inquiries or issues brought up for discussion in relating to the Risks therein the report. It was however noted that following a board development meeting, it was decided to remove the assurance line from the template, considering them part of the Board Assurance Framework. This modification received the Committee's endorsement.

RESOLVED: The Committee *agreed to endorse*;
· The management response of the Internal Audit report.
· Recommendations to updating of the Risk Management Group (3 x a year Risk Forum and monthly Risk Scrutiny Group).
· Key updates and changes to the Risk Framework and Procedures.
· The Corporate Risk Register updates.

AC24.97 Breaches of SFIs and Scheme of Delegation	
AC24.97.1 The Interim Director of Finance reported to the Committee that there were no breaches to report at the meeting.	

AC24.98 Standards of Business Conduct

AC24.98.1 The Director of Corporate Governance introduced the item, reporting that Internal Audit had recently completed their audit of the Standards of Business Conduct Declarations of Interest, Gifts, and Hospitality, and reported that sadly the audit received a limited assurance rating.

AC24.98.2 The Director referred to the standards scope, which covered not just the Board, but also certain individuals within the organisation in terms of declarations. The compliance and complexities of the policy was raised, along with challenges within the organisation and staff shortages within the team.

AC24.98.3 It was confirmed that detailed work was to be undertaken, with the Head of Corporate Affairs leading the efforts to address the recommendations and system challenges. The Director also mentioned the implementation of the system and procurement. The strengthening of governance and communication was fully acknowledged, along with various challenges throughout the previous 18-month period. It was noted that the Director would feedback to the Committee in relation to updates on progress in the November Audit Committee.

PW

AC24.98.4 The Head of Corporate Affairs then updated the Committee in relation to actions which had been implemented since the review

AC24.98.5 The Chair referred to nil declarations and approvals, it was agreed for the Head of Corporate Affairs to ensure the element of the process was actioned. The Chair also referred to twice-yearly reports being presented to the Committee, which had been agreed between the Chair and the Director of Corporate Governance.

AC24.98.6 A discussion ensued relating to declarations relating to Executives, Board Members and Independent Members. The system implementation was referred to, along with issues that required addressing, as noted therein the report.

AC24.98.7 An IM (RWJ) queried the deadlines in relation to various actions within the report, noting that most had a deadline of 31st July 2024. It was confirmed that where actions do not achieve the target date, the date would be revised accordingly and that work was ongoing.

AC24.98.8 The Chair of the Health Board welcomed the ongoing work and summarised the public transparency, particularly regarding concerns in relation to employees conflicting existences.

AC24.98.9 A discussion ensued concerning the process and corporate governance capacity in relation to the reviews of declarations, as part of the planned role going forwards.

AC24.98.10 The Head of Internal Audit addressed a point in the report about the procurement of the Civica System, explaining that it was acquired by a former Interim Board Secretary. It was clarified that the Audit Team neither recommends nor has ever recommended systems for procurement. Additionally, the Head of Internal Audit mentioned that they had not used the Civica System, as they utilise an in-house ESR system, which is also available to the Health Board.

AC24.98.11 The Chair of the Committee referred to item 2.1.3 regarding an inheritance to the organisation in the report and the Committee acknowledged the detail in the report.

RESOLVED; The Audit Committee noted:
- The Internal Audit and its findings.
- The actions proposed to address the issues raised.
- To report back to the Committee in November.

AC24.100 SFI Conformance Report – Quarter 1 24/25 & AC24.97 Breaches of SFIs and Scheme of Delegation

AC24.100.1 The Interim Finance Director, Operational Finance

presented the conformance report for April to June 2024 to the Committee with an overview of regulatory compliance, assurance, and good practice expectations.

AC24.100.2 The Interim Finance Director, Operational Finance explained that there had been a continued reduction in non-compliance with purchase orders during the quarter, it was confirmed that the data was relative to the size of the organisation. It was noted that purchase orders that required review would be considered as call off orders going forwards, in place of retrospective purchase ordering.

AC24.100.3 The implementation of a new process involving 'File Notes' to capture and record instances of procurement spend outside of the SFIs/Scheme of Reservation and Delegation (SoRD) was raised.

AC24.100.4 The Interim Director also clarified that the NWSSP were reviewing the All Wales purchase order exemption list, as part of the updated Policy on behalf of NHS Wales.

AC24.100.5 It was reported that Single Waivers had significantly decreased in the number of approved waivers.

AC24.100.6 The Interim Director referred to an action point in relation to receivables and conformance with payroll procedures; therefore, a brief was provided within the report highlighting the recovery actions in place, along with housekeeping and review updates.

AC24.100.7 In terms of salary overpayments; it was explained that continued education of line managers was taking place, in addition the NWSSP were in the process of agreeing an All Wales overpayment procedure, with the aim to strengthen the Health Boards governance and processes, in relation to recovering salary overpayments.

AC24.100.8 Details in relation to payables and conformance with Public Sector Payment Policy was provided. It was reported that links with the Director of Corporate Governance were also in place, in relation to Chairs Actions, as per standing orders.

AC24.100.9 Losses and special payments were also referred to with regards to medical negligence, Welsh Risk Pool claims and patients property.

AC24.100.10 The Chair of the Committee queried overpayments to staff in receipt of benefits. It was clarified that if a staff member had an increased salary payment, then benefits would reduce when benefits were being claimed. It was noted that the Health Board do not to recover this type of claim, due to the benefits reduction being recovered via the public sector. The Interim Director then expressed the further need to continue to educate staff in relation to overpayments.

AC24.100.11 An IM (DJ) queried the East Purchase Order Breaches being higher than the West and Central Areas. The Interim Director acknowledged the point and confirmed that improvements were significantly improving and referred to higher amount of managed GP Practices in the East.	
AC24.100.12 The Chair of the Committee then requested clarification on the "phases" of breaches in the report on page 6 of 21, in relation to purchase order breaches. It was agreed for the Interim Director to follow up on the detail and report back to the Chair.	**AH**
AC24.100.13 An IM (RWJ) requested clarification in relation to LAC charges, it was confirmed that LAC charges refer to Looked after Children. It was agreed to ensure that all abbreviations are clear in future reports.	
AC24.100.14 IM (RWJ) also questioned the system for logging of staff overpayments the monitoring of non-completion of leavers notifications. The Interim director assured the IM that work is underway with workforce colleagues to reduce the instances and continue to educate lines managers whilst also targeting repeat offenders.	
AC24.100.15 A further question was raised by IM (RWJ) with regards to lost property (hearing aids), and the management of lost property on the wards. The Interim Director acknowledged the financial costs to the unfortunate loss of hearing aids. A discussion ensued in relation to the hearing aid market, in relation to second hand devices and ward procedures.	
AC24.100.16 The Chair also congratulated the Finance Team on the collection of monies to the long-standing debtors, as noted in the report summary. The Chair also requested that a "movements" column be inserted into the report data in future reports to indicate progress or otherwise.	**AH**
AC24.100.17 The Chair of the Committee also referred to procurement contracts and in particular of accredited NEBOSH courses within the health board, along with the associated costs verses outside training. The Director of Corporate Governance noted the comments made by the Chair.	
RESOLVED; The Audit Committee noted and discussed the elements of performance and approved the report.	
AC24.101 To receive the Internal Audit Progress Report **AC24.101.1** The Head of Internal Audit presented the 2 and a half-month period update to the Committee, which included the status of recommendations, including proposed changes to the process and completion of audit recommendations. The briefing also covered updates on recommendations with 'none' or 'limited' assurances.	

AC24.101.2 The Head of Internal Audit requested the Committee's approval for changes to the Grievance Management and Business Cases: Capital and Revenue reviews. The Executive Director of Transformation and Strategic Planning and the Director of Corporate Governance had already approved the changes, pending the Audit Committee's approval. The Committee was provided with background information and ongoing work details supporting the request. After consideration, the Committee agreed to approve the deferral of the Grievance Management review and the split review of the Business Cases for capital and revenue.

AC24.101.3 The Committee was also informed regarding the Key Performance Indicators, noting the positive status of being green, despite the Health Board's downward trajectory to 77% from a previous 100%. The Chair requested that improvements in the response time be made going forward.

AC24.101.4 The Head of Internal Audit expressed gratitude to the Corporate Governance Team in relation to the progression of Audits, but highlighted delays in owner engagement with the Audit Team, which caused further delays. The Chair questioned if there were mitigating circumstances for these delays and requested that the issues be raised with Executives regarding the delays and implications for the Audit Team. The Director of Corporate Governance assured that feedback would be provided to the Chief Executive on this matter.

AC24.101.5 The Deputy Head of Internal Audit presented key highlights from recent reviews. It was noted that one report regarding the Orthopaedic Hub had not yet been finalised, as it was returned for management review due to queries and challenges raised. It was confirmed that the report would be finalised soon following the outcome of discussions.

AC24.101.6 The Deputy Head of Internal Audit also outlined that the majority of the reports listed had been limited, with key themes including compliance with policies, governance, and risk management. The Committee acknowledged the progress made in the limited risk report over the year to date, despite operational issues and inconsistencies in the quality and detail of risk registers and risk management. It was also noted that the Deputy Head was meeting with the Head of Risk Management on a monthly basis to discuss issues related to ongoing audits.

AC24.101.7 The Committee discussed the Health and Safety Report, noting limited assurances and inconsistencies with Risk Assessments along with the re-approval of the Policy. Recent changes within Health & Safety were also noted. The Chair raised a previous concern with regards to the policy and it was clarified that the policy would be taken for approval at the September Health Board Meeting.   During the discussion the Head of Internal Audit stated that there was a lack of clarity in terms of the responsible officer for Health and Safety due to the vacancy for the Director of Environment and Estates. The Director of Corporate Governance confirmed that the CEO was the accountable officer and the lead for Health and Safety.

AC24.101.8 An IM (UF) questioned resistance regarding responses to audit requests for detail. A discussion followed, explaining changes in team staffing, culture, and clarity around issues related to Internal Audit's requests. It was noted that the People and Culture Committee had agreed to standardise the item on their agenda going forward.

AC24.101.9 Budgetary management was discussed in relation to the limited report. The Deputy Head of Audit emphasised the progress made over the last year, changes in senior leadership, and key issues arising from the lack of detailed procedures and accountability letters. The Chair asked for clarification on whether accountability letters had been issued to budget holders for 2024/25 and was assured that they had been issued for the period.

AC24.101.10 An Independent Member (RWJ) questioned whether the assurances were heading towards "reasonable" assurance. The Head of Internal Audit explained that the weighting was caveated within all audit reports. It was explained that the report received a "limited" status due to a previously agreed commitment to review and update procedures, which was subsequently not actioned. The Deputy Finance Director then commented on the scoring of the limited assurances, noting the improved position, particularly the additional grip and control improvements. It was also noted that targeted dates for actions related to procedures were being worked on, along with additional training. The Director of Corporate Governance also highlighted the significant improvements in the work undertaken by the team. The Chair of the Health Board also commented on the progress made to date, whilst recognising the significant achievements so far. The Chair of the Health Board also emphasised the importance of continuing this progress to achieve the recommendations as outlined in the report.

AC24.101.11 The Committee noted the Discharge Arrangements report, focusing on the Discharge to Recover Requirements (D2RA) and the complexities related to training, procedures, and adverse discharge processes. Ongoing work on the recommended actions was acknowledged. An IM (UF) questioned whether local authorities were included in the audit as part of the system review, and it was confirmed that details related to BCUHB were not within the remit. IM (RWJ) raised concerns about delays in discharging patients to community hospitals and care pathways, including acute site involvement. An Audit Wales Lead confirmed that a regional report had been conducted, with similar themes identified. Independent Member (RWJ) clarified her query regarding bed availability and patient progression through Health Board care. Independent Member (DJ) commented on the disparity in approaches and controls among the six local authorities.

AC24.10.12 The Chair of the Health Board made comment in relation to the technical aspects of the report scope and queries, which had arisen in relation to the system approaches. The Director of Corporate Governance explained the process of the report tracking.

AC24.101.13 An IM (RWJ) requested clarification on the role of the Trusted Assessor and the strengthening of this role within the overall process. The Director of Corporate Governance noted the request and agreed to arrange for the clarification to be provided to all Independent Members. **AC24.101.14** The Committee noted the unsatisfactory Operating Model report, which was mainly due to the lack of benefits and measures in place in the offset of the plan, making assessment difficult within the audit. The Deputy Head of Internal Audit highlighted the challenges. The Chair informed the Committee of ongoing work in this area, and the Director of Corporate Governance emphasised the report as a key priority in the annual plan. It was confirmed that the review was conducted at the request of the Chief Executive. **AC24.101.15** IM (RWJ) requested clarity of a date in relation to the engagement process with Board Members. The Director of Corporate Governance clarified that the engagement work was to be undertaken within Quarter 2. **RESOLVED:** The Committee approved; · Changes to the proposed process around the introduction of new Internal Audit Reports. The Committee received; · The progress report.	**PW**
AC24.102 Internal / External Audit Tracking Progress Report – Report **AC24.102.1** The Director of Corporate Governance presented the update report on the current status of recommendations, including proposed changes to the process and completion of audit recommendations. The briefing also covered updates on recommendations with 'none' or 'limited' assurances. **AC24.102.2** In particular, the Director informed the Committee of the tracker having gaps within the reports going back to 2021, which had been identified through a process gap check undertaken with Audit Wales and Internal Audit. **AC24.102.3** A summary on the current position of recommendations was provided to the Committee, noting the absences of the Medical Director and an Acting Executive in relation to non-closures. **AC24.102.4** Recommendations per director, particularly those with limited and no assurances were flagged therein the report. The Director raised whether the Chair would like to invite Executive Directors to provide updates to the Committee in terms of oversight of limited and no assurance recommendations in the future. **AC24.102.5** It was also explained that the Team was reviewing other systems used within other Health Boards, as the current system was Excel-based.	

AC24.102.6 The Director further summarised the details of the recommendations in the report along with the external audit process.

AC24.102.7 The Chair of the Committee expressed concern that the report did not evidence the status, in relation to medium and high risks, overdue items, relating to limited and unsatisfactory audit reports. The Chair did not feel assured with the report as it stood but agreed that returning to the spreadsheet tracker was not desirable. It was agreed by the Committee that the need for better insight into the status of recommendations should be within the report.

PW

AC24.102.8 An IM (RWJ) also commented and expressed her wish to be signposted to the more critical needs and highlighted that not all needs are ultimate priorities. She suggested that signposting and grouping would be better. IM (UF) reiterated that she agreed with the suggested comments, emphasising the importance of time management for the agenda and noting that inviting the Executive Directors would add more time.

AC24.102.9 The Chair then commented upon the process, noting the terms of ownership and the clear flow chart in place. The Director of Corporate Governance was happy to take forward the comments and discussed the balance of detail in relation to assurances in previous reports. The Director agreed on the need for further in-depth analysis of specific details and pointed out the public domain element of the management responses. A summary of the Director's thoughts was provided whilst confirming that detailed information was available to members between meetings.

AC24.102.10 The Head of Internal Audit explained that the health board was not an outlier in terms of spreadsheet use for logging internal audits. The Director of Corporate Governance acknowledged the high level of recommendations due to the health board's situation and expressed efforts to reduce the number of recommendations, providing an overview of the recommendation content.

AC24.102.11 An IM (RWJ) expressed her dislike for the A3 spreadsheets and suggested inviting Executives to the table to focus on the recommendations in the reports over the next few months. The Head of Internal Audit agreed with the IM's comments, particularly regarding the Head of Nursing and Midwifery and the outstanding recommendations.

AC24.102.12 The Chair of the Committee then summarised the overview provided. The Committee discussed the recommendations for closure. It was noted that 22 recommendations had been approved for closure by the Executive Team and would be brought to Internal Audit for ratification. Clarification was also provided in relation to the recommendations signed off by the Executive Team.

RESOLVED: The Committee *approved and noted;*
·   Changes to the proposed process around the introduction of new Internal Audit Reports.
·   Changes to the new audit recommendation closure process.

- All 'no' or 'limited' assurance recommendations.
- The current update position to all open recommendations, which were awaiting Internal Audit approval for final closure approval.
- The position and review of all Audit Reports included on Audit Tracker and next steps

AC24.103 Audit & Risk Committee Update – Report

AC24.103.1 The External Audit Manager (ME) presented an update on current and planned audit work within the Health Board, specifically focusing on Accounts and Performance Audits. The detailed focus and status of each review were discussed.

AC24.103.2 Particular attention was given to the submission of the Health Board accounts and the next stages. The Chair of the Health Board expressed her gratitude, thanking and congratulating the Audit and Finance Team for all their hard work to date.

AC24.103.3 The Chair then highlighted the All Wales Thematic work on urgent and Emergency Care audits, which had been noted in an earlier agenda item. An Audit Wales Lead (FJ) summarised the planned care setup delays and the engagement and setup of the current year's structured assessment, which is scheduled to take place during the autumn period.

AC24.103.4 The Audit Wales Lead (FJ) then informed the Committee and provided overviews of the National Reports by the Auditor General, namely the Community Pharmacy data-matching pilot, From Firefighting to Future-Proofing, and the BCUHB Board Effectiveness follow-up.

AC24.103.5 A discussion ensued regarding the clarification of the data matching pilot, and it was confirmed that the work was in line with NHS Counter Fraud. An IM (UF) expressed her concern regarding discharge issues and the high-level coordination of the approaches. The Audit Wales Lead (FJ) confirmed the key focus with the 6 Goals programme board, particularly goals 5 and 6, and the driving changes. The IM also queried the innovation of the programme. The Audit Lead confirmed the work and follow-up of the spending, along with difficulties in spend analysis, which was noted across Wales.

AC24.103.6 The Chair then questioned whether pharmacists were reimbursed on prescription dispensing. It was clarified that there was a tariff within England and Wales, which was attached to a dispensing fee.

RESOLVED;
The Committee *received* and discussed the following Audit Reports:
- Community Pharmacy Data Matching Pilot - Audit Wales
- From firefighting to future-proofing – the challenge for Welsh public services - Audit Wales
- Board Effectiveness Follow-up - Betsi Cadwaladr University Health Board - Audit Wales

AC24.104 National audit reports for information

AC24.104.1 The Audit Wales Lead provided an update to the Committee, in relation to the Discharge Planning Progress with a detailed summary of the scope.

AC24.104.2 Key concerns within the report had been raised with regards to training and an absence of regular audit cycles to inform improvements. Key challenges were recognised. It was confirmed that recommendations had been updated in relation to new arrangements.

AC24.104.3 Members noted concern, in particular to a lack of consistency and key risks to the system approach of the organisation and connections with the local authority.

AC24.104.4 The Chair of the Health Board informed Members that the report had been taken to the Executives, whilst expressing to the group the high levels of activity and the need for the coordinated approach. A discussion ensued, it was noted that the report would be considered as part of a wider Board discussion in September on scheduled care, and in collaboration with the relevant Committee. To further note, the discharge planning report was commented upon and the Audit Lead briefed the Committee on the publication. It was also confirmed that the recommendations had been included for onwards monitoring within the External Audit Tracker.

AC24.104.5 An IM (RWJ) referred to assessment delays, along with the Trusted Assessment process. The IM also raised concern with the "ongoing" status within tracking reports. Measurement and timetabling of reporting along with key themes were also raised. The Audit Lead agreed that the ongoing status was not helpful. The Chair of the Health Board also requested the sharing of common themes in relation to access to Care Homes and access issues.

RESOLVED:
The Committee received and discussed the following Audit Reports:
- Discharge Planning Progress (Update) BCUHB.
- Urgent and Emergency Care - Flow out of Hospital (North Wales region)

AC24.105 Agree Items for referral to Board / other Committees

AC24.105.1 There were no items discussed for referral to Board, or other Committees.

AC24.106 Chairs Assurance Report

AC24.106.1 The relevant items were noted for inclusion in the report.

AC24.107 Review of Meeting Effectiveness

AC24.107.1 Independent Member (UF) highlighted the importance of addressing the packed agenda and scheduling challenges faced by the committee.

AC24.107.2 A discussion ensued on how to effectively manage the issues, with a consensus on the need for allocating more time. The Chair of the Committee agreed to extend the meeting's end time by half an hour.

AC24.107.3 The Director of Corporate Governance noted to consider additional flexibility, in scheduling to accommodate the committee's needs, especially given the involvement of external attendees.

AC24.107.4 The importance of involving Internal Audit in agenda planning was also noted.

AC24.108 Date of next meeting

Thursday 12th September 2024, 9.30-14.00pm

AC24.109 Resolution to Exclude the Press and Public

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

Audit Committee Action Log (Public)

Action No.	Minute Ref.	Date	Agreed Action	Lead	Timescale	Status
Open Actions						
REMAIN OPEN						
	AC24.57.7.5	07.05.24	Audit Tracker - progress recommendations against External & Internal Audit Reports - The need for a clearer process for monitoring timeliness, performance, and principles on a case-by-case basis was raised. It was agreed that the process for external audits needed to be different to the proposal in 2.1 of the report.	Russell Caldicott, Interim Executive Director of Finance Pam Wenger, Director of Corporate Governance	~~July 2024~~ Revised timescale Nov 2024	**Remain Open** **03.07.24** Process to be developed and agreed with External Audit following the end of year accounts process being concluded. **02.09.24** Director of Corporate Governance to discuss with External Audit to agree closure process.
1.	**AC24.60.1.8**	07.05.24	Quality, safety and commissioned services. The Committee agreed to a 6-month deferral requesting that the review take place before the end of the current financial year - it was agreed to inform the QSE of this decision and for the QSE committee to drive progress on recommendations from the May 23 report.	Philippa Peake Jones to inform the Quality, Safety and Experience Committee (QSE)	~~May 2024~~ Revised timescale Nov 2024	**Remain Open** **02.09.24** PPJ confirmed that this has been referred to QSE Committee however the issue has not yet been resolved therefore the action remains open.
	AC24.60.1.10	07.05.24	Limited Assurances relating to the Lessons Learnt Report dated July	Karen Balmer	~~July 2024~~	**Remain Open** **18.07.24** To be raised at the next

			2023, and the follow up progress to date. Chair / Director of Corporate Governance to raise in the Audit Chair's Committee Meeting, as an emerging topic.		Revised timescale Nov 2024	meeting in August 2024 as part of feedback from the Audit Committee Chair. **02.09.24** Update to be provided during the meeting.
	AC24.62.1.4	07.05.24	F03 [BCUHB Counter Fraud Policy](#) is due for review – to be approved by August 2024. (Audit Committee Agenda in September).	Sjef Molmans	~~Sept 2024~~ Revised timescale Nov 2024	**Remain Open** **20.05.24** Item now on CoB for September 2024. **26.06.24** Counter Fraud Policy F03, is in the process of being reviewed by the team and will be placed out for wider consultation in July. **05.09.24** The Counter Fraud Policy required further work and has been included on the forward workplan for the November meeting
	AC24.94.9	18.07.24	The Chair of the Committee referred to the number of open complaints since April, and questioned the position at the end of June. The Director agreed to forward the detail to the Chair following the meeting, it was noted that overdue complaints had significantly reduced. It was also agreed to provide a future update on the impact of the actions being taken, with regards to the reduction of outstanding complaints responses at a future meeting.	IHC Director Central (Libby Ryan Davies) Di Platt / Gareth Evans	~~Sept 2024~~ Revised timescale Nov 2024	**Remain Open** **03.09.24** Since the July meeting there has been a change in the IHC Director Central role. The team are aware of the action and will provide a response ahead of the November meeting.
	AC24.99.8	18.07.24	The Committee Chair requested details on the availability of	Amanda Legge	~~Sept 2024~~	**Remain Open** **02.09.24** Amanda Legge confirmed

			comparative trend analysis, including geographical data (in relation to East, Central and West IHC areas). The All Wales Post Payment Verification (PPV) Manager (NWSSP) agreed to provide this information.		Revised timescale Nov 2024	that this information can be provide by locality area (e.g. Flintshire, Wrexham, Denbighshire, Conwy, Gwynedd & Anglesey). A prototype is being developed to include trend data and will be shared once available.
	AC24.99.9	18.07.24	The Director of Corporate Governance questioned if any particular themes had been raised upon the visits in terms of learning, and of the resolutions or progress and (where applicable) to counter fraud. The NWSSP Lead provided an overview of the current actions taken and it was agreed to include any anonymised common themes within future reports to the Committee.	Amanda Legge	~~Sept 2024~~ Revised timescale Nov 2024	<mark>**Remain Open**</mark> **02.09.24** As per action above AC24.99.8 the information being collated will include any issues and common themes.
	AC24.100.12	18.07.24	The Chair of the Committee requested clarification on the "phases" of breaches in the SFI Conformance Report on page 6 of 21, in relation to purchase order breaches. It was agreed for the Interim Director to follow up on the detail and report back to the Chair.	Andrea Hughes	~~Sept 2024~~ Revised timescale Nov 2024	<mark>**Remain Open**</mark> **02.09.24** Clarity to be provided at the September meeting on the information required for the Conformance Report to be presented to the Committee in November 24.
	AC24.101.13	18.07.24	An IM requested clarification on the role of the Trusted Assessor and the strengthening of this role within the overall process. The Director of Corporate Governance noted the request and agreed to arrange for the	Pam Wenger	~~Sept 2024~~ Revised timescale Nov 2024	<mark>**Remain Open**</mark> **04.09.24** Briefing on the role of the Trusted Assessor to be commissioned.

			clarification to be provided to all Independent Members.			
<mark>PROPOSE CLOSED</mark>						
	AC24.20.1	12.01.24	The Acting Board Secretary to work with the Committee Chair, Interim Executive Director of Finance, Chief Executive and Internal Audit on progress relating to the Audit Tracker report, to provide assurances in future meetings.	~~Phil Meakin~~ Pam Wenger	March 2024	<mark>**Action proposed for closure**</mark> **05.03.24** There has been some significant work on this including the review of approach at the Executive Team Meeting following the last AC. A meeting is being arranged between the Executive Director of Operations and Audit Chair. A process developed with IA agreement on how to check completion. **04.03.24** IA report produced on closed recommendations to follow at May 2024 AC. **15.03.24** Item to be kept open – Significant work had been noted at the recent Executive Team Meeting. It was raised that an Internal Audit Report was produced on closed recommendations and the report would be provided at the AC in May 2024. **02.09.24** Following discussion with Chair propose the action is closed as reporting will include presentation and recommendations at each meeting. The Audit Tracking Report has been included on the cycle of business as a regular item.

| | AC24.39.8 | 02.03.24 | The Committee discussed the repository of learning. It was agreed to share the paper. | Item ref 2: March 2024

Chris Lynes, Deputy Executive Director of Nursing | May 2024 | <mark>Action proposed for closure</mark>
Actions aligned (Jan 23 & March 24 – items 11 & 2)
23.04.24 Associate Director of Governance contacted Deputy Exec Dir of Nursing to check complete.
26.04.24 Feedback received via Deputy Director of Quality. The specification and "wireframe" for the app has been designed and a prototype is in place. The next and current phase is to begin testing the app, which will be done with the MHLD Division. This user testing will help further refine the app through identifying any bugs or technical issues and inform enhancements from practical use by front line clinicians, prior to wider roll-out. This testing will take place over the coming quarter.
22.05.24 Item requested for sharing.
12.06.24 Item to be kept open – further detail requested by the Director of Corporate Governance.
26.06.24 Confirmed that there is no paper but the detail of the repository will be covered in the Quality Paper to the Board.
02.09.24 Matt Joyes confirmed that details of the learning portal |

						development have been included in the Integrated Quality Report, the report was submitted to QSE Committee in August 24 and can be found in the papers via the link below (item QS24.92 – page 30 of report) QSE Quality Report
	AC24.45.12	15.03.24	The current Health & Safety Policy is overdue for review. It was agreed to follow up the urgency to update the out of date Policy.	~~Phil Meakin~~ Pam Wenger	May 2024	**Action proposed for closure** **23.04.24** Head of H&S contacted on 23.4.24 Note action owner is Assistant Director of Occupational Health and Safety. Update as follows - The responsible officer agreed an extension on this for 6 months (that lasts until June 2024). This will enable the new Exec responsibilities to be defined, as the policy has to be rewritten as the accountabilities are changing. The version is drafted ready for confirmation of accountabilities. **22.05.24** PW reported that the Health & Safety Policy is being revised and it is expected to be considered by the Board in July 2024. **03.07.24** Health & Safety Policy scheduled for People & Culture Committee in August 24 and Board approval in September 24. **02.09.24** Discussion held with CEO and Chair of Audit Committee to

					confirm that the policy has been included on the agenda for the Board in September 24
	AC24.46.2 & AC24.46.3	15.03.24	Overdue audit recommendations. A log of the recommendations for closure signed off by Internal Audit would form part of the future reporting. It was agreed to correct an error, as pointed out by the Chair, in the statistics within the report.	Pam Wenger Nesta Collingridge Glesni Driver	May 2024	<mark>Action proposed for closure</mark> **18.04.24** An update on the current position with all recommendations will be provided for the May AC, which will include a log of recommendations that are awaiting approval at the different stages of the approval process. **23.04.24** The Audit Committee will receive a report on this in May – Proposed to keep open until received and considered. **02.09.24** This action is linked to AC24.20.1, reporting will include presentation and recommendations at each meeting. The Audit Tracking Report has been included on the cycle of business as a regular item.
	AC24.46.6	15.03.24	The Chair commented upon the tracker as a whole, and suggested that the Internal and External Audits be placed upon separate documents for the next financial year and it was noted that in future, the reports would be condensed and easier to manage.	Pam Wenger Nesta Collingridge Glesni Driver	May 2024	<mark>Action proposed for closure</mark> **08.04.24** The internal and external audits recommendations will be reported separately at future Audit Committees. **07.05.24** Proposed to keep this open due to the need to gain assurance in the meeting. **02.09.24** This action is linked to AC24.20.1, reporting will include

						presentation and recommendations at each meeting. The Audit Tracking Report has been included on the cycle of business as a regular item.
	AC24.61.2.4	07.05.24	Structured Assessment - An Independent Member suggested that completion dates be provided within the reports, against historical recommendations where they had not been complete. The Director of Corporate Governance would provide an update to the historical recommendations at a future meeting.	Pam Wenger	Future report/ agenda item to be confirmed	<mark>Action proposed for closure</mark> **03.07.24** To be included on the July agenda as part of the audit tracking report and a report on progress against the Structured Assessment would be reported in September 2024. **02.09.24** PW confirmed that this information will be included in the report going forward.
	AC24.80.7	09.07.24	The Chair requested clarification around the publication of the Accounts. The Director of Corporate Governance clarified that the *draft* accounts had been published in the public domain and the support and preparation of the Communications Team was in place. It was confirmed that the Director of Corporate Governance intended to provide support to the Communications Team in order to share the thoughts of the Committee.	Pam Wenger	Sept 2024	<mark>Action proposed for closure</mark> **02.09.24** The Annual Report and Accounts have been laid by the Senedd. The Annual General Meeting will take place on 25.09.24
	AC24.86.3	09.07.24	The Director of Corporate Governance referred to 3 minor updates to the Annual Report 2023/24, which would be made prior	Pam Wenger	Sept 2024	<mark>Action proposed for closure</mark> **02.09.24** The updates were referred to in the presentation at the Health Board meeting where the Board

					approved the accounts.
			to presentation to the Health Board. It was proposed to work with Audit Wales, to finalise the points, to address the specific issues raised.		
AC24.90.2	18.07.24	It was agreed that items on the action log that were closed by the Committee would be noted in the minutes of the meeting going forward.	Jody Evans	Sept 2024	<mark>**Action proposed for closure**</mark> **02.09.24** Laura Jones as secretariat to the Audit Committee going forward will action this for future minutes.
AC24.91.1	18.07.24	It was agreed that a review of the actions from the previous meeting be reviewed and an update provided to the Chair to ensure that there were no actions missing. It was noted that the column advising of the revised deadline date was missing which was an oversight and would be reinstated.	Philippa Peake-Jones Laura Jones	Sept 2024	<mark>**Action proposed for closure**</mark> **02.09.24** This has been discussed and the actions agreed for closure at the meeting on 18.07.24 have been noted in the action log. In relation to the additional column, going forward original timescales will have a strikethrough and a revised timescale will be included.
AC24.94.10	18.07.24	It was agreed to share the Effective Governance – Integrated Health Community (IHC) Central Final Internal Audit Report with the Performance, Finance and Information Governance Committee.	Philippa Peake-Jones	Sept 2024	<mark>**Action proposed for closure**</mark> **02.09.24** The report will be shared at a future meeting of the PFIG Committee.
AC24.95.7	18.07.24	It was noted to arrange a future session with Board Members to further discuss the role and operations of Shared Services.	Pam Wenger	Sept 2024	<mark>**Action proposed for closure**</mark> **02.09.24** This has been included on the Audit Committee forward workplan and the Audit Committee Development Plan.
AC24.98.3	18.07.24	It was confirmed that detailed work was to be undertaken in relation to the Standards of Business Conduct,	Pam Wenger Philippa Peake-Jones	Nov 2024	<mark>**Action proposed for closure**</mark> **02.09.24** A new Standards of Business Conduct policy is currently

Action No.	Minute Ref.	Date	Agreed Action	Lead	Timescale	Status
			with the Head of Corporate Affairs to address the recommendations and system challenges. It was noted that the Director would feedback to the Committee in relation to updates on progress in the November Audit Committee.			being drafted and all the relevant processes that align to the policy are being updated to ensure they are consistent. This policy will also align with the rest of Wales.
	AC24.100.16	18.07.24	The Chair requested that a "movements" column be inserted into the SFI Conformance Report data in future reports to indicate progress or otherwise.	Andrea Hughes	Sept 2024	**Action proposed for closure 02.09.24** This will be incorporate into the Q2 report due to be received by the Committee in Nov 24.
	AC24.102.7	18.07.24	In relation to the internal / external audit tracker, concerns were raised that the report did not evidence the status in relation to medium and high risks and overdue items relating to limited and unsatisfactory audit reports. It was agreed the need for better insight into the status of recommendations should be included in the report.	Pam Wenger	Sept 2024	**Action proposed for closure 02.09.24** Discussion has taken place with the Chair of the Audit Committee. Additional detail is provided in the report with more analysis on the appendices. A presentation has been included by the Director of Corporate Governance in terms of the outstanding recommendations.
				**Closed Actions**		
Action No.	**Minute Ref.**	**Date**	**Agreed Action**	**Lead**	**Timescale**	**Status**
1.	AC23.93	15.09.23	In relation to the National Audit Report the Acting Board Secretary to add digital inclusion to the Exec agenda and update the Audit Committee through the matter arising.	Associate Director of Governance	Nov 2023	Agreed to close action at meeting on 18.07.24 Acting Board Secretary updated the Executive Team work plan - for inclusion by end of November 2023

							05.03.24 Tabled at the Executive Team (ET) Meeting of the 13 March 2024. *Proposed for closure* – Acting Board Secretary to confirm item is agreed at ET. 15.03.24 Item not agreed for closure - Closure of this item is dependent upon the work plan being agreed at the Executives Meeting. 16.04.2024 – Item to be kept open – To continue to monitor and focus on historical data in relation to learning and progression. Associate Director of Governance (PM) has met with CDIO (DR) and agreed that this will be tabled at Informal Exec Team agenda for 15 May or 29th May 24 This item was included on the agenda for the meeting on 18.07.24.
1.	AC24.57.7.7	07.05.24	Audit Tracker Report format to be reviewed for future reporting, in terms of accessibility.	Director of Corporate Governance	July 2024		<mark>Agreed to close action at meeting on 18.07.24</mark> 10.06.24 - The update at the May Audit Committee was to provide Members with an overarching view of the progress since January 2024. The level of detail provided in the annexes has been reviewed.
2.	AC24.57.7.10	07.05.24	Audit Tracker Report - It was agreed for the flow of live recommendations in relation to Appendix 7 be reviewed.	Chair/ Director of Corporate	July 2024		<mark>Agreed to close action at meeting on 18.07.24</mark> 10.06.24 - Future reports to the Audit

				Governance		Committee will ensure that there is clearer alignment in terms of the recommendations that are closed.
3.	AC24.57.8.4	07.05.24	Tracking of Special Measures - It was agreed to review the tracking process through Committee Structures, in order to maintain oversight.	Director of Corporate Governance	July 2024	Agreed to close action at meeting on 18.07.24 10.06.24 - The tracking of Special Measures will be integrated into the performance reporting at the Board and Committees. First report will be considered by the Board in July 2024.
4.	AC24.58.5	07.05.24	Progress of Risk Management. It was agreed to; Establish the requirement to review the reporting updates of the Risk Management Group, through to Executive Team Meetings. To review frequency in relation to reporting of BAF and CRR at Committees.	Director of Corporate Governance / Head of Risk Management	July 2024	Agreed to close action at meeting on 18.07.24 10.06.24 - Proposal to be discussed at the Board Development in July and report to be presented to the Audit Committee in July before the Board at the end of July.
5.	AC24.16.1 & 2	11.01.23	Lessons Learnt 'Make it safe reviews' system. The Interim Executive Director of Finance suggested the development be sighted in the Executive Team 6Meeting and that QSE has sight of the quality of the system.	Interim Executive Director of Finance	March 2024	Agreed to close action at meeting on 18.07.24 **Actions aligned (Jan 23 & March 24 – items 11 & 2)** Update to the action to be provided at the 15 March Committee. 15.03.24 Item to be kept open – The development of the "make it safe reviews" system was yet to be sighted at Executive Team Meeting, with onwards progression to the Quality, Safety Experience

						Committee. 05.03.24 Minor amendment to reflect EDOF agreement to propose alignment to Action 2 07.05.24 The Interim Executive Director of Finance confirmed that the action was moving forwards and being shared via Operational Teams. The Integrated Concern of Policy and Framework was being developed and would be taken through to the July 2024 Board Meeting. It was also stated that the Quality Management System will also be taken to Board in May 2024 22.05.24 Item requested for sharing. 12.06.24 There is a new Integrated Concerns Policy; which is due at Board in July - Final Copy to be provided to the Committee thereafter. It was also confirmed that the Quality Management System was taken to the last Health Board Meeting.
6.	AC24.57.3.1	07.05.24	To update the draft minutes to edit the word *"review"* to *"conclude"* in the reference: AC24.44.1.3.	Secretariat	May 2024	==Agreed to close action at meeting on 18.07.24== 20.5.24 Item complete. The confirmed minutes are now available on the Public Web Site: Audit Committee - Betsi Cadwaladr University Health Board (nhs.wales).
7.	AC24.57.6.2	07.05.24	Brief written report, listing agenda	The Director of	May 2024	==Agreed to close action at meeting on==

			items taken in "Private Session" to be provided.	Corporate Governance Head of Corporate Affairs		18.07.24 Complete – written summary to be provided at each meeting.
8.	AC24.57.6.3	07.05.24	Terminology change - from "In committee" to "Private" in all Board and Committee Meetings for consistency.	Director of Corporate Governance / Head of Corporate Affairs	May 2024	Agreed to close action at meeting on 18.07.24 Complete – terminology changed
9.	AC24.58.7.1	07.05.24	Risk updates – To update Financial Risks 24.05 and delivery to the financial plan.	Interim Executive Finance Director	May 2024	Agreed to close action at meeting on 18.07.24 24.06.24 The Corporate Risk relating to the 24/25 Financial Plan has been fully updated and has been shared with the Risk Management Group – see CRR24-05.
10.	AC24.58.9	07.05.24	It was agreed for existing due dates to be left extant, along with updated due dates therein. Additional controls should be linked through to the Actions necessary to mitigate the risks. Target risk score of 1 in planned care. Head of Risk Management to revise the target risk, which had been discussed with the relevant lead.	Head of Risk Management	May 2024	Agreed to close action at meeting on 18.07.24 17.06.24 Risks have been further quality assured by the risk team to ensure gaps in controls follow as actions and this has been communicated to corporate risk leads. The target score for planned care was subsequently amended by the risk lead.
11.	AC24.59.2.7	07.05.24	Conformance Report - The Chair and Interim Director of Finance briefly discussed payables and the comparison of detail, value and volume, to the previous year end.	Interim Executive Director	May 2024	Agreed to close action at meeting on 18.07.24 26.06.24 Conformance Report (comparison of PSPP (payables) Data) – Non NHS invoices paid by

			Interim Executive Director to communicate the detail to the Chair.			number 94.5% (22/23 95.0%) and by value 97.0% (22/23 96.8%)
12.	AC24.59.2.14	07.05.24	Quarter 1 Conformance Report update to be provided to the Committee to provide evidence of progress in relation to payable balances over 6 months old in relation to 22/23 financial year.	Interim Executive Director	July 2024	<mark>Agreed to close action at meeting on 18.07.24</mark> 26.06.24 The Q1 Conformance Report will include additional details on the progress made to obtain payment of receivables >6months old.
13.	AC24.59.3.2 AC24.59.3.3	07.05.24	Content of Annual Accounts Meeting – 21/05/24 • Draft Annual Governance Statement (AGS) be provided in advance of the meeting, to Internal and External Audit for comment. It was also agreed to provide the full submission of the AGS to the July 2024 Committee Meeting. It was agreed that the Functional Standard Fraud Return be included within the 21 May Committee meeting for wider discussion.	Director of Corporate Governance / Head of Corporate Affairs	May 2024 and July 2024	<mark>Agreed to close action at meeting on 18.07.24</mark> Completed – agenda planning has taken place.
14.	AC24.60.1.6	07.05.24	Internal Audit update - Work in Progress summary - Lack of progress on Health & Safety and the Operating Model reviews was raised. It was agreed for the responses to be submitted to Internal Audit, along with the Chair of Audit Committee as soon	Director of Corporate Governance	June 2024	<mark>Agreed to close action at meeting on 18.07.24</mark> Completed – reports finalised, agreed to receive the reports at the meeting in July 2024.

			as possible.			
16.	AC24.61.1.6	07.05.24	External Audit Update - The Committee acknowledged the ongoing work and the positive partnership working. With regards to the performance with unscheduled care; it was confirmed that the Audit Lead would update Chair accordingly. It was also noted that the Corporate Governance Director would share the draft reports with members.	Audit Wales Lead / Corporate Governance Director	July 2024	<mark>Agreed to close action at meeting on 18.07.24</mark> 10.06.24 Detail confirmed and forwarded to Committee Members.
17.	AC24.61.2.3	07.05.24	Structured Assessment - Tracking of recommendations, along with systems to manage the process – The progress against tracking of recommendations and regulatory reports would be provided to the Committee.	Corporate Governance Director	July 2024	<mark>Agreed to close action at meeting on 18.07.24</mark> 10.06.24 All recommendations from Structured Assessments since 2019 are now included on the Audit Tracker, with a report on progress to the Audit Committee.
18.	AC24.61.2.6	07.05.24	It was agreed that the Annual Audit Letter would be provided as an appendix to the draft assessment at the next Health Board Meeting. It was also agreed to include the Structured Assessment bi monthly on the Audit Committee Cycle of Business to ensure the delivery of recommendations.	Corporate Governance Director	May 2024 Bi Monthly - CoB	<mark>Agreed to close action at meeting on 18.07.24</mark> Completed.
19.	AC24.61.5.2	07.05.24	National Accounts update - letter issued in February 2024, with regards to the Accounts Audit Approach. It was agreed to circulate to the Audit	Audit Wales Lead/ Audit Committee Secretariat	May 2024	<mark>Agreed to close action at meeting on 18.07.24</mark> 20.05.24 Item Circulated to all Audit Committee Members and Attendees.

			Committee for information.			
20.	AC24.62.1.7	07.05.24	Counter Fraud - Written reports to be provided at Public Session going forwards. (Non-confidential items only).	Counter Fraud Lead	July 2024	<mark>Agreed to close action at meeting on 18.07.24</mark> 26.06.24 Future Counter Fraud Quarterly Update Reports will be written for the Public Session, with only sensitive issues being reported to the Private Session.
21.	AC24.63.1.1	07.05.24	Items for referral to other Committees were agreed as follows: Board Assurance Framework, Corporate Risk Register items, Audit Tracker reporting, and Contracting of Patient Services review and follow up. A discussion also ensued with regards to elements with regards to health and safety, risk oversight, tracking and annual accounts processes.	Head of Corporate Affairs	May/June 2024	<mark>Agreed to close action at meeting on 18.07.24</mark> Completed. Also, the Integrated Governance Advisory Group receives the items that have been referred to Committees.

Teitl adroddiad: ***Report title:***	Board Assurance Framework (BAF) & Risk Governance Arrangements
Adrodd i: ***Report to:***	Audit Committee
Dyddiad y Cyfarfod: ***Date of Meeting:***	Thursday, 12 September 2024
Crynodeb Gweithredol: ***Executive Summary:***	This report provides an updated position on the Board Assurance Framework risks following the approval of the Three-Year Plan and Strategic Objectives. The Executive Team are considering Five Strategic Risks and how these will map to the re-aligned Board Assurance, as agreed by the Board. Good progress has been made in the delivery of the internal recommendations on risk management with a focus on driving down the risks and reviewing the actions to ensure that risks and being managed within the tolerances set by the Board.
Argymhellion: ***Recommendations:***	Members are asked to**:** • **NOTE the** progress on the BAF risks and **RECEIVE** assurance on the risk management governance arrangements.
Arweinydd Gweithredol: ***Executive Lead:***	Pam Wenger, Director of Corporate Governance
Awdur yr Adroddiad: ***Report Author:***	Nesta Collingridge Head of Risk Management

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

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

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

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

Cyswllt ag Amcan/Amcanion Strategol: *Link to Strategic Objective(s):*	Detailed in the BAF report and how the CRR aligns to the revised BAF
Goblygiadau rheoleiddio a lleol: *Regulatory and legal implications:*	It is essential that the Board has robust arrangements in place to assess, capture and mitigate risks, as failure to do so could have legal implications for the Health Board.
Yn unol â WP7, a oedd EqIA yn angenrheidiol ac a gafodd ei gynnal? *In accordance with WP7 has an EqIA been identified as necessary and undertaken?*	Not applicable for this report
Yn unol â WP68, a oedd SEIA yn angenrheidiol ac a gafodd ei gynnal? *In accordance with WP68, has an SEIA identified as necessary ben undertaken?*	Not applicable for this report
Manylion am risgiau sy'n gysylltiedig â phwnc a chwmpas y papur hwn, gan gynnwys risgiau newydd (croesgyfeirio at y BAF a'r CRR) *Details of risks associated with the subject and scope of this paper, including new risks(cross reference to the BAF and CRR)*	Board Assurance Framework paper
Goblygiadau ariannol o ganlyniad i roi'r argymhellion ar waith *Financial implications as a result of implementing the recommendations*	The effective and efficient mitigation and management of risks has the potential to leverage a positive financial dividend for the Health Board through better integration of risk management into business planning, decision-making and in shaping how care is delivered to our patients thus leading to enhanced quality, less waste and no claims.
Goblygiadau gweithlu o ganlyniad i roi'r argymhellion ar waith *Workforce implications as a result of implementing the recommendations*	Failure to capture, assess and mitigate risks can impact adversely on the workforce.
Adborth, ymateb a chrynodeb dilynol ar ôl ymgynghori	First iteration for Risk Scrutiny Group review and subsequently to the committees.

Feedback, response, and follow up summary following consultation	
Cysylltiadau â risgiau BAF: (neu gysylltiadau â'r Gofrestr Risg Gorfforaethol) *Links to BAF risks:* *(or links to the Corporate Risk Register)*	Board Assurance Framework risks will all be linked to corporate risks
Rheswm dros gyflwyno adroddiad i fwrdd cyfrinachol (lle bo'n berthnasol) *Reason for submission of report to confidential board (where relevant)*	This report is available as part of the main committee papers

Camau Nesaf:

Next Steps:
1. Executive Team to provide feedback on draft risks in anticipation of presenting recommended BAF risks to responsible committees for final approval and subsequently to the Nov 2024 Board.
2. Following Board approval, risk authors complete a BAF risk template.
3. Present BAF risks reports in full back to the Risk Scrutiny Group and Executive Team Oct 2024.

Rhestr o Atodiadau:

List of Appendices:

1. Risk Management Report

The purpose of this report is to present the Board Assurance Framework in line with Strategic Objectives. This paper provides assurance to the Audit Committee on the Health Board's risk governance arrangements, progress update on the June 2024 Internal Audit findings, and outlining the Risk Management team's progress in enhancing risk management practices.

2. Board Assurance Framework (BAF)

Every NHS organisation is required to have a board assurance framework, as part of the organisation's approach to risk management. The BAF brings together all of the relevant information on the risks to the delivery of the Board's strategic objectives. It acts as the source of evidence that the Board can rely on to be confident that risks of the delivery of the Board's strategic objectives are being managed and controlled effectively.

2.1 Re-alignment of the Board Assurance Framework

The Annual Delivery Plan set out a delivery action to re-align the Board Assurance Framework with risk appetite, and the emerging strategic objectives of the Health Board by the end of Quarter 3.

Progress has been made to begin to re-align the Board Assurance as described below:

- The Board held a Risk Management Board Developmental Session in June 2024 and discussed the role and purpose of a Board Assurance Framework, considered good practice in the development and design of Board Assurance Frameworks and how BAFs differ from the corporate risk register, and discussed how it could develop the Board Assurance Framework. The Board considered some of the strategic risks the Health Board might face in delivering each of the five new strategic priorities.

- An initial set of proposed strategic risks were proposed to the Board and subsequently approved by the Board in July 2024. As part of the commitments in the Annual Delivery Plan to re-align the Board Assurance Framework to the strategic priorities, the Risk Team in their review recommend that to allow the Board to consider fully the risks to the delivery of the strategic priorities, that the initial strategic risks identified should be expanded to allow more in-depth review and assurances to be provided to the Board.

- The BAF paper was produced following the session, and here is presented to the Risk Scrutiny Group (August 2024) for further review and Executive Team for subsequent discussion at the Audit Committee in September before progressing to the Board.

- The Audit Committee will oversee the development of the Board Assurance Framework on behalf of the Board, with regular updates on progress to re-align the BAF. There will be a much improved BAF in place by the end of March 2025.

2.2 Strategic Risks

- Five strategic risks were developed based on the 5 strategic priorities and were presented at the Board's risk development session 27 June 2024.

  The Executive Team have been asked to consider the 5 strategic risks and practicalities of reporting against the risks.

1. There is a risk of ineffectively deploying strategies for **long-lasting change**, fulfilling our **Environmental and Social Duties** and ambitions and gaining meaningful **engagement** with the population and partners in developing the 10-year strategy and clinical services plan.	**Responsible Executive:** Executive Director of Transformation & Strategic Planning

2.	There is a risk that the Health Board may insufficiently delivery on the required **digital** and information infrastructure to support organisational transformation or make inadequate progress in strengthening the organisation as an **intelligence-driven learning** health system. And further supporting a **culture** that values **continuous learning** and improvement.	**Responsible Executive:** Chief Digital & Information Officer / Deputy Director of People & OD / Executive Director of Nursing
3.	There is a risk that the Health Board may be unable to make required **financial** improvement achieve long term financial sustainability or inefficiencies in resource allocation and utilisation in relation to investments required for **transformational long-lasting change**.	**Responsible Executive:** Executive Director of Finance
4.	There is a risk that the Health Board may be unable to make required **performance improvements** in key challenged services like planned care, urgent care, mental health, and cancer care. This could be caused by resource constraints, **workforce challenges**, or ineffective **improvement strategies**.	**Responsible Executive:** Executive Medical Director / Chief Operating Officer
5.	There is a risk that the Health Board may fail to deliver on R&D **innovative**, application of best practices, to support organisational transformation and drive the required **cultural changes** and embed **compassionate leadership** principles. This could be caused by inadequate training and support for leaders, competing operational pressures and demands.	**Responsible Executive:** Executive Medical Director / Executive Director of Nursing / Deputy Director of People & OD

3. Risk Governance Arrangements

3.1 Risk Scrutiny Group (RSG)

Following a review of the risk governance arrangements, the risk scrutiny group was established. The first meeting was held in June 2024 and has been meeting regularly on a monthly basis, reporting directly to the Executive Team and addressing the recommendations from Internal Audit and the need to streamline the agenda and group membership.

The Terms of Reference and cycle of business is pending Executive Team approval on September 11, 2024. The group have implemented a quarterly cycle of risk audit for all Directors, Divisions, and Integrated Health Communities (IHCs) which assesses risk maturity levels: Basic, Developing, Established, Advanced. The group provides targeted recommendations and provides a route of escalation to significant risks for all Directors, Divisions, IHCs.

Following the commencement of the risk audits conducted July - August 2024, five audits have been completed. The scoring reflects the maturity levels of risk management practices in each area. Scoring: Basic, Developing, Established, Advanced, which has a detailed point scoring system and template audit to which maturity can be measured.

3.1.1 Risk Audit Results Aug 24:

1. Office of the Nurse Director (OND): Established (88 points)
2. Corporate Governance Directorate (CGD): Established (82 points)
3. Finance Directorate: Developing (60 points)
4. Workforce and Organisational Development (WOD): Basic (50 points)
5. Cancer Services Directorate: Basic (42 points)

Detailed feedback is provided to the directorate/divisions with an agreed improvement plan.

3.1.2 Key Findings on Risk Audits

OND and CGD demonstrate well-maintained risk registers with high compliance in mandatory fields and correct risk descriptions. Finance Directorate shows good alignment of risks to appropriate tiers and timely risk reviews. All directorates are correctly aligning risks to their appropriate tiers.

3.1.3 Areas for Improvement on Risk Audits and Driving Maturity

Action plan quality and timeliness is a common issue across Finance, WOD and Cancer, with many lacking SMART criteria. Risk management training coverage could be improved across all areas. Cancer Services and WOD required significant improvements across multiple areas of risk management. In particular timely risk reviews and updates are inconsistent.

The team will support the prioritisation of improvement efforts for Cancer Services and WOD, given their 'Basic' risk maturity level. Some guidance for the Finance Directorate in enhancing the quality action plans and timeliness of management. OND and CGD have been encouraged to address minor areas for improvement to maintain their 'Established' status. Targeted risk management training is being organised.

Follow-up reviews will be conducted for all but, in particular for Finance, WOD, and Cancer Services Directorates in the next quarter to assure improvements have been made. The risk team will continue with ongoing reviews for various Directorates as business as usual and report back to the Risk Scrutiny Group on progress at the following meetings.

The current risk management governance scoring reveals a range of maturity in managing risk across the Health Board. While some directorates demonstrate established practices, others require improvement as anticipated but through measuring and providing focused feedback, there is now clarity on the improvements required. The Risk Management team is committed to supporting all areas in enhancing their risk management maturity and will provide regular updates on progress to the RSG, ET and Audit Committee.

3.2 Internal Audit Findings and Responses

The June 2024 Internal Audit on Risk Management received a Limited Assurance rating. Progress on the four high-priority recommendations:

Recommendation & Status	Progress
Operational Risk Registers Status: Open	- Regular communications to risk leads for overdue risks. Noted improvement from

	53% to 35% (tolerance for overdue risks being 15%) - Automated monitoring and email notification system launch planned for September 2024.
Formal Review of Operational Risk Registers Status: Closure Pending Executive Team approval	- Quarterly risk register audit cycle implemented. - Formal escalation route established through RSG. - Recommendations provided to services/IHCs with monitoring in place.
Review of Corporate Risk Register Status: Open	- Initial review and quality assurance completed by corporate risk team. - Scheduled for Executive Team review on September 18, 2024 and monthly there after.
Review of Risk Management Group Status: Open	- RSG established, meeting monthly from June 2024. - Risk Forum created for broader engagement. - Awaiting Executive Team approval of Terms of Reference and cycle of business.

4. Risk Management Team Progress

The risk management team have made progress in ongoing strengthening of risk arrangements Health Board wide and track progress in a detailed annual work plan which feeds into a wider three year plan for the team, with the aim of continuous improvement.

4.1 Risk Management Annual Work Plan

- Quality Assurance: 64% of risks have been quality assured against December target of 85%. This strengthens all risks maintained on Datix, ensuring quality of risks documented.

- Overdue/Beyond Target Risks: Reduced from 53% to 35% (overdue) and 25% to 19% (beyond target). Tolerance level to be 15% for both.

- Mandatory Training (partially completed): Level 1 basic mandatory training for all staff remains pending final review. The Level 2 Operational Risk Management for all Datix risk leads, due to be uploaded to ESR. The Level 3 Strategic Risk Management Training have been arranged face to face targeting senior leaders across the Health Board, three dates have been booked in Sept across all three acute sites with 225 senior leaders booked, mop up session planned for November 2024.

4.2 Key Initiatives

- Developing a maturity matrix for risk management.

- Implementing a risk management dashboard for better benchmarking, oversight of all risk KPIs to improve reporting and measuring of governance in relation to risk with the aim to increase the maturity of the Health Board. Pilot to be completed end of Sept for roll out across the Health Board.

- Power Automate integration for risk processes for ease of risk reminders on overdue risks, overdue actions and risks beyond their target date for reduction.

- Reviewing the Planning and Performance Framework ensuring risk management is integrated fully.

4.3 Training and Development

- Conducted Board training on risk management and risk appetite (completed June 27, 2024).

4.4 Communication and Transparency

- Implemented fortnightly communications on overdue/beyond target risks (completed).

- Updated risk management policies (RM01/RM02) presented to Audit Committee and Board highlighting changes to the RSG and escalation routes (completed).

5. Conclusion

The Corporate Risk Team are progressing in line with targets on all Internal Audit findings, implementing structural and procedural changes to enhance risk governance. The Risk Management team continues to make progress in improving risk oversight, training, and communication. While some initiatives are still pending final approval or implementation, there is evidence of a systematic and comprehensive approach to elevating risk management practices across the organisation.

Next steps
- Present recommended BAF risks to responsible committees and Audit Committee for final approval and subsequently to the Nov 2024 Board Meeting.
- Following Board approval, risk authors complete a BAF risk template.
- Present BAF Risks to the Risk Scrutiny Group and Executive Team Oct 2024

- BAF to be fully developed and progress reported through to Nov Audit Committee.

Board Assurance Framework

June

Initiation

June Board Developmental Session Identifying BAF Risks

Risk Scrutiny Group and Executive Team review BAF dashboard in anticipation of completing a full BAF report. To be presented at Committees for further approval and approval at Sept 2024 Board

Aug

Planning

Oct

Execution

Dec

Once risks approved at Executive Team meeting, BAF risks to be drafted in anticipation of individual Executive review and Risk Scrutiny Group Oct

BAF risks reported back to Risk Scrutiny Group in Oct & Dec in anticipation of full BAF report at committees and subsequently Board in March

Feb

Monitoring

Mar

Teitl adroddiad: *Report title:*	Review of Speaking up Safely (whistle blowing arrangements)			
Adrodd i: *Report to:*	Audit Committee			
Dyddiad y Cyfarfod: *Date of Meeting:*	Thursday, 12 September 2024			
Crynodeb Gweithredol: *Executive Summary:*	Beth yw pwrpas y papur, a yw'n eitem sefydlog/untro? Pa gamau sydd angen i'r Bwrdd eu cymryd gyda'r adroddiad hwn? This paper provides an update report on BCUHB's approach to supporting staff to raise concerns, Speaking Up Safely (SUS), including those related to public disclosure/whistleblowing			
Argymhellion: *Recommendations:*	Gofynnir i'r Bwrdd: Nodi/cymeradwyo .... The Committee is asked to **note** the continued development of the SUS approach in BCUHB.			
Arweinydd Gweithredol: *Executive Lead:*	Jason Brannan, Deputy Director of People Services			
Awdur yr Adroddiad: *Report Author:*	Gareth Evans, Senior Organisational Development Manager			
Pwrpas yr adroddiad: *Purpose of report:*	I'w Nodi *For Noting* ☒	I Benderfynu arno *For Decision* ☐		Am sicrwydd *For Assurance* ☒
Lefel sicrwydd: *Assurance level:*	Arwyddocaol *Significant* ☐ Lefel uchel o hyder/tystiolaeth o ran darparu'r mecanweithiau / amcanion presennol *High level of confidence/evidence in delivery of existing mechanisms/objectives*	Derbyniol *Acceptable* ☒ Lefel gyffredinol o hyder/tystiolaeth o ran darparu'r mecanweithiau / amcanion presennol *General confidence / evidence in delivery of existing mechanisms / objectives*	Rhannol *Partial* ☐ Rhywfaint o hyder/tystiolaeth o ran darparu'r mecanweithiau / amcanion presennol *Some confidence / evidence in delivery of existing mechanisms / objectives*	Dim Sicrwydd *No Assurance* ☐ Dim hyder/tystiolaeth o ran y ddarpariaeth *No confidence / evidence in delivery*

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

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

Cyswllt ag Amcan/Amcanion Strategol:

Link to Strategic Objective(s):	
Goblygiadau rheoleiddio a lleol: ***Regulatory and legal implications:***	e.e. Yr Awdurdod Gweithredol Iechyd a Diogelwch e.g. Public Interest Disclosure Act (PIDA) Welsh Govt. Speaking Up Safely framework All Wales Raising Concerns Policy and Procedure
Yn unol â WP7, a oedd EqIA yn angenrheidiol ac a gafodd ei gynnal? ***In accordance with WP7 has an EqIA been identified as necessary and undertaken?***	Do/Naddo *Y/N* Yes
Yn unol â WP68, a oedd SEIA yn angenrheidiol ac a gafodd ei gynnal? ***In accordance with WP68, has an SEIA identified as necessary been undertaken?***	Do/Naddo *Y/N* Not applicable
Manylion am risgiau sy'n gysylltiedig â phwnc a chwmpas y papur hwn, gan gynnwys risgiau newydd (croesgyfeirio at y BAF a'r CRR) ***Details of risks associated with the subject and scope of this paper, including new risks(cross reference to the BAF and CRR)***	(crynodeb o'r risgiau a rhagor o fanylion yma) Risks relate to: - capacity within the SUS team to provide a responsive service - uptake and use of SUS by staff from all sections of the workforce - awareness and promotion of SUS for staff without regular access to intranet or email
Goblygiadau ariannol o ganlyniad i roi'r argymhellion ar waith ***Financial implications as a result of implementing the recommendations***	No additional financial implications
Goblygiadau gweithlu o ganlyniad i roi'r argymhellion ar waith ***Workforce implications as a result of implementing the recommendations***	No additional workforce implications
Adborth, ymateb a chrynodeb dilynol ar ôl ymgynghori ***Feedback, response, and follow up summary following consultation***	(crynodeb o sut mae'r papur wedi cael ei adolygu, yr ymateb a pha newidiadau a wnaed ar ôl cael adborth) Not applicable – update report
Cysylltiadau â risgiau BAF: (neu gysylltiadau â'r Gofrestr Risg Gorfforaethol) ***Links to BAF risks:***	Not applicable

(or links to the Corporate Risk Register)	
Rheswm dros gyflwyno adroddiad i fwrdd cyfrinachol (lle bo'n berthnasol)	Amherthnasol
Reason for submission of report to confidential board (where relevant)	Not applicable

Camau Nesaf:
Gweithredu argymhellion

Next Steps:
Continued support for implementing SUS in BCUHB

Rhestr o Atodiadau:
    Dim

List of Appendices:

- Appendix 1: Welsh Government Speaking Up Safely framework
- Appendix 2: Word copy of SUS article on Betsi.Net
- Appendix 3: Word copy of SUS article on Betsi.Net linked to BCUHB statement around challenging sexual misconduct in the workplace

1. **Cyflwyniad / Cefndir**
   Y cyd-destun sy'n esbonio pam fod yr adroddiad yn cael ei gyflwyno i'r Bwrdd/Pwyllgor, unrhyw gamau ymgynghori blaenorol, a'r pwrpas o'i gyflwyno i'r Bwrdd

   Introduction/Background

   This report is submitted to the Audit Committee to provide an update as to the current situation in BCUHB related to the implementation and continued work of Speaking Up Safely (SUS), BCUHB's approach to supporting staff to confidently raise concerns when usual routes are unavailable.

   SUS was first implemented in BCUHB in July 2021 as Speak Out Safely. The name change in October 2023 coincided with the launch of the Welsh Government's Speaking Up Safely framework, to which BCUHB substantially contributed.

   Process:

   BCUHB's SUS approach consists of the following elements:

   o Freedom to Speak Up Guardian cohort (originally called Speak Out Safely Guardians)
   o A multi-disciplinary team consisting of senior clinical and corporate colleagues who would act as conduits for connecting concerns raised by staff to people and/or departments within BCUHB with a legitimate remit to address the specific nature of concern being raised
   o Provision of an independent web based platform that provides staff with the opportunity to raise concerns anonymously and engage in two-way conversation with a member of the MDT
   o Speaking Up Safely Champions who raise awareness of SUS in local work contexts, including how to access the service via the elements set out above
   o Betsi.Net information pages with details about the team, how to access Work in Confidence and what to expect when you've raised a concern. To date, over 2000 staff have visited the main Speaking Up Safely intranet page.

   This report provides an update to the Committee in the main on activity and developments within SUS across the last 12 months.

2. **Corff yr adroddiad /** *Body of report*

   Developments over the last 12 months:
   In October 2024, Welsh Government launched the Speaking up Safely framework for NHS Wales (see appendix 1). Members of the SUS team supported the national work

undertaken around the new framework, contributing to the development of the framework itself and the toolkit 1 – co-designing and implementing a Speaking up Safely culture. After the framework was launched, all NHS organisations completed a review of their current speaking up arrangements, based on a set of requirements set out in section six of the SUS framework. BCUHB have completed a review of our current offer and as per Welsh Government requirements submitted an action plan based on our findings to ensure alignment between BCUHB's offer and the minimum standards set out in the framework.

Following this, we have commenced refresh our organisational approach in line with the national framework in early 2024. This includes work on updating and refreshing our current BetsiNet pages, promotional materials, posters, and teaching content (e.g. Corporate Orientation, information provided on Leadership and Management development programmes, training sessions conducted with local university partners, etc.) to bring the branding and messaging in line with the national approach.

As part of the action plan work, we will be undertaking a comprehensive review of the SUS approach to date, seeking colleague and partner perspectives, input from our staff networks, as well as user feedback and staff stories, if staff are willing to share such. This will enable us to evaluate the experience and impact of SUS to date and ensure any improvements required are made as we transition to Speaking Up Safely. Core service elements such as the SUS MDT, F2SU Guardian and the use of the anonymous, two-way conversation platform, Work in Confidence will continue to be deployed and/or enhanced as per feedback and learning, as such already go beyond the minimum specifications for service provision set out in the national framework guidance.

Additionally, we have secured agreement at Executive level to support the recruitment of a permanent F2SU Lead Guardian (30hrs per week) at Band 8a. The advert for this post was put out in August 2024, and interviews are currently planned for September 2024.

During this 12 month period we have also worked on our communication and engagement work, providing both an update story about SUS on the Betsi.Net front page (see appendix 2), and providing information on how staff can access and use SUS to raise concerns linked to national media coverage around sexual misconduct in health care (see appendix 3). We have also collaborated with colleagues responsible for hosting BCUHB's Corporate Induction processes for all new starters to ensure information is provided on SUS and how to access support if required. Information on SUS is also included in our Foundations of Management and Leadership programme to ensure all people coming into their first management role, are aware of SOS and can effectively signpost staff to it if needed. Additionally, we continue to engage with colleagues in Bangor and Glyndwr Universities to provide awareness sessions to student nurses and physiotherapy students on placement in BCUHB. Finally, we are reviewing our current bi-lingual posters on the role of the F2SU Guardian and on how to use Work in Confidence to ensure they are branded in relation to the All Wales Speaking Up Safely framework.

Current team membership

Our current Freedom to Speak Up Guardians are:

- o   Tracey Eccles, Lead F2SU Guardian
- o   Kathryn Seeney, F2SU Guardian (fixed term contract until March 2025)

The current MDT membership is:

- o   Dr Jim Mcguigan, Deputy Executive Medical Director
- o   Andrea Orme – Associate Director of People Services
- o   Reena Cartmell – Director of Nursing Quality, Assurance and Learning
- o   Justine Parry – Assistant Director of Compliance and Business Management
- o   Dr Kath Clarke – Head of Quality
- o   Clare Jones – Corporate Health and Safety Manager
- o   Rebecca Testa – Head of Organisational Development
- o   Melany McKenna/Kate Shakespeare – Principle Clinical Psychologist/Clinical Psychologist (alternating meetings)
- o   Gareth Evans – Lead for SOS and Chair of the SOS MDT

Total activity data (Work in Confidence) since SUS commenced – 12th July 2021 – 1st August 2024

Category	Number Received	Percentage
Leadership & Management issues	42	23.3%
Bullying / Harassment	39	21.6%
Patient Safety/Quality	29	16.2%
Staff Safety	18	10%
Other	17	9.5%
Behavioural/Relationship	16	8.8%
Systems & Processes	10	5.6%
Equility, Diversity & Inclusion	8	4.5%
Infrastructure / Environmental	1	0.5%
Total	**180**	**100%**

Number of Cases Closed	Average Time to Respond	Average Time to Close	Average Satisfaction Rating
175 (97.2%)	6 days	77 days	4.4/5

375 staff registered to use the Work in Confidence platform during this period. Of that number, 335 have completed the registration process and have access to use the platform to raise concerns.

Twelve month activity data (Work in Confidence) – 1st August 2023 – 1st August 2024

Category	Number Received	Percentage
Bullying / Harassment	16	27.7%
Leadership & Management issues	15	26%
Patient Safety/Quality	11	19%
Equility, Diversity & Inclusion	5	8.6%
Other	4	6.8%

Behavioural/Relationship	3	5.2%
Staff Safety	2	3.4%
Systems & Processes	2	3.4%
Total	**58**	**100%**

Number of Cases Closed	Average Time to Respond	Average Time to Close	Average Satisfaction Rating
53 (91.3%)	4 days	42 days	4.57/5

74 staff (out of the total figure of 375) have initially registered with the Work in Confidence platform over the last 12 months, with 71 completing the full registration process allowing them access to the platform and the ability to raise concerns. Of note, over the last 6 months, the average response time has dropped to 3 days.

Total activity data for Freedom to Speak Up Guardians – 12th July 2021 – 1st August 2024

Category	Number Received	Percentage
Leadership & Management issues	18	28%
Bullying & Harassment	9	14.5%
Behavioural/Relationships	9	14.5%
Systems & Processes	8	12.5%
Patient Safety & Quality	7	10.9%
Other	6	9.3%
Equality, Diversity & Inclusion	5	7.3%
Staff Safety	2	3%
Total	**64**	**100%**

Twelve month activity date for F2SUG – 1st August 2023 – 1st August 2024

Category	Number Received	Percentage
Behavioural/Relationships	5	25%
Other	4	20%
Patient Safety & Quality	3	15%
Bullying & Harassment	3	15%
Leadership & Management issues	2	10%
Systems & Processes	2	10%
Equality, Diversity & Inclusion	1	5%
Total	**20**	**100%**

3. **Goblygiadau Cyllidebol / Ariannol / *Budgetary / Financial Implications***

There are no additional budgetary implications associated with this paper.

4. **Rheoli Risg / Risk Management**

> There are no risks associated with DATIX in relation to the provision of the SUS service and approach

5. **Goblygiadau Cydraddoldeb ac Amrywiaeth /** *Equality and Diversity Implications*

> This report does not relate to the need for a strategic level decision.

Gareth Evans
Senior Organisational Development Manager
Chair, Speaking Up Safely MDT

Speaking up **Safely**

A Framework for the NHS in Wales

Supporting people to **speak up safely and with confidence**

Contents

1. NHS Wales and the broader policy context

The principles and practices associated with Speaking Up Safely outlined in this framework document should be considered within the broader NHS Wales and UK policy context. Speaking Up Safely is an initiative which supports, rather than replaces, existing policy, such as:

- Procedure for NHS Staff to Raise Concerns
- NHS Wales Policy: Respect and Resolution
- Welsh Government Law: The Health and Social Care (Quality and Engagement) (Wales) Act
- UK healthcare regulation: e.g. codes of practice provided by the NMC, HCPC and GMC
- UK Law: Public Interest Disclosure Act 1998

The Speaking Up Safely Framework has also been informed by international guidelines[1,2] and research evidence[3, 4, 5].

Whistleblowing and Protected Disclosures - Definitions

'Whistleblowing' is the popular term applied to a situation where an employee, former employee or member of an organisation raises concerns to people who have the power and presumed willingness to take corrective action. 'Protected disclosure' is the legal term for whistleblowing and is referenced in the context of describing the protection that is afforded to the person raising the concern in the interest of the public.

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1. ISO 37002:2021 Whistleblowing management systems — Guidelines https://www.iso.org/standard/65035.html
2. UNODC (2021) Speak up for health! Guidelines to enable whistle-blower protection In the health-care sector
3. Jones A et al (2022) Evaluation of the implementation of Freedom to Speak Up Local Guardians in NHS Acute Hospital Trusts and Mental Health Trusts in England https://funding awards.nihr.ac.uk/award/16/116/25
4. Jones, A et al (2021) Interventions promoting employee "speaking-up" within healthcare workplaces: a systematic narrative review of the international literature. Health Policy 125 (3), pp. 375–384
5. Jones, A. and Kelly, D. M. (2014) Whistle-blowing and workplace culture in older peoples' care: qualitative insights from the healthcare and social care workforce. Sociology of Health and Illness 36 (7), pp. 986–1002.

2. Introduction

Following the publication of **A Healthier Wales** and the creation of the **Workforce Strategy for Health and Social Care**, it became clear that NHS Wales needed to develop its approach to organisational culture and behaviour. This links to the approach of developing healthy working relationships which aims to foster more compassionate, collective, healthier and fairer behaviours, workplaces and organisations. It is recognised that there are key pan-NHS Wales opportunities to lever change including **leadership development**, changing targets/ focus (such as colleagues' experiences of work) and using people 'policies'.

This Framework sets out the responsibilities of organisations, their executive teams and boards, along with those of managers and individual members of staff (and volunteers) in creating a culture in which 'Speaking Up', alongside timely and appropriate response to any concerns raised, is supported within a safe environment. This Framework will be supported in its implementation by a series of toolkits.

Having effective arrangements which enable staff to speak up (also referred to as 'raising a concern') helps to protect patients, the public and the NHS workforce, as well as helping to improve our population's experience of healthcare. It is essential to ensure that all individuals have a voice, are listened to, and receive a timely and appropriate response.

This Framework will support organisations to create that culture; one where individuals feel safe and able to speak up about anything that gets in the way of delivering safe, high-quality care or which negatively affects their experience. This includes, but is not limited to, matters related to patient safety, safe staffing, the quality of care, bullying and harassment (and cultures which enable this), as well as financial malpractice or fraud.

To support this, leaders and managers need to be willing to listen, and to be open to constructive challenge. Speaking up and bringing these issues into the open is a brave and vulnerable thing to do, and therefore should be welcomed and seen as an opportunity to listen, learn and improve.

This is the Framework that organisations, departments and teams are required to follow in order to establish and sustain a culture where no individual will suffer victimisation or detrimental treatment as a result of speaking up, and where organisations learn and improve as a result of listening and responding to concerns raised.

Not all sections of this framework will be relevant to everybody. However, while it is clear who the relevant sections are intended for, depending on your role within the NHS you may wish to familiarise yourself with sections which may not initially be relevant to you.

3. Principles of Speaking Up Safely

3.1   All those engaged with the NHS have a contractual right and duty to raise genuine concerns with their employer about malpractice, patient safety, financial impropriety or any other serious risks they consider to be in the public interest. In addition, staff have duties imposed upon them to raise such concerns by their respective professional regulatory bodies.

3.2   All organisations recognise the need to continuously improve to make every effort to address and correct issues threatening patient safety as quickly as possible, to work with colleagues to this end and to ensure that at all times they do all they can to act on the side of the solution. Consciously creating culture of 'Speaking Up Safely' is key to this aim.

3.3   All organisations, departments and teams have a duty to create a culture where individuals know how to raise a concern, are aware of the process that will follow, and where they can be confident that if they do raise a concern, they will receive support without experiencing personal or professional detriment.

3.4   It is not necessary for an individual to have concrete proof of an act that they wish to report – a reasonable belief is sufficient. Individuals are encouraged to raise any concern at the earliest opportunity so that there is time to assess the issues within a supportive environment.

3.5   Individuals who speak up do not have responsibility themselves for investigating the matter (where this is required). It is the organisation's responsibility to ensure that where appropriate, an investigation takes place.

3.6   Organisations also have responsibility to ensure that those responding to concerns are prepared and supported to respond promptly or are able to delegate to someone who can. Managers will have training on how to deal with concerns that have been raised.

3.7   Organisations should encourage individuals to raise concerns using the designated procedure in the first instance. If an individual is not sure whether or not to raise a concern, they should discuss the issue with a manager or the Workforce and OD department or for those registered with a trade/professional union, with their representative or their trade/professional union's employment advice service.

3.8   In line with NHS Wales policy, individuals are encouraged to raise the concerns within the organisation at the earliest possible opportunity. This framework seeks to ensure that the organisation has the appropriate mechanisms and culture in place through which concerns will be appropriately addressed.

3.9   If an individual speaks up or raises a concern in Welsh, it will not be treated any less favourably than if it had been raised in English. Individuals speaking up in Welsh can expect any subsequent written correspondence or response in Welsh. If meetings are arranged about the concern, the organisation will actively offer to conduct the meeting in Welsh.

3.10   Any matter raised will be reviewed thoroughly, promptly and confidentially, and the individual raising a concern will receive appropriate feedback (see Toolkits 2 and 3).

3.11   If an individual raises a genuine concern, they will not be at risk of losing their job or suffer any detriment. Where an individual (who has raised concerns) may nonetheless be at risk of or fear detriment or any potential harm by continuing to work in their existing

role or place of work, suitable action will be taken, in agreement with the individual, which could include redeployment.

3.12   Victimisation or harassment of an individual for speaking up / raising concerns will be considered a serious disciplinary offence, as will any action to 'cover-up' or wilfully ignore concerns.

3.13   Individuals are encouraged to raise concerns openly. However, there may be circumstances when individuals may request that their identity is not revealed. In this case, the organisation will not disclose their identity without their consent unless required to by law. There may, however, be times when the organisation may be unable to resolve a concern without revealing the individual's identity, for example where personal evidence is essential. In such cases, the organisation will discuss with the individual whether and how the matter can best proceed. Where the concern is a matter of staff or patient safety in line with Duty of Care, there may well be a need for escalation and anonymity may not be able to be maintained. Where this cannot be avoided, however, this will be made clear to the individual who has raised the concern.

3.14   Where an anonymous concern is received, a designated contact will still examine the contents of the concern with relevant senior managers and investigate where necessary. However, without the investigator being able to talk to the individual(s) who has (have) raised the concern and without possibly being able to attain any additional facts as a result, it needs to be recognised that it may be difficult for a full investigation to be undertaken. In these circumstances, supporting and protecting the individual, or giving them feedback, may be very difficult. Accordingly, The individual may not be able to be provided the assurances offered above. Organisations should routinely consider, log and monitor anonymous concerns.

3.15   All managers will have discussions within the PADR (Performance and Development Review) process about speaking up if staff members have any concerns, as well as within their own PADR in respect of dealing with concerns when they arise.

3.16   Organisations should identify an Independent Member/Non-Executive Director to act as a 'Speaking Up Safely Board Champion' and an Executive Director as 'Speaking Up Safely Executive Lead', as a minimum, and may wish to appoint additional roles for speaking up. As a minimum, organisations should ensure that those with responsibility for speaking up are sufficiently independent to provide staff with confidence when speaking up.

4. Expectations

Every employee involved in the NHS in Wales will have certain expectations placed upon them in relation to speaking up safely. The following sets out what those expectations are at different levels and roles within organisations.

4.1   Employees

All NHS Wales employees have a role in identifying issues and speaking up. Registered staff also have a professional responsibilities to identify and speak up appropriately. The following are expectations of all employees in the NHS.

* Behave in a way that encourages individuals to speak up.
* Where you have concerns, ensure these are raised in a timely and appropriate manner in line with local policies and procedures.
* Encourage and be supportive of those who speak up.
* Do not victimise, bully or discriminate.
* Embrace speaking up as an opportunity to learn and grow as an individual and as a team, as well as for the organisation as a whole.
* Utilise Toolkit 2 in this framework when speaking up.

4.2 Line Managers

All managers have a responsibility for creating a 'psychologically safe' culture which enables individuals to highlight problems and make suggestions for improvement. Speaking Up Safely is a fundamental part of that. An organisational or departmental culture of bullying and harassment, or one that is not welcoming of new ideas or different perspectives, will prevent individuals from speaking up, put patients at risk, affect many aspects of the well-being and working lives of staff, and reduce the likelihood that improvements can be made. Managers, as leaders, should understand the impact their behaviour can have on an organisation's culture and therefore how important it is that they reflect on whether their behaviour may inhibit or encourage someone from speaking up (See Toolkit 3).

Line Managers will:

* Be able to articulate both the importance of workers feeling able to speak up and how they will enable this within the organisation's vision.
* Speak up, listen and act (see Toolkit 3).
* Be visible and approachable and welcome staff who wish to speak up.
* Have insight into how their power and position could silence individuals, and how their own unconscious bias and belief systems could impact on how they receive individuals who speak up.
* Thank workers who speak up.
* Demonstrate that they have heard when workers speak up by providing feedback.
* Seek feedback from peers and workers to help them reflect on how effectively they demonstrate the organisation's values and behaviours.
* Accept challenging feedback constructively, publicly acknowledge mistakes and make improvements.

4.3 Boards

NHS Organisations in Wales are expected to implement the Speaking Up Safely approach outlined in this framework (see Toolkit 1). The Board should take into account the toolkits attached and align with the All-Wales branding that ensures individuals who move from one NHS Wales organisation to another can easily identify with the 'Speaking Up Safely' approach.

The Board should demonstrate its commitment to creating an open and honest culture where workers feel safe to speak up by:

* Having named Executive and Independent Member/Non-Executive Directors Leads responsible for speaking up.
* Acting as role models within the organisation.
* Including speaking up and other related cultural issues in board development programmes and Staff Partnership Fora.

- Having a sustained and ongoing focus on the reduction of bullying, harassment and incivility.
- Sending out clear and repeated messages that it will not tolerate the victimisation of workers who have spoken up, and taking action should this occur, with these messages echoed in relevant policies and training.
- Investing in sustained and continuous leadership development.
- Ensuring the organisation has an appropriately resourced Speaking up Safely approach and champion model.
- Supporting the creation of an effective communication and engagement strategy that encourages and enables workers to speak up, and promotes changes made as a result of speaking up.
- Inviting individuals who speak up to present their experiences in person to the board and staff partnership fora.
- Monitoring the extent to which concerns are being raised and addressed, and identifying learning and improvement needs as a result.

4.4 Independent Member/Non-Executive Director 'Board Champion' for Speaking Up Safely

The Independent Member / Non-Executive Director Champion for Speaking Up Safely is a senior, independent lead role specific to organisations with boards.

They should:

- Hold the Board and the Executive Team to account in the delivery of a Speaking up Safely culture.
- Seek assurance that the Board responsibilities and expectations of this framework are implemented.
- Be a 'fresh pair of eyes' to ensure that investigations are conducted with rigour and to help escalate issues, where needed.
- Have appropriate knowledge of Speaking Up Safely and be able to readily articulate:
  – why a healthy speaking-up culture is vital;
  – the indicators of a healthy speaking-up culture;
  – the indicators that there is sufficient support for speaking up and wider culture transformation;

  – the red flags that should trigger concern.
- Constructively challenge the most senior people in the organisation to reflect on whether they could do more to create a healthy, effective speaking-up culture. This might involve constructively raising awareness about poor behaviours.
- Be accessible to staff to provide support and guidance on how to and where to go to for advice and representation in Speaking Up Safely issues (with a clear delineation of roles). Independent members will not advocate, advise or represent employees in speaking up safely concerns.

Organisations/Hosted Organisations without Boards are likely to benefit from having an equivalent role.

4.5 Executive Leads for Speaking Up Safely

Having an Executive Lead for Speaking Up Safely helps demonstrate the organisation's commitment to speaking up. Importantly, this person should be widely considered a credible role-model of the behaviours that encourage speaking up. They should be able to show that they are clear about their role and responsibility, and to evidence how they have helped improve the organisation's speaking-up culture.

The Executive Lead should be accountable for:

- Co-designing, with the wider Executive Team, a plan for Speaking Up Safely, and implementing a Speaking Up Safely culture.
- Implementation and delivery, with the wider Executive Team, of a Speaking Up Safely Culture.
- Evaluating speaking-up arrangements and gaining assurance that the experience of workers who speak up is a positive one.
- Ensuring there is appropriate resource for Speaking Up Safely.
- How the organisation periodically reviews its speaking up safely arrangements.
- Ensuring there is a link to learning from events/incidents processes, and organisational governance arrangements.
- Liaising with the Independent Member/Non-Executive Director Champion.
- Providing the Board with assurance around all of the above.

5. Implementing and improving a Speaking Up Safely Culture

5.1 Implementation of Speaking Up Safety culture

In order to implement this framework, it is expected that organisations have a clear vision for the speaking up culture that links the importance of encouraging individuals to speak up with patient safety, staff experience and continuous improvement. Co-designing, implementing and improving a Speaking Up Safely culture should always be undertaken in social partnership. Toolkit 1 provides further information

Organisations will need to, in social partnership, develop a plan of how to deliver this framework. This should be led by the Executive Lead for Speaking Up Safely. The plan should also be informed by key Speaking Up Safely stakeholders, such as Trade Unions, HR, OD and those representing minority communities. The Board should discuss and agree the plan and be provided with regular updates. The plan and ongoing review is co-produced with the organisation's staff partnership arrangements, staff networks and organisational engagement arrangements.

Among other things, the Executive Lead for Speaking Up Safely and the IM/NED Speaking Up Safely Champion will:

- Review the plan annually in social partnership, including how it fits with the overall organisational strategy, using a range of qualitative and quantitative measures.

- Assess what has been achieved and what more there is to do, using a continuous improvement approach.

- Identify the barriers to Speaking Up and how they will be overcome.

- Identify whether the right indicators are being used to measure success (see Toolkit 4).

- Help drive collaboration on an All-Wales basis to deliver, as far as possible, a consistency of approach to Speaking Up Safely across organisations, noting local and organisational context.

5.2 Be assured your Speaking Up Safely Culture is Healthy and Effective

The Board must be continuously assured that individuals will speak up about things that get in the way of providing safe and effective care and that this will improve the experience of patients and staff. Boards should not assume that the Speaking Up Safely culture is static; culture can improve, regress or stagnate for a variety of reasons, and sub-cultures will exist within organisations. Boards must monitor trends in the reasons for staff speaking up. Boards will also need further assurance when there have been significant changes, where changes are planned, or there have been negative experiences such as:

- Before a significant change (such as a merger or major service change).

- When an investigation has identified a team or department has been poorly led, or a culture of bullying has developed.

- When there has been a significant service failing.

- Following a Healthcare Inspectorate Wales inspection where concerns have been identified.

- Following a triangulation of data from a range of sources such as turnover, exit interviews, TU colleague feedback, staff surveys, grievances, work-related stress sickness, and clinical/operational indicators (See toolkit 4).

It is the Executive Lead's responsibility, supported by and in conjunction with the wider-Executive Team, to ensure that the Board receives a range of assurance and regular updates in relation to the Speaking Up Safely plan and implementation

of this framework. The organisation's Speaking Up Safely arrangements must be based on the most recent NHS Wales policy and legal requirements (see examples on page 2 of this document). If the Board is not assured its staff feel confident and safe to speak up, it should consider requesting remedial action to address any concerns. The Board should use a range of resources for developing and monitoring its Speaking Up Safely culture. Toolkit 4 should be considered as a basis for the information that organisations should collect to inform their understanding of the cultures within their organisation.

5.3 Be open and transparent with external stakeholders

A healthy Speaking Up Safely culture is created by organisations and Boards that are open and transparent and see speaking up as an opportunity to learn. Executives are required to routinely discuss challenges and opportunities presented. The Board will welcome engagement with, and feedback from, these stakeholders. The Board is required to regularly discuss progress in this area (respecting the confidentiality of individuals), along with themes and issues arising from the Speaking Up Safely approach. Regular and in-depth reviews of leadership and governance arrangements in relation to Speaking Up Safely will help organisations to identify areas for further development.

6. Requirements for organisations

Organisations will:

a. Appoint an Independent Member/ Non-Executive Director as Speaking Up Safely Champion as well as an Executive Lead.

b. Ensure adequate investment that provides sufficient resource to support the continuous development of the organisational Speaking Up Safely approach and associated culture change.

c. Embed Speaking Up Safely in the functions of a board committee, which can be an existing committee, to support the champion/lead for speaking up in terms of guiding the organisation's approach. Membership of the committee should consist of a range of key stakeholders, including (but not limited to) some of those identified in Section 4.

d. Ensure that clear and easy to follow processes are in place to allow individuals to raise concerns (including anonymously). The NHS Wales Procedure for Staff to Raise Concerns is a necessary minimum standard, but is not in itself sufficient for facilitating and supporting a Speak Up Safely culture.

e. Identify those groups which experience the most barriers when speaking up and ensure that processes are inclusive and equitable.

f. Ensure that the response mechanism/process is continuously monitored, clear and timely (equally as important as the procedure to raise concerns – see Toolkit 4).

g. Ensure that individuals speaking up do not suffer detriment as a result of raising concerns.

h. Undertake regular reviews of responses, as well as of the leadership and governance arrangements in place, and provide regular reports to the appropriate committee.

i. Ensure that arrangements are in place to monitor concerns/issued raised against the protected characteristics of the Equality Act 2010 and the implementation of any learning as a result of this.

j. Request feedback from all individuals who have spoken up and evaluate the feedback received (consider inviting a sample of individuals who have spoken up to attend committees and Board meetings to discuss experiences and share learning).

k. Fully implement the All-Wales branding/messaging for Speaking Up Safely.

l. Continuously/consistently promote and raise awareness of speaking up and listening/responding as a pro-social/desirable behaviour.

m. Ensure that appropriate training to deliver a Speaking Up Safely culture is rolled out to leaders, managers and staff throughout the organisation, as part of leadership and management development arrangements.

Toolkit 1: **Co-designing and implementing a Speaking Up Safely Culture**

Introduction

This framework provides an outline of the process of Speaking Up, but organisations will need to develop their Speaking Up Safely culture. There may also need to be local difference to the process of speaking up in each organisation. This toolkit provides a guide that NHS organisations must follow to co-design and implement a Speaking Up Safely culture.

Section One:
What needs to be in place to develop a Speaking up Safely culture

Organisations need to ensure that their values and cultures create healthy speaking up environments in the workplace that provide the space for people to be listened to and taken seriously. This is essential in a safety culture and should be part of normal business for every individual in every organisation.

For staff in the NHS to feel safe speaking up, the following elements need to be implemented:

- Staff can have open conversations with managers, and managers listen.

- There is mutual trust between the person raising the concern and the person listening.

- Leaders display and encourage the behaviours required for staff to feel listened to.

- The approach uses **psychological safety** principles to create the conditions for people to be able to speak up.

- Organisations will ensure individuals are not penalised for highlighting mistakes, failures or concerns. Where psychologically safety is lacking, employees are less likely to speak up

and challenge inappropriate behaviours of colleagues or superiors.

- Organisations should recognise that individuals with protected characteristics are often more likely to be on the receiving end of poor practices, harassment or bullying. They are also least likely to speak up due to the fear of reprisals. This needs to be considered in the local approach and implementation.

- Feedback should be provided to individuals who raise concerns especially in relation to actions implemented

What organisations should do to co-produce their Speaking Up Safely culture and local processes

Organisations will be expected to co-produce their Speaking Up Safely culture and systems with trade / professional union partners, staff with protected characteristics, those with lived experience, and staff from ethnically and culturally diverse backgrounds. This approach is required to ensure the process is relevant and purposeful to those who may speak up.

Organisations should consider the following key principles when planning and co-designing a co-production approach:

1. Encourage active participation, the sharing of experience, and welcome diverse ideas and suggestions.

2. Engage in genuine dialogue around diverse perspectives and be open to the idea that all parties can be mutually influenced by the experience and ideas of others. Avoid the perception that decisions have already been made by a small number of senior people.

3. Consider how you can host events and conversations where differences of power, status, perceived expertise and privilege are minimised between those participating, i.e., leaders, staff, partners and stakeholders, and those with and without protected characteristics.

4. Actively listen so that there is a shared experience of inquiry, reflection, dialogue and shared discovery.

Consider the following when planning your co-production approach:

People –
who needs to be in the conversation with us?

Invitation –
how will we invite people into the conversation with us so as they want to be involved, and are able to participate?

Power and Privilege –
how will we acknowledge and work constructively with differences of power and privilege to ensure equity of contribution?

Inviting all to have their say –
how do we structure this conversation so that everyone gets time and has their voice heard?

Interface –
where and how will we meet (in person, online)?

Agreeing the practicalities –
how often should we meet, and for what time duration?

Finding shared meaning –
what are the common themes or sense of shared purpose that ties this all together?

Goals –
what are we hoping to achieve together?

How to respond best to disagreement and conflict –
how we will respond to any breakdowns in communication? What is our agreed way of doing this?

Section Two:
Guiding Principles, Process and Learning

- Map what staff, partners and stakeholders would see as the organisational barriers and enablers to Speaking Up Safely; co-produce interventions to reduce and remove barriers, monitor the effectiveness of these interventions, and share and implement enablers of speaking up.

- Widely and consistently communicate the agreed systems, processes for and learning from Speaking Up Safely.

- Ensure procedures for receiving, reviewing and responding to speaking up concerns are timely, transparent and regularly evaluated to ensure they are fit for purpose and able to reassure staff that the process will support them when raising their concerns.

- Use the lived experience of staff and others to help recognise the ways in which power and privilege manifest in the organisation and can become barriers to staff speaking up.

- Provide bias and cultural awareness training and/or supervision for those who will hear the concerns staff members raise – to ensure the diverse needs of staff with protected characteristics can be openly received, are not potentially dismissed due to possible differences in peoples' lived experiences, beliefs and views.

- Build anonymity into speaking up processes for those staff who fear detriment from publicly speaking out.

- Develop the skills of leaders to be able to listen to concerns openly, transparently and without prejudice and enable leaders to act on concerns raised. Leaders should demonstrate their skills in these areas in order to support a speaking up culture.

- Ensure there is timely access to staff support and wellbeing services – as speaking up can impact on the psychological health of staff.

- Review organisational data (as per Toolkit 4) with social partners through the organisation's board-level committee structure.

- Where staff experience detriment from speaking up, actively utilise restorative justice practices to address this, as per the All-Wales Respect and Resolution policy and process.

Section Three:
Questions to consider when co-producing the approach

- Who needs to be in this conversation – who has an important perspective, experience, or stake in the development of a Speaking Up culture?

- What processes can be developed for acknowledging and addressing issues when they arise? How can the organisation collaborate with staff, partners, and other stakeholders to ensure these processes are fair and supportive?

- How is learning shared across the organisation – at individual, team and service level, as well as more widely?

- How will the organisation engage with staff from diverse backgrounds, ethnicities and cultures to;
  - ensure their lived experiences improve your speaking up processes?
  - address issues related to bias, discrimination and inequity?
  - review whether organisational policies and processes might be unintentionally causing inequity and inequality?

- How can the organisation explore the ways in which hierarchy, entitlement, power and privilege might be marginalising and disadvantaging individuals groups?

- How can the organisation encourage and support this type of reflective conversation?

- How will the organisation identify barriers to speaking up within it? What actions can be taken to address and resolve any barriers when identified?

Resources

- National Guardians Office for England: https://nationalguardian.org.uk/

- HIW Guidance on Speaking Up: https://hiw.org.uk/speaking-keep-people-safe

- HEIW – Healthy Working Relationships: https://nhswalesleadershipportal.heiw. wales/healthy-working-relationships

- Just and Restorative Culture: NHS England » A just culture guide; The Mersey Care Just and Learning Culture

- Epistemic Injustice: Epistemic Injustice | Department of Philosophy | University of Bristol

- BMJ Research Article on Speaking Up and Culture within the NHS: Inter-professional model on speaking up behaviour in healthcare professionals: a qualitative study | BMJ Leader

Toolkit 2: **How to Speak Up**

Introduction

Our NHS Wales workforce goes above and beyond every day, and its dedicated efforts and commitment to services is inspirational. Yet there are times when things just don't go right, where there are issues or concerns, or there is a fear for patient care and colleague well-being. The need for Speaking Up Safely is a vital component for any NHS organisational culture and highlighted in reports from Francis (2015) and, more recently, Ockenden (2022).

The Francis report highlighted:

"Every organisation involved in providing NHS healthcare should actively foster a culture of safety and learning in which all staff feel safe to raise concerns.

"Raising concerns should be part of the normal routine business of any well-led NHS organisation.

"Freedom to speak up about concerns depends on staff being able to work in a culture which is free from bullying and other oppressive behaviours.

"All NHS organisations should ensure that there is a range of persons to whom concerns can be reported easily and without formality. They should also provide staff who raise concerns with ready access to mentoring, advocacy, advice and counselling"

How to Speak Up Safely in your organisation

Organisations across NHS Wales are committed to embedding speaking up safely as part of their cultures. To enable this, various methods and means will be used to ensure staff feel safe and comfortable in speaking up. This will vary across organisations as they implement local methods to support this agenda. There will be transparency where possible, on any actions taken because of staff speaking up to show they have been actively listened to.

The need for speaking up safely to be firmly embedded into everyday life and cultures across NHS Wales is a priority. The way and means of doing this will evolve with new initiatives added to ensure that issues can be safely explored.

"Culture change is not a one-off event, but requires constant attention and development."

Sir Robert Francis QC, 2015

Speaking Up Safely Process

If an individual needs further advice on Protected Disclosures or Whistleblowing they can contact the charity Protect on **020 3117 2520** or by email at **whistle@protect-advice.org.uk**

Follow the Wales Safeguarding Procedures **www.safeguarding.wales/en**

Also consider escalation to other bodies if all other avenues have been exhausted

Options

Member of staff wants to raise a concern

Is the concern related to the abuse of children or adults with vulnerabilities?

Yes

No

Is it relating to fraudulent activity?

No

Contact local fraud team

Yes

Can staff member raise it with their Line Manager?

Yes

No

Has feedback on the outcome been shared with staff member?

Yes

Is staff member satisfied with outcome?

No

Yes

Informal intervention (Respect and Resolution Policy)

Raise with relevant individual in the organisation e.g. IM/NED lead/ Speaking Up Safely lead

Local options for raising concerns

Trade Union rep

Human Resources

No

Assess nature of concern

Acknowledge receipt of concern within 7 days

Follow up on concern within 14 days

Communicate outcome to staff member within 28 days

Is staff member satisfied with outcome?

No

Yes

Use procedure for NHS staff to raise concern

End of process

Frequently Asked Questions

1. **I have a concern and I need to speak to someone, who do I tell?**

   Staff should be able to raise concerns with their line manager during routine discussions on service delivery and patient care, (e.g. problem-solving, service review, performance improvement, quality assessment, training, and development) as these are the most effective mechanisms for early warning of concerns, wrongdoing, malpractice or risks. Line managers are best placed to act on, deal with and resolve such concerns at an early stage.

   However, in some circumstances, this may not be appropriate and there are other methods you can use to raise a concern if you cannot speak to your line manager. Your local organisation will have more specific advice on what support you can obtain when you want to raise a concern and some examples are listed below.

2. **What support can I access when I want to raise a concern**

   Trade/professional unions (TUs) – these can provide support, advocacy and representation at all stages.

   Well-being support – refer to your local well-being support services within your organisation, which can be found on local intranet, or via your line manager/TUs/HR department.

   Independent Member (IM)/Non-Executive Director (NED) – IMs and NEDs provide scrutiny and seek assurance that the speaking up culture is working in an organisation. You can speak to an IM/NED about speaking up but they won't advocate or represent you on your specific case. However they may advise you of the best way to get support in raising your issue.

   Your local organisation will have more specific advice on what support you can obtain when you want to raise a concern.

3. **Do I have to have evidence of wrong-doing to raise a concern?**

   You do not need to have absolute proof of the activities you want to report; a reasonable belief is sufficient. We encourage all individuals to raise their concerns as early as they can. Any evidence that you do have such as letters, memos, diary entries, DATIX etc. will be useful to assist any further investigations.

4. **Will I be responsible for investigating the concern?**

   No, your concern will be investigated by a nominated individual, if appropriate to do so.

5. **How will I know if my concern has been dealt with?**

   Once an individual has told someone of their concern, whether verbally or in writing, the information will be assessed to see what action should be taken. This may involve an informal, review or a more formal investigation.

   You will be told who is handling the matter, how you can contact them and what further assistance may be needed. If there is to be a formal investigation the manager to whom you have reported their concern will appoint an Investigating Officer.

   If an internal investigation takes place this will be undertaken thoroughly and as quickly as possible considering the matters to be investigated. At your request, you will receive a written summary of your concern, setting out how it will be handled along with a time frame.

6. **What happens if I don't agree with the outcome of my concern, or I don't feel that it was dealt with properly?**

   The individual raising the concern will be entitled to a verbal response, as a minimum, and where appropriate, a written response may be required (noting any request to remain anonymous).

   The person responsible for providing this response will be either the manager to whom the concern was addressed, or the individual identified to provide such responses in any local processes in place to ensure that concerns can be raised.

   If you feel that your concern has not been dealt with appropriately, please contact your local Workforce and OD team for more information on how to escalate your concern.

7. **I want to raise a concern, but I want to remain anonymous because I'm worried that I'll be treated differently if I make myself known.**

    You are encouraged to raise concerns openly. However, there may be circumstances when individuals may request that their identity is not revealed. In this case, the organisation will not disclose their identity without their consent unless required to by law.

    There may, however, be times when the organisation may be unable to resolve a concern without revealing the individual's identity, for example where personal evidence is essential. In such cases, the organisation will discuss with the individual whether and how the matter can best proceed.

    Where the concern is a matter of staff or patient safety in line with Duty of Care, there may well be a need for escalation and anonymity may not be able to be maintained. Where this cannot be avoided, however, this will be made clear to the individual who has raised the concern.

8. **What happens if someone raises a concern that they know isn't true?**

    We acknowledge that in a very small number of cases, allegations may be made which are malicious or vexatious. Making allegations that are known to be false will be considered a serious matter. If it is concluded that an individual has deliberately made false allegations maliciously or vexatiously, or for personal gain, then the organisation may begin an investigation under the Disciplinary policy and procedure.

9. **What does the term 'Whistleblowing' mean?**

    Whistleblowing is the term used when a member of staff raises a concern about a possible risk, wrongdoing or malpractice that has a public interest aspect to it, usually, because it threatens or poses a risk to others (e.g., patients, colleagues or the public).

    This may include:

    - systematic failings that result in patient safety being endangered, e.g., poorly organised emergency response systems, or inadequate/broken equipment, inappropriately trained staff
    - poor quality care

- acts of violence, discrimination or bullying towards patients or staff
- malpractice in the treatment of, or ill-treatment or neglect of, a patient or client
- disregard of agreed care plans or treatment regimes
- inappropriate care of, or behaviour towards, a child/vulnerable adult
- the welfare of subjects in clinical trials
- staff being mistreated by patients
- inappropriate relationships between patients and staff
- illness that may affect a member of the workforce's ability to practise in a safe manner
- substance and alcohol misuse affecting ability to work
- negligence
- where a criminal offence has been committed/is being committed/or is likely to be committed (or you suspect this to be the case)
- where fraud or theft is suspected
- disregard of legislation, particularly in relation to Health and Safety at Work
- a breach of financial procedures
- undue favour over a contractual matter or to a job applicant has been shown
- information on any of the above has been/is being/or is likely to be concealed.

If an individual needs further advice, they can contact the charity Protect on **020 3117 2520**, or by email at whistle@protect-advice.org.uk.

Protect can advise individuals how to go about raising a matter of concern in the appropriate way at https://protect-advice.org.uk/.

There are prescribed bodies for Whistleblowing in Wales. You can find more information in stage 4 of the All Wales Procedure for NHS Staff to Raise Concerns. Namely these prescribed bodies include but are not limited to, Health Inspectorate Wales (HIW), Audit Wales, the Police and the Health and Safety Executive.

Alternatively, the Department of Health also provides a free, independent confidential advice service for NHS and Social Care employees and employers in England and Wales known as Speak Up.

They can be contacted on **08000 724 725** or via their website at https://speakup.direct/

Toolkit 3: **What to do if someone has 'Spoken up to you'**

There are three areas to consider when someone speaks up to you.

1. **Recognition and validation of the courage to speak up:**

   a. It is a big step for individuals to come to you raising a concern. It takes both courage from the individual and demonstrates their trust in you. You should thank them for choosing to share and for trusting you with this, reassure them that you know they must have thought long and hard before coming forward and that you are here to listen and agree what happens next.

   b. In most cases, individuals who raise a concern believe there are grounds for their concern. It has taken a lot of courage for them to raise the concern/s and it is important not to dismiss this, even if your view may differ.

   c. Validation of someone's concerns does not mean that you necessarily agree with them; it simply means you understand the impact their view and experience has had on them.

2. **Non-judgmentally and actively listening the concerns raised:**

   a. Active listening means demonstrating you are hearing and understanding what you are being told. This can be achieved by using skills such as reflecting and summarising; and being present – a private space without interruptions and distractions would be beneficial.

   b. Be open to the concerns. While concerns can sometimes feel personal or suggest that you are being criticised, it is often the case that it is organisational elements which need to be considered. Take time to move your attention to what the individual is saying and think about how they might

be feeling; there will be time for you to think about it from your own perspective after the discussion.

   c. Take it as an opportunity to learn and develop your team/service; even if it was not the service's or team's or an individual's intention to cause concern, it is important to recognise the impact on individuals.

   a. Be aware that you may have a different perspective and different lived experiences from the individual raising the concern, but don't dismiss them because you don't agree with their perspective. Think about how to see it from their point of view

   d. Be aware of your own positions of power and privilege in the conversation, and how can you ensure these power and privilege dynamics are minimised to enable the person to feel comfortable speaking up to you.

3. **Action taken as a result of speaking up:**

   b. Once someone has spoken up, it is important to ensure both they and anyone impacted by the concern are aware of, and have access to, support. Your local organisation will have more specific advice on what support can be accessed when speaking up.

   c. advice on what support can be accessed when speaking up

   d. The concern may be highly emotional or challenging, so it's important to recognise that we often benefit from taking a pause before acting unless there is immediate risk.

   e. As a manager, you may not have all the answers. Nor do you always have the power to make the changes that the person who raises the concerns wishes to see.

f.   Agree how often and by what means you will keep the person informed of the process and of the steps taken from the point of them discussing their concerns with you.

g.   It is important that you implement what elements you can and, as a minimum, implement everything that you say you will do. This is vital in maintaining trust.

h.   For those elements on which you cannot have an impact, it is suggested these are escalated through appropriate channels.

i.   Whatever happens, it is hugely important this is fed back to the individual who has spoken up. It is important that individuals don't feel that they haven't been heard or their concerns haven't been taken seriously; this is just as vital for our services, so that others can feel confident to speak up, as it is for the individual who has done so to you.

Remember most people in public service do so as they have a shared goal - to ensure the experiences of patients and staff are improved and are the best they can be. Starting conversations from this shared perspective will always be helpful.

The Process

The above outlines how you should approach conversation, but there are important steps you must take as a manager. These are outlined in the attached line manager process. Managers must:

- Listen to the concern that is being raised. If the concern is related to the abuse of children or adults with vulnerabilities, the Safeguarding Wales Processes should be followed.

- Once the concern has been raised, consider how the person want it dealt with. If you need to involve anybody else in the process, do so at this point. Or deal with it yourself if possible.

- Once it has been raised, it is important you communicate regularly with the individual to inform them of the outcome or action you have taken as a result of the concern being raised. You should also consider how you will share any learning about the concern more widely.

- If the issue is not within your ability to be managed, this should be clearly communicated with the individual.

- Once the outcome of the concern has been discussed with the individual, they should be informed of the other ways available to them to raise the concern if they are not satisfied with the outcome, as per the Line Managers Process.

Speaking Up Safely Process

Line Managers Process

If an individual needs further advice on Protected Disclosures or Whistleblowing they can contact the charity Protect on **020 3117 2520** or by email at whistle@protect-advice.org.uk

Follow the Wales Safeguarding Procedures www.safeguarding.wales/en

Member of staff has raised a concern with Line Manager

Is the concern related to the abuse of children or adults with vulnerabilities?

Is it relating to fraudulent activity?

Yes →

Contact local fraud team

Line Manager links in with other required individuals

— **Yes** — Does Line Manager need to involve anyone else in the process?

Consider how staff member wants the concern dealt with

Communicate staff member what will be done

Feedback outcome to staff member

Is staff member satisfied with outcome?

Options

Informal intervention (Respect and Resolution Policy)

Raise with relevant individual in the organisation e.g. IM/NED lead/ Speaking Up Safely lead

Local options for raising concerns

Trade Union rep

Human Resources

Assess nature of concern

Acknowledge receipt of concern within 7 days

Follow up on concern within 14 days

Communicate outcome to staff member within 28 dayss

Is staff member satisfied with outcome?

End of process

Use procedure for NHS staff to raise concern

Also consider escalation to other bodies if all other avenues have been exhausted

The aim is to foster a culture where concerns are openly raised, are dealt with promptly and appropriately and escalated appropriately if required. There are specific legal requirements on organisations should the concerns be considered as Whistleblowing or a Protected Disclosure. More information on whistleblowing is available in the FAQs in toolkit 2 and you can find more information in the All Wales Procedure for NHS Staff to Raise Concerns.

A protected disclosure is defined in law by the Employment Rights Act (ERA) 1996. For a concern to be classed as a protected disclosure it needs to meet certain requirements under the ERA (1996) and tends to show one or more of the following:

- That a criminal offence has been committed, is being committed or is likely to be committed

- That a person has failed, is failing or is likely to fail to comply with any legal obligation to which they are subject

- That a miscarriage of justice has occurred, is occurring or is likely to occur

- That the health or safety of any individual has been, is being or is likely to be endangered

- That the environment has been, is being or is likely to be damaged, or

- That information tending to show any matter falling within any one of the above has been, is being or is likely to be deliberately concealed

If you suspect the concern the member has raised potentially meets these requirements, you should discuss with the local Workforce and OD department for further advice and guidance.

Toolkit 4: **Recording and monitoring of concerns**

Points for recording and monitoring of individual concerns

Data Point 1: **Type of concern and characteristics**

(Note this data should be aggregated, and reported to the Board Committee with responsibility for Speaking Up Safely at least annually)

- Type of concern: Patient safety, Bullying/harassment, Incivility, Fraud, Management Concerns, System and Process, Discrimination/Inequality, Behaviour/Relationship, Worker Safety, Other.
  N.B. The 'usual' approach is for any 'guardians' to assign the 'type' of concern, in conjunction with the Workforce and OD team.

- Establish whether other existing processes are more appropriate: Respect and Resolution; Fraud; Incident Reporting.

- Establish Employee characteristics: staff/temporary staff/student; staff group; department and directorate; protected characteristics; N.B. organisations and guardians have identified this as a potential point of tension with anonymity.

- Is the concern raised anonymously?

- Establish the lead/s for responding to the concern.

Data Point 2: **Monitor the response**

- Monthly progress check with lead for response and the Workforce and OD Team.

- Feedback fortnightly to the person speaking up.

Data Point 3: **Closing**

- Triangulate with other concerns.

- Indicate case as closed.

- Identify and agree the outcome with the Workforce and OD Team.

- Identify the learning and/or improvement resulting from the concern.

- Evaluate the experience of the person speaking up and the person responding.

Data Point 1:
Establish (?)

(a) The type of concern
(b) The correct process
(c) Collect employee characteristic

→

Data Point 2:
Monitor response (🔍)

(a) Monitor progress monthly
(b) Update person raising concerns fortnightly

→

Data Point 3:
Closing (💬)

(a) Triangulate learning
(b) Communicate outcome
(c) Evaluate the outcome with the person raising concerns

Further resources

- National Guardians Office for England:
  https://nationalguardian.org.uk/

- HIW Guidance on Speaking Up:
  https://hiw.org.uk/speaking-keep-people-safe

- HEIW: Compassionate Leadership Principles
  https://nhswalesleadershipportal.heiw.wales/compassionate-leadership

- NHS Wales Respect and Resolution Policy and Processes:
  https://heiw.nhs.wales/files/programmes-resources/respect-and-resolution-at-work-policy/

- HEIW – Healthy Working Relationships:
  https://nhswalesleadershipportal.heiw.wales/healthy-working-relationships

- Just and Restorative Culture:
  NHS England » A just culture guide;
  The Mersey Care Just and Learning Culture

- Epistemic Injustice : Epistemic Injustice | Department of Philosophy | University of Bristol

- BMJ Research Article on Speaking Up and Culture within the NHS:
  Interprofessional model on speaking up behaviour in healthcare professionals:
  a qualitative study | BMJ Leader

Appendix 2 – BetsiNet update piece on Speaking Up Safely

Speak Out Safely – Update on our approach to raising concerns

Speak Out Safely (SOS) is part of our approach to supporting staff who need to raise concerns in BCUHB.

Launched around two years ago, SOS provides staff with an opportunity to raise concerns anonymously through the Work in Confidence app, or by speaking directly to one of our Speak Out Safety Guardians.

To date, more than 300 staff have accessed Work in Confidence, which provides a fully anonymous two-way consultation with members of the Speak Out Safely team. Close to 2,000 NHS Wales staff have visited our Speak Our Safely resources on BetsiNet.

One thing we want to make clear is that raising concerns is a healthy and welcome practice. We sincerely want all our staff to feel they have the freedom to challenge behaviour, practices and conditions which are problematic.

Whether that's by having an open and constructive discussion with a line manager or service lead, or following the secure concerns raising process we provide, we need staff to feel empowered to take action and feel safe.

There will be occasions when a staff member sees, hears or experiences something that they know is not right, safe or appropriate.

It can be difficult to speak up about concerns as even when we know it is the right thing to do; it can make us feel vulnerable, or fearful of the consequences of doing so.

Speaking up about worries and concerns takes courage and is important – it allows the organisation to take action and make things right. Speaking up supports people to be heard, listened to and have their concerns taken seriously.

It helps us take the necessary steps to becoming an organisation that cares, is fair, is just and can learn from the times when things are not as they should be.

Our performance to date

Since launch, we've had a positive overall response to our approach. Satisfaction survey results returned are at 4.5 out of 5.

It's also encouraging that staff are using our service to share openly and honestly their worries about a range of issues, such as bullying in the workplace, concerns around leadership, both patient and staff safety, and the quality of services being provided.

Staff have also been clear in where we can improve. We've received feedback that we can work at being quicker to respond to concerns when they are raised, and that we need to provide more frequent updates on progress with concerns too. We

recognise this as being something we can improve on and in the last six months, we are now on average responding within 24 hours of a new conversation being started.

Our numbers since launching

Method of raising a concern	Conversations started	Conversations closed	Closure rate
Work in Confidence platform	129	125	96.9%
Speak Out Safely Guardian	46	39	84.8%

Category	Number Received
Leadership & Management issues	46
Bullying / Harassment	31
Patient Safety / Quality	24
Behavioural / Relationship	18
Staff Safety	17
Other	15
System / Process	15
Equality, Diversity & Inclusion	8
Infrastructure / Environmental	1
Total	175

We have also been out and about raising awareness of Speak Out Safely through meetings and training sessions across the Health Board and also with our University

partners. In addition, we have developed a range of Welsh and English posters for Work in Confidence that can be accessed and downloaded via the SOS Intranet page here, providing staff who don't have routine access to a computer with a way of raising a concern.

Our future

If you would like to offer us feedback on your experience of using Speak Out Safely, or share your views, thoughts or any ideas you have for how we can continue to develop and improve what we do, then please do so using the link below. The form has been set up to be anonymous.

You can find more information on SOS, Work in Confidence, how to become a SOS Champion, and about our SOS Guardian and SOS Multi-disciplinary team on our intranet pages on BetsiNet.

Finally, if you would like us to come and talk to your team about SOS then we would be happy to – get in touch with our MDT Chair, Gareth on Gareth.Evans6@wales.nhs.uk.

Gareth Evans (BCUHB - Workforce & Organisational Development)

Senior Organisational Development Manager

Appendix 3: SUS article on Betsi.Net linked to BCUHB statement around challenging sexual misconduct in the workplace

Sexual misconduct in Healthcare – call it out

You may have seen the recent BBC news story about sexual misconduct in healthcare.

The study, by the University of Exeter, the University of Surrey and the Working Party on Sexual Misconduct in Surgery, details appalling experiences of mainly female surgical staff being subjected to sexual harassment and assault while working within the NHS.

You can read the report in full here or view the BBC's coverage of the report here.

Whilst the report does not focus specifically on evidence or instances within North Wales, or NHS Wales, it's themes and findings may have struck a chord with some of you.

We're clear that the sort of behaviour detailed in this report is wholly unacceptable. There is no room or excuse for it in surgery, or in any other aspect of healthcare.

We all have a role to play in calling out unacceptable behaviour and abuse of power.

From speaking up if you witness inappropriate behaviour, to having confidence in the mechanisms in place to raise concerns, everyone needs to play their part in making sure our valuable staff feel comfortable coming to work, and confident that they are safe here.

We know it can be difficult to speak out on this subject.

We know it takes a great deal of courage to challenge unacceptable behaviours at work.

We want you to know that we take allegations of this nature very seriously, and that support is available.

Last week's update on progress made over the last couple of years to support the concerns raising process here in BCU (You can read that update here) includes how you can raise concerns, and how we deal with concerns and whistleblowing on workplace behaviours.

Help and support resources

All Wales Respect and Resolution Policy

Our Speak Out Safely pages

Resources from report author WPSMS

GMC Good Medical Practice 2024, including updates toward challenging sexual misconduct

Help and support is available, as detailed on this page. Please take the opportunity to review the resources available and please seek support if needed.

Thank you

Carol Shillabeer (BCUHB - Corporate Office)
Chief Executive

Tom Davis (BCUHB - Office of the Medical Director)
Interim IHC Medical Director (Central)

Emma Jane Hosking (BCUHB - Corporate Office)
Integrated Health Community Medical Director (east)

Jim Mcguigan (BCUHB - Corporate Office)
Deputy Executive Medical Director

Karen Mottart (BCUHB - Anaesthetics)
Integrated Health Community Medical Director (west)

James Risley (BCUHB - Office of the Medical Director)
Deputy Executive Medical Director

Emma Woolley (BCUHB - Maxillo Facial)
Consultant Oral & Maxillofacial Surgery

Teitl adroddiad: *Report title:*	Internal and External Audit Tracker Report
Adrodd i: *Report to:*	Audit Committee
Dyddiad y Cyfarfod: *Date of Meeting:*	Thursday, 12 September 2024
Crynodeb Gweithredol: *Executive Summary:*	The purpose of this report is to provide the Audit Committee with: • an update on review of Audit Reports included on Audit Tracker • an update of the current position with regards to open recommendations, and those proposed for closure • details of all 'no', 'unsatisfactory' or 'limited' assurance recommendations • an update on providing additional assurance to the Audit Committee around high-risk audit reports.
Argymhellion: *Recommendations:*	The Audit Committee is asked to: • NOTE the current position with regards to open recommendations, those proposed for closure, and 'no', 'unsatisfactory' and 'limited' assurance recommendations • APPROVE the agreement made between the Director of Corporate Governance and Internal Audit relating to those recommendations listed as 'Closed – Verified' on the TeamMate update • APPROVE the presentation template for use by Executive Directors at Audit Committee presentation • AGREE on a nominated Executive Director to provide an update on their open 'no/limited/unsatisfactory' assurance recommendations at the November meeting.
Arweinydd Gweithredol: *Executive Lead:*	Pam Wenger, Director of Corporate Governance
Awdur yr Adroddiad: *Report Author:*	Glesni Driver, Head of Covid-19 Inquiry and Thirlwall Inquiry
Pwrpas yr adroddiad: *Purpose of report:*	I'w Nodi *For Noting* ☐ I Benderfynu arno *For Decision* ☒ Am sicrwydd *For Assurance* ☒

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

Cyfiawnhad dros y gyfradd sicrwydd uchod. Lle bo sicrwydd 'Rhannol' neu 'Dim Sicrwydd' wedi'i nodi uchod, nodwch gamau i gyflawni sicrwydd 'Derbyniol' uchod, a'r terfyn amser ar gyfer cyflawni hyn: *Justification for the above assurance rating. Where 'Partial' or 'No' assurance has been indicated above, please indicate steps to achieve 'Acceptable' assurance or above, and the timeframe for achieving this:*
Even though a considerable amount of work has been undertaken by action owners and Executive Directors since the last Audit Committee on 18th July 2024 to ensure that all open recommendations are updated with realistic implementation dates, a number of overdue recommendations remain open, with many of these being from 'limited' assurance reports, and of 'high' priority. As usual, guidance and support is provided by the Corporate Governance Directorate to all recommendation action owners and Executive Leads.

Cyswllt ag Amcan/Amcanion Strategol: *Link to Strategic Objective(s):*	Not applicable, other than those relating to individual audit reviews/recommendations.
Goblygiadau rheoleiddio a lleol: *Regulatory and legal implications:*	Compliance with Internal and External Audit requirements.
Yn unol â WP7, a oedd EqIA yn angenrheidiol ac a gafodd ei gynnal? *In accordance with WP7 has an EqIA been identified as necessary and undertaken?*	The Equality duty is not applicable. This 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
Yn unol â WP68, a oedd SEIA yn angenrheidiol ac a gafodd ei gynnal? *In accordance with WP68, has an SEIA identified as necessary been undertaken?*	The Socio-Economic duty is not applicable. 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.
Manylion am risgiau sy'n gysylltiedig â phwnc a chwmpas y papur hwn, gan gynnwys risgiau newydd (croesgyfeirio at y BAF a'r CRR) *Details of risks associated with the subject and scope of this paper, including new risks (cross reference to the BAF and CRR)*	Not applicable, other than those relating to individual audit reviews/recommendations.
Goblygiadau ariannol o ganlyniad i roi'r argymhellion ar waith *Financial implications as a result of implementing the recommendations*	Not applicable, other than those relating to individual audit reviews/recommendations.

Goblygiadau gweithlu o ganlyniad i roi'r argymhellion ar waith *Workforce implications as a result of implementing the recommendations*	Not applicable, other than those relating to individual audit reviews/recommendations.
Adborth, ymateb a chrynodeb dilynol ar ôl ymgynghori *Feedback, response, and follow up summary following consultation*	The Chair of Audit Committee met with the Interim Executive Director of Operations prior to her departure to gain further assurance on those recommendations where no update has been received.
Cysylltiadau â risgiau BAF: (neu gysylltiadau â'r Gofrestr Risg Gorfforaethol) *Links to BAF risks:* *(or links to the Corporate Risk Register)*	Not applicable, other than those relating to individual audit reviews/recommendations.
Rheswm dros gyflwyno adroddiad i fwrdd cyfrinachol (lle bo'n berthnasol) *Reason for submission of report to confidential board (where relevant)*	Not applicable

Camau Nesaf:
Gweithredu argymhellion

Next Steps:
Implementation of recommendations

The Tracker is normally presented to each quarterly meeting of the Audit Committee, but is presented at every bi-monthly meeting at present due to partial assurance.

Rhestr o Atodiadau:

List of Appendices:

- Appendix 1 - Summary of the rationale for closure
- Appendix 2 - Tracker with all Open 'No' Assurance Recommendations
- Appendix 3 - Tracker with all Open 'Unsatisfactory' Assurance Recommendations
- Appendix 4 - Tracker with all Open 'Limited' Assurance Recommendations
- Appendix 5 - Draft template for Executive Director presentation to Audit Committee
- Appendix 6 - Director of Corporate Governance presentation on outstanding recommendations.

INTERNAL AND EXTERNAL AUDIT RECOMMENDATIONS

1.   INTRODUCTION AND BACKGROUND

Since the last update to the Audit Committee, the Corporate Governance Directorate has undertaken a review of all internal and external audit reports published since 2022 to ensure that their recommendations are included on the audit tracker. An update on this is included within this report.

This report focusses also on the 'no', 'limited' or 'unsatisfactory' assurance recommendations, and provides an update on discussions between the Director of Corporate Governance and Internal Audit regarding historical recommendations, as well as a proposed process for Executive presentation of outstanding recommendations to the Audit Committee.

2   REVIEW OF AUDIT RECOMMENDATIONS INCLUDED ON THE AUDIT TRACKER

Following the publication of Recommendation 4 of the 2023 Structured Assessment, a review of all Audit Reports included on the Audit Tracker since 2022 has been undertaken by the Corporate Governance Directorate to identify missing recommendations and add them retrospectively to the audit tracker.

2.1   External Audit reports

A review of all published audit reports from 2022 relating to the Health Board was conducted from the Audit Wales website, and a total of 79 Audit Wales recommendations retrospectively added to the tracker. In addition to this, all Structured Assessment recommendations from 2019 to 2021 have also been retrospectively added to the audit tracker.

2.2   Internal Audit reports

As at 1st August 2024, all internal audit recommendations from reports published from 2022 onwards are now included on the audit tracker.

As previously updated, there were potentially recommendations from 40 internal audit reports to be added to the tracker, going back to 2022. Copies of all these 40 reports were received from Internal Audit, and the work to update the tracker with all these retrospective recommendations has been concluded. This resulted in a total of 208 recommendations being retrospectively added to the audit tracker.

2.2.1 TeamMate System updates

Internal Audit were able to supply the Corporate Governance Directorate with a copy of the detail contained within the TeamMate system when it was last used by the Health Board, and all this information was transposed onto the live audit tracker.

2.2.2 **Issues identified**

Many of the retrospectively added recommendations were listed as 'Closed – Verified' on the TeamMate system. From discussions between the Director of Corporate Governance and Internal Audit, this description meant that the recommendation had previously been submitted and approved for closure by the Audit Committee, and all Internal Audit recommendations verified by Internal Audit. Due to this, it is proposed that all the recommendations that have been retrospectively added to the tracker, and are listed as 'Closed – Verified' are listed as closed on the live tracker. All others recommendations will remain open, and follow the new closure approval process now in place.

3   **NEWLY PUBLISHED AUDIT REPORTS**

Since the last update to the Executive Management Team, a total of 19 recommendations from newly published internal and external audit reports have also been added to the audit tracker.

4   **CURRENT POSITION**

A request for updates up to the 30th June 2024 was submitted to action owner from the Corporate Governance Directorate relating to all open recommendation from audit reports published since 2022 – this was a request for updates for a total of 287 recommendations, and included those retrospectively added to the live tracker. In order to submit recommendations for updates, the Corporate Governance Directorate have had to identify new action owners for many of these historical recommendations, and it has taken time for those individuals to familiarise themselves with the audit report and recommendations. This was a huge undertaking for those involved, and it is appreciated that not all updates were received.

4.1 **Recommendations for closure approval**

Following the latest updates, the summary position is as follows:

- 81 recommendations were approved by the Executive Management Team for closure on 28th August 2024, following approval by the respective Executive
- 16 recommendations have been updated as completed by the action owner, but are awaiting Executive closure approval prior to submission to the Executive Team.

Executive Lead	Approved for closure	Awaiting approval by Executive
Acting Executive Director Therapies and Health Science	-	3
Chief Digital and Information Officer	16	-
Executive Director of Nursing and Midwifery	11	-
Executive Director of Transformation and Strategic Planning	3	-
Interim Director MHLD	12	-
Deputy Director of People	16	-
Executive Medical Director	-	13
Director of Corporate Governance	11	-
Interim Executive Director of Finance	12	-
Total	**81**	**16**

Table 1: A summary of all recommendations put forward for closure, by Executive Director

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

4.1.1 Recommendations awaiting Executive closure approval

A total of 16 recommendations have been put forward for closure by the action owners, but not received Executive approval due to absences. Once approved by the Executive, these will be submitted to a future Executive Management Team for approval.

4.2 Open recommendations

4.2.1 'No' assurance recommendations

Table 2 below shows a summary of the 'no' assurance recommendation, and its status:

Executive Lead	'No' Assurance recs - started	'No' Assurance recs - pending	'No' Assurance recs - for closure	Total open 'No' Assurance recs overdue original implementation date
Interim Executive Director of Finance	2	0	1	2
Total	**2**	**0**	**1**	**2**

Progress has been made in addressing the recommendations in these two reports, however, some of the recommendations will require the support of the Director of Performance and Commissioning who commences in October 2024.

In respect of audit recommendation 521 (Appendix 2), the monthly reporting of the overall finance position and of savings delivery will be against the savings target in the agreed financial plan and associated IMTP. The savings target for the year within the financial plan will take into account unachieved savings from the previous year and the requirement for savings in the plan year, but also the deliverability of savings.

A copy of the live tracker, which includes all open high priority - 'no' assurance reports is included in Appendix 2.

4.2.2 'Unsatisfactory' assurance recommendations

Table 3 below shows a summary of all 'unsatisfactory' assurance recommendation, and their status:

Executive Lead	'Unsatisfactory' Assurance recs - started	'Unsatisfactory' Assurance recs - pending	'Unsatisfactory' Assurance recs - for closure	Total open 'Unsatisfactory' Assurance recs overdue original implementation date
Deputy Director of People	1	0	0	1
Chief Executive	3	0	0	0
Total	**4**	**0**	**0**	**1**

The recommendations above relate to the Operating Model. Work is progressing in this area and these recommendations are being incorporated into the work led by the Chief Executive. An update on the Operating Model has been provided to the People and Culture Committee, and further updates will be provided to the Board in due course.

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

4.2.3 'Limited' assurance recommendations

Table 4 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
Interim Executive Director of Finance	18	1		17
Executive Medical Director	12	0		12
Chief Executive	11	1		8
Director of Corporate Governance	12	0		0
Deputy Director of People	1	0		1
Chief Operating Officer	25	1		15
Executive Director of Nursing and Midwifery	15	0		6
Total	**94**	**3**		**59**

A copy of the live tracker, which includes all open high priority - 'limited' assurance reports is included in Appendix 4.

All recommendations awaiting closure approval from the Executive are also included within the above totals.

5   SUMMARY OF ALL RECOMMENDATIONS

In order to provide an update on trends, Table 5 provides information as to number of 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
Newly added IA recommendations	19
Newly added AW recommendations	0
Open - 2022-present	190
Pending - awaiting Exec approval*	16
Pending - approved by Executive Team*	81
Pending IA closure approval	46

includes approval of pre-2022 recommendations

6 **INTERNAL AUDIT APPROVAL**

As previously reported, a total of 61 internal audit recommendations and supporting evidence were submitted to Internal Audit for their review. A total of 38 of these were returned from Internal Audit and deemed suitable for the next stage in the approvals process (for Audit Committee final closure approval). However, a total of 23 audit recommendations have come back requiring further evidence to support closure. The request has been shared with the recommendation owners and Executives, and to date, a total of 16 of these recommendations and supporting evidence has been returned to Internal Audit for their further review on 10th July 2024. The remainder will be submitted to Internal Audit once the additional supporting evidence is received.

7 **AUDIT COMMITTEE PRESENTATIONS**

Due to the risk associated with high priority recommendations with 'no', 'unsatisfactory' and 'limited' assurance, it is proposed that the Director of Corporate Governance identifies audit reports that pose the highest risks to the Health Board, and an invitation be extended by the Audit Committee to the lead Executive Director to present an update on those reports. In order to facilitate this, a draft presentation template for use by the Executive Lead at the Audit Committee is included in Appendix 5 for the Executive Team's consideration.

In order to commence this process, the Director of Corporate Governance will provide an update on outstanding recommendations falling within her remit at the Audit Committee on 12th September 2024. A copy of the presentation is included in Appendix 6.

The Audit Committee are invited to nominate an Executive Director to provide an update on their 'unsatisfactory/no/limited' assurance recommendations at the November meeting.

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.

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 'NO' ASSURANCE RECOMMENDATIONS

APPENDIX 3 – TRACKER WITH ALL OPEN 'UNSATISFACTORY' ASSURANCE RECOMMENDATIONS

APPENDIX 4 – TRACKER WITH ALL OPEN 'LIMITED' ASSURANCE RECOMMENDATIONS

APPENDIX 5 - DRAFT TEMPLATE FOR EXECUTIVE DIRECTOR PRESENTATION TO AUDIT COMMITTEE

APPENDIX 6 – DIRECTOR OF CORPORATE GOVERNANCE PRESENTATION ON OUTSTANDING RECOMMENDATIONS

SUMMARY OF AUDIT RECOMMENDATIONS PROPOSED FOR CLOSURE
FOR FORMAL EXECUTIVE TEAM APPROVAL ON 14/08/2024

		Summary of recommendation with rationale for closure	

CHIEF DIGITAL AND INFORMATION OFFICER

1	504	Fragmented Care Records	Meeting taken place with Deputy Executive Medical Director and agreement has been made for the Assistant Director of Patient Records to sit and report by exception on both the Strategic Clinical Effectiveness Group (CEG) and Patient Safety, Quality Group (PSQG).
2	524	Digital Operating Model	At present, there is no intention to appoint a IM with responsibility for Digital.
3	525		The Planning, Partnership and Population Health Committee is now in place, with approved Terms of Reference.
4	526		A Board Development Session is on the plan for 2024/25.
5	531		All IHC's have digital on their agendas. Each IHC reporting is different though and where digital is reported. Business Relationship Manager is now in post so cover in place for attendance and reporting at the meetings.
6	532		DDaT have been working with finance colleagues to fix historical budget issues and pressures that have not been funded or resolved from previous years that has resulted in a perennial deficit position at the start of every year. At the recent performance review of the service the Executive Director of Finance committed to resolving the main aspects of this to set a base foundation for the budget. This will not fund the required new posts but is a start.
7	533		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 HB 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
8	534		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.
9	640	Network and Information Systems Regulations 2018	Business Case developed and submitted to Committee and Board (TeamMate update)
10	641		Historical recommendation - TeamMate update - WG did not require Health Boards to complete the CAF submission during 2022.
11	642		Session to be arranged with Internal Audit to discuss areas that can be strengthened within the guide.
12	664	Welsh Information Governance Toolkit	Historical recommendation - TeamMate update - GDPR Training Compliance included on ATHR Staff Details log identifiying when certification completed.
13	665		Historical recommendation - TeamMate update - Action has been implemented, Improvement plan for 2021/22 updated with responsible persons. The IG toolkit sub group is commencing its first meeting for the 2022/23 submission in November and all priorities identified in the 2021/22 improvement plan will be managed through this group.
14	1257		Historical recommendation - TeamMate update - GDPR Training Compliance included on ATHR Staff Details log identifiying when certification completed.
15	1258		Historical recommendation - TeamMate update - GDPR Training Compliance included on ATHR Staff Details log identifiying when certification completed.
16	1259		Historical recommendation - TeamMate update - Action has been implemented, Improvement plan for 2021/22 updated with responsible persons. The IG toolkit sub group is commencing its first meeting for the 2022/23 submission in November and all priorities identified in the 2021/22 improvement plan will be managed through this group.

EXECUTIVE DIRECTOR OF NURSING AND MIDWIFERY

1	296	Falls Management	This is part of the WNCR roll out plan with no date as yet, but potentially into 2025/26. However, there is local mitigation in place. Whilst waiting for the enhanced functionality of the system, the HB has implemented the following - Promoting Therapy colleagues to access and update the Welsh Nursing Care Record following assessment and delivery of therapy 'How to' guide developed by Health Board Welsh Nursing Care Record team and will be shared with the Health Board Falls leads; the metrics for the Falls and Patient Handling risk assessments; Matron metrics completed on a monthly basis. In addition, the Ward Accreditation team are undertaking supportive visits on the wards where a sample of 3 inpatient records are reviewed in terms of quality of the risk assessment and interventions on the ward with the patient in real time to confirm accuracy at that point in time with the risk assessments; Welsh Nursing Care Record dashboard live, showing compliance with the risk assessments.
2	360	Deprivation of Liberty Safeguards (DoLS)	Level 3 MCA/DoLS and the 30 minute awareness training package has been updated. Gold standard templates are available on BetsiNet and promoted during engagement with the Team.
3	366		Agreed by Chairs of Safeguarding Forums for MCA/DoLS to become a standing agenda item. Now embedded into monthly agendas
4	367	Review of Quality Governance Arrangements	Following appointment of the Chief Executive, it was agreed to have and integrated strategy and plan for the HB. The new plan was approved at Board in May, and clearly shows alignment of actions (including quality actions) to the 5 organisational priorities of which key areas like patient experience and learning feature. The programme office are tracking delivery of the actions through the programme office assurance portal.
5	373		This action was superseded by the intention to develop a new Digital Learning Portal.
6	376		The Civica system is now implemented and reporting is to the QSE Committee.
7	378		A new Improving Quality Report to the Board has been developed. Local measures have been agreed for the Board IPR.
8	397	Structured Assessment 2023	QMS agreed at Board May 24. Complaints data reviewed.
9	401		The Quality Management System was approved at Board in May 2024.
10	638	Learning Lessons	The Quality Dashboard is now live. Work will now continue focused on ensuring data quality from the various systems into the Dashboard.
11	639		The Quality Dashboard is now live, and has report capabilities. Due to this, this action can be closed, screenshots provided for evidence. Work will now continue focused on ensuring data quality from the various systems into the Dashboard.

EXECUTIVE DIRECTOR OF TRANSFORMATION AND STRATEGIC PLANNING

1	210	Follow up - Audit Wales: Continuing Healthcare Arrangements Report	The CHC Value and sustainability work group is meeting monthly, with strengthened membership, and project management support requested. Prioritisation of schemes/opportunities completed, draft timeline/milestones to be agreed at the July meeting. PIDs developed for a number of schemes. Due to the current challenge to the fee setting process a Pan North Wales care provider business continuity meeting has been established, and a SOP for home closures/embargos being drafted.
2	226	Continuing Healthcare Arrangements	There is now consistency across the 3 IHCs in relation to structure, job descriptions, roles and responsibilities. Once national work has been completed, any recommendations will be made to the CHC Value and sustainability group, and incorporated into this workstream which has strong representation from IHCs, MH&LD, Childrens CHC and corporate.
3	389	Structured Assessment 2022	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, Prehabilitation 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.

			INTERIM DIRECTOR OF MHLD
1	1218	Mental Health &	Divisional Ligature Risk Reduction Group meeting Terms of Reference reviewed and approved.
2	1219	Learning Disabilities	Monthly Divisional Ligature Reduction Group Assurance Reports provided by each area into the monthly Divisional Ligature Risk Reduction Group meeting.
3	1220	Division	Monthly MHLD Ligature Risk Reduction Group (DLRG) Reports into MHLD Division Service Quality Delivery Group (QDG). Action to be marked as completed
4	1221		Monthly MHLD Ligature Risk Reduction Group (DLRG) Reports into MHLD DSLT Business meeting. Copy of the MHLD Ligature Risk Reduction Group (DLRG) Report presented in 25th June 2024 meeting. In addition an MHLD Ligature Risk Reduction Group (DLRG) Report including an update on door top alarms was also presented to the MHLD DSLT Business meeting held on the 18th June 2024.
5	1222		The MH&LD Division commissioned an external review completed by Tony Crumpton to review all the inpatient environments for ligature assessment to produce a report to identify high, medium and low risk ligature reduction work required across the Division. Heddfan and Coed Celyn were completed in June 2023, Ablett and Bryn Hesketh were completed in August 2023, and the West area were completed in October 2023.
6	1223		The MH&LD Division commissioned an external review completed by Tony Crumpton to review all the inpatient environments for ligature assessment to produce a report to identify high, medium and low risk ligature reduction work required across the Division. Heddfan and Coed Celyn were completed in June 2023, Ablett and Bryn Hesketh were completed in August 2023, and the West area were completed in October 2023.
7	1224		MH&LD audit schedule completed in October 2023. Fieldwork completed the report will be compiled and the expected date for the report will be mid-November. The template developed for exception reporting from each of the MH&LD SLT includes a section to escalate any variance aligned to the standards. The MH&LD Division and Health & Safety have arranged additional training for the MH&LD Division to undertake ligature assessments. This training will assist in the consistent application of procedure and assessment processes. The procedure has been updated following guidance from the Care Quality Commission Brief Guide: Ligature anchor points, ligatures and other means of self-harm using fixtures and furniture (CQC 2022). The procedure emphasises the importance of considering multiple factors in assessing the risk posed by ligature points.
8	1225		MH&LD Finance and Performance Group TOR's reviewed and approved.
9	1226		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. Action to be marked as complete
10	1227		MH&LD Governance Framework reviewed and strengthened. An Audit was completed completed in April 2024 aligned to evidence of up to date signed ToR's, Agendas and reporting cycle of business for each meeting within the Governance Framework and presented in OLM and DSLT. Another Audit will be completed in July 2024.
11	1228		MH&LD Governance Framework reviewed and strengthened. An Audit was completed completed in April 2024 aligned to evidence of up to date signed ToR's, Agendas and reporting cycle of business for each meeting within the Governance Framework and presented in OLM and DSLT. Another Audit will be completed in July 2024.
12	1229		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.

DEPUTY DIRECTOR OF PEOPLE

#	ID	Title	Update
1	149	Recruitment – Employment of Medical Locum Doctors	Due to capacity/resource reasons, the development of the BI Dashboard is temporarily paused. Having been reviewed recently in light in changes to the data source, it will require a Technical/ Specialist input to complete which is currently being scoped out. To ensure the risks identified are adequitely mitigated, a new Medical & Dental Bank Policy has been created and consuilted on, within the policy there is on-going performance management of the contract that includes oversight of KPIs by the Medical Workfroce Group. This group consists of Senior Medical Stakeholders and ensures on-going operational and governance infrastructure and performance improvement, long with improvement in the Policy & Procedure Framework
2	154	Establishment control – Leaver management	The Staff Movement Advice (SMA) form was implemented on the 15th April 2024. As part of the initial implementation, the IT workflow was not initiated to allow for some time for staff to become familiar and use the form. On the 23rd May 2024 the SMA Dashboard was shared with the Workforce Systems Team to review the data and workflows. Initial analysis has identified some data quality issues, therefore, the team have requested some further analysis from NWSSP regarding the fields and process for obtaining the data relating to remaining or leaving the NHS to inform the IT workflow
3	155		This has been implemented, with information included on the HB intranet, and the Weekly Bulletin.
4	387	Structured Assessment 2022	This work has been revisited with the appointment of the Chief Executive, and the revised version of this work is ongoing. The original recommendation was to strengthen substantive posts recruitment and significantly reduce the reliance on senior interims. This work has now been completed and so in reference to this specific action, it is recommended it is now closed.
5	405	Review of Workforce Planning Arrangements	All goals and targets have been built into the annual plan and are now in the process of being delivered. Alongside this, People Services have developed their annual objectives for 2024/25 delivery to further support this work.
6	600	Nursing Roster Management: Introduction of e-timesheets for Agency staff	Weekly reports are now shared with the senior nursing teams on a weekly basis.
7	601		All agencies are reminded of this requirement on a regular basis. Reports are shared with the senior nursing teams on a monthly basis.
8	620	Equality Impact Assessments: more than a tick box exercise?	The EIA process and guidance has been reviewed and revised as per the new guidance. This is monitiored on a regular basis by the Equalities team as part of duty of the Health Board in this area.
9	661	Voluntary Early Release Scheme (VERS) - July 2022	RTS post meeting note completed. VERS closure report considered at RTS meeting 01/09/22
10	662		All managers have been contacted to ensure that exit procedures adhered to. This process is built into the revised VERS policy which was approved at RTS Committee 01/09/2022.
11	1253		All managers have been contacted to ensure that exit procedures adhered to. This process is built into the revised VERS policy which was approved at RTS Committee 01/09/2022.
12	1263		RTS post meeting note completed. VERS closure report considered at RTS meeting 01/09/22
13	1265		All managers have been contacted to ensure that exit procedures adhered to. This process is built into the revised VERS policy which was approved at RTS Committee 01/09/2022.
14	660	Voluntary Early Release Scheme (VERS) - May 2022	This has been implemented, and reported at the Remuneration & Terms of Service Committee (R&TS) meeting on 01/09/2022.
15	1261		This has been implemented, and reported at the Remuneration & Terms of Service Committee (R&TS) meeting on 01/09/2022.
16	1262		This has been implemented, and reported at the Remuneration & Terms of Service Committee (R&TS) meeting on 01/09/2022.

			DIRECTOR OF CORPORATE GOVERNANCE
1	385	Structured Assessment 2022	This is a historical recommendation. 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.
2	395	Structured Assessment 2023	This has been completed, 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.
3	398		A new approval process for recommendations proposed for closure has been implemented, with final approval of this process at the July Audit Committee.
4	447	Structured Assessment 2019	A new approval process for recommendations proposed for closure has been implemented, approved at the July Audit Committee.
5	1246	Risk Management - June 2022	This is an old recommendation, no longer relevant. RM01 is on the risk landing page and not noted as a policy. IA noted substantial assurance for this in June 2024.
6	1247		This is an old recommednation, no longer relevant.
7	1248		This is an old recommedation, no longer relevant. The risk escalation report template for the risk scrutiny panel is provided as evidence that escalation will not be based on score alone. This was also addressed in RM01.
8	1249		The North Wales Medical School risk register submitted to RMG.
9	1250		Old recommendation, this will not be taken forward on the Once for Wales Datix system but committees will receive assurance in papers that the CRR has been approved.
10	1254		This is implemented, included in RMG COB.
11	1270	Risk Management - June 2024	Progressing and escalation route is noted on the Risk Scruity Panel agenda under governance arragements. COB for quarterly risk register audits completed for escalating to HoR and also recommendations back to the service/IHC and monitoring, escalation route formally through Risk scrutiny Group and on the agenda.

			INTERIM EXECUTIVE DIRECTOR OF FINANCE
1	198	Charitable Funds	The first stage of a new, more streamlined Charitable Funds and Charitable Partners grant application management system has been implemented and approved by the Charitable Funds Committee 15/04/24. The work on this is being led by the Head of Fundraising. Additional support within the Team is being introduced before the end of 2024/25 to support the administrative work associated with this.
2	390	Structured Assessment 2022	This formed part of the annual plan paper that was agreed at the Board on 30th May 2024.
3	403	Structured Assessment 2023	The Board approved the 2024/25 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.
4	404	Structured Assessment 2023	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. Also the 2023/24 Audit Wales opinion is that the Financial Accounts state a true and fair position.
5	435	Structured Assessment 2021 (Phase 2)	Regular transformation updates, which incorporates value-based healthcare and service improvement projects are now submitted to the PFIG Committee
6	436	Structured Assessment 2021 (Phase 2)	There have been three deep dives undertaken by PFIGC , Centre, East and West (which was in June 2024).
7	522	Delivery of Health Board Savings	The 2024/25 budget setting process will have superseded these issues. If a further VERS option is offered, the Finance department will ensure a formal process is written to ensure any actions from the outcome of the process are authorised, evidenced and enacted.
8	1203	Wrexham Maelor Continuity Phase 1	Contract are complete
9	1206	Wrexham Maelor Continuity Phase 1	This has been implemented.
10	1243	Budgetary Control User access & Delegated limits	The SFI's and SORD was fully refreshed, consulted upon, ratified by Audit Committee, and endorsed by the Board in November 2023.
11	1244	Budgetary Control User access & Delegated limits	This action has been superseded by another action in the 'Budgetary Control 23/24' audit.
12	1303	Budgetary Control	Accountability letters have been issued to all areas and were done so 13/06/2024 with return date of 28/06/2024.

AUDIT COMMITTEE - AUDIT TRACKER

ID	Internal Audit/ Audit Office	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
203	Internal Audit	Delivery of Health Board Savings	2023	No assurance	High	Matter Arising 4: Transformational Savings and the establishment of the Transformational Team (Operation)	4.1a *(listed as 3.1a in the Audit Report)* The Health Board: • Completes an updated review of transformational opportunities, underpinned by impact assessments but recognising these will likely take a long period of time to embed and deliver cash releasing savings. • Reviews the role of the Transformational Team in driving service change and savings.	4.1a *(listed as 3.1a in the Audit Report)* Work continues on development and ownership of transformational savings for the 2024/25 financial year and beyond (as part of planning formation).	Andrea Hughes, Interim Finance Director – Operational Finance	Russell Caldicott, Interim Executive Director of Finance	30/04/2023	31/07/2024	1	Update from Executive Team meeting on 19/06/2024 is that, in the absence of the Director of Commissioning and Performance, there will be an oversight of a number of Executive Directors. Work on progressing the commission arrangements for contracts is underway and a update will be provided to the PFIG in August.
521	Internal Audit	Delivery of Health Board Savings	2023	No assurance	High	Matter Arising 1: Board reporting (Design)	1.1a The finance monthly Board report details the full recurring savings requirement with the IMTP ensuring it details the complete recurring savings in its savings plan, inclusive of all unachieved recurring savings carried over.	1.1a All monthly reporting of the overall finance position and of savings delivery will be against the savings target in the agreed financial plan and associated IMTP. The savings target for the year within the financial plan will take into account unachieved savings from the previous year and the requirement for savings in the plan year, but also the deliverability of savings.	Russell Caldicott, Interim Executive Director of Finance	Russell Caldicott, Interim Executive Director of Finance	31/03/2024			No update provided to date

AUDIT COMMITTEE - AUDIT TRACKER

ID	Internal Audit/ Audit Office	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
454	Internal Audit	Operating Model	2024	Unsatisfactory	High	Matter Arising 1: Operating Model (Design and Operation)	1.1 The Health Board, through the Chief Executive should undertake a full review of the operating model including: ● A review of the Operating Model, as implemented, to ensure it is fit for purpose in delivering the Corporate/Strategic Objectives, long-term strategy/medium term plan of the Health Board. ● A review of all twenty-six services identified as 'Outstanding Design – Clinical' with urgency, noting some represent current risk to the Health Board. ● Review of the role, remit and accountability of corporate posts where the services they oversee are delivered through Operational Services, for which they have no delegated responsibility or accountability. ● A review of funding, to ensure any Operating Model/Structure is affordable and transparency in funding is ensured.	The Chief Executive has undertaken a review of the Executive Portfolios to improve governance and accountability. In April 2024, this process is near conclusion. A number of new roles have been advertised publicly on agreed job descriptions and JESP banding with the Welsh Government. These roles will be interviewed in May 2024	Jason Brannan, Deputy Director of People	Carol Shillabeer, Chief Executive	31/05/2024			The Chief Executive has undertaken a review of the Executive Portfolios to improve governance and accountability. In April 2024, this process is near conclusion. A number of new roles have been advertised publicly on agreed job descriptions and JESP banding. In addition, Independent Members that were in post have resigned as at 23 Feb 2023 and all new IMs appointed by the 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) A consultation with all staff has been lauched and results from the survey from staff will be collated and analysed by the end of July 2024. This is a longer term recommendation in nature so updates will be provided. Recommend an end date is agreed.
455	Internal Audit	Operating Model	2024	Unsatisfactory	High	Matter Arising 1: Operating Model (Design and Operation)	1.1 The Health Board, through the Chief Executive should undertake a full review of the operating model including: ● A review of the Operating Model, as implemented, to ensure it is fit for purpose in delivering the Corporate/Strategic Objectives, long-term strategy/medium term plan of the Health Board. ● A review of all twenty-six services identified as 'Outstanding Design – Clinical' with urgency, noting some represent current risk to the Health Board. ● Review of the role, remit and accountability of corporate posts where the services they oversee are delivered through Operational Services, for which they have no delegated responsibility or accountability. ● A review of funding, to ensure any Operating Model/Structure is affordable and transparency in funding is ensured.	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	Carol Shillabeer, Chief Executive	30/06/2024			The consultation has commenced. The recommendations will span a number of Quarters but is important to stress that work has commenced.
456	Internal Audit	Operating Model	2024	Unsatisfactory	High	Matter Arising 1: Operating Model (Design and Operation)	1.1 The Health Board, through the Chief Executive should undertake a full review of the operating model including: ● A review of the Operating Model, as implemented, to ensure it is fit for purpose in delivering the Corporate/Strategic Objectives, long-term strategy/medium term plan of the Health Board. ● A review of all twenty-six services identified as 'Outstanding Design – Clinical' with urgency, noting some represent current risk to the Health Board. ● Review of the role, remit and accountability of corporate posts where the services they oversee are delivered through Operational Services, for which they have no delegated responsibility or accountability. ● A review of funding, to ensure any Operating Model/Structure is affordable and transparency in funding is ensured.	Areas that have been identified as 'in design' will be considered as part of the wider review noted above, given there may be changes within the structure going forward. Stronger Together was the initial project that supported the change in organisational structures. To ensure we have an integrated approach going forward, a review will take place of the stronger together team and OD team. It is proposed that these teams be merged into one team to provide support to the implementation of any new organisational structure.	Jason Brannan, Deputy Director of People	Jason Brannan, Deputy Director of People	30/06/2024	31/12/2024	1	Work is still ongoing to merge the teams and as such a request to revise the implementation date to 31st Dec 24 is requested. The extended time taken in the merging of these 2 functions has not delayed delivery of any of the other key actions in place to support the wider ongoing work across the health board in this area.

| 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 | Carol Shillabeer, Chief Executive | Carol Shillabeer, Chief Executive | 30/06/2024 | | | The post of Director of Environment and Estates is currently advertised, with a closing date of 16/07/2024. |

AUDIT COMMITTEE - AUDIT TRACKER

ID	Internal Audit/ Audit Office	Report Title	Year	Assurance Level	Priority	Recommendation Title	Recommendation	Management Response	Action Owner	Final Approver	Recommendation State	Original implementation date	Revised implementation date	Number of Revisions	Latest update
154	Internal Audit	Establishment control – Leaver management	2022	Limited	High	Matter Arising 1 - Operational management compliance (Operation)	Workforce and OD should progress the plans to improve leaver management as a priority, to ensure all employment controls are adhered to by operational areas e.g. submission of staff termination form to Payroll Services; return of all Health Board property/ID badge; and Network access is revoked.	The Workforce Performance and Planning team which incorporates ESR and Establishment Control have already reviewed how terminations are actioned and concur with the above recommendation. The management action will be to make changes to the current processes which involve managers completing the current ESR Exception Form. This will be replaced by moving to this being actioned via ESR Self Service. The rationale for the change to ESR Self Service is that it will support through providing a prompt to the manager to request property and stop network access as part of the termination process. This will not guarantee the return, the onus would remain with the manager, however, ESR will serve as the prompt and workforce teams can monitor and escalate if compliance is not adhered to. The specific actions will be: 1. To advise the NWSSP Team, wider stakeholders i.e.; Finance, HR that with effect from the 1 February 2022 the team will be requesting all future agenda for change staff terminations to be completed via ESR Self Service. 2. Issue a BCU wide communication to advise that with effect from the 1 February 2022 all agenda for change staff terminations must be completed via the ESR Self Service system. 3. Initiate a mass upload from IBM to add against each staff member a minimum property list of ID Badge and IT equipment/Network access credentials. 4. ESR function actioned so that a notification is sent of individual staff terminations to specified colleagues/groups. This will be piloted with IT and Security to ensure the notifications are received with the relevant information i.e.: employee leaving date with a view to stop the monthly leavers report issued to IT as terminations will be notified in real-time.	Nick Graham, Associate Director of Workforce Optimisation	Jason Brannan, Deputy Director of People	Started	31/01/2022	31/07/2024	5	The Staff Movement Advice (SMA) form was implemented on the 15th April 2024. As part of the initial implementation, the IT workflow was not initiated to allow for some time for staff to become familiar and use the form. On the 23rd May 2024 the SMA Dashboard was shared with the Workforce Systems Team to review the data and workflows. Initial analysis has identified some data quality issues, therefore, the team have requested some further analysis from NWSSP regarding the fields and process for obtaining the data relating to remaining or leaving the NHS to inform the IT workflow. The team have requested an update from NWSSP by 20 June 2024 with an aim to implementing before 31 July 2024
158	Internal Audit	On-Call arrangements	2022	Limited	High	Matter Arising 1 – Review of on-call arrangements (Design)	The on-call review should be re-instated as a priority, to ensure arrangements match service requirements, and are reviewed considering changing needs as a result of changes due to VERS and the new Operating Model. Management should consider the feedback from our questionnaire when reviewing on-call arrangements, and how these can be addressed. Following completion of the review and update of guidance (see Matters Arising 2,3 and 4 below), this should be communicated to staff to ensure they understand their obligations and responsibilities for participating in the on-call rotas.	1.1a: The on-call review will be restarted and will be led by the Interim Regional Director of Delivery (IRDD), supported by the Strategic Emergency Preparedness Response and Resilience (EPRR) lead.	Chief Operating Officer	Chief Operating Officer - previously Gareth Evans, Acting Executive Director Therapies and Health Science, and Adele Gittoes, Interim Executive Director of Operations	Started	23/09/2022	01/06/2024	3	This matter is with Gareth Evans, Acting Executive Director Therapies and Health Science as lead going forward, as it is a highly complex and sensitive issue, which will involve WOD and trade unions.
159	Internal Audit	On-Call arrangements	2022	Limited	High	Matter Arising 2 – Rota guidance / sustainability (Design)	The following should be documented for on-call rotas: Minimum staff numbers; Seniority/experience mix; Timelines for preparation and issuing of rotas; Frequency and type of each employees commitment is equitable; Process for staff being added to the rota when commencing an applicable senior role; Process for staff being removed from the rota, ensuring the impact this will have on other staff is considered, with reasons approved at an Executive level. Any staff removed from the rota should be reviewed regularly to determine if they can be put back on it.	2.1 On-call document, covering the recommendations above will be issued to all staff.	Chief Operating Officer	Chief Operating Officer - previously Gareth Evans, Acting Executive Director Therapies and Health Science, and Adele Gittoes, Interim Executive Director of Operations	Started	01/07/2022	01/06/2024	1	This matter is with Gareth Evans, Acting Executive Director Therapies and Health Science as lead going forward, as it is a highly complex and sensitive issue, which will involve WOD and trade unions.
160	Internal Audit	On-Call arrangements	2022	Limited	High	Matter Arising 3 – Compensatory rest and payment (Operation)	Workforce policies to be reviewed and updated as necessary, including clear guidance on the requirement for taking compensatory rest. Guidance on compensatory rest and payment entitlement to be included on the staff intranet site and circulated to all staff included on on-call rotas. This should be done on a periodic basis to ensure new staff who are added to rotas are aware of their entitlements. Staff included in on-call rotas to be encouraged to take compensatory rest.	3.1a All on-call staff to be written to by the Interim Director of Regional Delivery, having agreed content of the letter with the Director of Workforce & OD, and Deputy CEO. *Audit notes: - The Rostering Policy has been reviewed and is with the Workforce Policy Group for consideration (action captured through the review of Nursing Roster Management) - re guidance on compensatory rest / payments - see action 4 below - manual with key information for staff to include this information.*	Chief Operating Officer	Chief Operating Officer - previously Gareth Evans, Acting Executive Director Therapies and Health Science, and Adele Gittoes, Interim Executive Director of Operations	Started	11/07/2022	01/06/2024	1	This matter is with Gareth Evans, Acting Executive Director Therapies and Health Science as lead going forward, as it is a highly complex and sensitive issue, which will involve WOD and trade unions.
161	Internal Audit	On-Call arrangements	2022	Limited	High	Matter Arising 4 – Training (Design)	The requirements of staff included in on-call rotas should be documented and staff provided with relevant information to ensure they are able to deal with expected issues whilst on-call i.e. key information about sites and services, as staff may not be familiar with the site they are responsible for during the on-call shift. Training should be provided to staff who are on the rotas to ensure they are aware of their responsibilities and possible scenarios of what they may have to deal with.	4.1a: Programme of training to be reviewed. The programme will take into account the areas identified within the audit survey.	Chief Operating Officer	Chief Operating Officer - previously Gareth Evans, Acting Executive Director Therapies and Health Science, and Adele Gittoes, Interim Executive Director of Operations	Started	28/09/2022	01/06/2024	1	This matter is with Gareth Evans, Acting Executive Director Therapies and Health Science as lead going forward, as it is a highly complex and sensitive issue, which will involve WOD and trade unions.

No	Type	Title	Year	Rating	Priority	Matter Arising	Recommendation	Management Response	Responsible Officer	Executive	Status	Date 1	Date 2	No.	Update
172	Internal Audit	Effective Governance - Ysbyty Wrexham Maelor Hospital	2022	Limited	High	Matter Arising 2: Finance (Operation)	2.1a Management to identify and progress savings schemes as a matter of urgency. 2.1b Management ensure financial scrutiny is in line with the requirements laid out in the Operating Model.	2.1a A revised control total has been set for the EIHC. E IHC is an exemplar area for CHC savings. 2.1b The Finance and Performance Sub Committee includes a duty to monitor progress with cost improvement programmes. Terms of Reference were signed off 16 November 2022.	Michelle Greene, Integrated Health Community Director (East)	Chief Operating Officer - previously Gareth Evans, Acting Executive Director Therapies and Health Science, and Adele Gittoes, Interim Executive Director of Operations	Final Client approved	31/03/2023	05/02/2024	1	Monthly meetings are held with teams to identify, monitor and share learning around the savings targets. This has allowed us to progress CRES targets. There is a monthly finance and performance meeting for all areas to report into and new for 2024 is the deep dives into the areas. The chief finance officers are an integral part of the IHC meetings and input to all decision making. The last meeting held on Wed 28th Feb. All meetings take place on the last Wednesday of every month, previous meetings 29th Nov, 25th Oct, 27th Sept on a rolling monthly occurrence. CRES meetings – monthly CRES meetings take place (not minuted) with all directorates to meet with the EAST IHC Directors and Finance to update on their financial position so far and to discuss savings plans and how they can help to deliver a balanced year end outturn. There was also a deep dive done on finance and EIHC presented at PFIG on 22nd February 2024.
175	Internal Audit	Effective Governance - Ysbyty Wrexham Maelor Hospital	2022	Limited	High	Matter Arising 5: Risk Management (Operation)	5.1a: The Risk Register requires review to ensure that risks are accurate and appropriate actions/dates are included. 5.1b: Management to review consistency of reporting in accordance with the revised Operating Model/governance structure.	EIHC Risk Management Group have met twice to date. All level 1 and 2 risk discussed and divisions tasked to review all risks within own areas. Some risks sit within East are corporate risks and some sit within operational estates. Ongoing review of risks, Level 3 – Quarterly, Level 2 – Bi Monthly Level 1 – Monthly. Risks for Acute Site, Childrens, HMP Berwyn, Primary Care, Facilities and Community Services have been amalgamated into an EIHC Integrated Risk Meeting, risk register currently under review.	Ian Donnelly, IHC Operations Director, East	Chief Operating Officer - previously Gareth Evans, Acting Executive Director Therapies and Health Science, and Adele Gittoes, Interim Executive Director of Operations	Final Client approved	31/03/2023		0	There is now a Wxm site Risk meeting, this reports to East IHC Risk and Governance Meeting as per the requirements of RMO1, this has been in place since September TOR attached. The monthly meetings are minuted, have an up to date TOR (we are waiting the new revised RMO1 so that we can update the TOR). Copy of agenda and minutes provided as evidence for closure.
178	Internal Audit	Effective Governance - Ysbyty Gwynedd (YG)	2022	Limited	High	Matter Arising 3: Clinical audit (Operation)	3.1a The list of Tier 3 audits should be shared with the QSCE to ensure there is no duplication of audits/efforts across the Ysbyty Gwynedd. This would also provide opportunities for work across more than one division/locality. 3.1b Results and lessons from Tier 3 audits should be shared across the Health Board. Noting that divisions/localities are responsible for Tier 3 audits, we would suggest the learning/feedback is provided to the QSCE and the Clinical Effectiveness Team and a process put in place to ensure that relevant learning/feedback is shared across the site and potentially the Health Board. 3.1c Management should ensure that staff contribute to Tier 2 audits where required, in order to progress the Health Board's Clinical Audit Plan.	3.1a A full list of Tier 3 audits will be Shared via the next Quality Safety and Clinical Effectiveness at Ysbyty Gwynedd, to ensure that these are appropriately focussed and do not duplicate effort. 3.1b Lessons learned from Tier 3 Audits to be a major item from discussion at the December 2022 QSCE, with all Directorates represented on a multi-disciplinary basis to ensure cross fertilisation of ideas and feedback. A report to be produced to consolidate this feedback to be shared via the Health Board level meeting in early 2023. 3.1c All appropriate staff encouraged to participate in Tier 2 audits and contribute to clinical audit, where possible being given allocated time for this, via a joint letter from the clinical members of the new IHC Leadership Team (Medical, Nursing	Janw Hughes-Evans, Interim Area Nurse Director West	Chief Operating Officer - previously Gareth Evans, Acting Executive Director Therapies and Health Science, and Adele Gittoes, Interim Executive Director of Operations	Final Client approved	31/12/2022	31/03/2023	2	A tier 3 audit programme has been developed for 2023-24. This was shared at the IHC's Quality Local Delivery Group on 31st October 2023. It is available on the Intranet based on those projects registered via the Clinical effectiveness portal. A weekly update on the delivery of tier 2 audits is also available on the Intranet. The audit and effectiveness monthly update that was shared at the Quality LDG on 28th November 2023 is attached. A monthly report is now provided in this format to track progress and as a means of escalation. An update on Tier 1 audit compliance (as at 15th January 2024) is attached, showing the west as the best performing IHC in relation to compliance (65% responded to in time, 22% response awaited but still in time, 9% no response and overdue.) Clinical teams are now better engaged with the process; for example the Surgical Directorate are about to commence a Consent to Treatment audit, and this will be reported through the Quality LDG. Downloads from the intranet detailing the current position can be shared for further assurance if required. Additional evidence relating to the audit provided as evidence for closure.
256	Internal Audit	Planned Care Recovery & Transformation Group	2023	Limited	High	Matter Arising 1: Planned Care Recovery & Transformation Group (Operation)	1.1 It is evident that benefits of establishing the Group have not been realised - the Health Board needs to decide if reinstating the Group is the way forward to provide assurance to the Health Board and Welsh Government that the planned care programme is being successfully implemented. If Group meetings to resume, then its membership and terms of reference should be reviewed and updated to enable the Group meet its objectives with measurable deliverables being developed and reviewed regularly. 1.2 Management should ensure there are sufficient resources allocated to the planned care agenda, to ensure the planned care programme is successfully implemented.	1.1 A draft revised programme is awaiting formalisation and there will be an inaugural meeting to launch the programme before the end of July. 1.2 Programme resources have been identified and we are working to appoint individuals into lead roles.	Rhys Blake, Associate Director of Planned Care	Nick Lyons, Executive Medical Director, previously Adele Gittoes, Interim Executive Director of Operations	Final Client approved	31/07/2023		0	Planned Care Programme established with agreed governance, meeting every 6 weeks. Copy of Programme Board TORs provided as additional evidence for closure
257	Internal Audit	Planned Care Recovery & Transformation Group	2023	Limited	High	Matter Arising 2: Reporting (Operation)	2.1 Review the mechanisms for reporting, ensure requirements have been clearly established and expectations communicated with the relevant Groups/Committee.	2.1 Reporting arrangements will be published once finalised with the programme initiation arrangements.	Rhys Blake, Associate Director of Planned Care	Nick Lyons, Executive Medical Director, previously Adele Gittoes, Interim Executive Director of Operations	Final Client approved	31/07/2023	31/03/2024	1	The Terms of Reference for the Planned Care Programme Board were ratified on 15/03/2024, and are attached for evidence. This recommendation can be put forward for closure.

261	Internal Audit	Contracted Patient Services: Quality and Safety Arrangements	2023	Limited	High	Matter Arising 1: Process management (Design)	1.1.1 and Management establish robust overarching Commissioning Assurance Framework, Policy, or relevant Standard Operating Procedure (SOP) to support the healthcare commissioning/contracting process. This should ensure that lines of escalation, roles, responsibilities, and requirements regarding the management and oversight of the quality aspect of services provided are clearly defined.	1.1.1 The Health Board will develop a Commissioning Assurance Framework (CAF) for the management of external healthcare contracts. This will set out the roles, responsibilities and processes and will cover not only the quality assurance of commissioned services but also the commissioning, performance management, business intelligence / analysis and other professional services that input to contract management both where the health board is commissioner and provider. *Update from Executive Team meeting on 19/06/2024 is that, in the absence of the Director of Commissioning and Performance, there will be an oversight of a number of Executive Directors. Work on progressing the commission arrangements for contracts is underway and an update will be provided to the PFIG in August.*	Russell Caldicott, Interim Executive Director of Finance: Angela Wood, Executive Director of Nursing and Midwifery; Pam Wenger, Director of Corporate Governance; Michelle Greene, IHC Director - East (until Director of Commissioning and Performance is in post) **(previously Adrian Tomkins, Associate Director of Healthcare Contracting);** Matthew Joyes, Deputy Director of Quality	Russell Caldicott, Interim Executive Director of Finance: Angela Wood, Executive Director of Nursing and Midwifery; Pam Wenger, Director of Corporate Governance; Michelle Greene, IHC Director - East **(until Director of Commissioning and Performance is in post),** previously Angela Wood, Executive Director of Nursing and Midwifery	Started	31/07/2023	30/09/2024	2	A meeting will take place between Pam Wenger, Director of Corporate Governance, Russell Caldicott, Interim Executive Director of Finance and Michelle Greene, IHC Director - East to discuss the way forward with this recommendation on 26th July 2024.
262	Internal Audit	Contracted Patient Services: Quality and Safety Arrangements	2023	Limited	High	Matter Arising 2: Contractual obligations (Design)	2.1.1 Management establish controls to ensure that all commissioned providers adhere to agreed contractual agreements and assess current contract review meeting arrangements to ensure appropriate levels of oversight and engagement.	2.1.1 The Health Board will, as part of the Commissioning Assurance Framework (CAF) mentioned above, establish roles, responsibilities and escalations for the review of contract performance, including contract meetings. *Update from Executive Team meeting on 19/06/2024 is that, in the absence of the Director of Commissioning and Performance, there will be an oversight of a number of Executive Directors. Work on progressing the commission arrangements for contracts is underway and an update will be provided to the PFIG in August.*	Russell Caldicott, Interim Executive Director of Finance: Angela Wood, Executive Director of Nursing and Midwifery; Pam Wenger, Director of Corporate Governance; Michelle Greene, IHC Director - East (until Director of Commissioning and Performance is in post) **(previously Adrian Tomkins, Associate Director of Healthcare Contracting);** Matthew Joyes, Deputy Director of Quality	Russell Caldicott, Interim Executive Director of Finance: Angela Wood, Executive Director of Nursing and Midwifery; Pam Wenger, Director of Corporate Governance; Michelle Greene, IHC Director - East **(until Director of Commissioning and Performance is in post),** previously Angela Wood, Executive Director of Nursing and Midwifery	Started	31/08/2023	30/09/2024	2	A meeting will take place between Pam Wenger, Director of Corporate Governance, Russell Caldicott, Interim Executive Director of Finance and Michelle Greene, IHC Director - East to discuss the way forward with this recommendation on 26th July 2024.
263	Internal Audit	Contracted Patient Services: Quality and Safety Arrangements	2023	Limited	High	Matter Arising 3: Quality measures (Operation)	3.1 Management to review contractual quality measures to ensure they are robust, effective, and appropriate.	3.1.1 For the 2023/2024 period, quality schedules will be included in contracts that reflect national requirements. *Update from Executive Team meeting on 19/06/2024 is that, in the absence of the Director of Commissioning and Performance, there will be an oversight of a number of Executive Directors. Work on progressing the commission arrangements for contracts is underway and an update will be provided to the PFIG in August.*	Russell Caldicott, Interim Executive Director of Finance: Angela Wood, Executive Director of Nursing and Midwifery; Pam Wenger, Director of Corporate Governance; Michelle Greene, IHC Director - East (until Director of Commissioning and Performance is in post) **(previously Adrian Tomkins, Associate Director of Healthcare Contracting);** Matthew Joyes, Deputy Director of Quality	Russell Caldicott, Interim Executive Director of Finance: Angela Wood, Executive Director of Nursing and Midwifery; Pam Wenger, Director of Corporate Governance; Michelle Greene, IHC Director - East **(until Director of Commissioning and Performance is in post),** previously Angela Wood, Executive Director of Nursing and Midwifery	Started	31/08/2023	30/09/2024	2	A meeting will take place between Pam Wenger, Director of Corporate Governance, Russell Caldicott, Interim Executive Director of Finance and Michelle Greene, IHC Director - East to discuss the way forward with this recommendation on 26th July 2024.

ID	Audit	Title	Year	Rating	Priority	Matter Arising	Recommendation	Management Response	Responsible Officer	Executive Lead	Status	Original Date	Revised Date	No.	Update
264	Internal Audit	Contracted Patient Services: Quality and Safety Arrangements	2023	Limited	High	Matter Arising 3: Quality measures (Operation)	3.2.1 Management to ensure procedures have provision for addressing and escalating quality issues that fall outside the agreed measures.	3.2.1 The Health Board will, as part of the Commissioning Assurance Framework mentioned in ID 263, establish roles, responsibilities and escalations for the review of contract performance, including the dissemination of reports, the interpretation and identification of issues, the escalation process, management of remedial actions and ongoing monitoring via ad hoc meetings, contract meetings or any other forum required. *Update from Executive Team meeting on 19/06/2024 is that, in the absence of the Director of Commissioning and Performance, there will be an oversight of a number of Executive Directors. Work on progressing the commission arrangements for contracts is underway and an update will be provided to the PFIG in August.*	Russell Caldicott, Interim Executive Director of Finance: Angela Wood, Executive Director of Nursing and Midwifery; Pam Wenger, Director of Corporate Governance; Michelle Greene, IHC Director - East (until Director of Commissioning and Performance is in post) (previously Adrian Tomkins, Associate Director of Healthcare Contracting); Matthew Joyes, Deputy Director of Quality	Russell Caldicott, Interim Executive Director of Finance: Angela Wood, Executive Director of Nursing and Midwifery; Pam Wenger, Director of Corporate Governance; Michelle Greene, IHC Director - East (until Director of Commissioning and Performance is in post), previously Angela Wood, Executive Director of Nursing and Midwifery	Started	31/10/2023	30/09/2024	2	A meeting will take place between Pam Wenger, Director of Corporate Governance, Russell Caldicott, Interim Executive Director of Finance and Michelle Greene, IHC Director - East to discuss the way forward with this recommendation on 26th July 2024.
265	Internal Audit	Contracted Patient Services: Quality and Safety Arrangements	2023	Limited	High	Matter Arising 4: Board assurance (Design)	4.1 Management to review governance and reporting arrangements to ensure English NHS provider quality and performance data is subject to Health Board review and scrutiny.	4.1 1 The Health Board will establish a six monthly report to the Quality, Safety and Experience Committee setting out a quality assurance position for commissioned services. The ownership and authorship of this report will be clarified in the CAF. *Update from Executive Team meeting on 19/06/2024 is that, in the absence of the Director of Commissioning and Performance, there will be an oversight of a number of Executive Directors. Work on progressing the commission arrangements for contracts is underway and an update will be provided to the PFIG in August.*	Russell Caldicott, Interim Executive Director of Finance: Angela Wood, Executive Director of Nursing and Midwifery; Pam Wenger, Director of Corporate Governance; Michelle Greene, IHC Director - East (until Director of Commissioning and Performance is in post) (previously Adrian Tomkins, Associate Director of Healthcare Contracting); Matthew Joyes, Deputy Director of Quality	Russell Caldicott, Interim Executive Director of Finance: Angela Wood, Executive Director of Nursing and Midwifery; Pam Wenger, Director of Corporate Governance; Michelle Greene, IHC Director - East (until Director of Commissioning and Performance is in post), previously Angela Wood, Executive Director of Nursing and Midwifery	Started	31/10/2023	30/09/2024	2	A meeting will take place between Pam Wenger, Director of Corporate Governance, Russell Caldicott, Interim Executive Director of Finance and Michelle Greene, IHC Director - East to discuss the way forward with this recommendation on 26th July 2024.
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.	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.	David Maslen-Jones, Acting Assistant Director of Occupational Health, Safety and Security	Angela Wood, Executive Director of Nursing and Midwifery	Started	01/01/2024	30/09/2024	2	Due to high levels of absence within the team, the situation remains static. East IHC have been unable to provide rooms for training which again impacts with high DNA rates on those booked. Advertisment has gone out for additional post in East and ECR completed for further role reeplacing band 6 trainer in establishment (but unable to recruit to) with a band 5. Decision taken to stop student training at contract end (March 2025) to free up capacity even though this reduces income.
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	Started	30/12/2023	30/06/2024	3	SOP has been amended and simplified following feedback form the membership of the Health Board Inpatient Falls group. To be recirculated for final approaval by membership prior to final approval by Health Board Patient Safety group (July 24). Following approval for sharing, communication and implementation across all weekly IHC meetings for review of ALL Inpatient Falls.
308	Internal Audit	Waiting List Management: Review of the WG initiated Patient Validation Exercise, Risk Stratification and patient removal from lists	2022	Limited	High	Matter Arising 1 - WG initiated, locally delivered tranche 'patient' validation exercise - (Operation)	The governance spreadsheet required tighter controls to ensure the integrity of the data relating to access and who is populating the spreadsheet with information. Robust back-up arrangements should be established to ensure this key source of waiting list data is available in the event of corruption/data loss, resulting in patient harm – Options should be reviewed to move away from a spreadsheet to a more stable	Action 1 - The Health Board recognises the need to improve upon and modernise the governance arrangements and management of validity of data and cleansing the waiting list. Funding was recognised as being required to address and strengthen the governance and management of the waiting lists.	Rhys Blake, Associate Director of Planned Care	Nick Lyons, Executive Medical Director, previously Adele Gittoes, Interim Executive Director of Operations	Final Client approved	31/07/2022	31/03/2024	1	The Health Board has completed the implementation of a single instance of WPAS which closes this action.
309	Internal Audit	Waiting List Management: Review of the WG initiated Patient Validation Exercise, Risk Stratification and patient removal from lists	2022	Limited	High	WG initiated, locally delivered tranche 'patient' validation exercise - (Operation)	The governance spreadsheet required tighter controls to ensure the integrity of the data relating to access and who is populating the spreadsheet with information. Robust back-up arrangements should be established to ensure this key source of waiting list data is available in the event of corruption/data loss, resulting in patient harm – Options should be reviewed to move away from a spreadsheet to a more stable	Action 2 - This project will use digital transformation in conjunction with process redesign to deliver significant and tangible improvements, removing much of the administration function – moving patient validation into business as usual rather than cohort or tranche activity. Phase 1 will be a proof of concept with one or more specialities. Funding is being sought via the WG (Welsh Government) who have engaged on the initiative with a view to scaling up pan-BCU (Due by 30/09/2022). The proof of concept to digitize and automate elements of the validation process is underway as part of the funded business case to establish a validation team.	Rhys Blake, Associate Director of Planned Care	Nick Lyons, Executive Medical Director, previously Adele Gittoes, Interim Executive Director of Operations	Final Client approved	30/09/2022	31/03/2024	1	The Health Board has completed the implementation of a single instance of WPAS which closes this action.

#	Audit	Title	Year	Rating	Priority	Matter	Recommendation	Management Action	Owner	Executive Lead	Status	Orig Date	Rev Date	No.	Update
310	Internal Audit	Waiting List Management: Review of the WG initiated Patient Validation Exercise, Risk Stratification and patient removal from lists	2022	Limited	High	WG initiated, locally delivered tranche 'patient' validation exercise - (Operation)	The governance spreadsheet required tighter controls to ensure the integrity of the data relating to access and who is populating the spreadsheet with information. Robust back-up arrangements should be established to ensure this key source of waiting list data is available in the event of corruption/data loss, resulting in patient harm – Options should be reviewed to move away from a spreadsheet to a more stable application.	Action 3 - Service validation model will be reviewed and redesigned as a component part of implementation of the substantive validation team, as part of the shift to business-as-usual processes under Action 1.	Rhys Blake, Associate Director of Planned Care	Nick Lyons, Executive Medical Director, previously Adele Gittoes, Interim Executive Director of Operations	Final Client approved	31/03/2023	31/03/2024	1	The Health Board has completed the implementation of a single instance of WPAS which closes this action.
311	Internal Audit	Waiting List Management: Review of the WG initiated Patient Validation Exercise, Risk Stratification and patient removal from lists	2022	Limited	High	Matter Arising 2 - Assessment of clinical risks relating to delays (Operation)	Patients who are identified as being overdue should be risk stratified as a priority. Records should be updated to confirm risk stratification has been completed and these should be reviewed on a regular basis to ensure there is minimal risk of patient harm	Action 4 - The Health Board recognizes the critical importance of risk stratification for overdue patients to minimize risk of patient harm. With the discontinuation of manual P value assignment under previous COVID protocols as noted in Actions 4 and 5, risk stratification now follows standing Welsh RTT guidance. A project is underway as part of the Planned Care Programme (see Action 7) to automate risk stratification based on referrals exceeding defined waiting time thresholds for their RTT classification. Automatic alerts will be generated for booking teams to facilitate urgent clinical review, re-prioritization, and escalation if needed. This multi-pronged approach will significantly strengthen oversight and proactive management of risk associated with overdue patients. Regular reporting will occur through the Planned Care Programme governance noted previously.	Site Directorate General Managers	Nick Lyons, Executive Medical Director, previously Adele Gittoes, Interim Executive Director of Operations	Final Client approved	30/04/2022		0	This recommendation refers to COVID restrictions which are no longer in place. This recommendation can therefore be closed.
312	Internal Audit	Waiting List Management: Review of the WG initiated Patient Validation Exercise, Risk Stratification and patient removal from lists	2022	Limited	High	Matter Arising 2 - Assessment of clinical risks relating to delays (Operation)	Patients who are identified as being overdue should be risk stratified as a priority. Records should be updated to confirm risk stratification has been completed and these should be reviewed on a regular basis to ensure there is minimal risk of patient harm.	Action 5 - P value for risk stratification no longer in use – stood down as part of the removal of covid restrictions. Standing RTT classifications now apply – i.e. USC, Urgent, Routine.	Site Directorate General Managers	Nick Lyons, Executive Medical Director, previously Adele Gittoes, Interim Executive Director of Operations	Final Client approved	31/05/2022		0	This recommendation refers to COVID restrictions which are no longer in place. This recommendation can therefore be closed.
313	Internal Audit	Waiting List Management: Review of the WG initiated Patient Validation Exercise, Risk Stratification and patient removal from lists	2022	Limited	High	Matter Arising 2 - Assessment of clinical risks relating to delays (Operation)	Patients who are identified as being overdue should be risk stratified as a priority. Records should be updated to confirm risk stratification has been completed and these should be reviewed on a regular basis to ensure there is minimal risk of patient harm.	Action 6 – Monitoring of routine RTT targets reported weekly to Welsh Government/NHS Executive). Weekly BCUHB Corporate access meeting monitors RTT performance and locally each IHC (Integrated Healthcare Communities) holds a weekly access meeting.	Site Directorate General Managers	Nick Lyons, Executive Medical Director, previously Adele Gittoes, Interim Executive Director of Operations	Final Client approved	31/03/2022		0	Corporate Access weekly meetings held with Welsh Government representation. Also included as evidence is the Extreme Wait summary at 26/02/2024, IQPD meeting agenda dated 19/03/2024, and Planned Care catch up presentation from 18/10/2023.
314	Internal Audit	Waiting List Management: Review of the WG initiated Patient Validation Exercise, Risk Stratification and patient removal from lists	2022	Limited	High	Matter Arising 2 - Assessment of clinical risks relating to delays (Operation)	Patients who are identified as being overdue should be risk stratified as a priority. Records should be updated to confirm risk stratification has been completed and these should be reviewed on a regular basis to ensure there is minimal risk of patient harm.	Action 7 – The Health Board recognizes the importance of aligned standardized removal reasons across all sites for consistency, improved analysis, and reduced errors or inconsistencies. Significant progress has already been made through the system consolidation actions updated below. Implementation of a single centralized Welsh Patient Administration System (WPAS) instance has established consistent removal coding structures across all Health Board sites and user groups. The migration to a unified WPAS platform with standardized data structures has eliminated the need for interim data alignment. By virtue of progress under Action 8 (action ID 315 in this tracker), removal reasons are now consistent organization-wide. With WPAS system convergence complete, the Health Board now has a single integrated structure for patient administration, referrals, waiting list management, and removals management. Standard operation procedures will reflect the centralized data system. This will further consolidate the gains from technical system consolidation to support consistency in removal reason usage. Progress will be monitored through Informatics governance.	Site Directorate General Managers	Nick Lyons, Executive Medical Director, previously Adele Gittoes, Interim Executive Director of Operations	Final Client approved	31/03/2022	30/06/2024	1	We also meet with WG in IQPD and Planned Care Recovery meeting where RTT is also discussed.
315	Internal Audit	Waiting List Management: Review of the WG initiated Patient Validation Exercise, Risk Stratification and patient removal from lists	2022	Limited	High	Matter Arising 3 - Patients removed from waiting lists (Operation)	Standardisation of the reasons for removal should be developed to ensure consistency across the Health Board and enable analysis of reasons why patients are removed from waiting lists. This would also potentially reduce any inputting errors.	Action 8 – The Health Board has completed the implementation of a single instance of WPAS which closes this action.	WPAS Standardisation lead	Nick Lyons, Executive Medical Director, previously Adele Gittoes, Interim Executive Director of Operations	Final Client approved	May 2022		0	As well as the above we provide weekly updates to WG on Extreme waits and a patient by patient update
316	Internal Audit	Waiting List Management: Review of the WG initiated Patient Validation Exercise, Risk Stratification and patient removal from lists	2022	Limited	High	Matter Arising 3 - Patients removed from waiting lists (Operation)	Standardisation of the reasons for removal should be developed to ensure consistency across the Health Board and enable analysis of reasons why patients are removed from waiting lists. This would also potentially reduce any inputting errors.	Action 9 – As per action 8 (ID 315 in this tracker) – completed and closed.	WPAS Standardisation lead	Nick Lyons, Executive Medical Director, previously Adele Gittoes, Interim Executive Director of Operations	Final Client approved	July 2022		0	The Health Board has completed the implementation of a single instance of WPAS which closes this action.
317	Internal Audit	Decarbonisation	2023	Limited	High	Matter Arising 1 - Governance Structure (Design), Monitoring & Reporting (Operation)	1.1a In accordance with the NHS Wales Decarbonisation Strategic Development Plan 2021–2030, establish appropriate, robust, and effective governance frameworks to implement the Health Board's Decarbonisation Action Plan to achieve net zero carbon emissions by 2030.	1.1a As articulated in the findings of the report the Health Board has formed an appropriate governance framework. The six subgroups formed aligns to the national recommendations and reports into the DPB which will then report to PPPH and the Board receiving assurance from this sub-committee. There is an acceptance of the infancy in which this framework has been formed and we will need to ensure the sub-groups offer the appropriate level of assurance to the DPB. The Decarbonisation Programme Board will ensure a formal governance framework is defined and agreed through the Terms of Reference. In addition this will align to the overall organisational governance structure, with reporting to PPPH once re-convened.	Russell Caldicott, Interim Executive Director of Finance; Programme Lead	Russell Caldicott, Interim Executive Director of Finance	Started	31/05/2024	31/07/2024	1	This will be complete by 31st July 2024 following presentation to PPPH.
320	Internal Audit	Lessons Learnt	2023	Limited	High	Matter Arising 1 - Lessons Learnt (Design)	1.1 Management to establish robust policy, guidance, or Standard Operating Procedure to support operational processes. Governance, reporting, and escalation requirements to be clearly defined.	1.1 A Putting Things Right (PTR) and Learning Policy will be developed to give clear guidance of operational processes, governance reporting and escalation requirements when learning is identified.	Matthew Joyes, Deputy Director of Quality	Angela Wood, Executive Director of Nursing and Midwifery	Started	29/02/2024	30/09/2024	1	Policy due to go to Board July 2024.

						Matter Arising	Recommendation	Management Response	Action Owner	Executive Lead	Status	Original Date	Revised Date	No.	Update
324	Internal Audit	Lessons Learnt	2023	Limited	High	Matter Arising 1: Lessons Learnt (Design)	1.3a Management to review implemented learning to ensure effectiveness.	1.3a The Quality Informatics and Learning Team will work with Clinical Effectiveness Team to explore how learning can be reviewed/audited as part of the learning cycle and feed into the annual audit cycle. *NB: Underpinning all this work is a Learning Improvement Project Plan which is in place and is being delivered as part of the Special Measures Programme – this includes development of a Learning Organisation Framework setting out cultural change (in partnership with Workforce and OD) and the Health Board will work with the national quality team on the creation of a learning healthcare system.*	Sarah Musgrave, Lead Manager - Learning	Angela Wood, Executive Director of Nursing and Midwifery	Started	31/03/2024	30/09/2024	2	Work continues to progress.
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: 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.*	Sarah Musgrave, Lead Manager - Learning	Angela Wood, Executive Director of Nursing and Midwifery	Started	31/03/2024	30/09/2024	2	Work continues to develop the new Quality Learning Portal (evidence attached). The database is in place and work continues now on the front facing "apps" that will allow staff to enter and review learning. Colleagues within MHLD are supporting its development from a practical perspective. The work is now likely to be complete by end of September: 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.
327	Internal Audit	Lessons Learnt	2023	Limited	High	Matter Arising 2: Make it Safe (Plus) (Design)	2.1 Management to formally document and communicate the principles and requirements of Make it Safe (Plus) to ensure consistency across the Health Board. Governance, reporting, and escalation requirements to be clearly defined.	A full review of the incident process and procedure has been commenced, which will be co-designed with staff to ensure that the new procedure is fit for purpose and workable for staff undertaking rapid reviews/investigations and learning.	Tracey Radcliffe, Head of Patient Safety	Angela Wood, Executive Director of Nursing and Midwifery	Started	31/03/2024	30/09/2024	3	The Integrated Concerns Framework is going to Board in July 2024 with the aim to implement in September 2024.
340	Internal Audit	Water Safety	2024	Limited	High	Matter Arising 3: Training and competence (Operation)	3.1 Management to ensure all staff members that have been allocated tasks and responsibilities impacting water safety (including outlet flushing, wash-hand basin / tap cleaning, maintenance, strategy development etc) have received adequate training in respect of water hygiene and microbiological control appropriate to the task they are responsible for conducting.	3.1 Training package to be presented to all ward / departmental manager and facility management, the attendance at the training event will be monitored by reporting and escalating to the Water Safety Group / Strategic Infection Prevention Group.	Arwel Hughes, Head of Operational Estates	Russell Caldicott, Interim Executive Director of Finance	Started	31/05/2024	19/08/2024	1	Training undertaken within Central and planned for West and East. Attendance list to be presented at the Pan BCUHB Water Safety Group which will be held on 31st July 2024
343	Internal Audit	Water Safety	2024	Limited	High	Matter Arising 4: Risk management (Operation)	4.3 Management review Business Continuity Arrangements for loss of mains water and / or request assurance from water providers that their contingency plans / Emergency Response Action Plans are routinely tested.	4.3 There is a Business Continuity Plan in place for how Operational Estates manage the loss of Water within Hospital sites, but the Health Board does not have a Business Continuity for how operationally the sites will manage loss of water (Hand Hygiene, Provision of Drinking water etc.).	Sharon Scott, EPRR Lead	Russell Caldicott, Interim Executive Director of Finance	Started	01/05/2024	01/08/2024	1	The EPRR Lead has recently commenced in the Health Board, and therefore this recommendation will be progressed
344	Internal Audit	Water Safety	2024	Limited	High	Matter Arising 4: Risk management (Operation)	4.3 Management review Business Continuity Arrangements for loss of mains water and / or request assurance from water providers that their contingency plans / Emergency Response Action Plans are routinely tested.	4.3 Operational Estates have within the Water Safety Policy an annex that identifies where Local Water Authorities can connect water tankers to the existing infrastructure in the event of a prolonged water outage within the 3 acute sites.	Arwel Hughes, Head of Operational Estates	Russell Caldicott, Interim Executive Director of Finance	Started	01/04/2024	01/08/2024	2	Operational Estates awaiting confirmation from Welsh Water on resilience plan for Ysbyty Gwynedd.
356	Internal Audit	Deprivation of Liberty Safeguards (DoLS)	2024	Limited	High	Matter Arising 2: DoLS authorisations (Design)	2.1a: 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: Demand and capacity modelling for Best Interest Assessments to be developed by the Safeguarding Business Team to support data driven decisions.	Chris Walker, Head of Safeguarding Adults	Angela Wood, Executive Director of Nursing and Midwifery	Started	31/07/2024			Work continuing.
357	Internal Audit	Deprivation of Liberty Safeguards (DoLS)	2024	Limited	High	Matter Arising 2: DoLS authorisations (Design)	2.1a: 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: Increase the Supervisory Body's capacity to complete best interest assessments within agreed timescales and legislative compliance by training 5 additional BIA's from Q2 onwards.	Chris Walker, Head of Safeguarding Adults	Angela Wood, Executive Director of Nursing and Midwifery	Started	31/03/2025			Expression of Interest Memo shared. Closing date 24/06/24. Potential course dates July and August 2024. An additional staff member achieved the BIA qualification within Q2.
358	Internal Audit	Deprivation of Liberty Safeguards (DoLS)	2024	Limited	High	Matter Arising 2: DoLS authorisations (Design)	2.1a: 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: Work Based Quality Improvement programme to be developed and implemented within the 3 high referring areas with high QA rejection rates for applications.	Chris Walker, Head of Safeguarding Adults	Angela Wood, Executive Director of Nursing and Midwifery	Started	30/09/2024			Ongoing. The seconded DoLS administration post is currently focusing on quality improvement. The findings will be reported at the SGPG QDG and MH Legislation and compliance Committee
359	Internal Audit	Deprivation of Liberty Safeguards (DoLS)	2024	Limited	High	Matter Arising 2: DoLS authorisations (Design)	2.1a: 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: 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	Started	30/09/2024			An MCA Lead (seconded position) is in place and undertakes weekly visits and daily contact within high risk areas. The administration Team has been strengthened (seconded position) to provide support and feedback to the DGH and Community hospitals regarding the applications. Support sessions are currently being rolled out to provide QA sessions.
361	Internal Audit	Deprivation of Liberty Safeguards (DoLS)	2024	Limited	High	Matter Arising 2: DoLS authorisations (Design)	2.1a: 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).	2.1 Digitalise MCA and DoLS documentation to ensure that mandatory fields are completed prior to submission and audit standards.	Chris Walker, Head of Safeguarding Adults	Angela Wood, Executive Director of Nursing and Midwifery	Started	31/03/2025			Further updates were required following the national meeting in April. Next meeting in July to review the updates and approve. Potential to pilot the updated version.
362	Internal Audit	Deprivation of Liberty Safeguards (DoLS)	2024	Limited	High	Matter Arising 3: DoLS Documentation (Operational)	3.1a: Managing Authorities to ensure that the applications are completed appropriately and returned in a timely manner. Where issues are identified with quality or timeliness, the Supervisory Body should communicate issues with relevant staff, provide support and ensure staff have undertaken appropriate training. Where issues remain this should be escalated as appropriate.	3.1a: MCA/DoLS Team to review Standing Operating Procedure for DoLS Applications detailing timescales within the process.	Chris Walker, Head of Safeguarding Adults	Angela Wood, Executive Director of Nursing and Midwifery	Started	30/09/2024			Progress is reported via the Safeguarding Governance and Reporting Framework.

363	Internal Audit	Deprivation of Liberty Safeguards (DoLS)	2024	Limited	High	Matter Arising 3: DoLS Documentation (Operational)	3.1a: Managing Authorities to ensure that the applications are completed appropriately and returned in a timely manner. Where issues are identified with quality or timeliness, the Supervisory Body should communicate issues with relevant staff, provide support and ensure staff have undertaken appropriate training. Where issues remain this should be escalated as appropriate.	3.1a: MCA/DoLS Team to provide key performance data regarding compliance of applications within timescales to the managing authorities.	Chris Walker, Head of Safeguarding Adults	Angela Wood, Executive Director of Nursing and Midwifery	Started	30/09/2024			No change
364	Internal Audit	Deprivation of Liberty Safeguards (DoLS)	2024	Limited	High	Matter Arising 3: DoLS Documentation (Operational)	3.1a: Managing Authorities to ensure that the applications are completed appropriately and returned in a timely manner. Where issues are identified with quality or timeliness, the Supervisory Body should communicate issues with relevant staff, provide support and ensure staff have undertaken appropriate training. Where issues remain this should be escalated as appropriate.	3.1a: Provide the Managing Authority with opportunities to reflect on the quality of documentation through quarterly learning sessions to commence in Q2. As per action 2.1a: Develop a Work Based Quality Improvement Plan based on themes and trends of the data analysis initially focussing on high referral areas to support reduced rejection rates at QA. Within the improvement plan identify measure for reduction in rejection rates and provide bi-monthly updates on progress and areas that require action with agreed escalation in place to managing authority.	Chris Walker, Head of Safeguarding Adults	Angela Wood, Executive Director of Nursing and Midwifery	Started	31/03/2025			Formal documentation, schedule of activities for MCA/DoLS Supervision sessions are under development. To support and inform this activity BIA's are present on the wards throughout all DGH and Community hospitals and provide advice and support.
365	Internal Audit	Deprivation of Liberty Safeguards (DoLS)	2024	Limited	High	Matter Arising 3: DoLS Documentation (Operational)	3.1a: Managing Authorities to ensure that the applications are completed appropriately and returned in a timely manner. Where issues are identified with quality or timeliness, the Supervisory Body should communicate issues with relevant staff, provide support and ensure staff have undertaken appropriate training. Where issues remain this should be escalated as appropriate.	3.1a: The Standing Operating Procedure for the completion of DoLS documentation to include criteria for triggering an escalation process for areas of concern i.e. high % of rejection at QA, low % compliance with agreed time frames.	Chris Walker, Head of Safeguarding Adults	Angela Wood, Executive Director of Nursing and Midwifery	Started	31/12/2024			Assurance gained in relation to the Supervisory Body linking directly with the ward to request the necessary amendments ensuring the applications are completed correctly.
458	Internal Audit	Discharge Arrangements	2024	Limited	High	Matter Arising 1: Policy, guidance, and training (Design)	1.1: Management: • Establish an overarching policy or Standard Operating Procedure(s) to support the management of patient discharges and implementation of D2RA. Governance, reporting, and escalation requirements to be clearly defined. • Ensure all staff (substantive, temporary, bank, and agency) involved with patient discharges / flow have a sound understanding of D2RA requirements and expectations.	1.1a: Draft revised BCUHB Hospital Discharge policy has been developed to replace the Covid discharge requirements and the former NU01 BCUHB Hospital Discharge Policy which is out of date. The revised draft policy will bepresented through the Health Board's governance process for approval, this will include a consultation period on the BCUHB website and sign off by relevant Health Board committee. Other supporting documentation including Choice & Reluctant Discharge Guidance and Criteria Led discharge is also being reviewed as part of this review of discharge documentation.	Jane Trowman, Acting Assistant Director Care Homes Support and CHC Commissioning; Claire Brennan, Programme Manager (Operations)	Chief Operating Officer - previously Gareth Evans, Acting Executive Director Therapies and Health Science, and Adele Gittoes, Interim Executive Director of Operations	Started	30/09/2024			Revised draft policy being progressed through HB governance route with other supporting discharge documentation Criteria led discharge protocol discussed with IHCs and agreed to refresh and review simplified process.
459	Internal Audit	Discharge Arrangements	2024	Limited	High	Matter Arising 1: Policy, guidance, and training (Design)	1.1: Management: • Establish an overarching policy or Standard Operating Procedure(s) to support the management of patient discharges and implementation of D2RA. Governance, reporting, and escalation requirements to be clearly defined. • Ensure all staff (substantive, temporary, bank, and agency) involved with patient discharges / flow have a sound understanding of D2RA requirements and expectations.	1.1b: Training Needs Analysis will be undertaken across each acute and community hospital.	Libby Ryan-Davies, IHC Director - Central	Chief Operating Officer - previously Gareth Evans, Acting Executive Director Therapies and Health Science, and Adele Gittoes, Interim Executive Director of Operations	Started	30/09/2024			i) Goal 6 lead attended Senior Nursing meeting to provide updates of POCD and D2RA where it was agreed to establish a number of learning events across NW to 'refresh' the programme of work for Goals 5 & 6 (optimal hospital patient flow). ii) Reviewed ward accreditation documentation to ensure D2RA and POCD feature within the metrics. iii) Identified the need to link into TNA for 'back to floor' nursing staff returning to wards
460	Internal Audit	Discharge Arrangements	2024	Limited	High	Matter Arising 1: Policy, guidance, and training (Design)	1.1: Management: • Establish an overarching policy or Standard Operating Procedure(s) to support the management of patient discharges and implementation of D2RA. Governance, reporting, and escalation requirements to be clearly defined. • Ensure all staff (substantive, temporary, bank, and agency) involved with patient discharges / flow have a sound understanding of D2RA requirements and expectations.	1.3c: Establish training plan, informed by TNA (to include staff across acute, community hospitals and from disciplines, doctors, nursing, AHP as well as students and including agency / bank staff).	Libby Ryan-Davies, IHC Director - Central	Chief Operating Officer - previously Gareth Evans, Acting Executive Director Therapies and Health Science, and Adele Gittoes, Interim Executive Director of Operations	Started	31/12/2024			i) Goal 6 lead attended Senior Nursing meeting to provide updates of POCD and D2RA where it was agreed to establish a number of learning events across NW to 'refresh' the programme of work for Goals 5 & 6 (optimal hospital patient flow). ii) Reviewed ward accreditation documentation to ensure D2RA and POCD feature within the metrics. iii) Identified the need to link into TNA for 'back to floor' nursing staff returning to wards. In addition, in relation to TNA, a refocus of the existing online e-learning for Critieria Led Discharge. Discharge competency framework developed in West IHC has been shared across other 2 IHC areas.
461	Internal Audit	Discharge Arrangements	2024	Limited	High	Matter Arising 2: D2RA performance Measures (Design)	2.1: Management: • Establish formal escalation arrangements to address and support areas of low / non-compliance. • Ensure that all patients without an allocated D2RA pathway are identified and highlighted to the relevant ward managers. Persistent failure to meet mandated requirements to be escalated.	2.1a: Develop Comms and engagement plan, informed by TNA to refocus and raise awareness to increase focus & awareness on D2RA pathways, STREAM, etc.	Libby Ryan-Davies, IHC Director - Central; Jane Trowman, Acting Assistant Director Care Homes Support and CHC Commissioning; Claire Brennan, Programme Manager (Operations)	Chief Operating Officer - previously Gareth Evans, Acting Executive Director Therapies and Health Science, and Adele Gittoes, Interim Executive Director of Operations	Started	30/06/2024	31/03/2025	1	Partially complete - raised awareness of D2RA which is now a standing item of the STREAM Development Group and will be part of the learning events to be held in each IHC. Propose to revise implementation date to end of March 2025 as the work will be ongoing following the learning events, training and ongoing project support.

468	Internal Audit	Discharge Arrangements	2024	Limited	High	Matter Arising 3: Pathways of Care Delays (Design)	3.1: Management: • Establish formal escalation framework to address and support resolution of Pathways of Care Delays. • Ensure working practice complies with Welsh Government requirements.	3.1a: Stock take of which areas are doing Board rounds twice daily with the aim of developing an improvement plan to support improved compliance.	Libby Ryan-Davies, IHC Director - Central	Chief Operating Officer - previously Gareth Evans, Acting Executive Director Therapies and Health Science, and Adele Gittoes, Interim Executive Director of Operations	Started	30/06/2024			This action is still to be progressed with clarification of UEC lead pan BCU at senior management level in the absence of COO currently which is to be confirmed. Amend implementation date to end September. This work will be key to implementing Red to Green which is not yet implemented in BCUHB but is part of the Goal 5 programme of work that is to be taken forward imminently - additional resource is being recruited to the 6 Goals programme team with interviews being held w/c 8th July and will support this implementation. Additional resource is also confirmed from the transformation team.
469	Internal Audit	Discharge Arrangements	2024	Limited	High	Matter Arising 3: Pathways of Care Delays (Design)	3.1: Management: • Establish formal escalation framework to address and support resolution of Pathways of Care Delays. • Ensure working practice complies with Welsh Government requirements.	3.1b: Agree robust reporting and governance arrangements at RPB level.	Jane Trowman, Acting Assistant Director Care Homes Support and CHC Commissioning	Chief Operating Officer - previously Gareth Evans, Acting Executive Director Therapies and Health Science, and Adele Gittoes, Interim Executive Director of Operations	Started	30/09/2024			Meeting held with Head of Regional Collaboration of the NWRPB during w/c 27th June to discuss governance process for POCD and TA action plans. Agreed to present next update of POCD action plan to RLG on 26th July for submission to NHS Executive.
470	Internal Audit	Discharge Arrangements	2024	Limited	High	Matter Arising 3: Pathways of Care Delays (Design)	3.1: Management: • Establish formal escalation framework to address and support resolution of Pathways of Care Delays. • Ensure working practice complies with Welsh Government requirements.	3.1c: Regional action plan refreshed in April 2024 discussed with each IHC and respective LAs to ensure actions align with top delays / areas of challenge and submitted to NHS Exec (quarterly). QUARTER 1	Libby Ryan-Davies, IHC Director - Central; Jane Trowman, Acting Assistant Director Care Homes Support and CHC Commissioning; Claire Brennan, Programme Manager (Operations)	Chief Operating Officer - previously Gareth Evans, Acting Executive Director Therapies and Health Science, and Adele Gittoes, Interim Executive Director of Operations	Started	30/06/2024	30/09/2024	1	Revised schedule of monitoring meetings to be established with IHCs and NW Local Authorities and national NHS Executive team to support monthly reporting to WG Care Action Committee. It is expected that POCD action plans will be required to be submitted monthly rather than quarterly going forwards.
471	Internal Audit	Discharge Arrangements	2024	Limited	High	Matter Arising 3: Pathways of Care Delays (Design)	3.1: Management: • Establish formal escalation framework to address and support resolution of Pathways of Care Delays. • Ensure working practice complies with Welsh Government requirements.	3.1c: Regional action plan refreshed in April 2024 discussed with each IHC and respective LAs to ensure actions align with top delays / areas of challenge and submitted to NHS Exec (quarterly). QUARTER 2	Libby Ryan-Davies, IHC Director - Central; Jane Trowman, Acting Assistant Director Care Homes Support and CHC Commissioning; Claire Brennan, Programme Manager (Operations)	Chief Operating Officer - previously Gareth Evans, Acting Executive Director Therapies and Health Science, and Adele Gittoes, Interim Executive Director of Operations	Started	30/09/2024			Regional POCD action plans continue to be developed and progress monitored. Next submission due 24th July will be reviewed retrospectively at NW Regional Leadership Group to ensure collaborative H&SC review and sign off. Trajectory tool developed nationally to support reduction of delays - work ongoing to identify trajectories across BCUHB and at an individual IHC level to ensure these are achieveable and realistic Likely to increase reporting to monthly from quarterly - awaiting confirmation from NHS Exec. Specific focus on reducing assessment delays which remain the largest reported delay consistently
472	Internal Audit	Discharge Arrangements	2024	Limited	High	Matter Arising 3: Pathways of Care Delays (Design)	3.1: Management: • Establish formal escalation framework to address and support resolution of Pathways of Care Delays. • Ensure working practice complies with Welsh Government requirements.	3.1c: Regional action plan refreshed in April 2024 discussed with each IHC and respective LAs to ensure actions align with top delays / areas of challenge and submitted to NHS Exec (quarterly). QUARTER 3	Libby Ryan-Davies, IHC Director - Central; Jane Trowman, Acting Assistant Director Care Homes Support and CHC Commissioning; Claire Brennan, Programme Manager (Operations)	Chief Operating Officer - previously Gareth Evans, Acting Executive Director Therapies and Health Science, and Adele Gittoes, Interim Executive Director of Operations	Started	31/12/2024			Regional POCD action plans continue to be developed and progress monitored. Next submission due 24th July will be reviewed retrospectively at NW Regional Leadership Group to ensure collaborative H&SC review and sign off. Trajectory tool developed nationally to support reduction of delays - work ongoing to identify trajectories across BCUHB and at an individual IHC level to ensure these are achieveable and realistic Likely to increase reporting to monthly from quarterly - awaiting confirmation from NHS Exec. Specific focus on reducing assessment delays which remain the largest reported delay consistently
473	Internal Audit	Discharge Arrangements	2024	Limited	High	Matter Arising 3: Pathways of Care Delays (Design)	3.1: Management: • Establish formal escalation framework to address and support resolution of Pathways of Care Delays. • Ensure working practice complies with Welsh Government requirements.	3.1c: Regional action plan refreshed in April 2024 discussed with each IHC and respective LAs to ensure actions align with top delays / areas of challenge and submitted to NHS Exec (quarterly). QUARTER 4	Libby Ryan-Davies, IHC Director - Central; Jane Trowman, Acting Assistant Director Care Homes Support and CHC Commissioning; Claire Brennan, Programme Manager (Operations)	Chief Operating Officer - previously Gareth Evans, Acting Executive Director Therapies and Health Science, and Adele Gittoes, Interim Executive Director of Operations	Started	31/03/2025			Regional POCD action plans continue to be developed and progress monitored. Next submission due 24th July will be reviewed retrospectively at NW Regional Leadership Group to ensure collaborative H&SC review and sign off. Trajectory tool developed nationally to support reduction of delays - work ongoing to identify trajectories across BCUHB and at an individual IHC level to ensure these are achieveable and realistic Likely to increase reporting to monthly from quarterly - awaiting confirmation from NHS Exec. Specific focus on reducing assessment delays which remain the largest reported delay consistently

474	Internal Audit	Discharge Arrangements	2024	Limited	High	Matter Arising 3: Pathways of Care Delays (Design)	3.1: Management: • Establish formal escalation framework to address and support resolution of Pathways of Care Delays. • Ensure working practice complies with Welsh Government requirements.	3.1d: Health & Social Care Trusted Assessor joint action plan submitted monthly to NHS Exec to monitor progress of additional roles and functions to support assessment delays. **QUARTER 1**	Libby Ryan-Davies, IHC Director - Central; Jane Trowman, Acting Assistant Director Care Homes Support and CHC Commissioning; Claire Brennan, Programme Manager (Operations)	Chief Operating Officer - previously Gareth Evans, Acting Executive Director Therapies and Health Science, and Adele Gittoes, Interim Executive Director of Operations	Started	30/06/2024			TA action plan has been updated and submitted each month of Q1 with subsequent meetings held with the NHS Executive to discuss data ahead of presentation to Care Action Committee. Further work ongoing to increase the TA role and function in line with this national programme of work as one initiative to reduce assessment delays, acknowledging that this action alone is not sufficient to address the significant assessment delays. Additional funding has been made available from the 6 goals (national). We are currently putting in a bid to support TA roles for care home. funding is also being explored from the Value Health Care grants.
475	Internal Audit	Discharge Arrangements	2024	Limited	High	Matter Arising 3: Pathways of Care Delays (Design)	3.1: Management: • Establish formal escalation framework to address and support resolution of Pathways of Care Delays. • Ensure working practice complies with Welsh Government requirements.	3.1d: Health & Social Care Trusted Assessor joint action plan submitted monthly to NHS Exec to monitor progress of additional roles and functions to support assessment delays. **QUARTER 2**	Libby Ryan-Davies, IHC Director - Central; Jane Trowman, Acting Assistant Director Care Homes Support and CHC Commissioning; Claire Brennan, Programme Manager (Operations)	Chief Operating Officer - previously Gareth Evans, Acting Executive Director Therapies and Health Science, and Adele Gittoes, Interim Executive Director of Operations	Started	30/09/2024			First month of Q2 action plan due submitted in July. Additional narrative in 474 above also applies.
476	Internal Audit	Discharge Arrangements	2024	Limited	High	Matter Arising 3: Pathways of Care Delays (Design)	3.1: Management: • Establish formal escalation framework to address and support resolution of Pathways of Care Delays. • Ensure working practice complies with Welsh Government requirements.	3.1d: Health & Social Care Trusted Assessor joint action plan submitted monthly to NHS Exec to monitor progress of additional roles and functions to support assessment delays. **QUARTER 3**	Libby Ryan-Davies, IHC Director - Central; Jane Trowman, Acting Assistant Director Care Homes Support and CHC Commissioning; Claire Brennan, Programme Manager (Operations)	Chief Operating Officer - previously Gareth Evans, Acting Executive Director Therapies and Health Science, and Adele Gittoes, Interim Executive Director of Operations	Started	31/12/2024			Trusted Assessor action plan continues to be submitted monthly and meetings held with NHS Exec team on a monthly basis also with H&SC colleagues. Some progress noted in the increase of TA roles and functions but further work ongoing to increase further. Work is focusing on reduction of assessment delays and not just increasing TA roles.
477	Internal Audit	Discharge Arrangements	2024	Limited	High	Matter Arising 3: Pathways of Care Delays (Design)	3.1: Management: • Establish formal escalation framework to address and support resolution of Pathways of Care Delays. • Ensure working practice complies with Welsh Government requirements.	3.1d: Health & Social Care Trusted Assessor joint action plan submitted monthly to NHS Exec to monitor progress of additional roles and functions to support assessment delays. **QUARTER 4**	Libby Ryan-Davies, IHC Director - Central; Jane Trowman, Acting Assistant Director Care Homes Support and CHC Commissioning; Claire Brennan, Programme Manager (Operations)	Chief Operating Officer - previously Gareth Evans, Acting Executive Director Therapies and Health Science, and Adele Gittoes, Interim Executive Director of Operations	Pending	31/03/2025			Trusted Assessor action plan continues to be submitted monthly and meetings held with NHS Exec team on a monthly basis also with H&SC colleagues. Some progress noted in the increase of TA roles and functions but further work ongoing to increase further. Work is focusing on reduction of assessment delays and not just increasing TA roles.
478	Internal Audit	Discharge Arrangements	2024	Limited	High	Matter Arising 4: Adverse discharges / Incidents (Design)	4.1: Management establish formal overarching policy or Standard Operating Procedure to support the operational management of incidents, including providing for adverse discharges. Governance, reporting, and escalation requirements must be clearly defined.	4.1: Each IHC to establish an Adverse Discharge Group with clear ToRs.	Libby Ryan-Davies, IHC Director - Central	Chief Operating Officer - previously Gareth Evans, Acting Executive Director Therapies and Health Science, and Adele Gittoes, Interim Executive Director of Operations	Started	30/09/2024			This is well established in west and scoping work underway to establish groups in East and Central
488	Internal Audit	Health and Safety	2024	Limited	High	Matter Arising 1: Policies & Procedures (Operation)	1.1b Executive level responsibility for Occupational Health and Safety should be considered, to ensure Health and Safety is a key focus within the Health Board	1.1b The Chief Executive is the responsible Executive Lead until there is a substantive appointment to the Director of Environment post.	Carol Shillabeer, Chief Executive	Carol Shillabeer, Chief Executive	Started	Immediately			The post is currently advertised, with a closing date of 16/07/2024.
489	Internal Audit	Health and Safety	2024	Limited	High	Matter Arising 2: Monitoring and reporting of Health and Safety (Operation)	2.1a Management ensure regular monitoring, reporting, communication, escalation and de-escalation of Health & Safety issues through the appropriate governance structure, in line with the HS01 policy and terms of reference for relevant meetings (Strategic Occupational Health and Safety Group, Quality Safety and Experience Committee and Risk Management Group).	2.1a Reporting to QSE recommened in December 2023, however SOHSG will now report to People and Culture Committee, we are assuming this committee will escalate issues to RMG	David Maslen-Jones, Acting Assistant Director of Occupational Health, Safety and Security	Carol Shillabeer, Chief Executive	Started	29/02/2024			SOHSG now reporting to People and Culture Committee
490	Internal Audit	Health and Safety	2024	Limited	High	Matter Arising 2: Monitoring and reporting of Health and Safety (Operation)	2.1b The Strategic Health and Safety Operational Group to confirm the reporting required to the group by services and ensure this is communicated to all relevant areas. Instances of non-reporting should be communicated to the services and escalated appropriately, via the Executive or QSE	2.1b To ensure that reports are received by the Chair of SOHSG from all relevant areas, TOR to be recirculated to departmental leads, chair of SOHSG needs to be an Executive Director in order to be quorate so will need to be appointed by Executive team. Will be included in SOHSG reports from 2nd Quarter 2024 through People and Culture Committee, responsibility of responsible Executive Director	David Maslen-Jones, Acting Assistant Director of Occupational Health, Safety and Security	Carol Shillabeer, Chief Executive	Started	29/02/2024			The revised TOR have been drafted but agreement reached at SOHSG that they will need to be led by the New Director of Estates and Environment. Meeting has been arranged between the Chief Executive and Acting Assistant Director of Occupational Health, Safety and Security to discuss forward meeting structure of SOHSG and TOR

ID	Type	Area	Year	Rating	Priority	Matter Arising	Recommendation	Management Response	Responsible Officer	Accountable Officer	Status	Date	Date 2	No.	Notes
492	Internal Audit	Health and Safety	2024	Limited	High	Matter Arising 4: Health & Safety Reviews (Corporate Health & safety) (Design)	4.1 Health Board Policy 5.3.4 is reviewed to ensure that all Corporate Health & Safety recommendations are agreed, assigned to owners, allocated appropriate dates and are subject to follow-up	4.1 New Process already instigated to ensure that a timetable for H&S visits by the corporate H&S team takes place over the coming year with a minimum number of visits per advisor, but also to ensure the quality of the response. It is the responsibility of Managers within the Health Board to assign and follow up responsibility of IHC/Divisional Director	David Maslen-Jones, Acting Assistant Director of Occupational Health, Safety and Security; Ffion Johnstone, IHC Director - West; Libby Ryan Davies - IHC Director - Centre; Michelle Greene – IHC Director - East	Carol Shillabeer, Chief Executive	Final Client approved	01/01/2024			New KPI's set for corporate H&S team require minimum number of visits per quarter per individual, and a rolling programme of visits over 2 years. The following is attached as evidence to support closuren for Centre, East and West:•H&S minutes •H&S reports, timetable •P&C Minutes
493	Internal Audit	Health and Safety	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	Carol Shillabeer, Chief Executive	Started	30/04/2024			Gap Analysis review completed and shared with the CEO, actions taken to include in H&S Strategy plan for next five years
495	Internal Audit	Health and Safety	2024	Limited	High	Matter Arising 7: Self Assessments (Design)	7.1 A process to monitor and review department self-assessments should be put in place to ensure departments are adhering to the Health and Safety Policy. This should also include escalation where self-assessments are not completed, reviewing self-assessments for potential risks / issues and identifying areas of similarities / opportunities across departments	7.1 A calendar has been completed to schedule actual H&S Visits. There is insufficient resource available for the current H&S Advisors to review all selfassessments of every department within the health board so the responsibility for management at IHC/Divisional Director needs to be delegated to appropriate persons for review of compliance and escalation to management teams, this will then be reported Quarterly as part of the quarterly report to SOHSG	David Maslen-Jones, Acting Assistant Director of Occupational Health, Safety and Security; Ffion Johnstone, IHC Director - West; Libby Ryan Davies - IHC Director - Centre; Michelle Greene – IHC Director - East	Carol Shillabeer, Chief Executive	Final Client approved	01/05/2024			This is an IHC Directors responsibility to ensure that all managers in the service conduct safety assessments, to be included in revised TOR when agreed with Chair of SOHSG/ Environment and Estates Director. The following is attached as evidence to support closure from Centre, East and West: •H&S minutes •H&S reports, timetable •P&C Minutes
513	Internal Audit	Contracted Patient Services: Quality and Safety Arrangements	2023	Limited	High	Matter Arising 1: Process management (Design)	1.1.2 Management establish robust overarching Commissioning Assurance Framework, Policy, or relevant Standard Operating Procedure (SOP) to support the healthcare commissioning/contracting process. This should ensure that lines of escalation, roles, responsibilities, and requirements regarding the management and oversight of the quality aspect of services provided are clearly defined.	1.1.2. The Health Board will develop a training package for staff engaged in the contract management process to support the delivery of the CAF. Note: the development of the CAF is likely to identify significant gaps in resource across functions in respect of meeting the organisational need identified in this audit, which would therefore be subject to a business case to achieve the required improvement in contract management practices including quality oversight. *Update from Executive Team meeting on 19/06/2024 is that, in the absence of the Director of Commissioning and Performance, there will be an oversight of a number of Executive Directors. Work on progressing the commission arrangements for contracts is underway and an update will be provided to the PFIG in August.*	Russell Caldicott, Interim Executive Director of Finance: Angela Wood, Executive Director of Nursing and Midwifery; Pam Wenger, Director of Corporate Governance; Michelle Greene, IHC Director - East (until Director of Commissioning and Performance is in post) *(previously Adrian Tomkins, Associate Director of Healthcare Contracting)*; Matthew Joyes, Deputy Director of Quality	Russell Caldicott, Interim Executive Director of Finance: Angela Wood, Executive Director of Nursing and Midwifery; Pam Wenger, Director of Corporate Governance; Michelle Greene, IHC Director - East *(until Director of Commissioning and Performance is in post)*, previously Angela Wood, Executive Director of Nursing and Midwifery	Started	31/08/2023	30/09/2024	2	A meeting will take place between Pam Wenger, Director of Corporate Governance, Russell Caldicott, Interim Executive Director of Finance and Michelle Greene, IHC Director - East to discuss the way forward with this recommendation on 26th July 2024.
514	Internal Audit	Contracted Patient Services: Quality and Safety Arrangements	2023	Limited	High	Matter Arising 2: Contractual obligations (Design)	2.1.2 Management establish controls to ensure that all commissioned providers adhere to agreed contractual agreements and assess current contract review meeting arrangements to ensure appropriate levels of oversight and engagement.	2.1.2 The Health Board will ensure all agreements with Providers are backed up by a signed contract. *Update from Executive Team meeting on 19/06/2024 is that, in the absence of the Director of Commissioning and Performance, there will be an oversight of a number of Executive Directors. Work on progressing the commission arrangements for contracts is underway and an update will be provided to the PFIG in August.*	Russell Caldicott, Interim Executive Director of Finance: Angela Wood, Executive Director of Nursing and Midwifery; Pam Wenger, Director of Corporate Governance; Michelle Greene, IHC Director - East (until Director of Commissioning and Performance is in post) *(previously Adrian Tomkins, Associate Director of Healthcare Contracting)*; Matthew Joyes, Deputy Director of Quality	Russell Caldicott, Interim Executive Director of Finance: Angela Wood, Executive Director of Nursing and Midwifery; Pam Wenger, Director of Corporate Governance; Michelle Greene, IHC Director - East *(until Director of Commissioning and Performance is in post)*, previously Angela Wood, Executive Director of Nursing and Midwifery	Started	31/08/2023	30/09/2024	2	A meeting will take place between Pam Wenger, Director of Corporate Governance, Russell Caldicott, Interim Executive Director of Finance and Michelle Greene, IHC Director - East to discuss the way forward with this recommendation on 26th July 2024.

515	Internal Audit	Contracted Patient Services: Quality and Safety Arrangements	2023	Limited	High	Matter Arising 2: Contractual obligations (Design)	2.1.3 Management establish controls to ensure that all commissioned providers adhere to agreed contractual agreements and assess current contract review meeting arrangements to ensure appropriate levels of oversight and engagement.	2.1.3 The Health Board will review current contracts and ensure all Contracts include updated reporting requirements, schedules, timetables, and meeting requirements. *Update from Executive Team meeting on 19/06/2024 is that, in the absence of the Director of Commissioning and Performance, there will be an oversight of a number of Executive Directors. Work on progressing the commission arrangements for contracts is underway and an update will be provided to the PFIG in August.*	Russell Caldicott, Interim Executive Director of Finance: Angela Wood, Executive Director of Nursing and Midwifery; Pam Wenger, Director of Corporate Governance; Michelle Greene, IHC Director - East (until Director of Commissioning and Performance is in post) *(previously Adrian Tomkins, Associate Director of Healthcare Contracting)*; Matthew Joyes, Deputy Director of Quality	Russell Caldicott, Interim Executive Director of Finance: Angela Wood, Executive Director of Nursing and Midwifery; Pam Wenger, Director of Corporate Governance; Michelle Greene, IHC Director - East *(until Director of Commissioning and Performance is in post)*, previously Angela Wood, Executive Director of Nursing and Midwifery	Started	31/08/2023	30/09/2024	2	A meeting will take place between Pam Wenger, Director of Corporate Governance, Russell Caldicott, Interim Executive Director of Finance and Michelle Greene, IHC Director - East to discuss the way forward with this recommendation on 26th July 2024.
516	Internal Audit	Contracted Patient Services: Quality and Safety Arrangements	2023	Limited	High	Matter Arising 2: Contractual obligations (Design)	2.1.4 Management establish controls to ensure that all commissioned providers adhere to agreed contractual agreements and assess current contract review meeting arrangements to ensure appropriate levels of oversight and engagement.	2.1.4 The Health Board will review re-establish the internal monitoring of Provider reporting returns to include the escalation process should information not be provided. *Update from Executive Team meeting on 19/06/2024 is that, in the absence of the Director of Commissioning and Performance, there will be an oversight of a number of Executive Directors. Work on progressing the commission arrangements for contracts is underway and an update will be provided to the PFIG in August.*	Russell Caldicott, Interim Executive Director of Finance: Angela Wood, Executive Director of Nursing and Midwifery; Pam Wenger, Director of Corporate Governance; Michelle Greene, IHC Director - East (until Director of Commissioning and Performance is in post) *(previously Adrian Tomkins, Associate Director of Healthcare Contracting)*; Matthew Joyes, Deputy Director of Quality	Russell Caldicott, Interim Executive Director of Finance: Angela Wood, Executive Director of Nursing and Midwifery; Pam Wenger, Director of Corporate Governance; Michelle Greene, IHC Director - East *(until Director of Commissioning and Performance is in post)*, previously Angela Wood, Executive Director of Nursing and Midwifery	Started	31/08/2023	30/09/2024	2	A meeting will take place between Pam Wenger, Director of Corporate Governance, Russell Caldicott, Interim Executive Director of Finance and Michelle Greene, IHC Director - East to discuss the way forward with this recommendation on 26th July 2024.
517	Internal Audit	Contracted Patient Services: Quality and Safety Arrangements	2023	Limited	High	Matter Arising 2: Contractual obligations (Design)	2.1.5 Management establish controls to ensure that all commissioned providers adhere to agreed contractual agreements and assess current contract review meeting arrangements to ensure appropriate levels of oversight and engagement.	2.1.5 The Health Board will re-establish its internal Contract Assurance Group, reviewing the Terms of Reference to ensure the remit and representation are adequate to make the meeting effective. *Update from Executive Team meeting on 19/06/2024 is that, in the absence of the Director of Commissioning and Performance, there will be an oversight of a number of Executive Directors. Work on progressing the commission arrangements for contracts is underway and an update will be provided to the PFIG in August.*	Russell Caldicott, Interim Executive Director of Finance: Angela Wood, Executive Director of Nursing and Midwifery; Pam Wenger, Director of Corporate Governance; Michelle Greene, IHC Director - East (until Director of Commissioning and Performance is in post) *(previously Adrian Tomkins, Associate Director of Healthcare Contracting)*; Matthew Joyes, Deputy Director of Quality	Russell Caldicott, Interim Executive Director of Finance: Angela Wood, Executive Director of Nursing and Midwifery; Pam Wenger, Director of Corporate Governance; Michelle Greene, IHC Director - East *(until Director of Commissioning and Performance is in post)*, previously Angela Wood, Executive Director of Nursing and Midwifery	Started	31/08/2023	30/09/2024	2	A meeting will take place between Pam Wenger, Director of Corporate Governance, Russell Caldicott, Interim Executive Director of Finance and Michelle Greene, IHC Director - East to discuss the way forward with this recommendation on 26th July 2024.

518	Internal Audit	Contracted Patient Services: Quality and Safety Arrangements	2023	Limited	High	Matter Arising 3: Quality measures (Operation)	3.1.2 Management to review contractual quality measures to ensure they are robust, effective, and appropriate.	3.1.2 The Health Board will review its quality measures and develop a standard suite of measures, retaining the flexibility to include contract specific measures including the capture of patient feedback and will seek to negotiate these into contract documents with Providers. This will take effect from the next contract period – 2024/2025. *Update from Executive Team meeting on 19/06/2024 is that, in the absence of the Director of Commissioning and Performance, there will be an oversight of a number of Executive Directors. Work on progressing the commission arrangements for contracts is underway and an update will be provided to the PFIG in August.*	Russell Caldicott, Interim Executive Director of Finance: Angela Wood, Executive Director of Nursing and Midwifery; Pam Wenger, Director of Corporate Governance; Michelle Greene, IHC Director - East (until Director of Commissioning and Performance is in post) (previously Adrian Tomkins, Associate Director of Healthcare Contracting); Matthew Joyes, Deputy Director of Quality	Russell Caldicott, Interim Executive Director of Finance: Angela Wood, Executive Director of Nursing and Midwifery; Pam Wenger, Director of Corporate Governance; Michelle Greene, IHC Director - East (until Director of Commissioning and Performance is in post), previously Angela Wood, Executive Director of Nursing and Midwifery	Started	31/03/2024	30/09/2024	2	A meeting will take place between Pam Wenger, Director of Corporate Governance, Russell Caldicott, Interim Executive Director of Finance and Michelle Greene, IHC Director - East to discuss the way forward with this recommendation on 26th July 2024.
519	Internal Audit	Contracted Patient Services: Quality and Safety Arrangements	2023	Limited	High	Matter Arising 3: Quality measures (Operation)	3.1.3 Management to review contractual quality measures to ensure they are robust, effective, and appropriate.	3.1.3 The Health Board will, as part of the Commissioning Assurance Framework, review information already produced by Providers, Regulators etc and as part of that review assess what assurance can be taken from these sources and how that can be captured and utilised by the Health Board e.g. Lead Commissioner/CQC. *Update from Executive Team meeting on 19/06/2024 is that, in the absence of the Director of Commissioning and Performance, there will be an oversight of a number of Executive Directors. Work on progressing the commission arrangements for contracts is underway and an update will be provided to the PFIG in August.*	Russell Caldicott, Interim Executive Director of Finance: Angela Wood, Executive Director of Nursing and Midwifery; Pam Wenger, Director of Corporate Governance; Michelle Greene, IHC Director - East (until Director of Commissioning and Performance is in post) (previously Adrian Tomkins, Associate Director of Healthcare Contracting); Matthew Joyes, Deputy Director of Quality	Russell Caldicott, Interim Executive Director of Finance: Angela Wood, Executive Director of Nursing and Midwifery; Pam Wenger, Director of Corporate Governance; Michelle Greene, IHC Director - East (until Director of Commissioning and Performance is in post), previously Angela Wood, Executive Director of Nursing and Midwifery	Started	31/07/2023	30/09/2024	2	A meeting will take place between Pam Wenger, Director of Corporate Governance, Russell Caldicott, Interim Executive Director of Finance and Michelle Greene, IHC Director - East to discuss the way forward with this recommendation on 26th July 2024.
520	Internal Audit	Contracted Patient Services: Quality and Safety Arrangements	2023	Limited	High	Matter Arising 4: Board assurance (Design)	4.1 Management to review governance and reporting arrangements to ensure English NHS provider quality and performance data is subject to Health Board review and scrutiny.	4.1 2 The CAF will establish the reporting requirements and governance process for Contract Management including the reestablishment of the Healthcare Contracts Assurance Group and the onward flow of reports regarding Finance, Performance and Quality including escalation route. *Update from Executive Team meeting on 19/06/2024 is that, in the absence of the Director of Commissioning and Performance, there will be an oversight of a number of Executive Directors. Work on progressing the commission arrangements for contracts is underway and an update will be provided to the PFIG in August.*	Russell Caldicott, Interim Executive Director of Finance: Angela Wood, Executive Director of Nursing and Midwifery; Pam Wenger, Director of Corporate Governance; Michelle Greene, IHC Director - East (until Director of Commissioning and Performance is in post) (previously Adrian Tomkins, Associate Director of Healthcare Contracting); Matthew Joyes, Deputy Director of Quality	Russell Caldicott, Interim Executive Director of Finance: Angela Wood, Executive Director of Nursing and Midwifery; Pam Wenger, Director of Corporate Governance; Michelle Greene, IHC Director - East (until Director of Commissioning and Performance is in post), previously Angela Wood, Executive Director of Nursing and Midwifery	Started	31/08/2023	30/09/2024	2	A meeting will take place between Pam Wenger, Director of Corporate Governance, Russell Caldicott, Interim Executive Director of Finance and Michelle Greene, IHC Director - East to discuss the way forward with this recommendation on 26th July 2024.

ID	Type	Audit	Year	Rating	Priority	Matter Arising	Recommendation	Management comment	Responsible	Lead	Status	Date			Update
564	Internal Audit	Clinical Audit	2022	Limited	High	Matter Arising 2 – Annual Clinical Audit Plan (Operation)	2.2a Justification for each of the reviews included within the plan should be retained by the Clinical Effectiveness department.	2.2 – Management comment There is a need for more clarity from key stakeholders on what is expected from Tier 2 project and what is required from project leads, this would help improve the information when sharing, such as: • providing the required information on the project, for example risks, methodology, the aim of the project • how local stakeholders will progress taking project forward and outline how the audit results are going to drive improvements • clear progress updates provided to the Clinical Effectiveness team on quarterly basis throughout the year, including action planning when complete or a rationale of why a project has not progressed in year as planned Complete 30th September 2022 (sub: to release of operating model) • wider information required from the project lead at point of suggesting topic (or retrospectively for this year), which clearly identifies the rationale for the project, risks, methodology, and aim (refer to attached gap analysis document) The Clinical Effectiveness team have been introducing the new management/tracking software, Audit Monitoring and Tracking (AMaT), this software will provide greater facility to document actions in the future. Once data for all required fields, mentioned above, is more readily available, when the Tier 2 projects are uploaded on to AMaT, this will improve the visibility of all projects and assist with the monitoring and tracking of the results and actions. AMaT also has the ability to be used for data collection, where appropriate. This will also enable support of monitoring and tracking through AMaT with regular (quarterly) communication with the projects leads, asking for progress using the attached proforma (may need to be reviewed/updated). AMaT structure is that the data entry fields are based on the key points of methodology that would be expected to be found in protocols for national studies. AMaT will not allow registration to proceed unless the fields are populated, therefore the services would have to provide the required information as their audits could not be registered otherwise. AMaT implementation was paused due to the Covid surge and redeployment of the Project Lead December 2021. The required staff capacity to progress implementation (therefore provide the required system to track and manage the additional detail required under 2.12) was included within the Clinical Effectiveness business case, submitted September 2021. Currently identified as	Joanne Shillingford, Head of Clinical Effectiveness	Nick Lyons, Executive Medical Director	Final Client approved	30/02/2022			AMaT has now been implemented in the Health Board, and is being utilised to capture actions from clinical audits, and provides greater facility to document actions. Suggest this is put forward for closure as this is a historical recommendation.
602	Internal Audit	On-Call arrangements	2022	Limited	High	Matter Arising 1 – Review of on-call arrangements (Design)	The on-call review should be re-instated as a priority, to ensure arrangements match service requirements, and are reviewed considering changing needs as a result of changes due to VERS and the new Operating Model. Management should consider the feedback from our questionnaire when reviewing on-call arrangements, and how these can be addressed. Following completion of the review and update of guidance (see Matters Arising 2,3 and 4 below), this should be communicated to staff to ensure they understand their obligations and responsibilities for participating in the on-call rotas.	1.1b Proposals will be presented to the Executive Team, for approval.	Chief Operating Officer	Chief Operating Officer - notified by Adele Gittoes that this was Gareth Evans, but he was not informed of this	Started	12/10/2022			This matter is with Gareth Evans, Acting Executive Director Therapies and Health Science as lead going forward, as it is a highly complex and sensitive issue, which will involve WOD and trade unions.
603	Internal Audit	On-Call arrangements	2022	Limited	High	Matter Arising 4 – Training (Design)	The requirements of staff included in on-call rotas should be documented and staff provided with relevant information to ensure they are able to deal with expected issues whilst on-call i.e. key information about sites and services, as staff may not be familiar with the site they are responsible for during the on-call shift. Training should be provided to staff who are on the rotas to ensure they are aware of their responsibilities and possible scenarios of what they may have to deal with.	4.1b Manual to be developed with key information, and details for those on call.	Chief Operating Officer	Chief Operating Officer - notified by Adele Gittoes that this was Gareth Evans, but he was not informed of this	Started	24/10/2022			This matter is with Gareth Evans, Acting Executive Director Therapies and Health Science as lead going forward, as it is a highly complex and sensitive issue, which will involve WOD and trade unions.
604	Internal Audit	On-Call arrangements	2022	Limited	High	Matter Arising 4 – Training (Design)	The requirements of staff included in on-call rotas should be documented and staff provided with relevant information to ensure they are able to deal with expected issues whilst on-call i.e. key information about sites and services, as staff may not be familiar with the site they are responsible for during the on-call shift. Training should be provided to staff who are on the rotas to ensure they are aware of their responsibilities and possible scenarios of what they may have to deal with.	4.1c All staff to receive training with a programme and timescale set for refresher training every two years.	Chief Operating Officer	Chief Operating Officer - notified by Adele Gittoes that this was Gareth Evans, but he was not informed of this	Started	12/12/2022			This matter is with Gareth Evans, Acting Executive Director Therapies and Health Science as lead going forward, as it is a highly complex and sensitive issue, which will involve WOD and trade unions.
605	Internal Audit	On-Call arrangements	2022	Limited	High	Matter Arising 4 – Training (Design)	The requirements of staff included in on-call rotas should be documented and staff provided with relevant information to ensure they are able to deal with expected issues whilst on-call i.e. key information about sites and services, as staff may not be familiar with the site they are responsible for during the on-call shift. Training should be provided to staff who are on the rotas to ensure they are aware of their responsibilities and possible scenarios of what they may have to deal with.	4.1d Real time log to be introduced for all levels of on-call to aid action learning with a rolling process of review by the IRDD and Strategic EPRR lead.	Chief Operating Officer	Chief Operating Officer - notified by Adele Gittoes that this was Gareth Evans, but he was not informed of this	Started	10/09/2022			This matter is with Gareth Evans, Acting Executive Director Therapies and Health Science as lead going forward, as it is a highly complex and sensitive issue, which will involve WOD and trade unions.
1269	Internal Audit	Risk Management - June 2024	2024	Limited	High	Matter Arising 1: Operational risk registers (Operation)	1.1 Health Board management are reminded of the importance of: • Reviewing risks and ensuring they are up to date, with appropriate actions and timescales. • The need for risk management to be embedded into governance structures through regular risk meetings and assurance to the appropriate leadership team It is recognised that this is likely to improve following Risk Management Training.	1.1 Communication will be sent to all service leads reminding them of their responsibilities relating to maintaining up-to-date risk registers with appropriate actions and timescales. A system of sending automatic reminder to handlers and owners where risks need to be updated will be set up. Target Date: Communication by 30 July 2024; Automated; Monitoring and E mail notification system to be launched in September	Nesta Collingridge, Head of Risk Management	Pam Wenger, Director of Corporate Governance	Started	30/07/2024 and 30/09/2024			Communication has been sent to all risk leads for overdue risks and this will be business as usual. To close this recommendation after the notification system has been set up.

1271	Internal Audit	Risk Management - June 2024	2024	Limited	High	Matter Arising 2: Corporate Risk Register (Operation)	2.1 Head of Risk Management and Corporate Risk Team to review lines of assurance, controls and future actions of corporate risks.	2.1 All corporate risks to be reviewed and quality assured by corporate risk team	Nesta Collingridge, Head of Risk Management	Pam Wenger, Director of Corporate Governance	Started	30/08/2024			First round completed. To be reviewed again at the risk scruity panel.
1272	Internal Audit	Risk Management - June 2024	2024	Limited	High	Matter Arising 3: Risk Management Group (Operation)	3.1 Consideration should be given to the role of the Risk Management Group and whether alternative arrangements may provide effective and regular scrutiny of operational risk registers, and corporate risks for escalation/de-escalation	3.1 The role and remit of the Risk Management Group will be reviewed, and a paper has been drafted for discussion of 'the role and future of RMG' with proposed options at the June meeting. The proposals also notes the need to increase this meeting to monthly. Options will be further considered by the Executive Team for alternative arrangements to provide more effective, regular scrutiny of operational risks and corporate risks. The new arrangement will be approved by Executive Team and Audit Committee. A new arrangement will be established following approval in Q2. Any agreed changes will be reflected in a revised Risk Management Framework and supporting procedures. A terms of reference will be drafted for this meeting following establishment and review Q3 2024. New meeting to be established in September 2024	Nesta Collingridge, Head of Risk Management	Pam Wenger, Director of Corporate Governance	Started	30/09/2024			Risk Scruity Panel 09.06.24 (monthly) and Risk Forum (3x year). Draft TOR, agenda and COB to be reviewed in the first meeting.
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: • Update policy to reflect current working practice and systems. • Ensure that the requirements regarding mandatory annual declarations of interest for staff that fall outside the documented pay band thresholds are clearly stated.	1.1 • Review and update Policy to ensure that it is in line with the rest of Wales • Review Policy to ensure that the pay bands are consistent with the rest of Wales • 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	Started	31/07/2024			This will be taken forward as part of the Action plan to address recommendations from the Internal Audit Report which has been received and agreed at Execs and will go to the Audit Committee on 18 July 2024.
1275	Internal Audit	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	Started	30/06/2024			This will be taken forward as part of the Action plan to address recommendations from the Internal Audit Report which has been received and agreed at Execs and will go to the Audit Committee on 18 July 2024.
1276	Internal Audit	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.	2.1b • Review monthly published data to ensure that it is accurate and can be reconciled to source data.	Philippa Peake-Jones, Head of Corporate Affairs	Pam Wenger, Director of Corporate Governance	Started	30/06/2024			This will be taken forward as part of the Action plan to address recommendations from the Internal Audit Report which has been received and agreed at Execs and will go to the Audit Committee on 18 July 2024.
1277	Internal Audit	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.	2.1c • 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	Philippa Peake-Jones, Head of Corporate Affairs	Pam Wenger, Director of Corporate Governance	Started	30/06/2024			This will be taken forward as part of the Action plan to address recommendations from the Internal Audit Report which has been received and agreed at Execs and will go to the Audit Committee on 18 July 2024.
1278	Internal Audit	Standards of Business Conduct - Declarations of Interest, Gifts and Hospitality - June 2024	2024	Limited	High	Matter Arising 3: Audit Committee Reporting (Operation)	3.1 Management: • Review reporting arrangements and ensure staff declarations are subject to Audit Committee oversight and scrutiny in line with policy requirements.	3.1 • Update Cycles of business and submit to the Audit Committee twice a year	Philippa Peake-Jones, Head of Corporate Affairs	Pam Wenger, Director of Corporate Governance	Started	18/07/2024			This will be taken forward as part of the Action plan to address recommendations from the Internal Audit Report which has been received and agreed at Execs and will go to the Audit Committee on 18 July 2024.
1279	Internal Audit	Standards of Business Conduct - Declarations of Interest, Gifts and Hospitality - June 2024	2024	Limited	High	Matter Arising 4: Board Members declarations of interest (Operation)	4.1 The Director of Corporate Governance: • Ensures Board Member declarations are accurate and comprehensive throughout the year – not limit due diligence work to year-end. • 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. • Ensures the public register of Board Member interests is maintained and kept up to date.	4.1a • Monitor and review declarations on a weekly basis	Philippa Peake-Jones, Head of Corporate Affairs	Pam Wenger, Director of Corporate Governance	Started	30/06/2024			This will be taken forward as part of the Action plan to address recommendations from the Internal Audit Report which has been received and agreed at Execs and will go to the Audit Committee on 18 July 2024.
1280	Internal Audit	Standards of Business Conduct - Declarations of Interest, Gifts and Hospitality - June 2024	2024	Limited	High	Matter Arising 4: Board Members declarations of interest (Operation)	4.1 The Director of Corporate Governance: • Ensures Board Member declarations are accurate and comprehensive throughout the year – not limit due diligence work to year-end. • 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. • Ensures the public register of Board Member interests is maintained and kept up to date.	4.1b • Produce a targeted communication campaign and implement • Any changes to Board Member interests will be uploaded publicly when received. Accurate as of 1 June 2024	Philippa Peake-Jones, Head of Corporate Affairs	Pam Wenger, Director of Corporate Governance	Started	Ongoing			This will be taken forward as part of the Action plan to address recommendations from the Internal Audit Report which has been received and agreed at Execs and will go to the Audit Committee on 18 July 2024.

ID	Type	Title	Year	Assurance	Priority	Matter Arising	Recommendation	Management Response	Lead Officer	Executive	Status	Target Date			Update
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: • Ensure line mangers are aware of their responsibilities regarding approving declarations of interest (and gifts and hospitality). • Ensure staff understand when, and how often, a declaration should be made. • Establish controls and /or oversight arrangements to manage and escalate non-responses (from Decision Makers) and failure to approve (by line managers). • Ensure data extracted from Declare is reviewed and adjusted appropriately prior to reporting (e.g. to Audit Committee).	5.1 • Draft a new communication plan and SOP for Declarations to include flow charts so that Managers are clear about their responsibilities. • Work with the Workforce Directorate on options around including Declarations on PADR templates • 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	Started	30/09/2024			This will be taken forward as part of the Action plan to address recommendations from the Internal Audit Report which has been received and agreed at Execs and will go to the Audit Committee on 18 July 2024.
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: • Ensure all offers of hospitality and sponsored events are declared, reviewed, and approved prior to attending per policy requirements. All retrospective declarations to be escalated. • All hospitality and sponsored events to be approved by a Director / Assistant Director. • Ensure all declarations pending approval are reviewed and approved / declined. • Ensure provider details are recorded to enable effective monitoring per policy requirements.	6.1 • Reviewed gift, hospitality, and sponsored event declarations and produce a SOP and flow chart to ensure clarity. • Produce a communications plan to raise awareness and compliance	Philippa Peake-Jones, Head of Corporate Affairs	Pam Wenger, Director of Corporate Governance	Started	31/10/2024			This will be taken forward as part of the Action plan to address recommendations from the Internal Audit Report which has been received and agreed at Execs and will go to the Audit Committee on 18 July 2024.
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.	Libby Ryan-Davies, IHC Director - Central	Carol Shillabeer, Chief Executive	Started	31/07/2024			Central IHC have refreshed their local IHC UEC meetings and also established groups for each of the 4 workstreams that the 6 goals have been restructured into with a clear reporting structure.
1284	Internal Audit	Effective Governance – Integrated Health Community (IHC) Central	2024	Limited	High	Matter Arising 2: Financial control assurance (Operation)	2.1 The IHC Director ensures the Financial Control Group complies with its Terms of Reference and actively supports the IHC in delivering its expenditure reduction to meet its allocated resource.	2.1 Financial Recovery Plan meetings have been re-established and the ToR will be developed to reflect the reporting arrangements to Performance, Finance and Information Governance (PFIG). The purpose of these groups will be to oversee the planning and delivery of financial targets whilst understanding the impacts of the necessary change to deliver a reduction in financial spend. The implementation of the Financial Recovery framework for the IHC including regular meetings supported by the ToR, will be in place by end of July 2024.	Libby Ryan-Davies, IHC Director - Central	Carol Shillabeer, Chief Executive	Pending	31/07/2024			Due to commence end of July
1285	Internal Audit	Effective Governance – Integrated Health Community (IHC) Central	2024	Limited	High	Matter Arising 3: Clinical Audit (Operation)	3.1 IHC to ensure that all audits at Tier 1, 2 and 3 are undertaken, and all outstanding responses are received. Findings and lessons learnt must be shared across the IHC and Health Board.	3.1 The Central IHC Clinical Effectiveness Group (CEG) will be the responsible forum for ensuring that required clinical audit is completed and assurance will be overseen by QODG.	Jane Owen, Associate Director of Nursing - Centre (until IHC Director of Nursing - Central is in post)	Carol Shillabeer, Chief Executive	Started	31/07/2024			This action is ongoing, with trajectories being measured weekly. There is still work to do. These trajectories are also discussed weekly at HMT, with information being escalated via QDG
1286	Internal Audit	Effective Governance – Integrated Health Community (IHC) Central	2024	Limited	High	Matter Arising 3: Clinical Audit (Operation)	3.2 IHC Clinical Effectiveness Group (CEG) and Quality Operational Delivery Group (QODG) meetings are aligned appropriately so that CEG meets prior to the QODG to enable the reporting of assurance/matters for escalation in a timely manner	3.2 The TOR will be reviewed to ensure that this is reflected.	Jane Owen, Associate Director of Nursing - Centre (until IHC Director of Nursing - Central is in post)	Carol Shillabeer, Chief Executive	Started	31/07/2024			This action is ongoing, with trajectories being measured weekly. There is still work to do. These trajectories are also discussed weekly at HMT, with information being escalated via QDG
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: • Ensures the IHC responds to all complaints according to expected reporting timelines and all learning is shared across the IHC. • Ensures operational management review all open incidents.	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	Jane Owen, Associate Director of Nursing - Centre (until IHC Director of Nursing - Central is in post)	Carol Shillabeer, Chief Executive	Started	31/07/2024			This action is ongoing, with trajectories being measured weekly. There is still work to do. These trajectories are also discussed weekly at HMT, with information being escalated via QDG
1288	Internal Audit	Effective Governance – Integrated Health Community (IHC) Central	2024	Limited	High	Matter Arising 5: Risk Management (Operation)	5.1 The IHC Director: • Ensures regular member attendance at the Health & Safety and Risk Management Group in order that they and the Senior Management Team receive assurance concerning the review and progression of all risks. • Ensures that all services regularly review their risks in accordance with RM02 Risk Management Procedures - 6.1 registers.	5.1 All services will regularly review their service risks in accordance with RMO2 Risk Management Procedures – 6.1 registers. Assurance will be received at the CIHC Health & Safety Risk Management Group. A review of the terms of reference will be undertaken in July 2024 to support regular member attendance.	Libby Ryan-Davies, IHC Director - Central	Carol Shillabeer, Chief Executive	Started	31/07/2024			The TORs will be on the agenda for the next meeting on the 25 July.
1302	Internal Audit	Budgetary Control	2024	Limited	High	Matter Arising 1: Budgetary Control Procedures (Design)	1.1a The Health Board develops a budgetary control Framework / Policy/ Procedure to support budget holders and managers in discharging their responsibilities.	1.1a The management response is to articulate there to already be in existence a Budget Manager Handbook, which satisfies this recommendation and is published on the intranet. This includes all relevant guidance for the control environment (the intention being to offer guidance on the control environment, as described in full within the published Standing Orders, Standing Financial Instructions and Scheme of Reservation and Delegation) and is therefore the framework for managers to work within. We are happy to explore with Internal Audit areas that can be strengthened within the guide, the intention being to give managers a single place to seek guidance. A training programme is also in force throughout the Health Board and we will review in conjunction with these sessions the appetite for an alternative means of disseminating this information (expanding as determined necessary) in conjunction with budget managers.	Joanna Garrigan Finance Director - Commissioning and Strategy	Russell Caldicott, Interim Executive Director of Finance	Pending	30/09/2024			No update provided to date
1305	Internal Audit	Budgetary Control	2024	Limited	High	Matter Arising 4: Journal Entries (Design)	4.1a The Executive Director of Finance/Nominated deputy reviews the process surrounding the completion, upload and posting of all journals and develops a Standard Operating Procedure. Management could consider retrospective scrutiny via a transaction report for the month, where set criteria is met and reviewed within Finance.	4.1a Management accepts this recommendation from prior years is yet to be implemented, noting the rating deteriorating from prior year owing to this recommendation remaining outstanding. The volume of journals results in a full check being impracticable, though a commitment was made as part of a prior year recommendation and thus a standard operating procedure will be produced and implemented to satisfy this outstanding request.	Michelle Jones, Head of Financial Reporting	Russell Caldicott, Interim Executive Director of Finance	Started	30/09/2024			Discussions around how best to provide assurance in this area have commenced, and will be developed and finalised in time for the deadline.

Audit Reports presented:

Insert name of Audit reports, including date of publication, and brief outline of report

Internal Audit/ Audit Wales	Report Title	Year	Assurance Level	Total number of report recommendations	Total number of report recommendations implemented/ complete / awaiting approvals	Total number of report recommendations open

[Insert name] Audit Report:

Provide outline of progress to date

GIG CYMRU NHS WALES | Bwrdd Iechyd Prifysgol Betsi Cadwalar University Health Board

[Insert name] Audit Report:

Provide outline of barriers to implementation/delivery

GIG CYMRU NHS WALES | Bwrdd Iechyd Prifysgol Betsi Cadwalar University Health Board

[Insert name] Audit Report:

Provide outline of mitigation in place to ensure implementation/delivery

[Insert name] Audit Report:

Plan and timeline for delivery

GIG CYMRU NHS WALES | Bwrdd Iechyd Prifysgol Betsi Cadwalar University Health Board

Limited/No assurance Audit Reports presented:

Internal Audit/ Audit Wales	Report Title	Year	Assurance Level	Number of report recommendations	Number of recommendations implemented/ complete /pending approval	Total number of report recommendations open
Internal Audit	Risk Management - June 2024	2024	Limited	4	1 (approved at ET on 28/08/2024)	3
Internal Audit	Standards of Business Conduct - Declarations of Interest, Gifts and Hospitality - June 2024	2024	Limited	10	0	10

Risk Management - June 2024:

PROGRESS TO DATE	BARRIERS TO IMPLEMENTATION/DELIVERY	MITIGATION IN PLACE TO ENSURE IMPLEMENTATION/ DELIVERY	PLAN AND TIMELINE FOR DELIVERY
• One recommendations being put forward for closure, and approved at ET on 28/08/2024 • Communication sent to all risk leads for overdue risks and this will be business as usual. • Progressing and escalation route is noted on the Risk Scrutiny Panel agenda under governance arrangements. Calendar of business for quarterly risk register audits completed for escalating to Head of Risk and also recommendations back to the service/IHC and monitoring, escalation route formally through Risk scrutiny Group and on the agenda • First round of review of all corporate risks completed, and QA by corporate risk team – to be reviewed again at Risk Scrutiny Panel. The next CRR will be reviewed at ET on the 18/09/2024 • Monthly Risk Scrutiny held 09/06/24, and Risk Forum (3x year). Draft TOR, agenda and COB to be reviewed in the first meeting. For approval at 21/08/24 Executive team meeting.	N/A	N/A	• Notification system about overdue risks to be set up – implementation date due 30/09/2024

Standards of Business Conduct - Declarations of Interest, Gifts and Hospitality - June 2024:

PROGRESS TO DATE	BARRIERS TO IMPLEMENTATION/DELIVERY	MITIGATION IN PLACE TO ENSURE IMPLEMENTATION/ DELIVERY	PLAN AND TIMELINE FOR DELIVERY
• Four out of the six actions are proposed for closure, and will be submitted to the Executive Team for approval The remaining actions align to a new policy being adopted and the software company removing NHS England logos on guidance documents. This request has been made	• Resource	• Increased resource has been allocated and Declaration of Interests are being monitored weekly and any queries answered daily where possible.	• A policy is in draft and near completion which aligns with the other NHS Organisations in Wales • Civica have been chased to action the change as a matter of urgency.

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Teitl adroddiad: *Report title:*	Update on Health Board Policies and Written Control Documents
Adrodd i: *Report to:*	Audit Committee
Dyddiad y Cyfarfod: *Date of Meeting:*	Thursday, 12 September 2024
Crynodeb Gweithredol: *Executive Summary:*	The purpose of this report is to provide the Audit Committee with: • an update on all corporate policies and written control documents (WCDs) that have been identified as being overdue their review date • to provide an update on progress to date around updating overdue WCDs • to provide the Audit Committee with an overview of all WCDs that will become overdue in the next quarter • to provide the Audit Committee with an update around the change in the approval process for all Health Board-wide clinical or non-clinical policies, including those with an element of medicine management, following the creation of the Executive Policy Oversight Group, and it delegated responsibilities from the Executive Team.
Argymhellion: *Recommendations:*	The Audit Committee is asked to: • NOTE the current status of all out-of-date policies and WCDs • NOTE the policies and WCDs that will become overdue per quarter in 2024/2024 • APPROVE the change in the approval process for all Health Board-wide clinical or non-clinical polices, including those with an element of medicine management.
Arweinydd Gweithredol: *Executive Lead:*	Pam Wenger, Director of Corporate Governance
Awdur yr Adroddiad: *Report Author:*	Glesni Driver, Head of Covid-19 Inquiry and Thirlwall Inquiry

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

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

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

Justification for the above assurance rating. Where 'Partial' or 'No' assurance has been indicated above, please indicate steps to achieve 'Acceptable' assurance or above, and the timeframe for achieving this:	
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 or WCDs. However, despite this, as can be seen from the review of progress over the last few months contained within this report, there still remains a large number of overdue policies and WCDs. The Corporate Governance Directorate will continue to provide support and guidance to policy owners and Executive Directors to progress this work.	
Cyswllt ag Amcan/Amcanion Strategol: *Link to Strategic Objective(s):*	Not applicable, other than those relating to individual policies and written control documents
Goblygiadau rheoleiddio a lleol: *Regulatory and legal implications:*	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
Yn unol â WP7, a oedd EqIA yn angenrheidiol ac a gafodd ei gynnal? *In accordance with WP7 has an EqIA been identified as necessary and undertaken?*	The Equality duty is not applicable. This 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).
Yn unol â WP68, a oedd SEIA yn angenrheidiol ac a gafodd ei gynnal? *In accordance with WP68, has an SEIA identified as necessary been undertaken?*	The Socio-Economic duty is not applicable. 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).
Manylion am risgiau sy'n gysylltiedig â phwnc a chwmpas y papur hwn, gan gynnwys risgiau newydd (croesgyfeirio at y BAF a'r CRR) *Details of risks associated with the subject and scope of this paper, including new risks (cross reference to the BAF and CRR)*	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
Goblygiadau ariannol o ganlyniad i roi'r argymhellion ar waith *Financial implications as a result of implementing the recommendations*	Not applicable, other than those relating to individual policies or written control documents
Goblygiadau gweithlu o ganlyniad i roi'r argymhellion ar waith *Workforce implications as a result of implementing the recommendations*	There will be a resource implementation due to the need to update outdated policies and written control documents
Adborth, ymateb a chrynodeb dilynol ar ôl ymgynghori *Feedback, response, and follow up summary following consultation*	This paper will form a six-monthly update on Health Board policies to the Executive Management Team
Cysylltiadau â risgiau BAF: (neu gysylltiadau â'r Gofrestr Risg Gorfforaethol) *Links to BAF risks:* (or links to the Corporate Risk Register)	Not applicable, other than those relating to individual policies and written control documents.
Rheswm dros gyflwyno adroddiad i fwrdd cyfrinachol (lle bo'n berthnasol)	Not applicable

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

Camau Nesaf:
Gweithredu argymhellion

Next Steps:
Implementation of recommendations

The Corporate Governance Directorate will continue to engage and support Executive Directors and WCD owners in order to ensure that any overdue WCDs are updated as timely as possible.

Rhestr o Atodiadau:

List of Appendices:

Appendix 1 – list of all overdue policies and WCDs, sorted by Executive Director lead
Appendix 2 – list of policies and WCDs that will need a review in 2024/25 as part of business as usual

UPDATE ON HEALTH BOARD POLICIES AND WRITTEN CONTROL DOCUMENTS

1. **INTRODUCTION AND BACKGROUN**

    The Health Board is committed to having a suite of current and relevant policy and Written Control Documents (WCDs), and in Special Measures, has pledged to prioritising its outstanding policies and WCDs by the end of 2024/25.

    As there are several out-of-date policies and WCDs, the Health Board has identified that updating these would be an ongoing piece of work requiring a programme approach as it would not be possible to update all these documents at once.

    From February 2024, the Corporate Governance Directorate, as the gatekeeper for all policies and WCDs, and the Policy Management System (PMS), has put in place a programme of work around policies and WCDs to ensure that there are processes in place to manage overdue documents so that progress can be monitored, and any areas of concern appropriately escalated.

    The Corporate Governance Directorate has engaged with policy and WCD owners and Executive Directors in order to, where necessary re-allocate policies to other services due to changes in the Health Board structure, amalgamate existing policies and WCDs, reassign policy and WCD authors, as well the work around planning of reviews. This work will continue until the Executive Team and Audit Committee is satisfied that the Health Board has fulfilled its commitment around overdue policies and WCDs.

2. **PROGRESS UPDATE**

    In January 2024, there were a total of 422 overdue policies and WCDs from the 958 listed on the PMS. This amounted to 44% of the total. Please see table 1 below.

Executive Lead	Number of policies or WCDs	Number of overdue policies or WCDs	% total overdue
Board Secretary	17	4	24%
Chief Digital Information Officer	39	12	31%
Director of Estates and Facilities	22	4	18%
Director of MHLD	69	41	59%
Director of Partnerships, Engagement and Communications	1	0	0%
Director of Women's Services	37	2	5%
Executive Director of Finance	23	19	83%
Executive Director of Integrated Clinical Services	145	86	59%
Executive Director of Nursing	129	31	24%
Executive Director of Public Health	47	5	11%
Executive Director of Therapies and Health Sciences	34	11	32%
Executive Director of Transformation and Planning	2	2	100%
Executive Director of Workforce	177	112	63%
Executive Medical Director	216	93	43%
Grand Total	**958**	**422**	**44%**

Please note that this provides details of the assigned Executive Director at that time.

Please also note that the detail within this update includes the total of **all** documents listed on the PMS, which includes appendices to policies and WCDs, and All-Wales policies.

In table 2 below, on 23rd May 2024, a total of 451 out of 964 policies and WCDs had already passed their review date, with 163 of these without an anticipated review date, and 144 without an author/owner.

Executive Lead	Number of WCDs	Number of overdue WCDs	% total overdue	Total overdue with no updated review date	Total all WCDs with no author
Chief Digital Information Officer	38	14	37%	4	0
Chief Operating Officer	68	47	69%	47	15
Director of Corporate Governance	22	4	18%	0	1
Director of Partnerships, Engagement and Communications	1	0	0%	0	0
Executive Director of Finance	45	24	53%	2	0
Executive Director of Nursing and Midwifery	239	78	33%	23	13
Executive Director of Public Health	41	0	0%	0	0
Executive Director of Therapies and Health Sciences	39	10	26%	3	0
Executive Director of Transformation, Strategic Planning and Commissioning	2	2	100%	2	1
Executive Director of Workforce and Organisational Development	180	115	64%	61	89
Executive Medical Director	214	108	50%	18	12
HB Lead for MHLD and Welsh Language	75	49	65%	3	13
Grand total	**964**	**451**	**47%**	**163**	**144**

The current position stands as detailed in table 3 below, which is information as at 28th June 2024.

Executive Lead	Number of WCDs	Number of overdue WCDs	% total overdue	Total overdue with no updated	Total all WCDs with no author
Chief Digital Information Officer	38	17	45%	6	0
Chief Operating Officer	67	47	70%	47	14
Director of Corporate Governance	22	4	18%	2	1
Director of Partnerships, Engagement and Communications	1	0	0%	0	0
Executive Director of Finance	45	24	53%	2	0
Executive Director of Nursing and Midwifery	244	69	28%	24	14
Executive Director of Public Health	41	0	0%	0	0
Executive Director of Therapies and Health Sciences	39	12	31%	1	0
Executive Director of Transformation, Strategic Planning and Commissioning	2	2	100%	2	1
Executive Director of Workforce and Organisational Development	184	109	59%	53	81
Executive Medical Director	214	114	53%	17	11
HB Lead for MHLD and Welsh Language	76	48	63%	5	12
Grand total	**973**	**446**	**46%**	**159**	**134**

2.1 Summary of overdue WCDs

Table 4 below shows the comparison between the position in January 2024 to the current position, as at 28th June 2024.

Number of WCDs			Number of overdue WCDs			% total overdue		
January 2024	May 2024	June 2024	January 2024	May 2024	June 2024	January 2024	May 2024	June 2024
958	964	973	422	451	446	44%	47%	46%
-	↑	↑	-	↑	↓	-	↑	↓

From January until May 2024, there was an increase of 6 policies and WCDs recorded on the PMS, and a further increase of 9 from May until June.

In relation to the number of overdue WCDs, there was an increase in the number of overdue policies and WCDs from January to May, but a decrease in June. This is still 24 more overdue policies and WCDs in June than there was in January 2024.

Even though there is an improvement in the percentage total of overdue policies and WCDs from May to June 2024, the overall picture shows a deterioration of 2% in the total. It must be noted that the additional 15 new policies or WCDs do not impact the total number of those overdue as they are new and are not due for a review for some time.

As previously mentioned, it is not possible to provide the comparison detail by Executive Director from January to present, however, below in table 5 is the comparison detail between May and June 2024.

Executive Lead	Number of WCDs		Number of overdue WCDs		% total overdue		Overdue with no updated review date		All WCDs with no author	
	May	June	May	June	May	June	May	June	May	June
Chief Digital Information Officer	38	38	14	17	37%	45%	4	6	0	0
Chief Operating Officer	68	67	47	47	69%	70%	47	47	15	14
Director of Corporate Governance	22	22	4	4	18%	18%	0	2	1	1
Director of Partnerships, Engagement and Communications	1	1	0	0	0%	0%	0	0	0	0
Executive Director of Finance	45	45	24	24	53%	53%	2	2	0	0
Executive Director of Nursing and Midwifery	239	244	78	69	33%	28%	23	24	13	14
Executive Director of Public Health	41	41	0	0	0%	0%	0	0	0	0
Executive Director of Therapies and Health Sciences	39	39	10	12	26%	31%	3	1	0	0
Executive Director of Transformation, Strategic Planning and Commissioning	2	2	2	2	100%	100%	2	2	1	1
Executive Director of Workforce and Organisational Development	180	184	115	109	64%	59%	61	53	89	81
Executive Medical Director	214	214	108	114	50%	53%	18	17	12	11
HB Lead for MHLD and Welsh Language	75	76	49	48	65%	63%	3	5	13	12
Grand total	964	973	451	446	47%	46%	163	159	144	134

2.2 Overdue WCDs for review by quarter

Table 6 below provides details of the number of overdue policies and WCDs, which have been listed for review in each quarter of 2024/25.

Executive Lead	Q2 2024/25	Q3 2024/25	Q4 2024/25
Chief Digital Information Officer	-	-	13
Executive Director of Finance	7	9	2
Executive Director of Nursing and Midwifery	14	5	1
Executive Director of Therapies and Health Sciences	9	-	2
Executive Director of Transformation, Strategic Planning and Commissioning	-	-	2
Executive Director of Workforce and Organisational Development	3	2	23
Executive Medical Director	29	3	63
HB Lead for MHLD and Welsh Language	11	15	3
Grand Total	**73**	**34**	**109**

2.3 WCDs due a review in quarters as BAU

Table 7 provides details of all policies and WCDs that are currently in date, but will become overdue per quarter in 2024/25:

Executive Lead	Q2 2024/25	Q3 2024/25	Q4 2024/25
Chief Digital Information Officer	1	6	1
Director of Corporate Governance			3
Executive Director of Finance	3		1
Executive Director of Nursing and Midwifery	13	16	16
Executive Director of Therapies and Health Sciences			1
Executive Director of Workforce and Organisational Development	4	1	8
Executive Medical Director	1	1	2
HB Lead for MHLD and Welsh Language	2	1	1
Grand Total	**24**	**25**	**33**

This does not include those policies and WCDs that have already been identified for update in a particular quarter, detailed in section 2.2 above.

The most overdue policy and WCDs should have been reviewed on 1st April 2011.

A list of all overdue policies and WCDs, sorted by Executive Director lead is included in Appendix 1.

A list of all policies and WCDs that will need a review in 2024/25 as part of business as usual is included in Appendix 2.

3   **APPROVAL OF ALL HEALTH BOARD-WIDE POLICY AND WRITTEN CONTROL DOCUMENTS**

The Terms of Reference for the Executive Policy Oversight Group have now been approved.

Dates have been identified for these Group meetings, and a list of all policies, in line with the agreed TORs will be provided to Group members prior to those meetings.

3.1   **Change in current approval process**

As the implementation of the Executive Policy Oversight Group is an addition to the current approval process contained within the '*Management of Policies, Procedures & other Written Control Documents Policy*', all policies subject to approval by the Executive Policy Oversight Group will now not automatically be uploaded onto the intranet once the consultation is completed, as is currently the case. From 14th August 2024, all policies will now follow this new approval process, and therefore will only be uploaded onto the intranet once approved has been given by the Group and thereafter the Executive Team.

All those who submit policies subject to review by the Executive Policy Oversight Group will be notified that their document will follow this new process.

As this process is new, the first Executive Policy Oversight Group was stood down as no policies had been submitted for review. The next meeting is due to be held on 19th September 2024.

4   **NEXT STEPS**

As there is a change in the approval process around policies, in line with the delegation of responsibilities from the Executive Team to the Executive Policy Oversight Group, the '*Management of Policies, Procedures & other Written Control Documents Policy'* will be amended accordingly, in line with other proposed changes required in order to ensure good governance.

The Corporate Governance Directorate will continue to engage and support Executive Directors and policy and WCD owners in order to ensure that any overdue documentation is updated as timely as possible.

The Corporate Governance Directorate are also working on updating the PMS so that it has the capability to track the progress of overdue policies and WCDs. This will include automatic reminders to owners of any of policies and WCDs that are due a review in the coming months, as well as working with owners to provide updates on progress around their overdue documents, and provide assistance where required.

5   **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.

6   **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 on Datix relating to this.

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.

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 – list of all overdue policies and WCDs, sorted by Executive Director lead

Appendix 2 – list of policies and WCDs that will need a review in 2024/25 as part of business as usual

Name	Policy type	Effective Date	Review Date	Author	Responsible Director	Qtr for Review
All Wales Email Use Policy - V2.pdf	Policy	26/06/2018	26/06/2018	Lisa Parry (BCUHB - Digital, Data and Technology);#102	Chief Digital Information Officer	Q4 2024/2025
All Wales Information Governance Policy - V2.pdf	Policy	14/01/2021	13/01/2023	Lisa Parry (BCUHB - Digital, Data and Technology);#102	Chief Digital Information Officer	Q4 2024/2025
All Wales Information Security Policy - V2.pdf	Policy	14/01/2021	13/01/2023	Lisa Parry (BCUHB - Digital, Data and Technology);#102	Chief Digital Information Officer	Q4 2024/2025
All Wales Internet Use Policy - V3.pdf	Policy	14/01/2021	13/01/2023	Lisa Parry (BCUHB - Digital, Data and Technology);#102	Chief Digital Information Officer	Q4 2024/2025
HR4 - Access to Health Records Procedure - V5.0.pdf	Procedure	14/06/2011	01/05/2023	Nia Aspinall (BCUHB - Digital, Data and Technology);#16780	Chief Digital Information Officer	Q4 2024/2025
HR4a - Guidance on the Management of Receiving & Responding to Requests for Police Medical Witness Statements - V2.0.pdf	Other	10/03/2020	10/03/2024	Nia Aspinall (BCUHB - Digital, Data and Technology);#16780	Chief Digital Information Officer	Q4 2024/2025
IG02 - Appendix C - Corporate Records Retention Schedule - V4.pdf	Appendix	10/04/2019	10/07/2022	Lisa Parry (BCUHB - Digital, Data and Technology);#102	Chief Digital Information Officer	Q4 2024/2025
IG07 - Procedure for Dealing with SARs Under Data Protection Legislation - V9.pdf	Procedure	19/08/2021	01/07/2024	Lisa Parry (BCUHB - Digital, Data and Technology);#102	Chief Digital Information Officer	Q4 2024/2025
IG1 - Appendix A - EQIA.pdf	Appendix	30/06/2023	01/04/2024	Carol Johnson (BCUHB - Digital, Data and Technology);#96	Chief Digital Information Officer	Q4 2024/2025
IG1 - Information Governance Strategy.pdf	Strategy	30/06/2023	01/04/2024	Carol Johnson (BCUHB - Digital, Data and Technology);#96	Chief Digital Information Officer	Q4 2024/2025
IG10 - Procedure for Requesting Approval and Review of an Information System for Investigation Purposes.pdf	Procedure	25/05/2022	01/04/2024	Carol Johnson (BCUHB - Digital, Data and Technology);#96	Chief Digital Information Officer	
IG14 - Appendix 2 - Leavers & Movers Checklist.pdf	Appendix	25/05/2022	01/04/2024	Lisa Parry (BCUHB - Digital, Data and Technology);#102	Chief Digital Information Officer	
IG14 - Appendix 3 - Mobile Working Risk Assessment.pdf	Appendix	26/11/2020	26/11/2022	Lisa Parry (BCUHB - Digital, Data and Technology);#102	Chief Digital Information Officer	
IG24 - Notification of Personal Data Breach Procedure.pdf	Procedure	30/06/2022	01/05/2024	Lisa Parry (BCUHB - Digital, Data and Technology);#102	Chief Digital Information Officer	Q4 2024/2025
IG28 - Bring Your Own Device (BYOD) Procedure.pdf	Procedure	30/05/2022	30/05/2023	Lisa Parry (BCUHB - Digital, Data and Technology);#102	Chief Digital Information Officer	Q4 2024/2025
INF03 - Informatics Change Management Policy - V1.pdf	Policy	21/01/2020	13/01/2023	John Thomas (BCUHB - Digital, Data and Technology);#9090	Chief Digital Information Officer	Q4 2024/2025
INF04 - Informatics Change Management Procedure - V1.pdf	Policy	08/05/2019	19/05/2023	John Thomas (BCUHB - Digital, Data and Technology);#9090	Chief Digital Information Officer	Q4 2024/2025
A Clinical Policy for DNACPR For Adults in Wales - V4.pdf	Policy	01/12/2020	01/12/2022		Chief Operating Officer	
AN01 - Guideline for Acupuncture as Pain Relief in Adults - V0.2.pdf	Guideline	04/12/2013	01/01/2020	Lucy Jones (BCUHB - Pain Management);#227;#Dawn Davies (BCUHB - Anaesthetics);#228	Chief Operating Officer	

Title	Type	Date 1	Date 2	Author	Owner	
BCUHB SACT Prescribing Competency Passport.pdf	Other	01/08/2015	01/08/2018	Tracy Parry (BCUHB - Pharmacy);#501;#Anna Mullard (BCUHB - Oncology);#499	Chief Operating Officer	
CA02 - Adult Breaking Bad News Policy - V0.1.pdf	Policy	10/06/2014	01/07/2016		Chief Operating Officer	
CA04 - Guidance for the Management of Metastatic Spinal Cord Compression in Adults - V0.1.pdf	Other	01/06/2016	01/07/2018	Claire Fuller (BCUHB - Medical Oncology);#498	Chief Operating Officer	
CA05 - Acute Oncology Operational Guidance - V0.1.pdf	Other	01/10/2016	01/10/2018	Beryl Roberts (BCUHB - Cancer Services);#496;#Anna Mullard (BCUHB - Oncology);#499	Chief Operating Officer	
CA06 - Guidelines for Treatment of Oral Mucositis in Oncology & Haematology Patients - V0.1.pdf	Guideline	01/11/2016	01/11/2019		Chief Operating Officer	
CA07 - Cancer Key Worker Procedure for use within Secondary Care - V0.1.pdf	Procedure	09/10/2016	09/10/2017		Chief Operating Officer	
CA3 - Cancer & Specialist Palliative Medicine Guideline for Management of Neutropenic Sepsis - V0.3.pdf	Guideline	01/12/2014	01/04/2016	Beryl Roberts (BCUHB - Cancer Services);#496;#Louise Preston-Jones (BCUHB - Cancer Services);#497	Chief Operating Officer	
CSPM01 - Guidance for Ensuring Safety and Quality of Chemotherapy Services - V0.1.pdf	Other	22/07/2013	01/04/2016	Catherine Bale (BCUHB - Cancer Services);#500;#Beryl Roberts (BCUHB - Cancer Services);#496	Chief Operating Officer	
CSPM02 - Guidelines for the Management of Tumour Lysis Syndrome in Haematological & Solid Tumour Malignancies - V2.pdf	Guideline	01/11/2018	01/12/2021		Chief Operating Officer	
CSPM03 - Precautionary Measures in the Event of Spillage Involving Cytotoxics - V1.0.pdf	Guideline	13/02/2019	01/02/2022	Katherine White (BCUHB - Pharmacy and Medicines Management);#353;#Hannah Greaves (BCUHB - Pharmacy);#375	Chief Operating Officer	
CSPM04 - Guideline for Requesting Non-Formulary or Off-Protocol SACT - V2.0.pdf	Guideline	01/08/2017	01/10/2017	Tracy Parry (BCUHB - Pharmacy);#501	Chief Operating Officer	
CSPM1 - Clinical Guidelines for the Management of Chemotherapy & Radiotherapy Induced Nausea & Vomiting - V1.2.pdf	Guideline	30/09/2014	01/10/2017	Tracy Parry (BCUHB - Pharmacy);#501	Chief Operating Officer	
CSPM2 - Hydration Protocol for Cisplatin Chemotherapy - V1.3.pdf	Protocol	16/06/2015	01/07/2018	Tracy Parry (BCUHB - Pharmacy);#501	Chief Operating Officer	
CSPM3 - Guidelines for the use of Granulocyte Colony Stimulating Factors (G-CSF) in Adult Haematology & Oncology Patients - V2.pdf	Guideline	01/12/2017	01/11/2020		Chief Operating Officer	
CSPM4 - Guidelines for the Management of Chemotherapy Induced Diarrhoea in Adult Patients with Cancer - V1.0.pdf	Guideline	01/10/2018	01/10/2021	Anne Marie Humphreys (BCUHB - Cancer Services);#502	Chief Operating Officer	
CW01 - BCUHB Paediatric Escalation Policy - V3.pdf	Policy	01/09/2018	01/09/2019	Martin Mcspadden (BCUHB - Paediatrics);#469	Chief Operating Officer	
EH01 - Protocol for Support of Registered Children's & other Nurses working within CAMHS - V0.1.pdf	Protocol	01/01/2013	13/12/2015	Patrick Howells (BCUHB - Child & Adolescent Health);#12570	Chief Operating Officer	

Irmer Procedures Manual for Radium-223 Treatment for Bone Metastases from Prostate Cancer - V3.pdf	Procedure	23/07/2018	01/04/2021	Julian Macdonald (BCUHB - North Wales Medical Physics (inc EBME));#24	Chief Operating Officer	
LAC04 - Procedure for the Recovery of Costs associated with Looked After Children placed within BCUHB - V1.0.pdf	Procedure	09/04/2014	01/04/2015	Susan Battery (BCUHB - Child & Adolescent Health);#2559;#Llinos Edwards (BCUHB - Child & Adolescent Health);#4860	Chief Operating Officer	
MH2 - Guidance for Crisis Care Pathway for Children & Young People Presenting with Mental Health Issues - V0.6.pdf	Other	01/12/2016	01/12/2019	Lesley Bayley (BCUHB - Community Child Health);#12572;#Tina Owen (BCUHB - Child & Adolescent Health);#5324	Chief Operating Officer	
MM24 - Hypomagnesaemia Management in Cancer Patients - V0.1.pdf	Guideline	01/09/2016	01/09/2018		Chief Operating Officer	
MP01 - Chemotherapy Protocol Validation - V1.pdf	Protocol	01/03/2018	01/03/2020	Tracy Parry (BCUHB - Pharmacy);#501	Chief Operating Officer	
NU01 - Discharge Policy & Protocol - V0.2.pdf	Policy	16/01/2015	21/09/2018	Lowri Welnitschuk (BCUHB - Patient Safety);#57;#Lorraine Hughes (BCUHB - Continuing Health Care);#58	Chief Operating Officer	
NU32 - Guideline for Managing Continuous Subcutaneous Insulin Infusion (CSII, or 'Insulin Pump') Therapy in Adults.pdf	Guideline	23/06/2021	01/06/2024	Iona Collins (BCUHB - Diabetes & Endocrinology);#17754;#Timothy Hoe (BCUHB - Dietetics);#860;#Muhammed Murtaza (BCUHB - Diabetes & Endocrinology);#576	Chief Operating Officer	
OP01 - Protocol for the Management of Emergency Pressures & Escalation - V0.2.pdf	Protocol	13/11/2014	13/10/2015	Daniel Menzies (BCUHB - Respiratory Medicine);#94	Chief Operating Officer	
OP02 - Protocol for the Safe Management of Patients During Ambulance Handover- V0.1.pdf	Protocol	10/11/2014	10/11/2015		Chief Operating Officer	
OPH01 - SOP Intravitreal Injections of Anti-VEGF Medication for Macluar Disease by Non-Medical HC Practitioners - V9.pdf	Procedure	11/10/2016	11/06/2018	Alison Birch (BCUHB - Ophthalmology);#90	Chief Operating Officer	
OPH02 - Protocol for Ophthalmic Nurse Practitioners alongside Medical Officer to Monitor Patients with Advanced Glaucoma - V1.pdf	Protocol	05/12/2019	05/11/2020	Lucy Bubb (BCUHB - Ophthalmology);#91	Chief Operating Officer	
OPH03 - Protocol for Ophthalmic Nurse Practitioners Working in Glaucoma Operational Diagnostic Treatment Centre Clinic - V1.pdf	Protocol	05/12/2019	05/12/2020	Lucy Bubb (BCUHB - Ophthalmology);#91	Chief Operating Officer	
PA01 - Appendix D - Point of Care Testing (PoCT) Request Form - V0.1.pdf	Appendix	11/02/2014	05/01/2017	Geoffrey Armstrong (BCUHB - Clinical Biochemistry Services);#73	Chief Operating Officer	
PA01 - Procedure for Point of Care Testing (PoCT) - V0.1.pdf	Procedure	11/02/2014	05/01/2017	Geoffrey Armstrong (BCUHB - Clinical Biochemistry Services);#73	Chief Operating Officer	
PCSM01 - Clinical Protocol for Shingles Vaccination by Community Nurses - V0.1.pdf	Protocol	01/02/2015	01/06/2018	Leigh Pusey (BCUHB - Health Visiting);#229	Chief Operating Officer	

Title	Type	Date	Review Date	Author	Owner	
PCSM02 - Clinical Protocol for Influenza & Pneumococcal Vaccination by Nurses - V0.1.pdf	Protocol	01/02/2015	01/06/2018	Leigh Pusey (BCUHB - Health Visiting);#229	Chief Operating Officer	
Polisi Clinigol DNACPR Ar Gyfer Oedolion Yng Nghymru - V4.pdf	Policy	01/12/2020	01/12/2022		Chief Operating Officer	
Procedure for the Transfer of Blood & Blood Components between Hospitals - V4.0.pdf	Policy	01/06/2019	01/06/2022		Chief Operating Officer	
PTH-TR-1008 - Blood and Blood Component Requesting and Authorisation Procedure - V2.0.pdf	Procedure	23/09/2020	23/09/2022		Chief Operating Officer	
PTH-TR-POL602 - Blood and Blood Components Transfusion Collection & Administration Policy - V2.0.pdf	Policy	17/11/2021	17/11/2022		Chief Operating Officer	
RAD 034 - Standard Operating Procedure – Undertaking Imaging of Suspected Inflicted Injury (formerly NAI).pdf	Procedure	11/07/2022	01/03/2024	Helen Hughes (BCUHB - Radiology);#37;#Lisa Ruffley-Fuller (BCUHB - Radiology);#126;#Shiromi Ellis (BCUHB - Community Child Health);#5087	Chief Operating Officer	
RAD 036 - Operation of Mobile Mini C-Arm X-Ray Fluroscopy Equipment Outside Radiology - V2.pdf	Other	12/09/2019	12/08/2021	Pat Youds (BCUHB - Radiology);#26;#Peter Hiles (BCUHB - North Wales Medical Physics (inc EBME));#23;#Julian Macdonald (BCUHB - North Wales Medical Physics (inc EBME));#24	Chief Operating Officer	
RAD IR 083 - Procedure for Entitlement of IR(ME)R Functions to Perform Endovascular Procedures by Vascular Surgeons without a Consultant Radiologist being Present and Use of the Hybrid Theatre.pdf	Procedure	14/04/2022	01/02/2024	Helen Hughes (BCUHB - Radiology);#37;#Peter Hiles (BCUHB - North Wales Medical Physics (inc EBME));#23;#Lisa Ruffley-Fuller (BCUHB - Radiology);#126	Chief Operating Officer	
RAD NM 024 - Transport of Radioactive Materials within BCUHB Joint Working Procedure - V1.pdf	Procedure	12/09/2020	14/01/2021	David Jones (BCUHB - Radiology);#38;#Andrew Merriman (BCUHB - Pharmacy);#39;#Julian Macdonald (BCUHB - North Wales Medical Physics (inc EBME));#24	Chief Operating Officer	
SCH03 - SOP for the Management of Children & Young People at a Hospital Setting due to Self Harm & Suicidal Behaviour - V1.pdf	Procedure	01/03/2012	01/08/2013	Marilyn Wells (BCUHB - Child & Adolescent Health);#772	Chief Operating Officer	
SH09 - SOP for School Nursing Service for Children who are on Elective Home Education - V0.1.pdf	Procedure	06/12/2013	01/01/2016		Chief Operating Officer	
Steroid Tapering Guidance.pdf	Other	20/12/2018	20/12/2021		Chief Operating Officer	
TH&S01 - Guidance and Procedure for Non-Medical Dental Referrals for Radiological Investigations - V0.1.pdf	Procedure	09/12/2014	13/10/2016	Pat Youds (BCUHB - Radiology);#26;#Adrian Thomas (BCUHB - Therapies & Health Science);#22;#Helen Hughes (BCUHB - Radiology);#37	Chief Operating Officer	

Document	Type	Date 1	Date 2	Author	Responsible Director	Review Due
GC05 - Appendix B - Proforma for Accessing Legal Advice.pdf	Appendix	01/01/2016	01/02/2018	Phil Meakin (BCUHB - Governance & Communications);#29246;#Glesni Driver (BCUHB - Corporate Office);#14210	Director of Corporate Governance	Q1 2024/2025
GC05 - Procedure for Accessing Legal Advice - V0.2.pdf	Procedure	01/01/2016	01/02/2018	Phil Meakin (BCUHB - Governance & Communications);#29246;#Glesni Driver (BCUHB - Corporate Office);#14210	Director of Corporate Governance	Q1 2024/2025
OBS03 - Procedure for Naming Buildings & Units of BCUHB - V2.pdf	Procedure	17/03/2021	01/03/2024	Glesni Driver (BCUHB - Corporate Office);#14210	Director of Corporate Governance	Q1 2024/2025
OBS04 - Procedure for Co-ordinating Cabinet Secretary, Ministerial or VIP Visits & Official Openings - V2.pdf	Procedure	28/02/2018	28/02/2021		Director of Corporate Governance	Q1 2024/2025
AL01 - Financial Procedures - V1.11.pdf	Procedure	09/09/2019	09/09/2022	Neil Williams (BCUHB - Finance);#40900	Executive Director of Finance	Q2 2024/2025
AL02 - Fund Advisor Handbook & Accountability Agreements - V1.pdf	Other	01/01/2017	01/01/2018	Kirsty Thomson (BCUHB - Corporate Services);#218	Executive Director of Finance	Q2 2024/2025
AL03 - Collaborative Working Protocol - V0.1.pdf	Protocol	12/09/2016	12/09/2017	Kirsty Thomson (BCUHB - Corporate Services);#218	Executive Director of Finance	Q2 2024/2025
All Wales Policy on Insurance, NHS Indeminity & related Risk Management for Potential Losses & Special Payments.pdf	Policy	11/09/2018	11/09/2020	Simon Weaver (BCUHB - Finance);#43;#Kirsty Thomson (BCUHB - Corporate Services);#218	Executive Director of Finance	Q3 2024/2025
Contractors Safety Guidance - V9.pdf	Other	01/04/2019	01/12/2020	Tanya Coppack (BCUHB - Estates);#1268	Executive Director of Finance	Q3 2024/2025
ES03 - Waste Management Policy - V5.pdf	Policy	01/09/2020	01/09/2023	Natalie Scott-Lakey (BCUHB - Estates);#1271;#Cynthia Williams (BCUHB - Estates);#1272;#Jenny Usher-Jones (BCUHB - Estates);#1273	Executive Director of Finance	Q3 2024/2025
ES04 - Policy for the Managment of Fire Safety - V0.4.pdf	Policy	01/11/2020	01/04/2022	Rod Taylor (BCUHB - Estates);#1184;#Gareth Griffiths (BCUHB - Estates);#1269	Executive Director of Finance	Q3 2024/2025
F01 - Patients Property and Monies - Wards and Departments.pdf	Procedure	08/01/2020	01/11/2022	Simon Weaver (BCUHB - Finance);#43	Executive Director of Finance	Q3 2024/2025
F04 - Cash Collection Receipting and Banking Arrangements - V0.2.pdf	Procedure	14/07/2017	19/07/2019	Simon Weaver (BCUHB - Finance);#43	Executive Director of Finance	Q1 2024/2025
F05 - Income and Debt Recovery - V0.2.pdf	Procedure	02/02/2017	15/02/2019	Simon Weaver (BCUHB - Finance);#43	Executive Director of Finance	Q1 2024/2025
F06 - Losses and Special Payments - V0.2.pdf	Procedure	02/02/2017	15/02/2019	Simon Weaver (BCUHB - Finance);#43	Executive Director of Finance	Q3 2024/2025
F07 - Petty Cash Procedure- V0.2.pdf	Procedure	25/07/2017	19/07/2019	Simon Weaver (BCUHB - Finance);#43	Executive Director of Finance	Q2 2024/2025
F08 - Purchasing Card Procedure - V0.2.pdf	Procedure	02/02/2017	15/02/2019	Simon Weaver (BCUHB - Finance);#43	Executive Director of Finance	Q2 2024/2025

F09 - Reimbursement of Travel to Hospital Costs - V3.pdf	Procedure	19/02/2020	17/02/2023	Simon Weaver (BCUHB - Finance);#43	Executive Director of Finance	Q4 2024/2025
F10 - Retention and Disposal of Property Found on Health Board Premises - V0.2.pdf	Procedure	28/03/2018	20/03/2020	Simon Weaver (BCUHB - Finance);#43	Executive Director of Finance	Q3 2024/2025
F11 - Debit and Credit Card Payment Procedure - V0.1.pdf	Procedure	27/09/2017	20/09/2019	Simon Weaver (BCUHB - Finance);#43	Executive Director of Finance	Q1 2024/2025
F12 - Debit and Credit Card Refund Procedure - V0.1.pdf	Procedure	27/09/2017	20/09/2019	Simon Weaver (BCUHB - Finance);#43	Executive Director of Finance	Q1 2024/2025
F13 - Procedure For Use and Completion of Request To Waive SFIs - V0.1.pdf	Procedure	07/03/2018	17/01/2020	Neil Williams (BCUHB - Finance);#40900	Executive Director of Finance	Q2 2024/2025
F14 - Financial Procedure Salary Overpayments and Underpayments - V2.pdf	Procedure	24/02/2021	16/02/2024	Simon Weaver (BCUHB - Finance);#43	Executive Director of Finance	Q4 2024/2025
F15 - Patients Property and Monies - General Office - V0.1.pdf	Guideline	31/10/2018	16/10/2020	Simon Weaver (BCUHB - Finance);#43	Executive Director of Finance	Q3 2024/2025
F16 - Arranging a Hospital Funeral - V0.1.pdf	Procedure	14/12/2018	18/12/2020	Simon Weaver (BCUHB - Finance);#43	Executive Director of Finance	Q2 2024/2025
F18 - Intermediaries Legislation (IR35) Procedure - V1.0.pdf	Procedure	12/02/2020	13/02/2023	Denise Roberts (BCUHB - Finance);#865	Executive Director of Finance	Q3 2024/2025
OPD HTM02-01 - Medical Gas Pipeline Systems - V1.pdf	Procedure	17/07/2019	01/08/2020	Tanya Coppack (BCUHB - Estates);#1268	Executive Director of Finance	
All Wales Birth Centre Guideline.pdf	Guideline				Executive Director of Integrated Clinical Services	
All Wales Best Practice Statement on the Prevention & Management of Moisture Leisions.pdf	Other	01/12/2014	01/12/2017	Paula Lawrence (BCUHB - Nursing, Midwifery & Patient Services);#427	Executive Director of Nursing and Midwifery	Q3 2024/2025
All Wales Guidance for the Use of Larval Debridement Therapy.pdf	Other	01/12/2013	01/12/2017	Paula Lawrence (BCUHB - Nursing, Midwifery & Patient Services);#427	Executive Director of Nursing and Midwifery	Q3 2024/2025
All Wales Pressure Ulcer Reporting and Investigation Guidance - V4.pdf	Other	01/12/2018	01/12/2021	Paula Lawrence (BCUHB - Nursing, Midwifery & Patient Services);#427	Executive Director of Nursing and Midwifery	Q3 2024/2025
BCU Criteria Led Discharge Protocol.pdf	Protocol	14/09/2021	01/10/2022	Claire Brennan (BCUHB - Corporate Office);#16690	Executive Director of Nursing and Midwifery	Q3 2024/2025
BCUHB - Claims Governance Policy Clinical Negligence and Personal Injury - V8.pdf	Policy	12/12/2019	01/07/2021	Matthew Joyes (BCUHB - Quality Directorate);#108	Executive Director of Nursing and Midwifery	Q2 2024/2025
BCUHB - Legal Services Department - Claims Governance & Management Procedure.pdf	Procedure	12/12/2018	16/07/2021	Matthew Joyes (BCUHB - Quality Directorate);#108	Executive Director of Nursing and Midwifery	Q2 2024/2025
Gyn 03 - Ovarian Hyperstimulation Syndrome - V3.pdf	Guideline	01/12/2020	01/12/2023	Arpana Jain (BCUHB - Obstetrics & Gynaecology);#3472	Executive Director of Nursing and Midwifery	
Gyn 05 - Oncology Nurse Led Telephone Clinic - V3.pdf	Procedure	01/12/2020	01/12/2023	Liz Hall (BCUHB - Obstetrics & Gynaecology);#7028	Executive Director of Nursing and Midwifery	
Gyn 08 - Gynaecology Escalation Procedure - V3.pdf	Procedure	16/03/2021	30/03/2024	Melissa Hewlett (BCUHB - Nursing, Midwifery & Patient Services);#4839	Executive Director of Nursing and Midwifery	
Gyn 09 - Emergency Gynaecology Unit Miscarriage and Ectopic Pregnancy - V2.pdf	Guideline	01/12/2020	01/12/2023	Nick Clerk (BCUHB - Obstetrics & Gynaecology);#7041	Executive Director of Nursing and Midwifery	
Gyn 11 - BCUHB Fertility Service.pdf	Protocol	01/12/2020	01/12/2023	Jayne Beattie (BCUHB - Family Services);#7046	Executive Director of Nursing and Midwifery	

Gyn 12 - Uterine Artery Embolisation - V2.pdf	Guideline	01/12/2020	01/12/2023	Gudrun Rieck (BCUHB - Obstetrics & Gynaecology);#7051	Executive Director of Nursing and Midwifery	
IPC23 - Notifiable Diseases Procedure.pdf	Procedure	13/06/2022	01/05/2024	Graham Brown (Public Health Wales);#22621;#Andrea Ledgerton (BCUHB - Infection Control Teams);#142	Executive Director of Nursing and Midwifery	Q1 2024/2025
ISU02 - Patient, Service User & Carer Procedure for the Production of Written Information - V4.02.pdf	Procedure	12/06/2020	16/06/2023	Leon Marsh (BCUHB - Nursing, Midwifery & Patient Services);#51036	Executive Director of Nursing and Midwifery	Q2 2024/2025
ISUE01 - Undertaking Patient Experience Stories - V2.0.pdf	Other	29/04/2021	14/04/2023	Eleri Anderson (BCUHB - Nursing, Midwifery & Patient Services);#46;#Hannah Hughes (BCUHB - Patient and Carer Experience);#47;#Bryn Knowles (BCUHB - Digital, Data and Technology);#48;#Marina Marzelos (BCUHB - Patient and Carer Experience);#49;#Alyshea Duff (BCUHB - Occupational Therapy);#50;#Zoe Gamble (BCUHB - Therapies & Health Science);#51	Executive Director of Nursing and Midwifery	Q2 2024/2025
Mat 06 - Supporting Births in Community Settings - V2.2.pdf	Other	01/05/2020	01/06/2021		Executive Director of Nursing and Midwifery	Q1 2024/2025
Mat 11a - Why Active Birth.pdf	Appendix	29/07/2019	29/07/2022		Executive Director of Nursing and Midwifery	Q1 2024/2025
Mat 11c - Hormones of Labour Active Birth.pdf	Appendix	29/07/2019	29/07/2022		Executive Director of Nursing and Midwifery	Q1 2024/2025
Mat 13 - Birth Planning When Women Choose Options That Are Outside BCUHB Policies - V1.pdf	Guideline	01/01/2021	01/01/2024	Meinir Clayton Evans (BCUHB - Maternity);#7119	Executive Director of Nursing and Midwifery	
Mat 16 - Fetal Medicine Scan on Consultant List - V2.pdf	Other	20/12/2019	20/12/2022	Bidyut Kumar (BCUHB - Obstetrics & Gynaecology);#7125	Executive Director of Nursing and Midwifery	
Mat 16a - Fetal Medicine Referral Form - V2.pdf	Appendix	20/12/2019	20/12/2022	Bidyut Kumar (BCUHB - Obstetrics & Gynaecology);#7125	Executive Director of Nursing and Midwifery	
Mat 21 - Prophylactic Anti D - V3.pdf	Guideline	01/04/2021	01/04/2024	Cathy Hughes (BCUHB - Antenatal);#4932	Executive Director of Nursing and Midwifery	
Mat 23 - Venous Thromboembolism in Pregnancy - Prevention, Diagnosis and Treatment - V3.pdf	Guideline	01/03/2021	01/04/2024	Joseph Mechery (BCUHB - Obstetrics & Gynaecology);#3578	Executive Director of Nursing and Midwifery	
Mat 23a - Venous Thromboembolism in Pregnancy Risk Assessment - V3.pdf	Appendix	01/03/2021	01/04/2024	Joseph Mechery (BCUHB - Obstetrics & Gynaecology);#3578	Executive Director of Nursing and Midwifery	
Mat 24 - Women Who Present In Labour Who Are Not Booked or Have Received No Antenatal Care or Initial Assessment - V3.pdf	Guideline	01/12/2020	01/12/2023	Eleri Pritchard (BCUHB - Maternity);#4373	Executive Director of Nursing and Midwifery	

Mat 25 - Acceptance or Assessment of Maternal and Fetal Wellbeing on the Outpatient Assessment Unit (MOAU) - V5.pdf	Guideline	01/06/2021	01/06/2024	Kizzy Williams (BCUHB - Maternity);#7160	Executive Director of Nursing and Midwifery	
Mat 28 - Small for Gestational Age and Fetal Growth Restricted Babies - Antenatal Management - V1.1.pdf	Other	01/06/2021	01/06/2024	Bidyut Kumar (BCUHB - Obstetrics & Gynaecology);#7125	Executive Director of Nursing and Midwifery	
Mat 29 - Twin and Triplet Pregnancies in the Antetnatal Period - V2.pdf	Guideline	01/12/2020	01/12/2023	Bidyut Kumar (BCUHB - Obstetrics & Gynaecology);#7125	Executive Director of Nursing and Midwifery	
Mat 30 - Women who Decline Blood Products Related to Pregnancy or the Puerperium - V2.pdf	Guideline	24/08/2018	30/06/2022	Hari Muppala (BCUHB - Obstetrics & Gynaecology);#7169	Executive Director of Nursing and Midwifery	
Mat 33 - Amniotic Fluid Embolism - V2.pdf	Guideline	01/12/2020	01/12/2023	Lynda Verghese (BCUHB - Obstetrics & Gynaecology);#1034	Executive Director of Nursing and Midwifery	
Mat 34 - Antepartum Haemorrhage - V2.pdf	Other	01/12/2020	01/12/2023	Mian Khurshid (BCUHB - Obstetrics & Gynaecology);#5588	Executive Director of Nursing and Midwifery	
Mat 35 - Assisted Vaginal Birth (formerly Operative Vaginal Delivery) - V3.pdf	Other	01/07/2021	01/07/2024	Neelam Singh (BCUHB - Obstetrics & Gynaecology);#7188	Executive Director of Nursing and Midwifery	
Mat 42 - Epilepsy in Pregnancy - V1.pdf	Policy	01/10/2018	01/10/2021	Maggie Armstrong (BCUHB - Obstetrics & Gynaecology);#7229;#Sheila Shepley (BCUHB - Outpatient Services);#5004;#Janet Quarmby (BCUHB - Maternity);#7085	Executive Director of Nursing and Midwifery	
Mat 42a - Epilepsy in Pregnancy - Key Messages for Community Midwives - V1.pdf	Appendix	01/10/2018	01/10/2021	Maggie Armstrong (BCUHB - Obstetrics & Gynaecology);#7229;#Sheila Shepley (BCUHB - Outpatient Services);#5004;#Janet Quarmby (BCUHB - Maternity);#7085	Executive Director of Nursing and Midwifery	Q1 2024/2025
Mat 42b - Epilepsy in Pregnancy - Flowchart for direct referral to epsilepsy specialist services - V1.pdf	Appendix	01/10/2018	01/10/2021	Maggie Armstrong (BCUHB - Obstetrics & Gynaecology);#7229;#Sheila Shepley (BCUHB - Outpatient Services);#5004;#Janet Quarmby (BCUHB - Maternity);#7085	Executive Director of Nursing and Midwifery	Q1 2024/2025
Mat 42c - Epilepsy in Pregnancy - Referral Letter to Walton for Specialist Epilepsy Appointment within BCUHB - V1.pdf	Appendix	01/10/2018	01/10/2021	Maggie Armstrong (BCUHB - Obstetrics & Gynaecology);#7229;#Sheila Shepley (BCUHB - Outpatient Services);#5004;#Janet Quarmby (BCUHB - Maternity);#7085	Executive Director of Nursing and Midwifery	Q1 2024/2025
Mat 43 - External Cephalic Version at Term - V2.pdf	Guideline	01/12/2020	01/12/2023	Devjani Das (BCUHB - Obstetrics & Gynaecology);#7232;#Masroor Cheema (Ysbyty Gwynedd - W042);#7233	Executive Director of Nursing and Midwifery	Q1 2024/2025

Document	Type	Issue Date	Review Date	Author	Executive Lead	Review Due
Mat 43a - External Cephalic Version - VBAC Flowchart - V1.pdf	Appendix	01/12/2020	01/12/2023	Devjani Das (BCUHB - Obstetrics & Gynaecology);#7232;#Masroor Cheema (Ysbyty Gwynedd - W042);#7233	Executive Director of Nursing and Midwifery	Q1 2024/2025
Mat 45 - Intermittent Auscultation of the Fetal Heart in Labour - V1.pdf	Other	01/01/2021	01/01/2024		Executive Director of Nursing and Midwifery	Q1 2024/2025
Mat 54 - ROM Plus Point of Care Testing for Rupture of Membranes - Standard Operating Procedure - V1.pdf	Procedure	27/03/2020	27/03/2023	Niladri Sengupta (BCUHB - Obstetrics & Gynaecology);#4668	Executive Director of Nursing and Midwifery	Q1 2024/2025
Mat 56 - Shoulder Dystocia - V3.pdf	Guideline	01/07/2021	01/07/2024	Niladri Sengupta (BCUHB - Obstetrics & Gynaecology);#4668	Executive Director of Nursing and Midwifery	
Mat 58 - Swab, Instrument and Needle Count within Maternity Care Settings - V4.pdf	Guideline	01/03/2020	01/03/2023	Julie Reeve (BCUHB - Obstetrics & Gynaecology);#3309	Executive Director of Nursing and Midwifery	Q1 2024/2025
Mat 63 - Umbilical Cord Blood Collection for the Harvesting of Stem Cells - V3.pdf	Other	01/12/2020	01/12/2023	Bethan Evans (BCUHB - Maternity);#330	Executive Director of Nursing and Midwifery	Q1 2024/2025
Mat 70 - Neonatal Examination of the Newborn by Midwives - V3.pdf	Guideline	24/05/2019	01/06/2022	Meinir Clayton Evans (BCUHB - Maternity);#7119	Executive Director of Nursing and Midwifery	Q1 2024/2025
Mat 74 - BCUHB Breastfeeding Policy.pdf	Policy	01/12/2020	01/12/2023	Sharon Breward (BCUHB - Maternity);#7905	Executive Director of Nursing and Midwifery	Q1 2024/2025
Mat 75 - Healthy Term Babies who are Reluctant to Feed in the Early Postnatal Period - V6.pdf	Guideline	01/12/2020	01/12/2023	Sharon Breward (BCUHB - Maternity);#7905	Executive Director of Nursing and Midwifery	Q1 2024/2025
Mat 77 - Infant Feeding Guideline (Unicef Baby Friendly Care Standards) - V2.pdf	Guideline	01/12/2020	01/12/2023	Sharon Breward (BCUHB - Maternity);#7905	Executive Director of Nursing and Midwifery	Q1 2024/2025
Mat 79 - Breastfeeding Peer Supporters as Volunteers in BCUHB - V4.pdf	Guideline	01/07/2020	01/08/2023	Sharon Breward (BCUHB - Maternity);#7905	Executive Director of Nursing and Midwifery	Q1 2024/2025
Mat 80 - Antenatal Hand Expressing of Colostrum - V3.pdf	Guideline	01/12/2020	01/12/2023	Sharon Breward (BCUHB - Maternity);#7905	Executive Director of Nursing and Midwifery	Q1 2024/2025
Mat 82 - Handover of Care Guideline - V3.pdf	Guideline	01/02/2021	01/03/2024	Julie Reeve (BCUHB - Obstetrics & Gynaecology);#3309	Executive Director of Nursing and Midwifery	Q1 2024/2025
Mat 86 - Maternal Mental Health Guideline.pdf	Guideline	01/01/2020	01/01/2023		Executive Director of Nursing and Midwifery	Q1 2024/2025
Mat 86A - Perinatal Community Mental Health Service Referral Form - Read only.docx	Appendix	01/01/2020	01/01/2023	Amy Lewis (BCUHB - Mental Health & Learning Disabilities);#14292	Executive Director of Nursing and Midwifery	Q1 2024/2025
Mat 87 - Maternal Death Guideline - V3.pdf	Guideline	01/12/2020	01/12/2023	Heledd Jones (BCUHB - Maternity);#169	Executive Director of Nursing and Midwifery	Q1 2024/2025
Mat 88 - Perinatal Bereavement Guideline - V3.pdf	Guideline	29/06/2021	29/06/2024	Lucy Dobbins (BCUHB - Maternity);#7925	Executive Director of Nursing and Midwifery	
Mat 89 - Bereavement Follow Up Appointments following Pregnancy Loss - Standard Operating Procedure - V1.pdf	Procedure	01/11/2020	01/12/2023	Lucy Dobbins (BCUHB - Maternity);#7925	Executive Director of Nursing and Midwifery	Q1 2024/2025
Mat 91 - Preceptorship Protocol for Newly Registered Midwives - V3.pdf	Protocol	01/12/2020	01/12/2023	Becky Ferneyhough (BCUHB - Maternity);#67	Executive Director of Nursing and Midwifery	Q1 2024/2025

NST03 - Parenteral Nutrition Clinical Protocol for Adults.pdf	Protocol	13/04/2021	13/04/2024	Ruth Davies (BCUHB - Nursing, Midwifery & Patient Services);#255;#Jennifer Wykes (BCUHB - Nursing, Midwifery & Patient Services);#980	Executive Director of Nursing and Midwifery	Q1 2024/2025
NU10 - Urinary Catheterisation (Adults) Protocol - V0.1.pdf	Protocol	13/01/2016	12/01/2018	Lisa Borders (BCUHB - Continence Service);#257	Executive Director of Nursing and Midwifery	Q2 2024/2025
NU16 - Guidance for Alcohol Detoxification in ED & Adult Inpatient Wards.pdf	Other	01/10/2019	01/05/2024	Akwasi Mintah (BCUHB - Pharmacy);#116;#Syed Bokhari (BCUHB - Medicine);#117	Executive Director of Nursing and Midwifery	Q2 2024/2025
NU19 - Patient Transfer Procedure - V3.pdf	Procedure	03/07/2018	09/02/2024	Eleri Roberts (BCUHB - Community Hospitals);#26182	Executive Director of Nursing and Midwifery	Q2 2024/2025
NU21 - Levels of Enhanced Care for Adult Inpatients Policy.pdf	Policy	15/07/2019	08/12/2023	Tracey Harris (BCUHB - Patient Safety);#65	Executive Director of Nursing and Midwifery	Q2 2024/2025
OBS1-IAF18-001 - Protocol for Referral for CT of the Head from Nurses Working in a Stroke Specialist Role - V0.1.pdf	Protocol	11/06/2019	11/06/2021	Janet Michell (BCUHB - Corporate Office);#7368	Executive Director of Nursing and Midwifery	Q2 2024/2025
PTR01 - Complaints Policy and Procedure - V1.pdf	Policy	02/03/2022	02/03/2023	Mandy Jones (BCUHB - Corporate Office);#886	Executive Director of Nursing and Midwifery	Q2 2024/2025
PTR02 - Claims Management Policy.pdf	Policy	02/05/2013	05/06/2017	Matthew Joyes (BCUHB - Quality Directorate);#108	Executive Director of Nursing and Midwifery	Q2 2024/2025
PTR03 - BCU Being Open Policy.pdf	Policy	03/06/2016	01/05/2019	Matthew Joyes (BCUHB - Quality Directorate);#108	Executive Director of Nursing and Midwifery	Q2 2024/2025
SA08 - Ward Accreditation Guidance for Safeguarding Information Reports.pdf	Guideline	30/11/2020	01/11/2023	Angela Roberts (BCUHB - Safeguarding);#455;#Lynda Collier (BCUHB - Safeguarding);#464	Executive Director of Nursing and Midwifery	Q2 2024/2025
SCH18 - Coping with Crying Guidance - V2.pdf	Other	14/09/2020	14/09/2023	Anna Davies (BCUHB - Safeguarding);#5966	Executive Director of Nursing and Midwifery	Q1 2024/2025
SFHCC09 - Enable Individuals to Effectively Evacuate their Bowels.pdf	Other	01/07/2019	01/07/2021	Lisa Borders (BCUHB - Continence Service);#257	Executive Director of Nursing and Midwifery	Q2 2024/2025
Stroke Thrombolysis Protocol - V4.pdf	Protocol	08/09/2018	04/09/2021	Janet Michell (BCUHB - Corporate Office);#7368	Executive Director of Nursing and Midwifery	Q3 2024/2025

DEM_PHOT 01 - BCUHB Canllawiau Clinigol Phototherapi.pdf	Guideline	20/05/2021	20/05/2023	Sali Anderson (BCUHB - Dermatology);#8557;#Heidi Evans (BCUHB - Dermatology);#4531;#Glenda Hill (BCUHB - Dermatology);#26737;#Rebecca Leavesley (BCUHB - Dermatology);#4544;#Linda2 Roberts (BCUHB - Dermatology);#463;#Fiona Welsh (BCUHB - Physiotherapy);#10409;#Miriam Williams (BCUHB - Dermatology);#2968	Executive Director of Therapies and Health Sciences	Q2 2024/2025
DEM_PHOT 01 - BCUHB Phototherapy Guideline.pdf	Guideline	20/05/2021	20/05/2023	Sali Anderson (BCUHB - Dermatology);#8557;#Heidi Evans (BCUHB - Dermatology);#4531;#Linda2 Roberts (BCUHB - Dermatology);#463;#Fiona Welsh (BCUHB - Physiotherapy);#10409;#Miriam Williams (BCUHB - Dermatology);#2968;#Rebecca Leavesley (BCUHB - Dermatology);#4544	Executive Director of Therapies and Health Sciences	Q2 2024/2025
Early Identification & Management of In-Patients with Dysphagia - Appendix 2 - Training Presentation - V1.0.pdf	Appendix	13/04/2021	17/12/2021	Cara Spencer (BCUHB - Speech & Language Therapy);#72	Executive Director of Therapies and Health Sciences	Q4 2024/2025
Early Identification and Management of In-patients with Dysphagia Process.pdf	Other	13/04/2021	01/12/2023	Cara Spencer (BCUHB - Speech & Language Therapy);#72	Executive Director of Therapies and Health Sciences	Q4 2024/2025
OTD-01 - BCUHB Organ Donation Policy - V1.0.pdf	Policy	12/12/2019	12/12/2022	Helen Bullock (BCUHB - Anaesthetics);#21	Executive Director of Therapies and Health Sciences	
RP01 - Ionising Radiation Protection Policy - V4.pdf	Policy	07/09/2021	03/06/2024	Peter Hiles (BCUHB - North Wales Medical Physics (inc EBME));#23;#Julian Macdonald (BCUHB - North Wales Medical Physics (inc EBME));#24	Executive Director of Therapies and Health Sciences	Q2 2024/2025
RP01 - Polisi Diogelu Rhag Ymbelydredd Ïoneiddio – V4.pdf	Policy	07/09/2021	03/06/2024	Peter Hiles (BCUHB - North Wales Medical Physics (inc EBME));#23;#Julian Macdonald (BCUHB - North Wales Medical Physics (inc EBME));#24	Executive Director of Therapies and Health Sciences	Q2 2024/2025

SOP1 - Referral, Triage and Allocation process for Stroke Rehabilitation Pathway- Early Supported Discharge (ESD) & Stroke Specialist Inpatient Rehabilitation (SSIR).pdf	Procedure	14/02/2023	03/11/2023	Sushmita Mohapatra (BCUHB - Therapies & Health Science);#16332;#Karl Jackson (BCUHB - Stroke Unit);#1859;#Nia Williams (BCUHB - Stroke Unit);#12131	Executive Director of Therapies and Health Sciences	Q2 2024/2025
SOP2 - Early Supported Discharge Multi-Disciplinary Team process for Stroke Rehabilitation Pathway.pdf	Procedure	14/02/2023	03/11/2023	Sushmita Mohapatra (BCUHB - Therapies & Health Science);#16332;#Karl Jackson (BCUHB - Stroke Unit);#1859;#Nia Williams (BCUHB - Stroke Unit);#12131	Executive Director of Therapies and Health Sciences	Q2 2024/2025
SOP3 - Discharge process for Stroke Rehabilitation Pathway- Early Supported Discharge (ESD).pdf	Procedure	14/02/2023	03/11/2023	Sushmita Mohapatra (BCUHB - Therapies & Health Science);#16332;#Karl Jackson (BCUHB - Stroke Unit);#1859;#Nia Williams (BCUHB - Stroke Unit);#12131	Executive Director of Therapies and Health Sciences	Q2 2024/2025
SOP4 - Multi-Disciplinary Team (MDT) process for Stroke Rehabilitation Pathway- Stroke Specialist Inpatient Rehabilitation (SSIR).pdf	Procedure	14/02/2023	03/11/2023	Karl Jackson (BCUHB - Stroke Unit);#1859;#Nia Williams (BCUHB - Stroke Unit);#12131;#Sushmita Mohapatra (BCUHB - Therapies & Health Science);#16332	Executive Director of Therapies and Health Sciences	Q2 2024/2025
SOP5 - Discharge process for Stroke Rehabilitation Pathway- SSIR.pdf	Procedure	14/02/2023	03/11/2023	Sushmita Mohapatra (BCUHB - Therapies & Health Science);#16332;#Karl Jackson (BCUHB - Stroke Unit);#1859;#Nia Williams (BCUHB - Stroke Unit);#12131	Executive Director of Therapies and Health Sciences	Q2 2024/2025
F17 - Appendix Revenue Business Case.pdf	Appendix	24/10/2019	24/10/2022	Ian Howard (BCUHB - Planning);#44	Executive Director of Transformation and Planning	Q4 2024/2025
F017 - Revenue Business Case Policy Approved.pdf	Policy	24/10/2019	24/10/2022	Ian Howard (BCUHB - Planning);#44	Executive Director of Transformation, Strategic Planning and Commissioning	Q4 2024/2025
Promoting Appropriate Behaviour Policy .pdf	Policy	24/11/2017	01/12/2020		Executive Director of Transformation, Strategic Planning and Commissioning	
All Wales Procedure for Addressing Concerns about Capability, Performance and Conduct of Doctors and Dentists - Upholding Professional Standards in Wales.pdf	Procedure	01/08/2015	01/08/2018		Executive Director of Workforce and Organisational Development	
Corporate Health & Safety Guidance on the Control of Noise in the Workplace - V7.pdf	Other	01/04/2021	01/04/2024		Executive Director of Workforce and Organisational Development	

[Corporate Health, Safety & Security Guidance - V2.pdf](#)	Other	16/07/2021	16/07/2024		Executive Director of Workforce and Organisational Development	
[HS01 - Occupational Health and Safety Policy.pdf](#)	Policy	09/12/2021	09/12/2023	Peter Bohan (BCUHB - Corporate Office);#1613	Executive Director of Workforce and Organisational Development	
[HS01 - Polisi Iechyd a Diogelwch Galwedigaethol.pdf](#)	Policy	09/12/2020	09/12/2023	Peter Bohan (BCUHB - Corporate Office);#1613	Executive Director of Workforce and Organisational Development	
[HS02 - Protecting Employees from Violence & Aggression - V2.pdf](#)	Other	01/03/2021	01/03/2024	Susan Morgan (BCUHB - Health & Safety);#1542;#David Baker (BCUHB - Health & Safety);#546	Executive Director of Workforce and Organisational Development	
[HS03 - General Risk Assessment Procedure - V2.pdf](#)	Procedure	01/03/2021	01/07/2021		Executive Director of Workforce and Organisational Development	
[HS03a - Appendices 1-6 Risk Assessment Forms - Read Only.doc](#)	Appendix	01/03/2021	01/07/2021		Executive Director of Workforce and Organisational Development	
[HS04 - Procedure Guidance Workplace Health, Safety & Welfare - V1.pdf](#)	Procedure	01/06/2017	01/07/2021		Executive Director of Workforce and Organisational Development	
[HS09 - Control of Noise at Work Procedure.pdf](#)	Procedure	01/01/2021	01/01/2023	Clare Jones (BCUHB - Health & Safety);#1544	Executive Director of Workforce and Organisational Development	
[HS10 - Guidance on Safe Management of Vibration - V1.pdf](#)	Guideline	01/07/2017	01/07/2020		Executive Director of Workforce and Organisational Development	
[HS13 - Appendix 1 - COSHH Risk Assessment Form - Read Only.doc](#)	Appendix	01/02/2021	01/07/2021		Executive Director of Workforce and Organisational Development	
[HS13 - Appendix 2 - Inventory of Hazardous Substance Form - Read Only.doc](#)	Appendix	01/02/2021	01/07/2021		Executive Director of Workforce and Organisational Development	
[HS13 - Appendix 3 - COSHH Inventory Checklist - Read Only.doc](#)	Appendix	01/02/2021	01/07/2021		Executive Director of Workforce and Organisational Development	
[HS17 - Appendix 1 - Display Screen Equipment Self Assessment Checklist - Read Only.doc](#)	Appendix	01/06/2018	01/06/2020	Clare Jones (BCUHB - Health & Safety);#1544	Executive Director of Workforce and Organisational Development	
[HS17 - Appendix 2 - Display Screen User Eyesight Test Request Form - Read Only.doc](#)	Appendix	01/06/2018	01/06/2020	Clare Jones (BCUHB - Health & Safety);#1544	Executive Director of Workforce and Organisational Development	
[HS17 - Appendix 5 - Display Screen Equipment Assessment Action Plan - Read Only.doc](#)	Appendix	01/06/2018	01/06/2020	Clare Jones (BCUHB - Health & Safety);#1544	Executive Director of Workforce and Organisational Development	
[HS17 - Procedure & Guidance Document for Display Screen Equipment Use - V1.pdf](#)	Procedure	01/06/2018	01/06/2020	Clare Jones (BCUHB - Health & Safety);#1544	Executive Director of Workforce and Organisational Development	
[HS19 - Staff Health Surveillance Screening Procedure - V0.2.pdf](#)	Procedure	10/03/2020	10/01/2023	Peter Bohan (BCUHB - Corporate Office);#1613	Executive Director of Workforce and Organisational Development	
[ISU03 - Volunteering Policy - V0.1.pdf](#)	Policy	09/12/2014	12/01/2017	Susan Marriott (BCUHB - Workforce & Organisational Development);#40;#Joy Lloyd (BCUHB - Workforce & Organisational Development);#4399	Executive Director of Workforce and Organisational Development	
[NHS Wales Social Media Policy - V0.10.pdf](#)	Policy	07/01/2016	07/01/2018		Executive Director of Workforce and Organisational Development	
[OHW02 - Staff Health and Wellbeing Guidelines - V0.1.pdf](#)	Guideline	01/10/2017	01/10/2020	Christina Billingham (BCUHB - Child & Adolescent Health);#240	Executive Director of Workforce and Organisational Development	Q4 2024/2025

Organisational Change Policy - Appendix 5 - Redeployment - V12 (20-12-16) Final.pdf	Appendix	23/03/2017	23/03/2020		Executive Director of Workforce and Organisational Development	
Organisational Change Policy - All Wales - V14 (20-12-16) - Final.pdf	Policy	23/03/2017	01/03/2020		Executive Director of Workforce and Organisational Development	
Safe Use of Step Ladders and Kick Stools - V7.pdf	Other	01/04/2021	01/04/2024		Executive Director of Workforce and Organisational Development	
SOP for Cleaning & Disinfection of JSP Force 8 Corpro Respirator Half Mask with Filters - V1.02.pdf	Procedure	04/06/2020	31/05/2022		Executive Director of Workforce and Organisational Development	
The NHS Wales Policy to ensure consistency of National Terms and Conditions (AFC) band outcomes following Merger of organisations.pdf	Policy	01/07/2013	01/07/2016		Executive Director of Workforce and Organisational Development	
WP11 - NHS Wales Managing Attendance at Work Policy - V0.1.pdf	Policy	01/10/2018	01/10/2021		Executive Director of Workforce and Organisational Development	
WP11 - Phased Return - Welsh Appendix 1 - WP11 - NHS Wales Managing Attendance at Work Policy.dotx	Appendix	01/10/2018	01/10/2021		Executive Director of Workforce and Organisational Development	
WP11 - Phased Return - English Appendix 1 - WP11 - NHS Wales Managing Attendance at Work Policy - V0.1.dotx	Appendix	01/10/2018	01/10/2021		Executive Director of Workforce and Organisational Development	
WP11 - Return to Work Tool (Word) - English - Read only.docx	Appendix	01/10/2018	01/10/2021		Executive Director of Workforce and Organisational Development	
WP11 - Return to Work Tool (Word) - Ffurflen Gymraeg - Read only.docx	Appendix	01/10/2018	01/10/2021		Executive Director of Workforce and Organisational Development	
WP12 - Orientation Appendices - V2b.pdf	Appendix	01/06/2019	01/04/2022		Executive Director of Workforce and Organisational Development	Q1 2024/2025
WP14 - Forms Final v5 - Read Only.doc	Appendix	01/03/2015	01/04/2016		Executive Director of Workforce and Organisational Development	Q4 2024/2025
WP14a - Interim Protocol on Pay While Undertaking Jury Service and the Recovery of Loss of Earnings - V1.pdf	Protocol	01/03/2015	01/04/2016		Executive Director of Workforce and Organisational Development	Q4 2024/2025
WP14b - All Wales Special Leave Policy English - V3.pdf	Policy	01/12/2020	01/12/2023		Executive Director of Workforce and Organisational Development	
WP14b - All Wales Special Leave Policy Cymru -December 2020.pdf	Policy	01/12/2020	01/12/2023		Executive Director of Workforce and Organisational Development	
WP14b - Special Leave Application Form - English version - Read only.docx	Appendix	01/12/2020	01/12/2023		Executive Director of Workforce and Organisational Development	
WP14b - Special Leave Application Form - Fersiwn Cymraeg - Read only.docx	Appendix	01/12/2020	01/12/2023		Executive Director of Workforce and Organisational Development	
WP14c - Appendix 4 - Examples of Shared Parental Leave (Dec.pdf	Appendix	01/12/2015	01/12/2018	Christina Billingham (BCUHB - Child & Adolescent Health);#240	Executive Director of Workforce and Organisational Development	Q4 2024/2025
WP14c - Appendix 5 - Shared Parental Leave FAQ's (Dec15).pdf	Appendix	01/12/2015	01/12/2018	Christina Billingham (BCUHB - Child & Adolescent Health);#240	Executive Director of Workforce and Organisational Development	Q1 2024/2025
WP14c - BCU Shared Parental Leave Procedure Final v1 (Dec15).pdf	Procedure	01/12/2015	01/12/2018	Christina Billingham (BCUHB - Child & Adolescent Health);#240	Executive Director of Workforce and Organisational Development	Q4 2024/2025

WP14c Appendix 1 - Curtailment Notice of Maternity-Adoption Leave Curtailment Notice - Read Only.docx	Appendix	01/12/2015	01/12/2018		Executive Director of Workforce and Organisational Development	Q4 2024/2025
WP14c Appendix 2 - Shared Parental Leave Application Form - Read Only.docx	Appendix	01/12/2015	01/12/2018		Executive Director of Workforce and Organisational Development	Q4 2024/2025
WP14c Appendix 3-Variation of Period of Leave Notice Form - Read Only.docx	Appendix	01/12/2015	01/12/2018		Executive Director of Workforce and Organisational Development	Q4 2024/2025
WP15 - BCUHB Partnership and Recognition Agreement - V1.pdf	Other	01/02/2010	01/04/2011		Executive Director of Workforce and Organisational Development	Q4 2024/2025
WP1a BCUHB Safe Recruitment Practices Guidelines - Final - V4.0.pdf	Guideline	01/04/2013	01/03/2016		Executive Director of Workforce and Organisational Development	
WP1b - Appendix A Application for Release on Secondment Extension (Cymraeg).dotx	Appendix	02/08/2021	01/07/2024	Llinos Jones (BCUHB - Workforce & Organisational Development);#1813	Executive Director of Workforce and Organisational Development	
WP1b - Appendix A Application for Release on Secondment Extension (English).dotx	Appendix	02/08/2021	01/07/2024	Llinos Jones (BCUHB - Workforce & Organisational Development);#1813	Executive Director of Workforce and Organisational Development	
WP1b - Appendix B Secondment Agreement Forms (Cymraeg).dotx	Appendix	02/08/2021	01/07/2024	Llinos Jones (BCUHB - Workforce & Organisational Development);#1813	Executive Director of Workforce and Organisational Development	
WP1b - Appendix B Secondment Agreement Forms (English).dotx	Appendix	02/08/2021	01/07/2024	Llinos Jones (BCUHB - Workforce & Organisational Development);#1813	Executive Director of Workforce and Organisational Development	
WP1b - NHS Wales Secondment Policy - English.pdf	Policy	01/07/2021	01/07/2024		Executive Director of Workforce and Organisational Development	
WP1b - Polisi Secondiad GIG Cymru .pdf	Policy	02/08/2021	01/07/2024	Llinos Jones (BCUHB - Workforce & Organisational Development);#1813	Executive Director of Workforce and Organisational Development	
WP2 - Retirement Policy Procedure Forms - V4 - Read only.docx	Appendix	01/11/2015	01/11/2021		Executive Director of Workforce and Organisational Development	Q4 2024/2025
WP2 - Retirement Policy Procedure - V6 .pdf	Procedure	01/11/2015	01/11/2021		Executive Director of Workforce and Organisational Development	Q4 2024/2025
WP21 - Appendices - Working Time Procedure V3 - Read only.doc	Appendix	01/03/2015	01/03/2018	Llinos Jones (BCUHB - Workforce & Organisational Development);#1813	Executive Director of Workforce and Organisational Development	Q1 2024/2025
WP21 - Working Time Procedure.pdf	Procedure	01/03/2015	01/03/2018	Llinos Jones (BCUHB - Workforce & Organisational Development);#1813	Executive Director of Workforce and Organisational Development	Q1 2024/2025
WP21a - Entitlement to Breaks for All NHS Staff covered by A4C Under review.pdf	Procedure	01/03/2015	01/03/2018		Executive Director of Workforce and Organisational Development	Q4 2024/2025
WP21b - BCUHB Working Time Procedure Forms Final v1 (April 14).pdf	Appendix	01/03/2015	01/03/2018		Executive Director of Workforce and Organisational Development	Q1 2024/2025
WP22 - BCU Mufti Allowance Procedure - Final v1 (Oct14).pdf	Procedure	01/10/2014	01/10/2017		Executive Director of Workforce and Organisational Development	Q1 2024/2025
WP22 - Mufti Allowance Procedure Forms Final v1(Oct14).pdf	Appendix	01/10/2014	01/10/2017		Executive Director of Workforce and Organisational Development	Q1 2024/2025
WP23-BCUHB Procedure for Checking of Registrations & Qualifications V3.pdf	Procedure	01/11/2015	01/10/2018		Executive Director of Workforce and Organisational Development	Q4 2024/2025
WP24b - BCUHB Gateway Protocol for the NHS Knowledge & Skills Framework- V1.pdf	Protocol	12/09/2013	01/10/2014		Executive Director of Workforce and Organisational Development	Q4 2024/2025

Name	Type	Start Date	End Date	Author	Owner	Review
WP24c - PADR Form - V1 - Read Only.docx	Appendix	01/12/2017	01/12/2020	Nia Thomas (BCUHB - Workforce & Organisational Development);#638	Executive Director of Workforce and Organisational Development	Q1 2024/2025
WP26 - Job Evaluation Processes.pdf	Procedure	01/10/2021	01/12/2023	Alex Tapley (BCUHB - Workforce & Organisational Development);#10915	Executive Director of Workforce and Organisational Development	Q1 2024/2025
WP27c - Managing Attendance at Work Reasonable Tailored Adjustments - Read Only.docx	Appendix	29/08/2019	01/05/2022		Executive Director of Workforce and Organisational Development	Q1 2024/2025
WP29 - BCU Relocation Expenses Policy V0.3.pdf	Policy	05/12/2016	05/12/2019	Karen Walker (BCUHB - Workforce & Organisational Development);#573	Executive Director of Workforce and Organisational Development	Q4 2024/2025
WP2b - BCUHB Options for staff considering accessing their NHS pension and continuing working in the Health Board - V1 .pdf	Other	01/11/2013	01/11/2021		Executive Director of Workforce and Organisational Development	Q4 2024/2025
WP30 - Statutory Mandatory Training Policy and Procedure - V0.3.pdf	Policy	22/03/2016	01/02/2022	Tracey Eccles (BCUHB - Workforce & Organisational Development);#236	Executive Director of Workforce and Organisational Development	Q1 2024/2025
WP33 - Stress Risk Assessment.Read onlydocx.docx	Appendix	20/09/2016	20/09/2019		Executive Director of Workforce and Organisational Development	Q4 2024/2025
WP33a - Appendix 3 - Wellness Action Plan - Read Only.docx	Appendix	20/09/2016	20/09/2019	Steve Cottrell (Public Health Wales);#233;#Helene North (BCUHB - Occupational Health);#234	Executive Director of Workforce and Organisational Development	Q4 2024/2025
WP33b - Appendix 3 - Wellness Action Plan - Welsh - Read Only.docx	Appendix	20/09/2016	20/09/2019	Steve Cottrell (Public Health Wales);#233;#Helene North (BCUHB - Occupational Health);#234	Executive Director of Workforce and Organisational Development	Q4 2024/2025
WP36 - Appendix B Flexi Time Attendance Record Sheet - V1.xls	Appendix	01/02/2014	01/11/2016		Executive Director of Workforce and Organisational Development	Q4 2024/2025
WP38 - Reserve Forces - Training and Mobilisation Policy - Cymraeg.pdf	Policy	01/03/2020	01/03/2022		Executive Director of Workforce and Organisational Development	
WP38 - Reserve Forces - Training and Mobilisation Policy .pdf	Policy	01/03/2020	01/03/2022		Executive Director of Workforce and Organisational Development	
WP3a - Capability Forms - V2 - Read only.docx	Appendix	01/07/2018	01/06/2021		Executive Director of Workforce and Organisational Development	
WP3a - Capability Policy - V21.pdf	Policy	01/07/2018	01/06/2021		Executive Director of Workforce and Organisational Development	
WP3a - Polisi a Threfn Galluogrwydd.pdf	Policy	01/07/2018	01/06/2021	Llinos Jones (BCUHB - Workforce & Organisational Development);#1813	Executive Director of Workforce and Organisational Development	
WP40 - All Wales Employment Break Scheme 01.2020.pdf	Policy	01/01/2020	01/01/2022		Executive Director of Workforce and Organisational Development	
WP40 -All Wales Employment Break Scheme 01.2020 Cymru.pdf	Policy	01/01/2020	01/01/2022		Executive Director of Workforce and Organisational Development	
WP41 - Protocol Taliadau Recriwtio a Chadw Rhag 2020.pdf	Protocol	01/12/2020	01/12/2023		Executive Director of Workforce and Organisational Development	Q2 2024/2025
WP41 - Recruitment and Retention Payment Protocol - V3.pdf	Protocol	01/11/2020	01/11/2023		Executive Director of Workforce and Organisational Development	Q2 2024/2025

WP42 - Guidance on Dealing with Hate Incidents Crimes Against BCUHB Staff.pdf	Guideline	01/08/2021	01/06/2024	Nick Such (BCUHB - Workforce & Organisational Development);#180;#David Baker (BCUHB - Health & Safety);#546	Executive Director of Workforce and Organisational Development	Q4 2024/2025
WP46 - Appendix A (Additional Annual Leave Purchase Scheme - Record of hours).xls.xls	Appendix	01/07/2018	01/08/2021		Executive Director of Workforce and Organisational Development	Q2 2024/2025
WP46 - BCU Additional Annual Leave Purchase Scheme Procedure - V4.pdf	Procedure	01/07/2018	01/08/2021		Executive Director of Workforce and Organisational Development	Q4 2024/2025
WP47 - BCUHB Telephone Line Rental Procedure - V1.pdf	Procedure	01/06/2015	01/04/2018	Claire Waddicor-Evans (BCUHB - Transformation & Improvement);#575	Executive Director of Workforce and Organisational Development	Q1 2024/2025
WP49 - All Wales Pay Progression Policy (Cymraeg).pdf	Policy	01/01/2020	01/01/2021		Executive Director of Workforce and Organisational Development	
WP49 - NHS Wales Pay Progression Policy - V2.pdf	Policy	01/01/2020	01/01/2021		Executive Director of Workforce and Organisational Development	
WP4A - Procedure for NHS Staff to Raise Concerns - V5.pdf	Procedure	01/06/2021	01/06/2024		Executive Director of Workforce and Organisational Development	
WP5 - All Wales Respect and Resolution Policy - V1.pdf	Policy	01/04/2021	01/05/2024		Executive Director of Workforce and Organisational Development	
WP5 - Respect and Resolution Policy FINAL April 2021 - Cymraeg.pdf	Policy	01/04/2021	01/04/2024		Executive Director of Workforce and Organisational Development	
WP52 - Study Leave Policy - (Applies to all staff apart from Medical & Dental) - V0.2.pdf	Policy	11/04/2016	01/01/2018	Nia Thomas (BCUHB - Workforce & Organisational Development);#638	Executive Director of Workforce and Organisational Development	Q4 2024/2025
WP54 - Appendix 1 - Study Leave Application Form - Read Only.docx	Appendix	11/04/2018	01/01/2018	Nia Thomas (BCUHB - Workforce & Organisational Development);#638	Executive Director of Workforce and Organisational Development	Q4 2024/2025
WP54 - Study Leave Process (Applies to all staff apart from Medical & Dental) - V0.2.pdf	Other	11/04/2016	01/01/2018	Nia Thomas (BCUHB - Workforce & Organisational Development);#638	Executive Director of Workforce and Organisational Development	Q4 2024/2025
WP56 - Procedure for the Management of the Larger Person.pdf	Procedure	01/02/2016	01/06/2020	Tracey Eccles (BCUHB - Workforce & Organisational Development);#236	Executive Director of Workforce and Organisational Development	
WP58 - Electronic Staff Record (ESR) System Policy - V0.1.pdf	Policy	01/05/2016	01/06/2019		Executive Director of Workforce and Organisational Development	Q3 2024/2025
WP59 - Personal Employee Record Management Procedure - V0.1.pdf	Procedure	01/10/2017	01/10/2020		Executive Director of Workforce and Organisational Development	Q3 2024/2025
WP60 - Exit Interview Procedure & Questionnaire V7.1 - Read only.doc	Procedure	12/11/2018	01/10/2020	Angela Johnson (BCUHB - Workforce & Organisational Development);#14093	Executive Director of Workforce and Organisational Development	Q4 2024/2025
WP60 - Guidance for Exit Interview Flow Chart - V7.1.pdf	Appendix	12/11/2018	01/10/2020	Angela Johnson (BCUHB - Workforce & Organisational Development);#14093	Executive Director of Workforce and Organisational Development	Q4 2024/2025
WP61 - Unpaid Carers Leave Policy - V1.0.pdf	Policy	01/10/2017	01/06/2019		Executive Director of Workforce and Organisational Development	Q4 2024/2025
WP62 - BCUHB Dress Code Guidelines.pdf	Guideline	22/07/2021	22/07/2024	Anne-Marie Rowlands (BCUHB - Corporate Nursing);#56;#Jacqueline Hughes (BCUHB - Radiology);#294	Executive Director of Workforce and Organisational Development	

WP62 - Canllawiau Cod Gwisg BIPBC.pdf	Guideline	22/07/2021	22/07/2024	Anne-Marie Rowlands (BCUHB - Corporate Nursing);#56;#Jacqueline Hughes (BCUHB - Radiology);#294	Executive Director of Workforce and Organisational Development	
WP66 - All Wales Menopause Policy - Cymraeg (1).pdf	Policy	01/12/2018	01/12/2021		Executive Director of Workforce and Organisational Development	
WP66 - NHS Wales Menopause Policy - V1 .pdf	Policy	01/12/2018	01/12/2021		Executive Director of Workforce and Organisational Development	
WP9 - Disciplinary Policy - Cymraeg.pdf	Policy	01/11/2015	01/03/2022	Llinos Jones (BCUHB - Workforce & Organisational Development);#1813	Executive Director of Workforce and Organisational Development	
WP9 - Disciplinary Policy.pdf	Policy	01/11/2015	01/03/2020		Executive Director of Workforce and Organisational Development	
All Wales - Upholding Professional Standards in Wales - 2015.pdf	Other	01/08/2015	01/08/2018		Executive Medical Director	
B01 - Sponsorship of Research - Health Research - Standard Operating Procedure.pdf	Procedure	14/04/2022	14/04/2024	Lona Tudor Jones (BCUHB - Research & Development);#27	Executive Medical Director	Q1 2024/2025
B02 - Risk Assessment of Health Research - Health Research - Standard Operating Procedure.pdf	Procedure	14/07/2021	14/04/2024	Lona Tudor Jones (BCUHB - Research & Development);#27	Executive Medical Director	Q1 2024/2025
B05 - Identifying Participants in Clinical Trials – Patient Medical Casenotes - Health Research - Standard Operating Procedure.pdf	Procedure	14/04/2022	14/04/2024	Lona Tudor Jones (BCUHB - Research & Development);#27	Executive Medical Director	Q1 2024/2025
Guidance on Administration of End of Life Care Medications if no Syringe Pumps Available - Covid-19 Response (to be read with MM58).pdf	Other	24/04/2020	24/04/2022	Jenny Sparks (BCUHB - Pharmacy);#351;#Elin Gwyn (BCUHB - Pharmacy and Medicines Management);#352	Executive Medical Director	
Guidance on Intravenous Fluid Prescribing for Adults in Hospital & Community Setting - V1.pdf	Guideline	01/12/2019	01/12/2022	Catrin Roberts (BCUHB - Pharmacy);#106	Executive Medical Director	Q4 2024/2025
HCSW SOP Administration of Ear Drops.pdf	Procedure	29/11/2019	29/11/2022	Lisa Morris (BCUHB - Pharmacy and Medicines Management);#444;#Suzanne Kenyon (BCUHB - Pharmacy);#10258;#Jackie Jones (BCUHB - Pharmacy and Medicines Management);#7412;#Amy Reynolds (BCUHB - Pharmacy and Medicines Management);#43178	Executive Medical Director	Q4 2024/2025
HCSW SOP Administration of Enemas and Suppositories.pdf	Procedure	29/11/2019	29/11/2022	Lisa Morris (BCUHB - Pharmacy and Medicines Management);#444;#Suzanne Kenyon (BCUHB - Pharmacy);#10258;#Jackie Jones (BCUHB - Pharmacy and Medicines Management);#7412;#Amy Reynolds (BCUHB - Pharmacy and Medicines Management);#43178	Executive Medical Director	Q4 2024/2025

[HCSW SOP Administration of Eye Drops.pdf](#)	Procedure	29/11/2019	29/11/2022	Lisa Morris (BCUHB - Pharmacy and Medicines Management);#444;#Suzanne Kenyon (BCUHB - Pharmacy);#10258;#Jackie Jones (BCUHB - Pharmacy and Medicines Management);#7412;#Amy Reynolds (BCUHB - Pharmacy and Medicines Management);#43178	Executive Medical Director	Q4 2024/2025
[HCSW SOP Administration of Inhalers.pdf](#)	Procedure	29/11/2019	29/11/2022	Lisa Morris (BCUHB - Pharmacy and Medicines Management);#444;#Suzanne Kenyon (BCUHB - Pharmacy);#10258;#Jackie Jones (BCUHB - Pharmacy and Medicines Management);#7412;#Amy Reynolds (BCUHB - Pharmacy and Medicines Management);#43178	Executive Medical Director	Q4 2024/2025
[HCSW SOP Administration of LMWH.pdf](#)	Procedure	04/12/2019	01/11/2022	Lisa Morris (BCUHB - Pharmacy and Medicines Management);#444;#Suzanne Kenyon (BCUHB - Pharmacy);#10258;#Jackie Jones (BCUHB - Pharmacy and Medicines Management);#7412;#Amy Reynolds (BCUHB - Pharmacy and Medicines Management);#43178	Executive Medical Director	Q4 2024/2025
[HCSW SOP Administration of Nebules.pdf](#)	Procedure	29/11/2019	29/11/2022	Lisa Morris (BCUHB - Pharmacy and Medicines Management);#444;#Suzanne Kenyon (BCUHB - Pharmacy);#10258;#Jackie Jones (BCUHB - Pharmacy and Medicines Management);#7412;#Amy Reynolds (BCUHB - Pharmacy and Medicines Management);#43178	Executive Medical Director	Q4 2024/2025

[HCSW SOP Administration of Non Medicated Topicals.pdf](#)	Procedure	29/11/2019	29/11/2022	Lisa Morris (BCUHB - Pharmacy and Medicines Management);#444;#Suzanne Kenyon (BCUHB - Pharmacy);#10258;#Jackie Jones (BCUHB - Pharmacy and Medicines Management);#7412;#Amy Reynolds (BCUHB - Pharmacy and Medicines Management);#43178	Executive Medical Director	Q4 2024/2025
[HCSW SOP Administration of Nose Drops.pdf](#)	Procedure	29/11/2019	29/11/2022	Lisa Morris (BCUHB - Pharmacy and Medicines Management);#444;#Suzanne Kenyon (BCUHB - Pharmacy);#10258;#Jackie Jones (BCUHB - Pharmacy and Medicines Management);#7412;#Amy Reynolds (BCUHB - Pharmacy and Medicines Management);#43178	Executive Medical Director	Q4 2024/2025
[HCSW SOP Administration of Oral Medicines.pdf](#)	Procedure	29/11/2019	29/11/2022	Lisa Morris (BCUHB - Pharmacy and Medicines Management);#444;#Suzanne Kenyon (BCUHB - Pharmacy);#10258;#Jackie Jones (BCUHB - Pharmacy and Medicines Management);#7412;#Amy Reynolds (BCUHB - Pharmacy and Medicines Management);#43178	Executive Medical Director	Q4 2024/2025
[HCSW SOP Administration of Oxygen.pdf](#)	Procedure	29/11/2019	29/11/2022	Lisa Morris (BCUHB - Pharmacy and Medicines Management);#444;#Suzanne Kenyon (BCUHB - Pharmacy);#10258;#Jackie Jones (BCUHB - Pharmacy and Medicines Management);#7412;#Amy Reynolds (BCUHB - Pharmacy and Medicines Management);#43178	Executive Medical Director	Q4 2024/2025

HCSW SOP Administration Removal and Disposal Transdermal Patches.pdf	Procedure	29/11/2019	29/11/2022	Lisa Morris (BCUHB - Pharmacy and Medicines Management);#444;#Suzanne Kenyon (BCUHB - Pharmacy);#10258;#Jackie Jones (BCUHB - Pharmacy and Medicines Management);#7412;#Amy Reynolds (BCUHB - Pharmacy and Medicines Management);#43178	Executive Medical Director	Q4 2024/2025
HCSW SOP Gastrostomy Administration of Medication.pdf	Procedure	29/11/2019	29/11/2022	Lisa Morris (BCUHB - Pharmacy and Medicines Management);#444;#Suzanne Kenyon (BCUHB - Pharmacy);#10258;#Jackie Jones (BCUHB - Pharmacy and Medicines Management);#7412;#Amy Reynolds (BCUHB - Pharmacy and Medicines Management);#43178	Executive Medical Director	Q4 2024/2025
HCSW SOP Ordering Stock Medication.pdf	Procedure	29/11/2019	29/11/2022	Lisa Morris (BCUHB - Pharmacy and Medicines Management);#444;#Suzanne Kenyon (BCUHB - Pharmacy);#10258;#Jackie Jones (BCUHB - Pharmacy and Medicines Management);#7412;#Amy Reynolds (BCUHB - Pharmacy and Medicines Management);#43178	Executive Medical Director	Q4 2024/2025
HCSW SOP Removal and Disposal of Subcut Infusions.pdf	Procedure	29/11/2019	29/11/2022	Lisa Morris (BCUHB - Pharmacy and Medicines Management);#444;#Suzanne Kenyon (BCUHB - Pharmacy);#10258;#Jackie Jones (BCUHB - Pharmacy and Medicines Management);#7412;#Amy Reynolds (BCUHB - Pharmacy and Medicines Management);#43178	Executive Medical Director	Q4 2024/2025

[HCSW SOP Second Check of Insulin Administration.pdf](#)	Procedure	29/11/2019	29/11/2022	Lisa Morris (BCUHB - Pharmacy and Medicines Management);#444;#Suzanne Kenyon (BCUHB - Pharmacy);#10258;#Jackie Jones (BCUHB - Pharmacy and Medicines Management);#7412;#Amy Reynolds (BCUHB - Pharmacy and Medicines Management);#43178	Executive Medical Director	Q4 2024/2025
[HCSW SOP Second Check of Oral CDs in Community Hospitals.pdf](#)	Procedure	29/11/2019	29/11/2022	Lisa Morris (BCUHB - Pharmacy and Medicines Management);#444;#Suzanne Kenyon (BCUHB - Pharmacy);#10258;#Jackie Jones (BCUHB - Pharmacy and Medicines Management);#7412;#Amy Reynolds (BCUHB - Pharmacy and Medicines Management);#43178	Executive Medical Director	Q4 2024/2025
[HCSW SOP Second Checker of CD Stock Levels.pdf](#)	Procedure	29/11/2019	29/11/2022	Lisa Morris (BCUHB - Pharmacy and Medicines Management);#444;#Suzanne Kenyon (BCUHB - Pharmacy);#10258;#Jackie Jones (BCUHB - Pharmacy and Medicines Management);#7412;#Amy Reynolds (BCUHB - Pharmacy and Medicines Management);#43178	Executive Medical Director	Q4 2024/2025
[HCSW SOP Second Checker SC Fluids (No Additives).pdf](#)	Procedure	29/11/2019	29/11/2022	Lisa Morris (BCUHB - Pharmacy and Medicines Management);#444;#Suzanne Kenyon (BCUHB - Pharmacy);#10258;#Jackie Jones (BCUHB - Pharmacy and Medicines Management);#7412;#Amy Reynolds (BCUHB - Pharmacy and Medicines Management);#43178	Executive Medical Director	Q4 2024/2025

HCSW SOP Storage Meds in Automated Cupboard.pdf	Procedure	29/11/2019	29/11/2022	Lisa Morris (BCUHB - Pharmacy and Medicines Management);#444;#Suzanne Kenyon (BCUHB - Pharmacy);#10258;#Jackie Jones (BCUHB - Pharmacy and Medicines Management);#7412;#Amy Reynolds (BCUHB - Pharmacy and Medicines Management);#43178	Executive Medical Director	Q4 2024/2025
MD09 - Medical & Dental Staff - Sabbatical Leave Policy - V0.2.pdf	Policy	31/03/2017	31/03/2018	James Risley (BCUHB - Office of the Medical Director);#42614;#Joanne Shillingford (BCUHB - Office of the Medical Director);#7797	Executive Medical Director	Q2 2024/2025
MD10 - Medical & Dental Staff Study Leave Policy - V0.1.pdf	Policy	20/10/2014	20/10/2017	James Risley (BCUHB - Office of the Medical Director);#42614;#Joanne Shillingford (BCUHB - Office of the Medical Director);#7797	Executive Medical Director	
MD11 - Medical & Dental Staff Professional Leave Policy - V0.1.pdf	Policy	20/10/2014	20/10/2017	James Risley (BCUHB - Office of the Medical Director);#42614;#Joanne Shillingford (BCUHB - Office of the Medical Director);#7797	Executive Medical Director	
MD13 - Annual Leave & Special Leave Policy for Medical & Dental Staff - V0.1.pdf	Policy	20/10/2014	20/10/2017	James Risley (BCUHB - Office of the Medical Director);#42614;#Joanne Shillingford (BCUHB - Office of the Medical Director);#7797	Executive Medical Director	
MD14 - Private Practice Policy - V0.1.pdf	Policy	27/07/2016	27/07/2018	James Risley (BCUHB - Office of the Medical Director);#42614	Executive Medical Director	
MD17 - Interventions Not Normally Undertaken (INNU) Policy - V1.1.pdf	Policy	24/07/2018	01/09/2021	Mark Walker (BCUHB - Corporate Office);#144;#Robert Atenstaedt (BCUHB - Public Health);#145;#Sarah Davies (BCUHB - Office of the Medical Director);#146;#Jill Newman (BCUHB - Performance Directorate);#147	Executive Medical Director	
MD21 - NHS Wales Policy on Making Decisions on Individual Patient Funding Requests (IPFR).pdf	Policy	01/06/2017	01/06/2020	Ann-Marie Matthews (Aneurin Bevan UHB - Medical Directors Office);#118	Executive Medical Director	Q4 2024/2025
MD23 - Procedure to Mitigate the Risks due to Failure to Act on Diagnostic Results - V1.pdf	Procedure	10/08/2016	15/08/2018	Conor Corr (BCUHB - Radiology);#61	Executive Medical Director	
MD24 - Recognition of Life Extinct for Adults in the Community - V1.0.pdf	Guideline	10/07/2020	10/07/2021	Melanie Maxwell (BCUHB - Office of the Medical Director);#119	Executive Medical Director	
MM01 - BCUHB Medicines Policy.pdf	Policy	18/03/2019	11/07/2022	Judith Green (BCUHB - Pharmacy);#344	Executive Medical Director	Q4 2024/2025

Document	Type	Date 1	Date 2	Author	Owner	Review
MM02 - Injectable Medicines Policy.pdf	Policy	08/07/2019	08/07/2022	Andrew Merriman (BCUHB - Pharmacy);#39	Executive Medical Director	Q4 2024/2025
MM05 - Intrathecal Chemotherapy Policy - V3.pdf	Policy	07/03/2018	01/03/2021	Andrew Merriman (BCUHB - Pharmacy);#39	Executive Medical Director	Q2 2024/2025
MM10 - Antimicrobial Prescribing Policy - V4.pdf	Policy	11/05/2021	01/05/2024	Charlotte Makanga (BCUHB - Pharmacy and Medicines Management);#339	Executive Medical Director	Q2 2024/2025
MM15 - Policy for Administration & Use of Emergency & Non Emergency Oxygen in Adults in Managed Services - V2.1.pdf	Policy	22/05/2019	01/02/2022	Pam Lloyd (BCUHB - Respiratory Medicine);#325;#Hannah John (BCUHB - Pharmacy);#8606	Executive Medical Director	Q2 2024/2025
MM16 - Guidance on the Transcription of Medicines by Registered Nurses in Exceptional Circumstances - V0.1.pdf	Guideline	04/03/2015	04/03/2017	Sioned Rees (BCUHB - Pharmacy);#8015	Executive Medical Director	Q4 2024/2025
MM20 - Guideline for the Administration of Subcutaneous Fluids in Adult Palliative Care Patients.pdf	Guideline	14/03/2022	01/06/2023	Caroline Usborne (BCUHB - Palliative Care);#3441	Executive Medical Director	
MM21 - Guideline for Supported or Self Administration of Medicines by Inpatients in BCUHB - V2.1.pdf	Guideline	01/10/2020	01/10/2023	Jackie Jones (BCUHB - Pharmacy and Medicines Management);#7412	Executive Medical Director	Q2 2024/2025
MM23 - Guidelines for Prescribing Steroids for Adults in Palliative Care - V1.1.pdf	Guideline	20/01/2022	01/02/2023	Tracy Parry (BCUHB - Pharmacy);#501	Executive Medical Director	Q4 2024/2025
MM26 - Guidelines on the Use of Antipsychotics in Children and Adolescents - V0.1.pdf	Guideline	01/11/2016	01/11/2018	Suzanne Cotter (BCUHB - Pharmacy);#332;#Prashant Bhat (BCUHB - Child & Adolescent Health);#333	Executive Medical Director	Q1 2024/2025
MM27 - Procedure for the Use of Alteplase & Urokinase via a Dysfunctional Tunnelled Haemodialysis CVC - V2.pdf	Procedure	01/09/2020	01/09/2022		Executive Medical Director	
MM28 - Standard Operating Procedure for Medicine Optimisation Tasks by BCUHB Medicines Management Team in Primary Care - V0.2.pdf	Procedure	08/05/2019	01/09/2021	Vicky Allum (BCUHB - Pharmacy and Medicines Management);#6793	Executive Medical Director	Q2 2024/2025
MM32 - Guidelines for Staff Use of Phenytoin in Adults - V1.pdf	Guideline	01/02/2018	01/03/2020	Lauren Williams (BCUHB - Pharmacy);#4072	Executive Medical Director	Q2 2024/2025
MM36 - BCUHB Adult Lipid Modification Guideline.pdf	Guideline	14/03/2022	01/03/2024	Catrin Roberts (BCUHB - Pharmacy);#106	Executive Medical Director	Q4 2024/2025
MM37 - Medical Gases - Staff Responsibilities across BCUHB - V1.1.pdf	Policy	28/11/2018	01/05/2021	Andrew Merriman (BCUHB - Pharmacy);#39	Executive Medical Director	Q4 2024/2025
MM40 - Influenza Pandemic Plan for Distribution of Antivirals.pdf	Other	21/05/2019	21/05/2021	Kailey Ben-Sassi (BCUHB - Covid Vaccination Programme);#12531	Executive Medical Director	Q4 2024/2025
MM41 - Covert Administration of Medication Clinical Policy.pdf	Policy	01/07/2019	01/06/2022	Elizabeth Bond (BCUHB - Pharmacy);#340	Executive Medical Director	Q1 2024/2025
MM42 - Unlicensed Medicines Policy - V1.pdf	Policy	21/05/2019	01/07/2022	Christopher Pritchard (BCUHB - Pharmacy);#14730	Executive Medical Director	Q2 2024/2025

MM43 - North Wales Neonatal Formulary for IV Medicines - V5.2.pdf	Guideline	11/09/2019	01/07/2022	Suzanne Cotter (BCUHB - Pharmacy);#332	Executive Medical Director	Q1 2024/2025
MM44 - Guideline for Prescribing, Preparation & Administration of Single Dose Mitomycin-C Bladder Instillations - V0.1.pdf	Guideline	13/03/2019	01/03/2021	Haimon Chaudhry (BCUHB - Pharmacy);#343	Executive Medical Director	Q4 2024/2025
MM45- Pharmacist Discharge Prescription Writing Guideline - V1.0.pdf	Guideline	08/11/2019	01/11/2022	Elena Jones (BCUHB - Pharmacy);#2784	Executive Medical Director	Q3 2024/2025
MM47 - Guidance for the Use of bDMARDS & Small Molecule Agents within Rheumatology during Peri-Operative Period - V0.1.pdf	Guideline	18/09/2019	01/09/2022	Beccy Houston (BCUHB - Pharmacy);#11549	Executive Medical Director	Q4 2024/2025
MM48 - Acute Management of Parkinson's Disease in Patients with Compromised Swallow or Nil by Mouth - V1.0.pdf	Other	12/12/2019	01/11/2022	Sue Lord (BCUHB - Pharmacy);#345	Executive Medical Director	Q2 2024/2025
MM49 - Protocol for the Control & Administration of Depot & Long Acting Antipsychotic Injections - V0.1.pdf	Protocol	12/02/2015	01/02/2017	Elizabeth Bond (BCUHB - Pharmacy);#340	Executive Medical Director	Q1 2024/2025
MM56 - Out Patient Parental Antimicrobial Therapy (OPAT) Governance Framework Guidelines - V1.0.pdf	Guideline	18/03/2020	01/03/2023	Charlotte Makanga (BCUHB - Pharmacy and Medicines Management);#339	Executive Medical Director	Q4 2024/2025
MM58 - BCUHB Guideline for the Administration of Medicines via the Subcutaneous Route in Adult Palliative Care Patients - V1.0.pdf	Guideline	24/04/2020	01/04/2023	Jenny Sparks (BCUHB - Pharmacy);#351;#Elin Gwyn (BCUHB - Pharmacy and Medicines Management);#352	Executive Medical Director	Q4 2024/2025
MM60 - BCU Management of Acute Nausea & Vomiting in Adult Surgical Inpatients - V0.1.pdf	Guideline	14/07/2020	01/02/2023	Haimon Chaudhry (BCUHB - Pharmacy);#343	Executive Medical Director	Q4 2024/2025
MM64 - Clinical Guideline for the Prescribing & Administration of Intravenous Morphine in Adults with Acute Sever Pain - V1.1.pdf	Guideline	01/09/2020	01/09/2023	Haimon Chaudhry (BCUHB - Pharmacy);#343	Executive Medical Director	Q4 2024/2025
MM64A - IV Morphine in Adults Presciption Chart - V1.1.pdf	Other	01/01/2021	01/07/2023	Haimon Chaudhry (BCUHB - Pharmacy);#343	Executive Medical Director	Q4 2024/2025
MM66 - BCUHB Iloprost Infusion for Treatment of Severe Chronic Ischaemia of Lower Limb in Adults - V1.0.pdf	Guideline	01/09/2020	01/08/2023	Haimon Chaudhry (BCUHB - Pharmacy);#343	Executive Medical Director	Q4 2024/2025
MM67 - Vitamin D Deficiency & Nutritional Rickets Supplementation & Treatment in Infants and Children - V1.pdf	Guideline	01/09/2020	01/09/2022	Suzanne Cotter (BCUHB - Pharmacy);#332	Executive Medical Director	Q3 2024/2025
MM68 - Guidelines for the Use of Rapid Tranquillisation (RT) in Children aged 12 years to 17 years.pdf	Guideline	01/07/2020	01/07/2022	Suzanne Cotter (BCUHB - Pharmacy);#332	Executive Medical Director	Q2 2024/2025
MM69 - Intravenous (IV) Potassium Procedure - V1.pdf	Procedure	13/11/2020	01/11/2023	Karen Pritchard (BCUHB - Pharmacy);#359	Executive Medical Director	Q2 2024/2025
MM70 - Remifentanil Patient Controlledanalgesia (PCA) in Labour & Covid-19 Pandemic Guideline - V1.pdf	Guideline	13/11/2020	01/11/2023	Malen Gwilym (BCUHB - Pharmacy);#2828;#Gwenllian Pugh-Jones (BCUHB - Pharmacy);#1333	Executive Medical Director	Q4 2024/2025

MM71 - Warfarin Management in Adults to Enable Safe Admission & Discharge - V2.pdf	Procedure	21/12/2020	01/01/2023	Catherine Strong (BCUHB - Pharmacy);#1756	Executive Medical Director	Q2 2024/2025
MM72 - Guideline for the Use of Methoxyflurane (Penthrox) in Acute Moderate to Severe Pain in Trauma, Orthopaedics & ED - V1.pdf	Guideline	20/01/2021	02/12/2023	Elaine Sturman (BCUHB - Pharmacy);#449	Executive Medical Director	Q4 2024/2025
MM73 - Bone Health Management for Children at Risk of Fractures for Health Professionals working in Secondary Care - V1.pdf	Guideline	05/03/2021	01/12/2023	Suzanne Cotter (BCUHB - Pharmacy);#332	Executive Medical Director	Q4 2024/2025
MM74 - BCUHB Acute Pain Guidelines for Adults in Acute Care Setting - V1.0.pdf	Guideline	01/07/2021	01/09/2023	Haimon Chaudhry (BCUHB - Pharmacy);#343	Executive Medical Director	Q4 2024/2025
MM75 - Hypophosphataemia Management for Adults Inpatients.pdf	Guideline	01/12/2021	01/12/2023	Anest Jones (BCUHB - Pharmacy);#364	Executive Medical Director	Q4 2024/2025
MM77 - Shortened Adult Acetylcysteine Prescribing and Administration Protocol for Paracetamol Overdose (Scottish and Newcastle Acetylcysteine Protocol SNAP.pdf	Protocol	05/04/2022	05/04/2024	Amber Smith (BCUHB - Pharmacy);#33551	Executive Medical Director	Q1 2024/2025
MM77a - SNAP Administration Chart - Appendix 1.pdf	Appendix	05/04/2022	05/04/2024	Amber Smith (BCUHB - Pharmacy);#33551	Executive Medical Director	Q1 2024/2025
MM85 - Vancomycin Dosing and Monitoring in Children Guideline - For Use on Children's Wards within Betsi Cadwaladr University Health Board.pdf	Guideline	12/09/2022	01/07/2024	Suzanne Cotter (BCUHB - Pharmacy);#332	Executive Medical Director	
MP02d - Procedure for the use of Medical Devices - V1.0.pdf	Procedure	24/04/2017	01/04/2020	Patrick Hill (BCUHB - North Wales Medical Physics (inc EBME));#164	Executive Medical Director	
MP02f - Disposal of Medical Devices Procedure - V1.pdf	Procedure	26/06/2017	01/07/2020	Patrick Hill (BCUHB - North Wales Medical Physics (inc EBME));#164;#Mel Lewis (BCUHB - North Wales Medical Physics (inc EBME));#176	Executive Medical Director	
NWCRF SOP02 - Standard Operating Procedure for Volunteer Screening and Recruitment.pdf	Procedure	04/10/2022	01/07/2024	Lona Tudor Jones (BCUHB - Research & Development);#27	Executive Medical Director	Q2 2024/2025
NWCRF SOP03 - Standard Operating Procedure for Medical Emergencies.pdf	Procedure	04/10/2022	01/07/2024	Orod Osanlou (BCUHB - Acute Medicine);#15008;#Lona Tudor Jones (BCUHB - Research & Development);#27;#Elizabeth Harrison (BCUHB - Research & Development);#735	Executive Medical Director	Q4 2024/2025
NWCRF SOP06 - Standard Operating Procedure for Training.pdf	Procedure	04/10/2022	01/07/2024	Lona Tudor Jones (BCUHB - Research & Development);#27	Executive Medical Director	Q2 2024/2025
NWCRF SOP09 - Standard Operating Procedure - Consent 4 Consent (C4C) Database.pdf	Procedure	04/10/2022	01/07/2024	Elizabeth Harrison (BCUHB - Research & Development);#735	Executive Medical Director	Q2 2024/2025

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NWCRF SOP11 - Standard Operating Procedure - For the Monika Prime Temperature Monitoring System.pdf	Procedure	04/10/2022	01/07/2024	Katharine Burton (Abergele - The Surgery (Abergele));#1250;#Elizabeth Harrison (BCUHB - Research & Development);#735	Executive Medical Director	Q2 2024/2025
NWCRF SOP15 - Standard Operating Procedure - for Requesting Access to GP Records for Trial Participants.pdf	Procedure	04/10/2022	01/07/2024	Elizabeth Harrison (BCUHB - Research & Development);#735	Executive Medical Director	Q2 2024/2025
NWCRF SOP17 - North Wales Clinical Research Facility - Standard Operating Procedure - Laboratory Procedures.pdf	Procedure	17/01/2023	01/07/2024	Rhiannon Mackay (BCUHB - Research & Development);#29755;#Elizabeth Harrison (BCUHB - Research & Development);#735	Executive Medical Director	Q2 2024/2025
PA04 - Pathology Standard Operating Procedure for Research & Development Studies & Clinical Trials - V7.pdf	Procedure	08/10/2020	01/09/2022	Bernadette Astbury (BCUHB - Pathology);#76;#Lona Tudor Jones (BCUHB - Research & Development);#27	Executive Medical Director	Q4 2024/2025
PCT01 - SOP for Clinical Trials - Pharmacy Clinical Trials Procedure - V1.5.pdf	Procedure	01/06/2021	01/06/2024	Geraldine Mccaffrey (BCUHB - Pharmacy);#583	Executive Medical Director	Q4 2024/2025
PCT02 - SOP for Clinical Trials - Emergency Code Breaking Procedure - V1.1.pdf	Procedure	01/09/2020	01/08/2023	Geraldine Mccaffrey (BCUHB - Pharmacy);#583	Executive Medical Director	Q1 2024/2025
PCT03 - SOP for Clinical Trials - Writing & Testing of Emergency Unblinding Procedures - V1.1.pdf	Procedure	01/09/2020	01/08/2023		Executive Medical Director	Q1 2024/2025
PCT04 - SOP for Clinical Trials - Pharmacy Personnel & Training - V1.0.pdf	Procedure	01/09/2020	01/08/2023	Geraldine Mccaffrey (BCUHB - Pharmacy);#583	Executive Medical Director	Q1 2024/2025
PCT05 - SOP for Clinical Trials - Storage of Clinical Trials Medication Outside a Pharmacy Department - V1.0.pdf	Procedure	01/10/2020	01/10/2023	Geraldine Mccaffrey (BCUHB - Pharmacy);#583	Executive Medical Director	Q4 2024/2025
PCT06 - SOP for Clinical Trials - Clinical Trials Prescriptions - V1.0.pdf	Procedure	01/06/2021	01/03/2024	Geraldine Mccaffrey (BCUHB - Pharmacy);#583	Executive Medical Director	Q4 2024/2025
PCT08 - SOP for Clinical Trials - Pharmacy Van Transport of Investigational Medicinal Products between BCUHB Pharmacy Departments - V1.0.pdf	Procedure	01/06/2021	01/04/2024	Geraldine Mccaffrey (BCUHB - Pharmacy);#583	Executive Medical Director	Q4 2024/2025
PCT09 - SOP for Clinical Trials - Code Break Envelopes - V1.0.pdf	Procedure	01/06/2021	01/06/2024	Geraldine Mccaffrey (BCUHB - Pharmacy);#583	Executive Medical Director	Q4 2024/2025
PCT10 - SOP for Clinical Trials - Pharmacist Clinical Validation of Clinical Trials Prescriptions - V1.0.pdf	Procedure	01/06/2021	01/04/2024	Geraldine Mccaffrey (BCUHB - Pharmacy);#583	Executive Medical Director	Q4 2024/2025
PCT11 - SOP for Clinical Trials - Dispensing Clinical Trials Prescriptions - V1.0.pdf	Procedure	01/06/2021	01/06/2024	Geraldine Mccaffrey (BCUHB - Pharmacy);#583	Executive Medical Director	Q4 2024/2025
PCT12 - SOP for Clinical Trials - Accuracy Checking Clinical Trials Prescriptions - V1.0.pdf	Procedure	01/06/2021	01/06/2024	Geraldine Mccaffrey (BCUHB - Pharmacy);#583	Executive Medical Director	Q4 2024/2025
PCTF01 - Emergency Unbinding Form - V1.doc	Other	01/06/2021	01/06/2024	Geraldine Mccaffrey (BCUHB - Pharmacy);#583	Executive Medical Director	Q4 2024/2025

PCTF02 - Pharmacy Research CV - V1.doc	Other	01/09/2020	01/08/2023	Geraldine Mccaffrey (BCUHB - Pharmacy);#583	Executive Medical Director	Q4 2024/2025
PCTF03 - Remote Storage Assessment Form - V1.docx	Other	01/09/2020	01/08/2023	Geraldine Mccaffrey (BCUHB - Pharmacy);#583	Executive Medical Director	Q4 2024/2025
PCTF04 - Remote IMP Monitoring Log - V1.docx	Other	01/09/2020	01/08/2023	Geraldine Mccaffrey (BCUHB - Pharmacy);#583	Executive Medical Director	Q4 2024/2025
PCTF05 - Production of Code Break Envelopes Form - V1.doc	Other	01/10/2020	01/10/2023	Geraldine Mccaffrey (BCUHB - Pharmacy);#583	Executive Medical Director	Q4 2024/2025
PCTF06 - Receipt of Code Break Envelopes Form - V1.doc	Other	01/06/2021	01/03/2024	Geraldine Mccaffrey (BCUHB - Pharmacy);#583	Executive Medical Director	Q4 2024/2025
PCTF07 - Distribution of Code Break Envelopes Form - V1.doc	Other	01/04/2021	01/02/2024	Geraldine Mccaffrey (BCUHB - Pharmacy);#583	Executive Medical Director	Q4 2024/2025
PCTF08 - Investigational Medicinal Product Site to Site Transfer Form - V1.doc	Other	01/06/2021	01/04/2024	Geraldine Mccaffrey (BCUHB - Pharmacy);#583	Executive Medical Director	Q4 2024/2025
PCTF09 - ACT File Note - V1.doc	Other	01/06/2021	01/06/2024	Geraldine Mccaffrey (BCUHB - Pharmacy);#583	Executive Medical Director	Q4 2024/2025
PCTT01 - Clinical Trials Prescription Template - V1.doc	Other	01/06/2021	01/06/2024	Geraldine Mccaffrey (BCUHB - Pharmacy);#583	Executive Medical Director	Q4 2024/2025
QA02 - Internal Audit of The Research Quality System Including Studies - Health Research - Standard Operating Procedure.pdf	Procedure	14/04/2022	14/04/2024	Lona Tudor Jones (BCUHB - Research & Development);#27	Executive Medical Director	Q1 2024/2025
QA04 - Research Contracts & Vendors - Health Research - Standard Operating Procedure.pdf	Procedure	14/04/2022	14/04/2024	Lona Tudor Jones (BCUHB - Research & Development);#27	Executive Medical Director	Q1 2024/2025
QA1 - Production, Review and Approval of All Wales SOPs - V1.0.pdf	Procedure	07/06/2018	07/06/2021		Executive Medical Director	
RD03 - Policy for Intellectual Property - V2.pdf	Policy	02/09/2020	01/08/2022	Lona Tudor Jones (BCUHB - Research & Development);#27;#Lynne Grundy (BCUHB - Research & Development);#69	Executive Medical Director	
RD04 - NHS R&D Finance Policy - V1.0.pdf	Policy	28/07/2017	20/07/2019	Lona Tudor Jones (BCUHB - Research & Development);#27	Executive Medical Director	
S03 - Standard Operating Procedure for Handling Medical Emergencies for Research Participants - V2.pdf	Procedure	28/10/2020	28/10/2022	Lona Tudor Jones (BCUHB - Research & Development);#27	Executive Medical Director	Q2 2024/2025
T01 - Research Quality System Training - Health Research - Standard Operating Procedure.pdf	Procedure	14/04/2022	14/04/2024	Lona Tudor Jones (BCUHB - Research & Development);#27	Executive Medical Director	Q1 2024/2025
TM01 - Participant Information Sheets and Informed Consent - Health Research - Standard Operating Procedure.pdf	Procedure	14/04/2022	14/04/2024	Lona Tudor Jones (BCUHB - Research & Development);#27	Executive Medical Director	Q1 2024/2025
TM04 - Procedure for Delegating Duties in Research - Health Research - Standard Operating Procedure.pdf	Procedure	14/04/2022	14/04/2024	Lona Tudor Jones (BCUHB - Research & Development);#27	Executive Medical Director	Q1 2024/2025
TM07 - SOP for Trial Supplies & Labelling - V4.pdf	Procedure	03/06/2020	03/06/2022	Lynne Grundy (BCUHB - Research & Development);#69	Executive Medical Director	Q1 2024/2025

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TM08 - Participant Selection and Recruitment - Health Research Standard Operating Procedure.pdf	Procedure	14/04/2022	14/04/2024	Lona Tudor Jones (BCUHB - Research & Development);#27	Executive Medical Director	Q1 2024/2025
TU1 - Policy & Procedure for Top up Payments - V0.2.pdf	Policy	28/08/2012	01/05/2017	Hannah Greaves (BCUHB - Pharmacy);#375	Executive Medical Director	Q2 2024/2025
Upholding Professional Standards in Wales - 2015 - Cymraeg.pdf	Other	01/08/2015	01/08/2018		Executive Medical Director	
MH01 - Protocol for Children Visiting Mental Health Learning Disability Wards MHLD Division.pdf	Protocol	01/12/2020	01/12/2023	Adrian Jones (BCUHB - Mental Health & Learning Disabilities);#474	HB Lead for MHLD and Welsh Language	Q1 2024/2025
MH02 - Procedure for Exceptional Admission of Children under 18 to an Acute Psychiatric Inpatient Unit.pdf	Procedure	01/12/2020	01/12/2023		HB Lead for MHLD and Welsh Language	Q2 2024/2025
MHLD 0002 DRAFT - Seclusion & Long Term Segregation Policy -V0.2.pdf	Policy	01/09/2020	01/09/2023		HB Lead for MHLD and Welsh Language	Q1 2024/2025
MHLD 0005 - Ty Llywelyn Patients Visitors Procedure.pdf	Procedure	21/03/2019	01/10/2022	Simon Allen (BCUHB - Mental Health & Learning Disabilities);#7367	HB Lead for MHLD and Welsh Language	Q3 2024/2025
MHLD 0008 - Threats to the Person and Environment within Forensic Establishments Policy (Ty Llywelyn Medium Secure Unit).pdf	Policy	15/01/2021	01/01/2024	Ian Jones (BCUHB - Mental Health & Learning Disabilities);#1180	HB Lead for MHLD and Welsh Language	Q2 2024/2025
MHLD 0009 - Major Incident Protocol - Ty Llywelyn Medium Secure Unit.pdf	Protocol	15/01/2021	15/01/2022	Ian Jones (BCUHB - Mental Health & Learning Disabilities);#1180	HB Lead for MHLD and Welsh Language	Q3 2024/2025
MHLD 002 - MHLD Supervision Guidance.pdf	Guideline	20/07/2021	01/07/2024	Nichaela Jones (BCUHB - Mental Health & Learning Disabilities);#4090;#Adrian Jones (BCUHB - Mental Health & Learning Disabilities);#474	HB Lead for MHLD and Welsh Language	
MHLD 0020 - S-CAMHS to Adult Transition Policy - V3.pdf	Policy	01/06/2021	01/03/2024		HB Lead for MHLD and Welsh Language	Q3 2024/2025
MHLD 0024 - Adults with a Learning Disability Requiring Admission to Acute Psychiatric In-patient Services - V0.1.pdf	Other	21/03/2017	01/03/2020	Simon Meadowcroft (BCUHB - Learning Disability Services);#1193	HB Lead for MHLD and Welsh Language	Q1 2024/2025
MHLD 0027 - BCUHB Mental Health Division - Open Door Policy - V0.1pdf.pdf	Policy	01/07/2017	01/07/2020	Sean Gallagher (BCUHB - Learning Disability Services);#16903;#Matthew Jarvis (BCUHB - Mental Health & Learning Disabilities);#5077	HB Lead for MHLD and Welsh Language	Q2 2024/2025
MHLD 0029 - Perinatal Mental Health Operational Policy - V0.1.pdf	Policy	01/06/2017	01/06/2019	Deborah Griffin (BCUHB - Mental Health & Learning Disabilities);#1156	HB Lead for MHLD and Welsh Language	Q2 2024/2025
MHLD 0030 - Policy for Information to Patients (S132_3 MHA).pdf	Policy	01/06/2021	01/06/2024	Wendy Lappin (BCUHB - Quality Directorate);#1196	HB Lead for MHLD and Welsh Language	
MHLD 0033 - MHLD Policy for the Implementation of Section 5(4) Nurses Holding Power.pdf	Policy	01/06/2021	01/06/2024	Wendy Lappin (BCUHB - Quality Directorate);#1196	HB Lead for MHLD and Welsh Language	
MHLD 0034 - MHLD Policy for Section 5(2) Doctors Holding Power in Psychiatric Units.pdf	Policy	01/06/2021	01/10/2023	Wendy Lappin (BCUHB - Quality Directorate);#1196	HB Lead for MHLD and Welsh Language	Q1 2024/2025

MHLD 0035 - Home Treatment Team Operational Policy - V0.5 (a).pdf	Policy	09/04/2018	01/04/2021		HB Lead for MHLD and Welsh Language	Q3 2024/2025
MHLD 0036 - Needle Syringe Provisions for Young People Guidelines - V0.1.pdf	Guideline	22/08/2018	01/08/2021		HB Lead for MHLD and Welsh Language	Q3 2024/2025
MHLD 0038 - Substance Misuse Service Allocation Waiting List Protocol - V0.3.pdf	Protocol	22/08/2018	22/08/2021		HB Lead for MHLD and Welsh Language	Q3 2024/2025
MHLD 0040 - Ty Llywelyn Postal Packets & Section 134 (MHA 1983_2007) Policy - V0.1.pdf	Policy	22/08/2018	01/08/2021	Simon Allen (BCUHB - Mental Health & Learning Disabilities);#7367	HB Lead for MHLD and Welsh Language	Q1 2024/2025
MHLD 0041 - MHLD Policy for Use of Handcuffs (specific to Ty Llywelwyn Medium Secure Unit).pdf	Policy	15/01/2021	15/01/2024	Paul Hanna (PTHB - Mental Health);#2476	HB Lead for MHLD and Welsh Language	Q4 2024/2025
MHLD 0045 - Bed Escalation Procedure - MHLD - V1.3.pdf	Procedure	13/07/2021	01/07/2024	Paul Hanna (PTHB - Mental Health);#2476	HB Lead for MHLD and Welsh Language	
MHLD 0048 - Operational Procedure for Community Forensic Mental Health Services -V3.pdf	Procedure	01/02/2019	01/02/2021	Greg Yates (BCUHB - Mental Health & Learning Disabilities);#1674	HB Lead for MHLD and Welsh Language	Q3 2024/2025
MHLD 0051 - Community Treatment Order Policy MHA 1983 - V0.1.pdf	Policy	16/07/2019	01/05/2022	Wendy Lappin (BCUHB - Quality Directorate);#1196	HB Lead for MHLD and Welsh Language	Q1 2024/2025
MHLD 0052 - Standard Operating Procedure for the use of Gyms & Sports Facilities.pdf	Procedure	11/09/2019	01/07/2022		HB Lead for MHLD and Welsh Language	Q2 2024/2025
MHLD 0053 - Meeting the Physical Health Care Needs of People Admitted to an Older Persons Mental Health Ward - V0.1.pdf	Guideline	13/09/2019	13/09/2022	Sean Page (BCUHB - Mental Health & Learning Disabilities);#9590	HB Lead for MHLD and Welsh Language	Q4 2024/2025
MHLD 0057 - North Wales Section 135 & 136 Mental Health Act 1983 Protocol.pdf	Protocol	01/04/2021	01/04/2024		HB Lead for MHLD and Welsh Language	Q3 2024/2025
MHLD 0058 - Hafod Mental Health Resource Centre - PocHi Operational Procedure - V0.1.pdf	Procedure	01/03/2020	01/02/2023	Iain Dawson (BCUHB - Pharmacy);#355	HB Lead for MHLD and Welsh Language	Q1 2024/2025
MHLD 0059 - Memory Services Operational Protocol.pdf	Protocol	01/11/2020	01/11/2022		HB Lead for MHLD and Welsh Language	Q2 2024/2025
MHLD 0060 - Criminal Justice Liaison Service Standard Operating Procedure.pdf	Procedure	01/08/2020	01/08/2023	Ruth Joyce (BCUHB - Mental Health & Learning Disabilities);#5002	HB Lead for MHLD and Welsh Language	Q2 2024/2025
MHLD 0067 - Patient Anti Bullying Procedure - Ty Llywelyn Medium Secure Unit - V1.pdf	Procedure	01/10/2020	01/10/2023	Simon Allen (BCUHB - Mental Health & Learning Disabilities);#7367	HB Lead for MHLD and Welsh Language	Q2 2024/2025
MHLD 0068 - Perinatal Guidelines for Pain Control in Women on Opioid Substitution Therapy - V4.3.pdf	Guideline	13/11/2020	16/11/2023		HB Lead for MHLD and Welsh Language	Q1 2024/2025
MHLD 0071 - Clinical Risk Management Procedure - V6.pdf	Procedure	01/10/2021	01/11/2023	Robyn Jones (BCUHB - Mental Health & Learning Disabilities);#5505	HB Lead for MHLD and Welsh Language	Q2 2024/2025
MHLD 0073 - Guidelines for the use of Buvidal® Injection within the Substance Misuse Service.pdf	Guideline	04/11/2020	03/11/2020	Luxman Parimelalagan (BCUHB - Substance Misuse Services);#2322	HB Lead for MHLD and Welsh Language	Q3 2024/2025
MHLD 0076 - SOP for End of Life Care for the Person with Dementia under the Care of In-patient Mental Health Services.pdf	Procedure	01/09/2019	01/09/2022	Sean Page (BCUHB - Mental Health & Learning Disabilities);#9590;#Alison Foster (BCUHB - Palliative Care);#5398	HB Lead for MHLD and Welsh Language	Q3 2024/2025

MHLD 0076a - End of Life Care on an OPMH Ward Checklist - Read Only.docx	Appendix	01/09/2019	01/09/2022	Sean Page (BCUHB - Mental Health & Learning Disabilities);#9590;#Alison Foster (BCUHB - Palliative Care);#5398	HB Lead for MHLD and Welsh Language	Q3 2024/2025
MHLD 0076b - End of Life Care on an OPMH Ward Pathway.pdf	Appendix	01/09/2019	01/09/2022	Sean Page (BCUHB - Mental Health & Learning Disabilities);#9590;#Alison White (BCUHB - Corporate Nursing);#385	HB Lead for MHLD and Welsh Language	Q3 2024/2025
MHLD 0078 - Nicotine Replacement Therapy (NRT) Supplementary Guidance for MHLD inpatients.pdf	Guideline	16/09/2022	01/09/2022	Elizabeth Bond (BCUHB - Pharmacy);#340;#Adrian Jones (BCUHB - Mental Health & Learning Disabilities);#474;#Premraj Muthuvelu (BCUHB - Mental Health & Learning Disabilities);#2553	HB Lead for MHLD and Welsh Language	
MHLD AC006 - Electroconvulsive Therapy Service Specification - DRAFT.pdf	Other	01/06/2020	01/07/2023	Linda Mcarthur (BCUHB - Mental Health & Learning Disabilities);#9591;#Sheryl Cave (BCUHB - Mental Health & Learning Disabilities);#9592	HB Lead for MHLD and Welsh Language	
MHLD RM04 - Risk Managment Procedure.pdf	Procedure	01/06/2019	01/12/2020	Hilary Owen (BCUHB - Mental Health & Learning Disabilities);#7407	HB Lead for MHLD and Welsh Language	Q3 2024/2025
MM17 - Guidelines for the Management of Delirium in Adults 18 years and older in Acute Care and Long Term Care Settings.pdf	Guideline	14/04/2022	14/04/2024		HB Lead for MHLD and Welsh Language	Q3 2024/2025
MM25 - Standard Operating Procedure for the Supply of Take Home Naloxone Preparations - V1.0.pdf	Procedure	12/09/2019	12/09/2022	Elizabeth Bond (BCUHB - Pharmacy);#340	HB Lead for MHLD and Welsh Language	Q4 2024/2025
MM35 - Pharmacological Management of Cognitive Symptoms in People Diagnosed with Dementia - V0.1.pdf	Other	01/03/2019	01/03/2022	Elizabeth Bond (BCUHB - Pharmacy);#340	HB Lead for MHLD and Welsh Language	Q1 2024/2025
MM50 - Medicines Management Guidelines for the Adult Mental Health Home Treatment Teams - V0.1.pdf	Guideline	01/06/2016	01/01/2019	Elizabeth Bond (BCUHB - Pharmacy);#340	HB Lead for MHLD and Welsh Language	Q1 2024/2025
MM51 - Guideline for Monitoring Physical Health in Adults with Psychosis or Schizophrenia - V0.1.pdf	Guideline	01/11/2017	01/11/2019	Elizabeth Bond (BCUHB - Pharmacy);#340	HB Lead for MHLD and Welsh Language	Q2 2024/2025
MM52 - Guideline for the Use of Antipsychotics in the Management of Behavioural & Psychological Symptoms of Dementia - V0.2.pdf	Guideline	06/06/2018	01/07/2021	Elizabeth Bond (BCUHB - Pharmacy);#340	HB Lead for MHLD and Welsh Language	Q3 2024/2025
MM55 - Hafen Wen (BCUHB SMS) Inpatient Detoxificaiton Prescribing Guidelines.pdf	Guideline	16/05/2019	01/05/2022	Elizabeth Bond (BCUHB - Pharmacy);#340	HB Lead for MHLD and Welsh Language	Q2 2024/2025
MM76 - BCUHB Guidelines for Inpatient Management of Acute Pain or Opioid Withdrawal in Adults Dependant on Opioids.pdf	Guideline	01/10/2021	01/11/2023	Haimon Chaudhry (BCUHB - Pharmacy);#343;#Ceri Thompson (BCUHB - Pharmacy);#362	HB Lead for MHLD and Welsh Language	

Rheoliadau Safonau'r Gymraeg 2018.pdf	Other	14/09/2018	14/09/2023	Eleri Hughes-Jones (BCUHB - Welsh Language Services);#52	HB Lead for MHLD and Welsh Language	Q1 2024/2025
Welsh Language Standards Regulations 2018.pdf	Other	14/09/2018	14/09/2023	Eleri Hughes-Jones (BCUHB - Welsh Language Services);#52	HB Lead for MHLD and Welsh Language	Q1 2024/2025
WP51 - Bilingual Skills Policy & Procedure -V0.1.doc.pdf	Policy	18/12/2020	15/09/2023	Eleri Hughes-Jones (BCUHB - Welsh Language Services);#52;#Clair Tipton (BCUHB - Workforce & Organisational Development);#53;#Meilyr Emrys (BCUHB - Welsh Language Services);#54	HB Lead for MHLD and Welsh Language	Q1 2024/2025
WP51 - Polisi a Gweithdrefn Sgiliau Dwyieithog - V0.1.pdf	Policy	18/12/2020	15/09/2023	Eleri Hughes-Jones (BCUHB - Welsh Language Services);#52;#Clair Tipton (BCUHB - Workforce & Organisational Development);#53;#Meilyr Emrys (BCUHB - Welsh Language Services);#54	HB Lead for MHLD and Welsh Language	Q1 2024/2025

Name	Policy type	Effective Date	Review Date	Author	Responsible Director
IG01 - Records Management Policy .pdf	Policy	08/12/2021	01/10/2024	Lisa Parry (BCUHB - Digital, Data and Technology);#102	Chief Digital Information Officer
IG02 - Corporate Records Management Procedure.pdf	Procedure	08/12/2021	01/10/2024	Lisa Parry (BCUHB - Digital, Data and Technology);#102	Chief Digital Information Officer
IG03 - Procedure for Compliance with the FOI Act 2000 & EIR 2004 - V7.pdf	Procedure	08/12/2021	01/10/2024	Lisa Parry (BCUHB - Digital, Data and Technology);#102	Chief Digital Information Officer
IG04 - Access to Information Policy - V5.pdf	Policy	08/12/2021	01/10/2024	Carol Johnson (BCUHB - Digital, Data and Technology);#96	Chief Digital Information Officer
IG08 - Email Procedure - V7.pdf	Procedure	08/12/2021	01/10/2024	Lisa Parry (BCUHB - Digital, Data and Technology);#102	Chief Digital Information Officer
IG17 - Photography, Video & Audio Recording Procedure for a Non-Clinical Purpose - V5.pdf	Procedure	27/01/2022	08/12/2024	Lisa Parry (BCUHB - Digital, Data and Technology);#102	Chief Digital Information Officer
BH-004 - Transfusion of Blood Components Outside the Acute Hospital Setting - V2.0.pdf	Policy	01/09/2021	01/08/2024	Lee Wong (Welsh Blood Service, Laboratory Services);#184;#Alister Jones (Welsh Blood Service, Better Blood Transfusion);#185	Chief Operating Officer
PTH-QMS-162 - Communication of Critical & Unexpected Pathology Results Procedure - V1.pdf	Procedure	07/01/2022	06/01/2025	Bernadette Astbury (BCUHB - Pathology);#76	Chief Operating Officer
OBS02 - Standards of Business Conduct Policy .pdf	Policy	15/03/2022	15/03/2025	Philippa Peake-Jones (BCUHB - Corporate Office);#6727	Director of Corporate Governance
RM02 - Gweithdrefnau Rheoli Risg.pdf	Procedure	21/02/2024	01/01/2025	Phil Meakin (BCUHB - Governance & Communications);#29246;#Nesta Collingridge (BCUHB - Risk and Assurance);#52677	Director of Corporate Governance
RM02 - Risk Management Procedures.pdf	Procedure	21/02/2024	31/01/2025	Phil Meakin (BCUHB - Governance & Communications);#29246;#Nesta Collingridge (BCUHB - Risk and Assurance);#52677	Director of Corporate Governance
ES05 - Policy for the Management of Ventilation Systems - V1.0.pdf	Policy	08/03/2022	08/03/2025	Tanya Coppack (BCUHB - Estates);#1268	Executive Director of Finance
F02 - Lease Car & Pool Vehicle Policy and Procedure - V.03.pdf	Policy	12/08/2021	15/08/2024	Denise Roberts (BCUHB - Finance);#865	Executive Director of Finance
F03 - Local Counter Fraud, Bribery and Corruption Policy (Cymraeg) .pdf	Policy	16/03/2022	01/08/2024	Karl Woodward (BCUHB - Finance);#41;#Sjef Molmans (BCUHB - Finance);#42;#Graham Jones (BCUHB - Finance);#763	Executive Director of Finance
F03 - Local Counter Fraud, Bribery and Corruption Policy.pdf	Policy	16/03/2022	01/08/2024	Karl Woodward (BCUHB - Finance);#41;#Sjef Molmans (BCUHB - Finance);#42;#Graham Jones (BCUHB - Finance);#763	Executive Director of Finance
All Wales Head Injuries in Neonates on the Postnatal Ward or NICU Guideline.pdf	Guideline	13/06/2023	01/12/2024	Faye Pritchard (BCUHB - Womens Services);#11401	Executive Director of Nursing and Midwifery
All Wales Maternity & Neonatal Network Guidelines - Prevention and Management of Postpartum Haemorrhage .pdf	Guideline	08/08/2023	01/11/2024	Faye Pritchard (BCUHB - Womens Services);#11401	Executive Director of Nursing and Midwifery
IPC06 - Infection Prevention Hand Hygiene Policy & Procedure (An Element of Standard Infection Control Precautions).pdf	Policy	14/06/2022	01/03/2025	Andrea Ledgerton (BCUHB - Infection Control Teams);#142;#Amanda Pagett (BCUHB - Nursing Midwifery & Patient Services);#9162	Executive Director of Nursing and Midwifery
IPC14 - Protocol for Prevention and Management of Pseudomonas Aeruginosa - V2.0.pdf	Protocol	14/09/2021	01/10/2024	Andrea Ledgerton (BCUHB - Infection Control Teams);#142	Executive Director of Nursing and Midwifery

Document	Type	Date	Review Date	Author	Approver
IPC16 - Food Safety in Ward Kitchens - V4.pdf	Procedure	14/09/2021	01/10/2024	Andrea Ledgerton (BCUHB - Infection Control Teams);#142	Executive Director of Nursing and Midwifery
IPC29 - Animals in Healthcare Procedure - V2.pdf	Procedure	14/09/2021	01/10/2024	Andrea Ledgerton (BCUHB - Infection Control Teams);#142	Executive Director of Nursing and Midwifery
Mat 08 - Midwife to Health Visitor Confirmation of Pregnancy and Holistic Assessment - V4.pdf	Other	01/11/2021	01/11/2024		Executive Director of Nursing and Midwifery
Mat 08a - Midwife to Health Visitor Transfer of Care Form - V3.pdf	Appendix	01/11/2021	01/11/2024		Executive Director of Nursing and Midwifery
Mat 08b - Midwife to Health Visitor Transfer Change in Circumstances - V2.pdf	Appendix	01/11/2021	01/11/2024		Executive Director of Nursing and Midwifery
Mat 09 - Health Pre-Birth Assessment by Midwife or Health Visitor - V5.pdf	Guideline	01/11/2021	01/11/2024		Executive Director of Nursing and Midwifery
Mat 17 - Fundal Height Meausurement and Follow Up - V10.pdf	Guideline	01/10/2021	01/10/2024	Janet Quarmby (BCUHB - Maternity);#7085	Executive Director of Nursing and Midwifery
Mat 17a - Fundal Height Quality Assurance Proforma - V1.pdf	Appendix	01/10/2021	01/10/2024	Janet Quarmby (BCUHB - Maternity);#7085	Executive Director of Nursing and Midwifery
Mat 40 - Cord Prolapse - V2.pdf	Guideline	01/08/2021	01/08/2024	Niladri Sengupta (BCUHB - Obstetrics & Gynaecology);#4668	Executive Director of Nursing and Midwifery
Mat 59 - Uterine Inversion - V2.pdf	Guideline	01/08/2021	01/08/2024	Niladri Sengupta (BCUHB - Obstetrics & Gynaecology);#4668	Executive Director of Nursing and Midwifery
Mat 71 - Identification of the Newborn - V3.pdf	Guideline	01/10/2021	01/10/2024	Jane Jones (BCUHB - Maternity);#2663	Executive Director of Nursing and Midwifery
Mat 81 - Expressing and Handling Mothers' Own Breast Milk in Hospital - V1.1.pdf	Guideline	23/07/2021	01/08/2024	Sharon Breward (BCUHB - Maternity);#7905	Executive Director of Nursing and Midwifery
Mat 94 - Health and Safety Management - Women's Directorate - V3.pdf	Procedure	28/01/2022	01/12/2024	Fiona Giraud (BCUHB - Maternity);#7935	Executive Director of Nursing and Midwifery
Mat 97 - Reduced or Altered Fetal Movements - V1.pdf	Guideline	01/08/2021	01/08/2024	Niladri Sengupta (BCUHB - Obstetrics & Gynaecology);#4668;#Julie Reeve (BCUHB - Obstetrics & Gynaecology);#3309	Executive Director of Nursing and Midwifery
MD07 - Protocol for Using Bed Rails Safety and Effectively.pdf	Protocol	22/06/2023	01/08/2024	Diane Read (BCUHB - Nursing, Midwifery & Patient Services);#384	Executive Director of Nursing and Midwifery
NU05 - Student Supervison and Assessment in Practice - V1.9.pdf	Procedure	20/09/2021	20/09/2024	Neirian Jennings (BCUHB - Corporate Nursing);#70	Executive Director of Nursing and Midwifery
NU18 - Appendix 1 - Initial Risk Assessment Review. Read Only.doc	Appendix	01/02/2022	01/02/2025	Anne-Marie Rowlands (BCUHB - Corporate Nursing);#56	Executive Director of Nursing and Midwifery
NU18 - Referral of Registrants to the Nursing and Midwifery Council Standard Operating Procedure .pdf	Procedure	01/02/2022	01/02/2025	Anne-Marie Rowlands (BCUHB - Corporate Nursing);#56	Executive Director of Nursing and Midwifery
NU25 - Health Care Support Worker Development Framework - V5.pdf	Other	20/09/2021	20/09/2024	Ade Evans (BCUHB - Corporate Nursing);#66	Executive Director of Nursing and Midwifery
NU26 - All Wales NHS HCA Induction Programme SOP - V1.pdf	Procedure	20/09/2021	20/09/2024	Ade Evans (BCUHB - Corporate Nursing);#66	Executive Director of Nursing and Midwifery
NU27 - Qualification Credit Framework (QCF) SOP.pdf	Procedure	22/10/2021	22/10/2024	Ade Evans (BCUHB - Corporate Nursing);#66	Executive Director of Nursing and Midwifery
NU28 - Appendix 10 - Standard Operating Procedure - Safecare (2).pdf	Appendix	20/01/2022	20/01/2025	Anne-Marie Rowlands (BCUHB - Corporate Nursing);#56	Executive Director of Nursing and Midwifery
NU28 - Appendix 2 - Nurse Staffing Levels Workforce Planning Template - Read Only.xlsx	Appendix	20/01/2022	20/01/2025	Anne-Marie Rowlands (BCUHB - Corporate Nursing);#56	Executive Director of Nursing and Midwifery
NU28 - Appendix 3 - Triangulation of Patient Harm Incidents Report - Read Only.xlsx	Appendix	20/01/2022	20/01/2025	Anne-Marie Rowlands (BCUHB - Corporate Nursing);#56	Executive Director of Nursing and Midwifery
NU28 - Appendix 4 - Movement of Staff - Read Only.docx	Appendix	20/01/2022	20/01/2025	Anne-Marie Rowlands (BCUHB - Corporate Nursing);#56	Executive Director of Nursing and Midwifery

Document	Type	Issue Date	Review Date	Author	Owner
NU28 - Appendix 5 (i) - Annual Assurance Report on compliance with the Nurse Staffing Levels (Wales) Act Template.pdf	Appendix	20/01/2022	20/01/2025	Anne-Marie Rowlands (BCUHB - Corporate Nursing);#56	Executive Director of Nursing and Midwifery
NU28 - Appendix 5 (ii) - Annual Report Appendix A to accompany annual assurance report.pdf	Appendix	20/01/2022	20/01/2025	Anne-Marie Rowlands (BCUHB - Corporate Nursing);#56	Executive Director of Nursing and Midwifery
NU28 - Appendix 6 (i) - Annual Presentation of Nurse Staffing Levels to the Board - Read Only.docx	Appendix	20/01/2022	20/01/2025	Anne-Marie Rowlands (BCUHB - Corporate Nursing);#56	Executive Director of Nursing and Midwifery
NU28 - Appendix 6 (ii) - Appendix to November report. Summary of Nurse Staffing Levels for 25B wards.pdf	Appendix	20/01/2022	20/01/2025	Anne-Marie Rowlands (BCUHB - Corporate Nursing);#56	Executive Director of Nursing and Midwifery
NU28 - Appendix 7 - Health Care Monitoring System (HCMS) User Guide.pdf	Appendix	20/01/2022	20/01/2025	Anne-Marie Rowlands (BCUHB - Corporate Nursing);#56	Executive Director of Nursing and Midwifery
NU28 - Appendix 8 - Nurse Staffing Levels Deployment Escalation Meeting - Read Only.docx	Appendix	20/01/2022	20/01/2025	Anne-Marie Rowlands (BCUHB - Corporate Nursing);#56	Executive Director of Nursing and Midwifery
NU28 - Appendix 9 - All Wales Paediatric Calculation Template - Read Only.docx	Appendix	20/01/2022	20/01/2025	Anne-Marie Rowlands (BCUHB - Corporate Nursing);#56	Executive Director of Nursing and Midwifery
NU28 - Nurse Staffing Levels Policy.pdf	Policy	01/01/2022	01/01/2025	Anne-Marie Rowlands (BCUHB - Corporate Nursing);#56	Executive Director of Nursing and Midwifery
NU29 - Patient Identification Standard Operating Procedure.pdf	Procedure	05/01/2024	01/02/2025	Anne-Marie Rowlands (BCUHB - Corporate Nursing);#56	Executive Director of Nursing and Midwifery
Policy for the Insertion and Maintenance of Nasogastric & Nasojejunal Feeding Tubes using CORTRAK2 Enternal Access System.pdf	Policy	01/10/2021	01/10/2024	Jane Power (BCUHB - Dietetics);#4709	Executive Director of Nursing and Midwifery
Procedure for Removing Percutaneous Endoscopic Gastrostomy (PEG) Tube using the Cut and Push Method.pdf	Procedure	01/11/2021	01/11/2024	Jennifer Wykes (BCUHB - Nursing, Midwifery & Patient Services);#980	Executive Director of Nursing and Midwifery
Procedure for Replacing a Bridle Ribbon.pdf	Procedure	01/09/2021	01/09/2024	Jennifer Wykes (BCUHB - Nursing, Midwifery & Patient Services);#980	Executive Director of Nursing and Midwifery
Procedure for the Placement and Removal of a Nasal Bridle.pdf	Procedure	30/09/2021	30/09/2024	Jennifer Wykes (BCUHB - Nursing, Midwifery & Patient Services);#980	Executive Director of Nursing and Midwifery
PTR04 - Unreasonable Demand and or Behaviour Complaints Procedure - V1.0.pdf	Procedure	17/02/2022	17/02/2025	Shan Kennedy (BCUHB - Quality Directorate);#1169	Executive Director of Nursing and Midwifery
PTR05 - Coronial and Inquest Procedure.pdf	Procedure	25/10/2023	25/10/2024	Matthew Joyes (BCUHB - Quality Directorate);#108;#Debbie Kumwenda (BCUHB - Corporate Office);#12816	Executive Director of Nursing and Midwifery
SCH14 - Procedure for the Safeguarding Children and Young People Admitted to Adult Wards & Environments - V1.pdf	Procedure	20/09/2021	20/09/2024	Chris Weaver (BCUHB - Safeguarding);#453;#Martin Mcspadden (BCUHB - Paediatrics);#469	Executive Director of Nursing and Midwifery
CMAT 001 - Standard Operating Framework for the Use of Diagnostic Ultrasound in CMATS - V1.0.pdf	Other	11/01/2022	11/01/2025	Yvonne Rimmer (BCUHB - Physiotherapy);#415	Executive Director of Therapies and Health Sciences
HS21 - Fit Testing Protocol.pdf	Protocol	24/12/2021	24/12/2024	Sam Newitt (BCUHB - Health & Safety);#1546	Executive Director of Workforce and Organisational Development
HS23 - CCTV and Body Worn Video (BWV) Policy - V1.0.pdf	Policy	15/03/2022	15/03/2025	David Baker (BCUHB - Health & Safety);#546	Executive Director of Workforce and Organisational Development
HS24 - Appendix A - Read Only.docx	Appendix	15/03/2022	15/03/2025	David Baker (BCUHB - Health & Safety);#546	Executive Director of Workforce and Organisational Development
HS24 - Appendix B - Read Only.docx	Appendix	15/03/2022	15/03/2025	David Baker (BCUHB - Health & Safety);#546	Executive Director of Workforce and Organisational Development
HS24 - Appendix D - Read Only.docx	Appendix	15/03/2022	15/03/2025	David Baker (BCUHB - Health & Safety);#546	Executive Director of Workforce and Organisational Development

HS24 - Appendix E.pdf	Appendix	15/03/2022	15/03/2025	David Baker (BCUHB - Health & Safety);#546	Executive Director of Workforce and Organisational Development
HS24 - Standard Operating Procedure for CCTV - V1.0.pdf	Procedure	15/03/2022	15/03/2025	David Baker (BCUHB - Health & Safety);#546	Executive Director of Workforce and Organisational Development
WP35 - Appendix 1 - Time Off In Lieu Recording Form.doc	Appendix	28/09/2023	01/02/2025	Llinos Jones (BCUHB - Workforce & Organisational Development);#1813;#Jason Brannan (BCUHB - Workforce & Organisational Development);#43958	Executive Director of Workforce and Organisational Development
WP35 - Time Off In Lieu (TOIL) Procedures.pdf	Procedure	28/09/2023	17/02/2025	Llinos Jones (BCUHB - Workforce & Organisational Development);#1813;#Jason Brannan (BCUHB - Workforce & Organisational Development);#43958	Executive Director of Workforce and Organisational Development
WP43 - Guidelines to Support Trans and gender diverse Staff in BCUHB .pdf	Guideline	20/08/2021	20/08/2024	Nick Such (BCUHB - Workforce & Organisational Development);#180	Executive Director of Workforce and Organisational Development
WP69 - Employer Pension Contributions – Alternative Payment Policy.pdf	Policy	26/04/2023	01/03/2025	Lesley Hall (BCUHB - Workforce & Organisational Development);#238	Executive Director of Workforce and Organisational Development
WP69 Alternative Payment Policy (Jul 2022) Cymraeg.pdf	Policy	26/04/2023	01/03/2025	Lesley Hall (BCUHB - Workforce & Organisational Development);#238	Executive Director of Workforce and Organisational Development
B03 - Standard Operating Procedure for NHS Research Passports, Letters of Access and Honorary Research Contracts.pdf	Procedure	18/01/2023	18/01/2025	Laura Longshaw (BCUHB - Research & Development);#267	Executive Medical Director
B04 - SOP for Fraud and Misconduct in Research.pdf	Procedure	02/08/2022	02/08/2024	Lynne Grundy (BCUHB - Research & Development);#69	Executive Medical Director
BCUHB National Institute for Health and Care Excellence (NICE, AWMSG & HTW) Implementation Protocol.pdf	Protocol	02/08/2022	02/11/2024	Joanne Read (BCUHB - Clinical Effectiveness);#4330	Executive Medical Director
Health Research SOP DM01 - Standard Operating Procedure for Accurate Data Collection.pdf	Procedure	28/11/2022	28/11/2024	Laura Longshaw (BCUHB - Research & Development);#267	Executive Medical Director
Health Research SOP T02 - Standard Operating Procedure for Study Specific Training.pdf	Procedure	28/11/2022	28/11/2024	Lona Tudor Jones (BCUHB - Research & Development);#27	Executive Medical Director
Health Research SOP TM03 - Standard Operating Procedure for Trial Master & Trial Site Files.pdf	Procedure	28/11/2022	28/11/2024	Lona Tudor Jones (BCUHB - Research & Development);#27	Executive Medical Director
MD01 - Policy on Consent to Examination or Treatment (Based on the All Wales Model Policy).pdf	Policy	20/01/2023	01/01/2025	Manon Gwilym (BCUHB - Office of the Medical Director);#93;#Ben Thomas (BCUHB - Renal);#112	Executive Medical Director
MM30 - Procedure for the preparation, observation, assessment & supervision of non-registered practitioners(HCSW) to undertake the administration of insulin for clinically stable named adults in community nursing.pdf	Procedure	01/12/2021	01/09/2024	Lisa Morris (BCUHB - Pharmacy and Medicines Management);#444	Executive Medical Director
MM31 - Guideline for the Prescribing, Supply & Administration of Methotrexate for Adults - V2.0.pdf	Guideline	14/02/2022	14/02/2025	Rhys Davies (BCUHB - Pharmacy);#2838	Executive Medical Director
MM82 - Guidelines on the use of oral antiplatelet medications in adults.pdf	Guideline	15/07/2022	01/02/2025	Sarah Stones (BCUHB - Pharmacy);#292	Executive Medical Director
NWCRF SOP07 - Standard Operating Procedure - Management of Volunteer Master File.pdf	Procedure	04/10/2022	01/08/2024	Elizabeth Harrison (BCUHB - Research & Development);#735	Executive Medical Director
NWCRF SOP08 - Standard Operating Procedure - The Over Volunteering Prevention Scheme (TOPS).pdf	Procedure	04/10/2022	01/08/2024	Elizabeth Harrison (BCUHB - Research & Development);#735	Executive Medical Director

Document	Type	Date 1	Date 2	Owner	Role
NWCRF SOP13 - Standard Operating Procedure - for Drug and Alcohol Testing in Clinical Trials.pdf	Procedure	04/10/2022	01/08/2024	Katharine Burton (Abergele - The Surgery (Abergele));#1250;#Elizabeth Harrison (BCUHB - Research & Development);#735	Executive Medical Director
R01 - SOP for Reporting of Deviations and breaches of protocol or GCP.pdf	Procedure	02/08/2022	02/08/2024	Lynne Grundy (BCUHB - Research & Development);#69	Executive Medical Director
R02 - Standard Operating Procedure for Data Protection and Confidentiality In Research.pdf	Procedure	18/01/2023	18/01/2025	Laura Longshaw (BCUHB - Research & Development);#267	Executive Medical Director
S01 - SOP for Urgent Safety Measures in Research.pdf	Procedure	02/08/2022	02/08/2024	Lynne Grundy (BCUHB - Research & Development);#69	Executive Medical Director
S02 - SOP for Safety Reporting in Research.pdf	Procedure	02/08/2022	02/08/2024		Executive Medical Director
TM09 - Standard Operating Procedure for Study Closure and Follow Up.pdf	Procedure	18/01/2023	18/01/2025	Laura Longshaw (BCUHB - Research & Development);#267	Executive Medical Director
TM10 - Standard Operating Procedure for Study Reporting.pdf	Procedure	18/01/2023	18/01/2025	Laura Longshaw (BCUHB - Research & Development);#267	Executive Medical Director
TM14 - SOP for Study Version and Document Control.pdf	Procedure	02/08/2022	02/08/2024		Executive Medical Director
MHLD 0032 - Procedure for Review of a Patients Detention or Community Treatment Order by the Managers Discharge Panel - V3.pdf	Procedure	14/02/2022	14/02/2025	Wendy Lappin (BCUHB - Quality Directorate);#1196	HB Lead for MHLD and Welsh Language
MHLD SM003 - Pregnancy Testing in Substance Misuse Service - V7.0.pdf	Protocol	10/12/2021	10/12/2024		HB Lead for MHLD and Welsh Language

Teitl adroddiad: *Report title:*	Update report on Structured Assessments
Adrodd i: *Report to:*	Audit Committee
Dyddiad y Cyfarfod: *Date of Meeting:*	Thursday, 12 September 2024
Crynodeb Gweithredol: *Executive Summary:*	The purpose of this report is to provide the Audit Committee with: • an update in respect of those Structured Assessment recommendations which have been completed, closed, or superseded • a position update in respect of those which remain open
Argymhellion: *Recommendations:*	The Audit Committee is asked to: • NOTE AND AGREE the recommendations which have been confirmed as completed, closed, or superseded • NOTE the progress and position in respect of those recommendations that currently remain open
Arweinydd Gweithredol: *Executive Lead:*	Pam Wenger, Director of Corporate Governance
Awdur yr Adroddiad: *Report Author:*	Glesni Driver, Head of Covid-19 Inquiry and Thirlwall Inquiry

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

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

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

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

Even though a considerable amount of work has been undertaken by action owners and Executive Directors on outstanding Structured Assessment recommendations, a number of

	these remain overdue. As usual, guidance and support is provided by the Corporate Governance Directorate to all recommendation action owners and Executive Leads
Cyswllt ag Amcan/Amcanion Strategol: *Link to Strategic Objective(s):*	Not applicable, other than those relating to individual audit reviews / recommendations
Goblygiadau rheoleiddio a lleol: *Regulatory and legal implications:*	Compliance with External Audit requirements.
Yn unol â WP7, a oedd EqIA yn angenrheidiol ac a gafodd ei gynnal? *In accordance with WP7 has an EqIA been identified as necessary and undertaken?*	The Equality duty is not applicable. This 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).
Yn unol â WP68, a oedd SEIA yn angenrheidiol ac a gafodd ei gynnal? *In accordance with WP68, has an SEIA identified as necessary been undertaken?*	The Socio-Economic duty is not applicable. 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).
Manylion am risgiau sy'n gysylltiedig â phwnc a chwmpas y papur hwn, gan gynnwys risgiau newydd (croesgyfeirio at y BAF a'r CRR) *Details of risks associated with the subject and scope of this paper, including new risks(cross reference to the BAF and CRR)*	Not applicable, other than those relating to individual audit reviews / recommendations
Goblygiadau ariannol o ganlyniad i roi'r argymhellion ar waith *Financial implications as a result of implementing the recommendations*	Not applicable, other than those relating to individual audit reviews / recommendations
Goblygiadau gweithlu o ganlyniad i roi'r argymhellion ar waith *Workforce implications as a result of implementing the recommendations*	Not applicable, other than those relating to individual audit reviews / recommendations
Adborth, ymateb a chrynodeb dilynol ar ôl ymgynghori *Feedback, response, and follow up summary following consultation*	Not applicable.
Cysylltiadau â risgiau BAF: (neu gysylltiadau â'r Gofrestr Risg Gorfforaethol) *Links to BAF risks:* (or links to the Corporate Risk Register)	Not applicable, other than those relating to individual audit reviews / recommendations
Rheswm dros gyflwyno adroddiad i fwrdd cyfrinachol (lle bo'n berthnasol) *Reason for submission of report to confidential board (where relevant)*	Not applicable.
Camau Nesaf: **Gweithredu argymhellion**	

Next Steps:
Implementation of recommendations

The Corporate Governance Directorate will continue to request progress updates from the action owners, and provide regular updates to the Executive Team and Audit Committee on developments.

Rhestr o Atodiadau:
List of Appendices:

Appendix 1 – Structured Assessment reports – details and updates

UPDATE REPORT ON STRUCTURED ASSESSMENTS

1. **INTRODUCTION**

   In line with Recommendation 4 of the 2023 Structured Assessment, the Corporate Governance Directorate has reviewed the Audit Wales recommendations included on the audit tracker, and concurs that not all Audit Wales recommendations made in 2023 were added to the audit tracker at the time of publication. Due to this, the Corporate Governance Directorate has now ensured all Audit Wales recommendation are added to the audit tracker in a timely fashion following publication.

2. **BACKGROUND AND CONTEXT**

   2.1 The Structured Assessment is an annual review undertaken by Audit Wales (formerly Wales Audit Office), which helps to inform the Auditor General's view and opinion on the Health Board's arrangements to secure efficient, effective, and economic use of its resources.

   2.2 Typically, the resulting report contains recommendations for the Health Board where improvement opportunities have been identified.

   2.3 Whilst no new recommendations were made in the 2020 Structured Assessment report, improvement opportunities were noted. Audit Wales (AW) have recorded their intention to review progress against these and any outstanding recommendations as part of their 2021 work.

3. **STATUS UPDATE**

   3.1 The Health Board Structured Assessment recommendations are at differing stages of approval and closure, and due to this, are categorised as follows within this report:

Recommendation closed by Audit Wales, or included in another Structured Assessment
Recommendation approved for closure by Audit Committee (old process pre-January 2024)
Recommendation going through current closure approval process (new process)
Recommendation ongoing and in progress

3.2 The following table summarises the current position in respect of recommendations made within Structured Assessment reports during the period 2019 to 2023, in line with the above categories:

STRUCTURED ASSESSMENT 2019 (includes recommendations from 2016 and 2017)			
Recommendation closed by Audit Wales, or included in another Structured Assessment	Recommendation approved for closure by Audit Committee (old process pre-January 2024)	Recommendation going through current closure approval process (new process)	Recommendation ongoing and in progress
18	6	1	0

STRUCTURED ASSESSMENT 2020			
Recommendation closed by Audit Wales, or included in another Structured Assessment	Recommendation approved for closure by Audit Committee (old process pre-January 2024)	Recommendation going through current closure approval process (new process)	Recommendation ongoing and in progress
4	2	0	0

STRUCTURED ASSESSMENT 2021 (PHASE TWO) – CORPORATE GOVERNANCE AND FINANCIAL MANAGEMENT ARRANGEMENTS			
Recommendation closed by Audit Wales, or included in another Structured Assessment	Recommendation approved for closure by Audit Committee (old process pre-January 2024)	Recommendation going through current closure approval process (new process)	Recommendation ongoing and in progress
1	2	1	0

STRUCTURED ASSESSMENT 2022			
Recommendation closed by Audit Wales, or included in another Structured Assessment	Recommendation approved for closure by Audit Committee (old process pre-January 2024)	Recommendation going through current closure approval process (new process)	Recommendation ongoing and in progress
6	1	6	3

STRUCTURED ASSESSMENT 2023			
Recommendation closed by Audit Wales, or included in another Structured Assessment	Recommendation approved for closure by Audit Committee (old process pre-January 2024)	Recommendation going through current closure approval process (new process)	Recommendation ongoing and in progress
n/a*	n/a**	6	4

* latest Structured Assessment report
** all recommendations are new, therefore subject to the new closure approval process

Please note that there were no recommendations included within the 'Structured Assessment 2021 (Phase Two) – Corporate Governance and Financial Management Arrangements' report.

3.3   Where recommendations have been recorded above as closed, by Audit Wales this has been documented in a subsequent Structured Assessment report.

3.4   The recommendations listed as approved for closure by the Audit Committee were closed as part of the previous approval process, in place pre-January 2024. This information has been obtained from information included on the TeamMate system, which was in use by the Health Board at that time.

3.5   The recommendations listed as going through the current closure approval process are at one of the following stages:

- Awaiting Executive Director approval
- Received Executive Director approval
- Awaiting Executive Team approval
- Received Executive Team approval
- Awaiting Internal Audit or Audit Wales approval
- Received Internal Audit or Audit Wales approval
- Awaiting Audit Committee approval for closure
- Approved for closure by the Audit Committee.

3.6   The full details of each recommendation, the detail included in the Structured Assessment reports, and the latest lead Executive Director update is included in Appendix 1.

4.   **SUMMARY OF PROGRESS**

Structured Assessment 2019

Recommendation 7 was approved for closure at the Executive Team on 28th August 2024, and is now awaiting Audit Wales and Audit Committee approval.

All other recommendations have been actioned from a Health Board perspective.

Structured Assessment 2020

All recommendations have been actioned from a Health Board perspective, therefore there are no outstanding recommendations.

Structured Assessment 2021 (Phase 2)

All recommendations have been actioned from a Health Board perspective, therefore there are no outstanding recommendations.

Structured Assessment 2022

Only three recommendations remain outstanding for the Health Board as below, and work is progressing in relation to these, as follows:

5
7
12b

Structured Assessment 2023

Only four recommendations remain outstanding for the Health Board as below, and work is progressing in relation to these:

2
5a
5b
6

5. **NEXT STEPS**

    The Corporate Governance Directorate will continue to request updates on all open Structured Assessment recommendations, and provide regular updates on progress to the Executive Team, and thereafter the Audit Committee.

6. **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.

7. **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.

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 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 - STRUCTURED ASSESSMENT REPORTS – DETAILS AND UPDATES

STRUCTURED ASSESSMENT REPORTS - DETAILS AND UPDATES

Performance rationale

Recommendation closed by Audit Wales, or included in another Structured Assessment
Recommendation approved for closure by Audit Committee (old process pre-January 2024)
Recommendation going through current closure approval process (new process)
Recommendation ongoing and in progress

STRUCTURED ASSESSMENT 2019

AUDIT WALES RECOMMENDATION	DESCRIPTION OF PROGRESS INCLUDED IN STRUCTURED ASSESSMENT 2019
Recommendation 2 - 2016	
The Health Board should build upon its assurance mapping work and work towards a board assurance map to complement the corporate risk register, and ultimately the IMTP.	The Health Board has continued to make with its board assurance mapping. Recommendation closed
Recommendation 4b - 2016	
The Health Board should strengthen its processes for systematically reporting, cascading and implementing lessons learnt (in relation to quality of services).	We will consider progress as part of our quality governance review during 2020.
Recommendation 1 - 2017	
Embed a savings approach based on targeting savings at areas where benchmarking demonstrates inefficiencies, to deliver longer term sustainability.	With the assistance of external consultants, savings schemes are better focussed across a range of areas, linked to benchmarking areas of opportunity. Recommendation closed
Recommendation 2 - 2017	
Identify where longer-term and sustainable efficiencies can be achieved through service modernisation and application of approaches such as value-based healthcare, productivity improvements and invest to save.	There is insufficient evidence that value based healthcare, productivity improvements, invest to save and service modernisation are having a sustained positive impact on the finances. This recommendation is open and has been amalgamated to recommendation 1 of the 2019 review.
Recommendation 3 - 2017	
Ensure that budget holders receive the necessary specialist support from enablers such as the Programme Management Office, workforce, procurement and informatics teams.	There is a significant package of work in place co-ordinated through the financial recovery group. Several interim management appointments are supporting and driving improvement. Shared Service Procurement services are actively engaged in the Health Board's financial recovery programme. Recommendation closed
Recommendation 4 - 2017	
Ensure that financial savings assumptions are fully integrated into annual and medium-term plans so that savings efficiencies form part of service modernisation.	Financial savings assumptions are clearly built into service plans and trajectories for annual planning, but this is less clear for the longer-term financial position. Recommendation closed
Recommendation 6 - 2017	
Further strengthen the corporate monitoring approach to ensure it supports and enables savings plans which are slipping and encourages longer-term savings and efficiency programmes.	Robust corporate monitoring is taking place which clearly identifies risks to achievement of savings, monthly trajectories and early identification on slippage. There are regular challenge meetings on each savings programme. Recommendation closed
Recommendation 7 - 2017	
Ensure that plans presented to the Board include costed options where applicable and contain sufficient information to indicate to the Board that they are affordable in the short, medium and long term.	Plans presented to the Board and committees now include costings, which is helping decision-makers to understand affordability of proposals within the current budget. Recommendation closed.

Recommendation 9 - 2017	
Build on the Health Board's programme of clinical audit to ensure it: • aligns with quality strategy priorities and risks; • sets out patient/quality outcomes or impact as a requirement of audit planning to help it understand the value that clinical audit is contributing; and • informs the Quality, Safety and Experience Committee with clear and focussed assurance reports	The Health Board has improved its clinical audit planning and accountability and started to consider reporting and assurance approaches. While there remains more to do, progress is positive and regularly overseen by the Audit Committee. Recommendation closed
Recommendation 10a - 2017	
Ensure financial savings are embedded into change programmes and plans.	Financial recovery both in the short term and longer term is increasingly becoming the dominant agenda item for the improvement groups and their developing programmes. Recommendation closed
Recommendation 10b - 2017	
Strengthen capacity and capability within centrally managed change programmes	The Health Board was in the process of strengthening the capacity and capability of the centrally managed change programmes, earlier in the year, but the attention has more recently been given to short-term financial recovery. There remains a need to build stronger change and programme management arrangements. This recommendation is open and has been amalgamated to recommendation 3 of the 2019 review
Recommendation 10c - 2017	
Strengthen change enabling capability and capacity in divisions	There has been some improvement to change enabling capacity, particularly in the acute setting with interim management. The organisation needs to build its own capacity and reduce the reliance on interim management. This recommendation is open and has been amalgamated to recommendations 3 and 5 of the 2019 review.
Recommendation 10d - 2017	
Ensure workforce, informatics and other enabling resources are integral to change delivery arrangements.	There are clear, approved and realistic workforce, informatics and estates plans that support and enable clinical and operational service improvements. Recommendation closed
Recommendation 10e - 2017	
Ensure clinical engagement and leadership are integral elements within change programmes.	Clinical engagement in service change, improvement and modernisation remains key to effective service modelling, and long-term sustainability of services. This is demonstrated in pockets. This recommendation is open and has been amalgamated to recommendation 2 of the 2019 review.
Recommendation 10f - 2017	
Strengthen accountability for progress against plans, including the annual operating plan and, when developed, the IMTP.	There is stronger accountability for delivery of plans and better oversight of progress. Recommendation closed
Recommendation 11a - 2017	
Work with educational partners, research partners and internal stakeholders to shape new job roles to increase the attractiveness of the job offer as part of clinical staff recruitment	There is now a clear commitment to work with education partners to shape job roles to improve the attractiveness of the role, particularly for some hard-to-fill vacancies. Recommendation closed
Recommendation 11b - 2017	
Increase tactical recruitment capacity to support delivery of R11a.	The new workforce management structure now has stronger recruitment support capacity. Recommendation closed

Recommendation 13 - 2017	
Increase investment in technology where this clearly will result in a greater level of returned cashable efficiencies or transformational economies.	Plans are starting to better incorporate digital investments to create efficiencies. Nevertheless, there remains significant opportunity for digitally enabled care services to drive service efficiency and productivity across care pathways. Recommendation closed.

AUDIT WALES RECOMMENDATION	MANAGEMENT RESPONSE	EXECUTIVE DIRECTOR LEAD UPDATE
Clinical strategy and service planning		
Recommendation 1 - 2019		
Ensure that work to develop a clinical services strategy is delivered to planned timescales and includes a fundamental review of the shape and location of clinical services across all three main hospital sites. This work should focus on solving a number of service sustainability issues including: • medical staffing, vacancy gaps and on-call rota management; • service efficiency and affordability; • ability to meet forecasted growth in service demand; • mitigate the impact of unscheduled care on the effectiveness of wider services; and • enabling sub-specialisation of clinical services, where beneficial.	A digitally enabled clinical strategy has been proposed and extensively discussed at health board meetings in September, October and November 2019. It sets out an ambitious approach to improving population health by focussing on prevention and systems changes, specifically establishing whole-system evidence based pathways; managed professional networks; and implementing a core bundle of digital healthcare technology, e.g. a digital health record. This strategy will disrupt traditional ways of working and enable greater digital literacy. It will build a system that focusses and measures outcomes and places less and less reliance on the site of care, moving to more accessible and personalised care. The strategy will reduce unwarranted variation in practice and outcomes, enhance specialisation and opportunities to improve research partnerships. The strategy will support prudent healthcare and improve the use of resources and maintain an affordable service that meets growth in demand. The Health Board is supporting the development of the strategy, with updates and the final implementation plan due by April 2020.	The Clinical Services Strategy has been through QSE Committee. Since then discussed with Executive Medical Director and Assistant Director of Transformation whose view is to seek to close this action as a clinical services strategy was developed and there have been various changes in leadership where the strategic context and approach has been reset since this action was taken in 2019.

Clinical engagement in service design and transformation		
Recommendation 2 - 2019		
Ensure clinical engagement and leadership are integral elements as part of the development of clinical strategy and associated change programmes	Clinical engagement has commenced, as part of a variety of initiatives including service transformation groups, cluster planning and medical and clinical staff involvement in the development of the proposed clinical services strategy. Further engagement is planned before April 2020, including a series of clinical summits, to develop the clinical leadership opportunities and formally appoint clinical leaders for the new pathways and networks, and to enhance the clinical informatics capability across the health board.	Clinical engagement is embedded in the development of the Clinical Strategy with Clinical and and non Clinical staff engagement planned, as per previous status update

Programme management arrangements supporting service change and transformation

Recommendation 3 - 2019

To support effective delivery of clinical strategy, introduce a clear programme management structure, change programmes and programme management methodology. This should incorporate both required central and corporate structure as well as resources to enhance division-level change management capacity.	The Health Board has agreed to establish a central improvement and portfolio management service. The aim of this service is to support the development and delivery of both an improvement system and methodology together with a portfolio management infrastructure. This recognises the need for both horizontal and vertical (strategic/tactical/operational) delivery of improvement across a complex system.	Co-ordinated transformation function established by the Exec Director of Primary Care & Community Services with the appointments of a Director of Transformation and a Deputy Director completed who have commenced during September. A Transformation Strategy is being developed which will incorporate transformation principles and 3 planes of transformation that have been agreed. The first phase of incorporating existing teams into a single transformation function has been completed which brings together the Service Improvement Team, QI hub and PMO into a single function unit accountable through the Director of Transformation to a single executive. The second phase involves working through the wider organisation to review and align any other relevant roles into the transformation function.

Executive team structure

Recommendation 4 - 2019

The Health Board should review the form and function of the executive team to: • ensure that there is clear responsibility for acute care services at an Executive level; • ensure that programme leadership for service transformation has clear executive director level responsibility or responsibilities; and • increase focus on strategy, organisational design and the capacity and capability within the organisation to deliver the necessary change.	Following discussion at the appropriate Board committee, agreement has been reached on a new structure to ensure there is clear responsibility for acute care services at an Executive level. Programme leadership for service transformation sits with the Executive Director of Workforce and Organisational Development. Increasing our focus on strategy, organisational design and the capacity and capability for change within the organisation will be addressed through our planning process for 2020-2023, culminating in a plan being agreed by the Board prior to April, though achieving the changes in organisational culture and approach will need to be an ongoing programme.	There is now clear responsibility for acute services at Executive level – which now rests with the Deputy Chief Executive / Executive Director of Nursing & Midwifery. Programme leadership for service transformation also has clear Executive Director alignment (Deputy Chief Executive / Executive Director of Nursing & Midwifery). In light of the COVID-19 pandemic, the organisation has developed and submitted Q1/Q2 plans and is currently working on the Q3/Q4 plan in line with Welsh Government requirements. Continued focus on strategy, organisational design and the capacity and capability for change will continue through the planning process.

Reliance on temporary management staffing

Recommendation 5 - 2019

As part of the Health Board's wider approach to workforce planning, aim to reduce reliance on external interim management by building the required senior manager capacity and capability within the organisation, especially in relation to service transformation and change.	A management review is underway under the workforce optimisation structure. One of the key objectives of this review is to determine the management capacity and capability required to move the organisation forward making best use of the system architecture. This is also intrinsically linked with our improvement structure/system and infrastructure as referenced above.	As of the 31st March 2024, there were no senior agency interims in the Health Board, and only a small amount of temporary senior staff (single figures) working through our bank.

Acute services structure

Recommendation 6 - 2019

Finalise and agree the management structure for acute services.	Following discussion at the appropriate Board Committee, agreement has been reached on a new structure.	The Health Board structure has changed since this recommendation, and has since implemented a new Operating Model with a different structure to what was in place when the Structured Assessment review was undertaken.

Audit recommendation tracking and sign-off		
Recommendation 7 - 2019		
Ensure that senior management processes for reviewing and sign-off are strengthened so that the audit committee is assured that progress is accurately reported and that actions in response to recommendations are delivered in a timely and effective manner.	The management of the Audit Tracker Tool and associated processes has recently been strengthened through the trialling of an alternative approach to reviewing tracker recommendations. This approach includes a reformatted tracker report focusing on high risk recommendations exceeding their original implementation date, Internal Audit sampling of closed recommendations to provide added assurance on actions taken, and greater accountability for overdue actions through requiring additional managers to present at Audit Committee meetings. A recent concerted effort to sharpen the focus on priorities has seen a significant number of audit tracker actions closed. This has made the Tracker Tool more manageable and will enable resources to be targeted at enhancing the quality of status updates to ensure they fully address the recommendation, and also at the achievement of realistic implementation dates.	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, with the report structure amended to be much more focused on key areas. 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.

STRUCTURED ASSESSMENT 2020

AUDIT WALES RECOMMENDATION	MANAGEMENT RESPONSE	UPDATE INCLUDED IN STRUCTURED ASSESSMENT REPORT	EXECUTIVE DIRECTOR LEAD UPDATE
Resilience/incident response planning			
Recommendation 1a - 2020			
Undertake a rapid learning exercise on COVID-19 governance to inform and adapt resilience and emergency response plans, so they can be implemented should they be required over the coming months. This should include consideration of: • any need to temporarily adapt the Scheme of Reservation and Delegation to ensure financial and decision-making authority is aligned and • the risk management approach adopted as part of command and control and workstream arrangements.	A debriefing programme was implemented across the BCU command and control structures. The objectives of the debrief were: • To allow the Health Board to reflect on the identification of lessons learned and shared good practice from the incident; • To identify organisational experience relative to individual roles and responsibilities relating to the incident; • To identify key areas for development for the future; • To assist in the development or formation of guidelines or protocols for future incidents; and • To capture lessons learnt to feed into future response planning. Following this review, a report was prepared by Civil Contingencies Group (CCG) and finalised by Executive Team.		Update from TeamMate "Update today supports approval of the implementation of this recommendation = Implemented, approved by Audit Committee"
Recommendation 1b - 2020			
Undertake a rapid learning exercise on COVID-19 governance to inform and adapt resilience and emergency response plans, so they can be implemented should they be required over the coming months. This should include consideration of: • any need to temporarily adapt the Scheme of Reservation and Delegation to ensure financial and decision-making authority is aligned and • the risk management approach adopted as part of command and control and workstream arrangements.	The report sets out areas of good practice, together with recommendations for improvement. An executive led action plan was developed in response to ensure improved arrangements going forwards. The report and action plan was presented to the Strategy, Partnerships and Population Health Committee for approval.	Listed as 'Complete' in the Structured Assessment 2021 (Phase Two) - Corporate Governance and Financial Management Arrangements audit report.	
Recommendation 1c - 2020			
Undertake a rapid learning exercise on COVID-19 governance to inform and adapt resilience and emergency response plans, so they can be implemented should they be required over the coming months. This should include consideration of: • any need to temporarily adapt the Scheme of Reservation and Delegation to ensure financial and decision-making authority is aligned and • the risk management approach adopted as part of command and control and workstream arrangements.	The action plan includes a full review of the existing COVID Command & Control structures led by COVID-19 Lead Director / Director of Planning and Performance. In addition, the decision-making protocol developed as part of the Command and Control Framework to be reviewed ensuring clarity at each level of the response. Led by Acting Board Secretary / Assistant Director of Information Governance & Risk. In addition to the debrief programme, a full review of the Health Board Major Emergency Plan has been undertaken along with revisions to Hospital Major Incident Plans to ensure that Covid considerations are included within key departmental action cards. Specific management arrangements have been developed for COVID-19 going forward, led by Director of Primary and Community Services. However, should a major incident be declared, command and control structures will be mobilised in line with outcomes of the above work.	Listed as 'Complete' in the Structured Assessment 2021 (Phase Two) - Corporate Governance and Financial Management Arrangements audit report.	
Stakeholder engagement in clinical strategy and plan development			
Recommendation 2a - 2020			
Ensure there is effective stakeholder engagement in the development of clinical strategy and any plans for significant service change.	During the first surge of Covid 19, the clinical strategy included a short cycle planning with a 'Once for North Wales' approach. The stakeholder engagement took place throughout, with the creation of pathways and the check and challenge approach at the Clinical Advisory Group (CAG). Further work is now ongoing to strengthen the CAG with further inclusion of stakeholders, such as Digital/Informatics. In addition to this work is now being undertaken to integrate the restart of essential services within the clinical strategy and to test the approach with CAG given its wider stakeholder presence. There is a standard operating procedure in place to ensure effective stakeholder engagement in the development of the clinical strategy and any plans for significant service change during our short cycle response.	Listed as 'Complete' in the Structured Assessment 2021 (Phase Two) - Corporate Governance and Financial Management Arrangements audit report.	
Recommendation 2b - 2020			
Ensure there is effective stakeholder engagement in the development of clinical strategy and any plans for significant service change.	As BCUHB considers further development of the longer-term clinical strategy, it is envisaged that there will a development of a wide stakeholder engagement plan. This will involve agencies such as CHC, local authority, primary and secondary care, Universities, Welsh Government, as examples.	Listed as 'Complete' in the Structured Assessment 2021 (Phase Two) - Corporate Governance and Financial Management Arrangements audit report.	

Reporting progress against delivery of plans			
Recommendation 3 - 2020			
Ensure that impacts and outcomes achieved as a result of delivery of actions are appropriately articulated within quarterly plan and annual plan monitoring reports. This may require strengthening of underpinning business benefits analysis processes.	The plan for quarters 3 and 4 is stronger on outcomes at a programme level than previous quarterly plans. Our chosen outcomes tie back to Living Healthier Staying Well and national outcome frameworks. Performance trajectories are also being developed for this planning round. In respect of reporting against performance, through direct engagement with operational leads, we are strengthening the narratives required for actions that are off track. Furthermore, we are looking at triangulation with the performance measures outlined in the NHS Wales Delivery Framework and how plan outcomes are impacting upon these.		IPR has now been agreed by the Board and is being used in Health Board meetings. Completed and presented to Audit Committee, and has been published by Audit Wales.

STRUCTURED ASSESSMENT 2021 (PHASE ONE) – OPERATIONAL PLANNING

No recommendations within this report

STRUCTURED ASSESSMENT 2021 (PHASE TWO) – CORPORATE GOVERNANCE AND FINANCIAL MANAGEMENT ARRANGEMENTS

AUDIT WALES RECOMMENDATION	MANAGEMENT RESPONSE	UPDATE INCLUDED IN STRUCTURED ASSESSMENT REPORT	EXECUTIVE DIRECTOR LEAD UPDATE
Financial reporting			
Recommendation 1 - 2021 - Phase 2			
Ensure improved focus on financial efficiency of services within finance reports. This could be achieved through periodic or thematic deep dives on financial efficiency, reporting on value-based healthcare progress, or as part of routine financial reporting.	1a The Health Board already produces comprehensive benchmarking data on clinical services, and this is used to help identify savings opportunities as well as initiatives to improve patient experience.		The Health Board already produces comprehensive benchmarking data on clinical services, and this is used to help identify savings opportunities as well as initiatives to improve patient experience. We also now provide regular transformation updates (which incorporate value-based healthcare (VBHC) and service improvement projects) to the Performance, Finance and Information Governance (PFIG) Committee. We have included 2 deep dives / meeting into divisional performance onto the cycle of business for the PFIG Committee
	1b We also now provide regular transformation updates (which incorporate value-based healthcare (VBHC) and service improvement projects) to the Performance, Finance and Information Governance (PFIG) Committee		An example of regular transformation updates, which incorporates value-based healthcare and service improvement projects to PFIG Committee
	1c We have included 2 deep dives / meeting into divisional performance onto the cycle of business for the PFIG Committee.	Assessment is this is now considered implemented and business as usual	
	1d The business case process is being updated and simplified and will include an assessment of: • the relative efficiency of the specific service; • what action has been considered to improve that efficiency ahead of the business case. The programme around clinical pathways and service reviews will include an assessment of relative financial and operational efficiency and what benefits can be expected from the implementation of the new pathway.		Action in regard to this recommendation is tied to the Special Measures independent review of Planning. We have formally received the review and it has been presented to a development session of PFIG. The management response contains actions to address this area and will be formally presented to PFIG on 30/04/24. Due to this being dealt with under the Special Measures independent review of Planning, and in order to avoid duplication of reporting, this recommendation is put forward for closure.

STRUCTURED ASSESSMENT 2022

AUDIT WALES RECOMMENDATION	MANAGEMENT RESPONSE	UPDATE INCLUDED IN STRUCTURED ASSESSMENT REPORT	EXECUTIVE DIRECTOR LEAD UPDATE
Review and where needed strengthen risk mitigating actions			
Recommendation 1 - 2022			
Despite recent changes to the Health Board's strategic and corporate risk arrangements, risk scores in some key areas are not decreasing. The Health Board should review the mitigating actions on the corporate risk register and Board Assurance Framework to ensure they are having the intended impact	R1a The Interim Board Secretary is overseeing the revision of the risk management framework, including consideration of the corporate risk register and Board Assurance Framework to ensure clear mitigations and associated timescales are in place as part of the process of refreshing these documents including robustness of risk action plans. This process will conclude in September 2023 and will be evidenced by a Board approved Risk Management Framework.		Note old recommendationa and the CRR was since reviewed and consolidated in Oct 2023. However the risk appetite session for the Board highlights key actions and where risk scores are above tolerance. A proposal is being presented that there is further scruity of these risks. The Risk Scruity Panel will commence 09/06/24, this will strengthen the scrutiny process.
	R1b In the period from this report to the 28 September, the Risk Management Group is overseeing the risks and the mitigating actions and challenges to the scores and mitigations come from the Risk Management Group. The Associate Director of Governance worked with the Risk Management Group to amend the Terms of Reference to reflect the meeting becoming a more "collective support and challenge" to reviewing the significant risks of the organisation.	This is listed as 'Completed' within the Structured Assessment 2022 report	
	R1c In addition, the Associate Director of Governance brings reports to the Executive Team meeting with key issues related to risk scores and mitigation. This has commenced. Also, the Associate Director of Governance has placed risk on the agenda of the Service Performance and Accountability review.	This is listed as 'Completed' within the Structured Assessment 2022 report	
Review of performance management assurance reporting			
Recommendation 2 - 2022			
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	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.		Plan monitoring has moved over to the Transformation Team since April 2023
Ensure accuracy of reporting Public Services Ombudsman for Wales figures			
Recommendation 3 - 2022			
There have been discrepancies between the complaint figures reported by the Public Services Ombudsman for the Health Board and the Health Board's own figures within previous annual reports. While the Health Board rectified this in its 2021-22 annual report, the Health Board should ensure such discrepancies do not reoccur. The Health Board should validate and verify Public Service Ombudsman for Wales complaint numbers prior to inclusion in annual reports.	Following the findings that the Health Board and Ombudsman were reporting different sets of data, monthly meetings were arranged to undertake validation. These have been held with the Head of Complaints Standards at PSOW and his team and the Health Board's Quality Governance Team. It has recently been agreed to reduce these meetings to quarterly, as there is confidence in the data and ongoing validation process. The Health Board also agreed that to avoid any repeat confusion, in our annual report we would use the Ombudsman's data definition and we would further validate the data before it is used in our report. This has happened this year as planned – evidence of this has been submitted to Audit Wales.	This is listed as 'Completed' within the Structured Assessment 2022 report. Also, in the Structured Assessment 2023, it was noted as Complete. The Health Board instigated monthly meetings with the office of the Public Services Ombudsman for Wales to validate data to ensure accurate annual reporting.	
Review Health Board policies			
Recommendation 4 - 2022			
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	R4a The Interim Board Secretary has secured dedicated resource back into the Office of the Board Secretary from 1 August 2023 to support the prioritisation and review of policies.	This is listed as 'Completed' within the Structured Assessment 2022 report	
	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		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.

Review audit recommendation tracker

Recommendation 5 - 2022

The audit recommendation tracker and report in their current format provide limited detail, particularly around actions considered complete. The Health Board should work with Audit Committee members to review the format of the audit tracker and report to ensure it provides sufficient information to provide assurance.	A revised internal and external audit tracker is due to be introduced within the Health Board. Key short-term actions (up to September 2023) include the review of the existing audit tracker to consolidate and/or close completed actions for reporting to the September Audit Committee. In parallel to this, the Statutory Compliance, Governance and Policy Manager (under the leadership of the Interim Board Secretary) will develop an in-house digital solution for the future tracking of recommendations		Significant work has been undertaken since January 2024 to (a) ensure that all internal and external audit recommendations are included on the tracker, and (b) that the Corporate Governance Directorate receives regular updates on progress so as to provide timely and useful updates to both the Executive Team and Audit Committee. This work has been extensive due to the number of recommendations and reports not included on the tracker from pre-2022, and due to the difficulties with the Health Board ceasing to use the TeamMate system. Due to this, over 800 recommendations have been added to the current tracker, dating back to 2015, and work to update or close these recommendations are ongoing. Once this work has been completed, and there is assurance that all recommendations that should be on the tracker are included, work will then start to review options of an electronic audit tracking system, and move the current tracker over to that system..

Implementation of the new operating model

Recommendation 6 - 2022

The Health Board should complete the implementation of the new operating model as a matter of urgency, particularly in respect of recruiting substantial post holders and reducing reliance on interim appointments.	The Stronger Together Operating Model is subject to a Stocktake Review as part of the organisation's Special measures response. This will assist in identifying elements that may need revision or strengthening. In the meantime, a recruitment plan for substantive postholders is being implemented. The Health Board undertook an executive search and selection for Chief Executive in summer 2023. A new search and selection partner will be appointed. The People and OD Directorate are working closely with Welsh Government on this. A plan is in place to advertise in quarter four. An interim CEO from the NHS in Wales has been appointed until March 23, and this allows for a portfolio review of the executive to take place (review undertaken by Welsh Government Special Advisor). Following this the Interim CEO will advertise to fill any vacancies substantively. Additional controls to reduce agency and interim reliance have been implemented. This has significantly reduced the number of interims over the past six months. All of the Integrated Healthcare Communities (IHC's) are now led by a substantive Executive Director of Operations, to stabilise and substantively recruit to positions in the IHC structures. A recruitment plan for MH&LD is being implemented to progress substantive appointments.		As of the 31st March 2024, there were no senior agency interims in the Health Board, and only a small amount of temporary senior staff (single figures) working through our bank.

Develop a supporting clinical delivery plan

Recommendation 7 - 2022

The Health Board has developed a clinical strategy for its services, however, there is lack of detail on how it will be implemented. The Health Board should develop supporting clinical delivery plan/plans and delivery structures to shape and implement sustainable service models. Clinical plans should inform workforce, estate, financial resource, and digital services planning	The Health Board will be taking stock of strategic commitments as part of the revised approach to planning. The Special Measures Response Plan includes a review of Planning and the development of an Internal Planning Framework. The Clinical Services Strategy was key to the prioritisation of IMTP proposals and it had been intended that two of the projects taken through the IMTP would be "blueprints" for developing a tool for developing a tool for bringing the strategy into the day to day thinking of the Health Board. However, as significant IMTP investment in new services was not possible this year it is now proposed that: • The clinical services strategy is refined as an operational tool within development of dermatology and urology services. • The current review of vascular service implementation is used to inform refinement of the strategy. Therefore, by October 2023 an operational appendix, including use of the National Clinical Framework, will have been agreed.		The Health Board is taking necassary steps to support the development of a robust Clinical Services Plan (CSP). A commitment to creating a draft CSP is included in our 2024/27 Three Year Plan, and Leads have been identified at Executive level to ovesee progress. The focus remains on delivering sustainable service models within agreed resources.

Reorting on the impact of value based healthcare initiatives

Recommendation 8 - 2022

We 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.	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		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, Prehabilitation 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.

Urgently implement financial recovery approaches to strengthen the financial position

Recommendation 9 - 2022

As of January 2023 the Health Board is off-track with its current savings plan and is slow to progress the savings plan for 2023-24. The Health Board should: • prepare appropriate financial recovery programmes as a matter of urgency for both the remainder of this, and the next financial year. • review options for estate and service disinvestment (i.e., where services are not demonstrating sufficient patient impact and outcomes). • target digital investments on areas of clear business benefits, i.e., where digital can be used to release service efficiency and/or quality gains elsewhere. • introduce stronger reporting and oversight of the medium term financial position, financial strategy and recovery approaches.	The Health Board has considered its digital plan for 2023-24 as part of the Annual Plan. Significant prioritisation discussion for the medium to longer term is required in order to appropriately assess and implement national and local priorities. The internal Planning Framework will include digital service planning in order that service efficiency and quality benefits are identified as part of prioritisation. Digital have delivered a proof of value for Single Sign On (SSO) that allows ED users to be able to log into their critical applications by tapping of their ID card and the simple entry of a pin number. The SSO application then takes over and automatically opens the applications without the need to enter login details for each application. This significantly expedites the login time of each user by an average of 30 minutes per shift which has been measured. This time can be refocused and invested in patient care. In addition to the time saving opportunity, SSO mitigates the need for generic accounts thus providing a secure environment improving auditability and ensuring compliance with data protection policies, procedures and best practice		This formed part of the annual plan paper that was agreed at the Board on 30th May 2024

Introduce stronger financial planning and control to reduce reliance on single tender waivers

Recommendation 10 - 2022

The Health Board has a track-record of substantial and growing use of single tender waivers. The Health Board should improve procurement planning and strengthen single tender waiver financial controls.	The single tender waiver process has been enhanced to ensure that these waivers are only processed where such an action would only be undertaken when compliant with legislation and offers value for money from not testing the wider market. The two key measures contained within the process are signature from the Head of Procurement to assure legality of placement of the award and sign off by the Director of Finance (Operational) to assure the placement of the award will represent value for money. The single tender waivers will be reported to Audit Committee for oversight and assurance of numbers being processed, basis for legality of award and value for money considerations. As part of Special Measures Response Plan a wider Procurement review will take place in order that further learning and improvements can be made, including to the control environment.	This is listed as 'Completed' within the Structured Assessment 2022 report, and in the Structured Assessment 2023, again listed as "Complete. The Health Board has strengthened single tender waiver controls which has reduced the overall extent of their use and associated expenditure committed to through waivers."	

Ensure effectiveness of staff wellbeing services

Recommendation 11 - 2022

The Health Board has introduced a programme of services to support staff wellbeing. However, it is not currently undertaking sufficient evaluation to ensure these are meeting the needs of staff. The Health Board should evaluate the impact of its staff wellbeing services to inform future investment decisions.	As part of a wider culture development programme, health and wellbeing of employees will be reviewed, to align Staff Supports Services (SUS) to the culture programme. Scoping of work programme taking place in Q1/2 to develop programme from Q3. As part of this work, a system of service measures and outcomes will be implemented.	Update in Structured Assessment 2023 - "We will review the progress against this recommendation later in 2024 as part of our next structured assessment review."	

Improve performance and financial oversight for digital and estates

Recommendation 12a - 2022

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.	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.		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 will upgrade infrastructure technology to prevent major IT failures and protect against cyber-attack. SE Learning Organisation. 5. The Health Board will work on safely delivering a defined number of priority projects most of which are critical to service continuity. 6. The Health Board will establish and embed intelligence and insight operating model, governance and architecture. There are significant funding gaps for the effective progression of these workstreams. The Electronic Health Care Records Strategic Outline Case that is yet to be submitted to Welsh Government will cost in the region of £149M over a 10 year contract all be it with some returns on investment. The Essential Service Programme has been costed at circa £6.5M capital a year recurrently with an allocation of circa £2.5M allocated for 2024/25. The necessary skills to recruit to modernise the delivery of DDaT is circa £1.6M recurrently with £500K allocated non-recurrently which is impacting on the ability to recruit the skills. This has been the case since it was identified in 2022/23. The result of this is high scoring BAF and CRR risks for which the Health Board must tolerate due to lack of funds: BAF SP13: There is a risk of failing to meet the Health Board's strategic and operational objectives caused by having inadequate arrangements for the identification, commissioning and delivery of Digital, Data and Technology enabled projects and change. CRR 24-17 There is a risk that we are unable to maintain the minimum level of service to our patients and population caused by having inadequate digital applications, infrastructure, security and resources that may result in major ICT failures or cyber attack. CRR 24-07 There is a risk that patient harm will be caused due to the lack of a joined up longitudinal Electronic Healthcare Record system that digitalises clinical workflow, alerts, hand overs and scheduling which could lead to deaths and harm. DDaT is seen as a priority and consideration will be made for addressing some of this throughout 2024/25 into 2025/26 alongside other priorities and plans to make representation to Welsh Government as investment in this area is a critical if we are to address the varied issues facing the Health Board.

Recommendation 12b - 2022			
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.	Although addressing deficiencies and risks are the priority proof of value, work in small affordable pockets are progressing and demonstrating the benefits that can be delivered if scaled.		- Reporting on the Digital Strategy is undertaken through the Executive Team and as part of the regular reporting to the Planning, Population Health and Partnerships Committee. - High Priority areas/projects are included within the Health Board's Annual Plan which are updated on a quarterly basis and reported within the Annual Plan Performance Report through to the Performance, Finance and Information Governance Committee. - The new Digital Roadmap for BCUHB is currently being finalised, the roadmap will provide a financial delivery update with the gaps identified with the caveat that some projects will be subject to a Business Case as at the time of writing the costs may be unknown. - In relation to the impact, DDaT are working on improving how the benefits lifecycle is managed for projects. An impact section will be included within the Roadmap. - The impact of the Digital Roadmap will be reported on an annual basis to the appropriate Planning, Population Health and Partnerships Committee but high priority areas within the strategy will be regularly reported through the Annual Plan.

STRUCTURED ASSESSMENT 2023

AUDIT WALES RECOMMENDATION	MANAGEMENT RESPONSE	EXECUTIVE DIRECTOR LEAD UPDATE
Transparency of board and committee business		
Recommendation 1 - 2023		
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.	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.	It is now 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.
Recommendation 2 - 2023		
The minutes for some committee meetings are missing from the website many months after the meeting date. This affects timely public access to committee discussions. The Health Board should introduce arrangements to ensure the public have timelier access to records of committee meetings as part of its wider efforts to enhance transparency of Board business.	Agreed. The Director of Corporate Governance will review the current process and the Standing Operating Procedure for Board and Committee meeting and agree this with the Board.	This is being taken forward as part of the Board and Committee Improvement work, the aim is to have committee reports available following the committee meetings
Changing trends in complaint numbers 2023-24		
Recommendation 3 - 2023		
There has also 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	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.	The Quality Management System was approved at Board in May 2024.
Recommendation tracking		
Recommendation 4 - 2023		
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.	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 (bimonthly) 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.	A new approval process for recommendations proposed for closure has been implemented, with final approval of this process at the July Audit Committee.

Recommendation 5a - 2023

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.	Agreed. A recent review of all of the Board Committee cycle of business (received at the Board in January 2024) has made some provision for recommendations received by non audit bodies. This includes QSE Committee and a People and Culture Committee.	Work to amalgamate all audit/non-audit or review recommendations onto one platform will be undertaken once the internal/external audit tracker work to include all missing recommendations and receive updates on all, to include closure of those that are no longer relevant has taken place.

Recommendation 5b - 2023

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.	Agreed. The Director of Corporate Governance will put in place a process and system to ensure that recommendations by other bodies are co-ordinated and have appropriate oversight at Committee and where appropriate Board level.	Work to amalgamate all audit/non-audit or review recommendations onto one platform will be undertaken alongside the work to implement an electronic audit tracker, once the internal/external audit tracker work to include all missing recommendations, and closure of old/outdated recommendations have taken place. This will ensure a complete and meaningful list of all recommendations included on the new electronic tracker. Once this is in place, a cycle of business will be put in place for the reporting of all these recommendations for review and approval at the relevant committees.

Recommendation 5c - 2023

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.	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.	The Quality Management System was approved at Board in May 2024.

Clinical engagement plan

Recommendation 6 - 2023

More needs to be done to reconfigure services to ensure they sustainably meet current and future population healthcare needs. To accompany its clinical strategy, the Health Board should undertake key stakeholder engagement plan to help it shape sustainable service models designed to meet current and future demand.	Agreed. The Health Board recognises the importance of this recommendation. As part of the priority actions for 2024-25, as laid out in the Three Year Plan, the Health Board has planned significant actions that together progress this recommendation. The following actions will be taken forward: During 2024-25 the Health Board will commence the development of a new Health Board strategy and Clinical Services plan. To support this, priorities are already identified to maximise the effect of the stakeholder engagement being planned to support this. These specific priority areas include general work to improve the Health Boards approach to citizen engagement, being a Good Partner, engaging with the national Value and Sustainability Board to incorporate learning from other organisations within NHS Wales, and engaging with clinicians within and outside of the Health Board.	The Health Board has committed to developing a draft Clinical Services Plan (CSP) during 2024/25, that will incorporate known clinical requirements for the next three years, and which will reflect our greatest areas of clinical risk. The Health Board has linked with Hywel Dda University Health Board on their CSP programme approach, and a session has been arranged for July to learn from their experiences on methodology and approach. The draft CSP will be revised in line with our emerging 10 Year Strategy.

Financial strategy		
Recommendation 7 - 2023		
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.	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.	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.

Monitoring progress against accounting issues		
Recommendation 8 - 2023		
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	Agreed. Progress reports will be schedule of part of the Audit Committee Programme of work.	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.

Teitl adroddiad: *Report title:*	Audit Committee Development Plan
Adrodd i: *Report to:*	Audit Committee
Dyddiad y Cyfarfod: *Date of Meeting:*	Thursday, 12 September 2024
Crynodeb Gweithredol: *Executive Summary:*	The purpose of this report is to provide the Audit Committee with: • A proposed plan of suggested items for development sessions
Argymhellion: *Recommendations:*	The Audit Committee is asked to: • **NOTE** AND **AGREE** the proposal to hold bi-monthly Audit Committee development sessions • **AGREE** the proposed topics for the development sessions
Arweinydd Gweithredol: *Executive Lead:*	Pam Wenger, Director of Corporate Governance
Awdur yr Adroddiad: *Report Author:*	Laura Jones, Project Support Manager (Corporate Governance)

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

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

Cyfiawnhad dros y gyfradd sicrwydd uchod. Lle bo sicrwydd 'Rhannol' neu 'Dim Sicrwydd' wedi'i nodi uchod, nodwch gamau i gyflawni sicrwydd 'Derbyniol' uchod, a'r terfyn amser ar gyfer cyflawni hyn: *Justification for the above assurance rating. Where 'Partial' or 'No' assurance has been indicated above, please indicate steps to achieve 'Acceptable' assurance or above, and the timeframe for achieving this:*
As the paper suggests a proposed approach with suggested topics, the assurance level has been stated as partial.

Cyswllt ag Amcan/Amcanion Strategol: *Link to Strategic Objective(s):*	This links to objective 1: Building an effective organisation
Goblygiadau rheoleiddio a lleol:	Not applicable for this report

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

Camau Nesaf:
Next Steps:
1. Following approval of the proposal, Audit Committee development session will be arranged on a bi-monthly basis.

Rhestr o Atodiadau:
List of Appendices:
Appendix 1 – Audit Committee Development Plan 2024-25

AUDIT COMMITTEE DEVELOPMENT PLAN 2024-25

1. INTRODUCTION

Effective development is critically important for both Executive and Independent Members. It is proposed to hold a programme of development sessions for the Audit Committee to meet on a bi-monthly basis during the opposite month to Committee meetings. The aim of these sessions will be to aid learning and understanding of organisational activities and development.

A proposed plan of suggested development items has been produced for consideration by the Audit Committee.

2. PROPOSED TOPICS FOR SESSIONS DURING 2024-25

It is proposed that the topics covered during the development sessions will include those items highlighted in the table below. Prior to the development sessions the presenters will be asked to provide a short briefing with any supporting information or signposting for members to consider in order to support the most effective and efficient use of time at the sessions.

Topic Title	Presenter	Month
Good Practice from Internal Audit Reports across NHS Wales	Simon Cookson	TBC
Role of External and Internal Audit	Dave Harries / Audit Wales	TBC
Counter Fraud	Head of Counter Fraud	TBC
Financial Awareness / Accounts / Tender Processes	Russell Caldicott	TBC
Corporate Governance	Pam Wenger	TBC
Annual Self-Assessment on Role of Audit Committee	Pam Wenger	TBC
Role and Operations of Shared Services	Pam Wenger	TBC

Teitl adroddiad: *Report title:*	Internal Audit Progress Report 1 July to 12 August 2024
Adrodd i: *Report to:*	Audit Committee
Dyddiad y Cyfarfod: *Date of Meeting:*	2 September 2024
Crynodeb Gweithredol: *Executive Summary:*	The progress report is produced in accordance with: • the requirements as set out within the Public Sector Internal Audit Standards: Standard 2060 – Reporting to Senior Management. • the Welsh Government NHS Wales Audit Committee Handbook – Section 4.5 Reviewing internal audit assignment reports. The report details the reviews with reports issued as draft and work in progress. We are in the process of preparing the Audit Plan for October 2024 – March 2025. Due to availability we have not been able to provide a proposed plan to this meeting of the Audit Committee, however we have provided an indicative plan to the Health Board. Following feedback from the Health Board, we will seek ratification of this plan from Committee members, via the Director of Corporate Governance, and present it formally at the November Audit Committee meeting.
Argymhellion: *Recommendations:*	The Committee is asked to: • Receive the progress report. • Approve changes to the plan for the People & OD Strategy, Civil Contingencies Act, Complaints and Concerns and Job Planning reviews.
Arweinydd Gweithredol: *Executive Lead:*	Director of Corporate Governance
Awdur yr Adroddiad: *Report Author:*	Dave Harries, Head of Internal Audit, CMIIA, QiCA Nicola Jones, Deputy Head of Internal Audit, CMIIA

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

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

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

Justification for the above assurance rating. Where 'Partial' or 'No' assurance has been indicated above, please indicate steps to achieve 'Acceptable' assurance or above, and the timeframe for achieving this:	
The report details internal audit assurance against specific reviews which emanate from the corporate risk register and/or assurance framework, as outlined in the internal audit plan. The Health Board assurance ratings differ from those agreed across NHS Wales for internal audit opinions and therefore the assurance level has intentionally been left blank.	
Cyswllt ag Amcan/Amcanion Strategol: *Link to Strategic Objective(s):*	N/A other than those relating to individual audit reviews / recommendations.
Goblygiadau rheoleiddio a lleol: *Regulatory and legal implications:*	The progress report is required in accordance with the Welsh Government NHS Wales Audit Committee Handbook – Section 4.5 Reviewing internal audit assignment reports.
Yn unol â WP7, a oedd EqIA yn angenrheidiol ac a gafodd ei gynnal? *In accordance with WP7 has an EqIA been identified as necessary and undertaken?*	The Equality duty is not applicable. This progress report is required in accordance with the Welsh Government NHS Wales Audit Committee Handbook – Section 4.5 Reviewing internal audit assignment reports. The associated public sector duties are not engaged (there are no associated impacts on any of the protected groups).
Yn unol â WP68, a oedd SEIA yn angenrheidiol ac a gafodd ei gynnal? *In accordance with WP68, has an SEIA identified as necessary been undertaken?*	The Socio-Economic duty is not applicable. This progress report is required in accordance with the Welsh Government NHS Wales Audit Committee Handbook – Section 4.5 Reviewing internal audit assignment reports. The associated public sector duties are not engaged (the report does not relate to a decision, strategic or otherwise).
Manylion am risgiau sy'n gysylltiedig â phwnc a chwmpas y papur hwn, gan gynnwys risgiau newydd (croesgyfeirio at y BAF a'r CRR) *Details of risks associated with the subject and scope of this paper, including new risks(cross reference to the BAF and CRR)*	N/A other than those relating to individual audit reviews/recommendations.
Goblygiadau ariannol o ganlyniad i roi'r argymhellion ar waith *Financial implications as a result of implementing the recommendations*	The progress report may record issues/risks, identified as part of a specific review, which has financial implications for the Health Board.
Goblygiadau gweithlu o ganlyniad i roi'r argymhellion ar waith *Workforce implications as a result of implementing the recommendations*	N/A other than those relating to individual audit reviews/recommendations.
Adborth, ymateb a chrynodeb dilynol ar ôl ymgynghori *Feedback, response, and follow up summary following consultation*	The progress report is produced independently of management. Progress report shared with the Director of Corporate Governance and Executive Team.
Cysylltiadau â risgiau BAF: (neu gysylltiadau â'r Gofrestr Risg Gorfforaethol)	N/A other than those relating to individual audit reviews.

Links to BAF risks: *(or links to the Corporate Risk Register)*	
Rheswm dros gyflwyno adroddiad i fwrdd cyfrinachol (lle bo'n berthnasol) *Reason for submission of report to confidential board (where relevant)*	N/A

Camau Nesaf:
Gweithredu argymhellion

Next Steps:
Implementation of recommendations

The progress report is presented in accordance with the Committee's cycle of business and in line with the requirements of the NHS Wales Audit Committee Handbook.

Rhestr o Atodiadau:

List of Appendices:
- Appendix 1: Progress report

Betsi Cadwaladr University Local Health Board

Audit Committee
Internal Audit Progress Report

1 July to 12 August 2024

NWSSP Audit and Assurance Services

Contents

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

Introduction

1. This progress report provides an update to the Audit Committee in respect of the assurances, key issues, and progress against the Internal Audit (IA) Plans for 2023/24 and 2024/25.

Reports Issued

2. Since the last progress report, three reviews have been issued as draft. No reviews have been finalised.

3. In reviewing the 2024/25 draft reports issued, image 1 details the high-level information from the reviews. This shows the key themes of recommendations to date relate to governance, performance monitoring, policies & procedures and reporting.

Image 1: Extract from the NHS Wales tracker for Betsi Cadwaladr University Health Board as at 12 August 2024 – 2024/25 overview
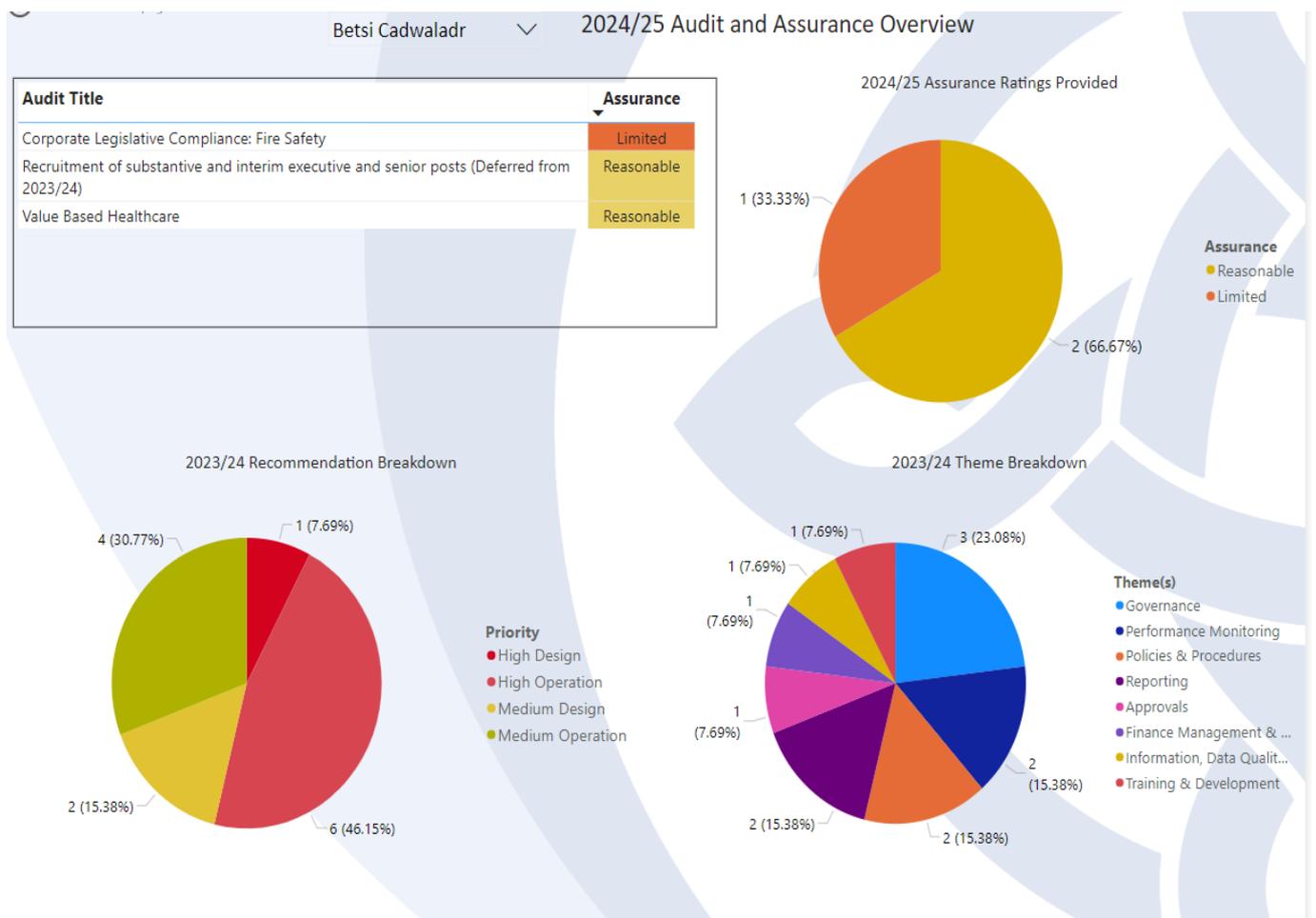
- Theme definition is included at Table 6.

Work in Progress Summary

4.   The following draft reports have been issued:

Table 1: Draft Reports issued.

Review	Status	Date draft report issued	Management response due
Orthopaedic Surgical Hub Llandudno Hospital (2023/24)	Management challenged accuracies within the report. These have been reviewed and responded to and an updated report issued.	20 May 2024 & 26 July 2024	17 June 2024 & 23 August 2024
Value Based Healthcare	Management response is expected.	22 July 2024	19 August 2024
Recruitment of substantive and interim executive and senior posts	Management response is expected.	7 August 2024	5 September 2024
Fire Safety	Management response is expected.	9 August 2024	6 September 2024

5.   The following 2024/25 reviews are currently in progress:

Table 2: Reviews in progress

Review	Draft report due:
Special Measures	August 2024
Charitable Funds	August 2024
Grievance Management	August 2024
Intelligence Led Organisation	August 2024
Establishment Control Process	October 2024

Contingency/Organisational Support/Advice

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

7.   We meet with Audit Wales, Healthcare Inspectorate Wales, Health & Safety Executive and Public Services Ombudsman for Wales regularly to discuss recent issues and areas of emerging risks to the Health Board.

Delivering the Plan

8.   The additional support provided to the Health Board with focused reviews is channelled through contingency.

9.   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.

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

Table 3: Changes to audit plans 2024/25

Audit Title	Reason for requesting deferral / removal from plan / adding to the plan
People & OD Strategy: Operational implementation (Deferred from 2022/23 & 2023/24)	On 11 April 2024, the People and Culture Committee received the Audit Wales report *Review of Workforce Planning Arrangements – Betsi Cadwaladr University Health Board* with recommendations made that cut across several of our identified objectives – Management response has recorded latest implementation by March 2025. We have agreed this in principle with the Director of Corporate Governance, subject to Audit Committee approval. **Recommendation: This review is deferred to 2025/26 to enable implementation of agreed management actions.**
Civil Contingencies Act	There have been delays in obtaining evidence for the review. Following escalation to the Director of Corporate Governance, we met with the recently appointed Head of Emergency Preparedness, Planning and Response. We are advised there is limited recent evidence available to meet the objectives of the review. Considering this, we do not believe there is merit in undertaking the review at this time. This is a significant risk area for the Health Board as a Category One Responder, but also for its own service continuity, that will require some additional assurance through to the Executive on progress. **Recommendation: This review is deferred to 2025/26 to enable management to review and progress the area.**
Quality Governance: Concerns and Complaints	The Health Board has recently approved the Integrated Concerns Policy, which supersedes current process. Noting the implementation plan presented at Board implies all expected actions will have been completed, we note that operationally there will need to be a lead time for the policy and associated governance arrangements to bed-down and do not believe there is merit in auditing the current process. Deferral to Quarter 1 2025/26 will allow eight months for the policy and standard operating procedures to bed down and provided us with meaningful evidence whether the policy and procedures are operating effectively, as well as confirming the changes have made the stated improvements. We have agreed this in principle with the Executive Director of Nursing & Midwifery. **Recommendation: This review is deferred to 2025/26 to enable implementation of the Integrated Concerns Policy.**
Consultant Job Planning	The Head of Internal Audit met the Chief Executive and Director of Corporate Governance 6 August 2024 to discuss this risk area and whether a review had been undertaken recently or could be undertaken recognising the impact effective job planning has on

Audit Title	Reason for requesting deferral / removal from plan / adding to the plan
	productivity – The review was an identified risk area under consideration but was not progressed as policy/procedure was being reviewed; the Chief Executive has requested this review is progressed. **Recommendation: This review is added to the 2024/25 internal audit plan.**

11. The following tables detail the planned performance indicators (Table 4) captured by Internal Audit in delivering the service and the planned delivery of the core internal audit plan (Table 5).

12. Table 4 is reporting a positive status across all indicators. Figures are based on thirty reports/briefing papers issued as final (or requiring no response) for 2023/24.

Table 4: Performance Indicators

Indicator	Status	Actual	Target	Red	Amber	Green
Report turnaround: time from fieldwork completion to draft reporting [10 days]	Green	100%	80%	v>20%	10%<v<20%	v<10%
Report turnaround: time taken for management response to draft report [20 days per Internal Audit Charter and Service Level Agreement]	Green	77%	80%	v>20%	10%<v<20%	v<10%
Report turnaround: time from management response to issue of final report [10 days]	Green	100%	80%	v>20%	10%<v<20%	v<10%

Table 5: Core Plan 2024-25 (April 2024 to September 2024)

Planned output	Outline timing	Status	Assurance (including draft report assurance opinions)
Corporate Legislative Compliance: Civil Contingencies Act 2004	June / July 2024	Brief agreed.	Recommended for deferral.
Special Measures	June / July 2024	Review in progress.	
Follow-Up of Internal Audit recommendations	April to September 2024	Review in progress (ongoing).	
Transformation & Improvement	August / September 2024	Brief issued.	
Charitable Funds (Deferred from 2023/24)	June / July 2024	Review in progress.	

Planned output	Outline timing	Status	Assurance (including draft report assurance opinions)
Value Based Healthcare	June / July 2024	Draft report issued.	Reasonable
Business Cases: Capital	July / August 2024	Brief agreed.	
Quality Governance: Concerns and Complaints	July / September 2024	Request for deferral.	Recommended for deferral.
Corporate Legislative Compliance: Health and Social Care (Quality and Engagement) (Wales) Act 2020 (Duty of Candour and Duty of Quality)	July / September 2024	Planning.	
Intelligence led organisation	July 2024	Review in progress.	
Network and Disaster Recovery	September 2024	Planning.	
People & OD Strategy: Operational implementation (Deferred from 2022/23 & 2023/24)	June / July 2024	Brief agreed.	Recommended for deferral.
Recruitment of substantive and interim executive and senior posts (Deferred from 2023/24)	June / July 2024	Draft report issued.	Reasonable
Establishment Control and Recruitment	July / August 2024	Review in progress.	
Integrated Assurance and Approval Plans (IAAP) • Llandudno Hospital Orthopaedic Hub • Ysbyty Glan Clwyd - Adult and Older Persons Mental Health Unit • Ysbyty Maelor Wrecsam - Infrastructure/ Continuity Works	April to September 2024	Planning.	
Corporate Legislative Compliance: Fire Safety	May 2024	Draft report issued.	Limited
Contracted Patient Services: Quality and Safety arrangements - Follow up (Deferred from 2023/24)	October 2024 to March 2025	Deferred.	

Audit Assurance Ratings

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

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

Table 6: Themes and definitions relating to Image 1

Ref.	Theme	Definition / Examples
1	Approvals	The internal control framework for securing approvals is ineffective. Appropriate approvals have not been sought/ obtained prior to key decisions.
2	Communication & Engagement	There is no clear communication strategy and/ or stakeholder identification arrangements. Information is not communicated clearly internally within teams, or externally with partners, for a or wider stakeholders. Lack of engagement with staff, partners and wider stakeholders. Engagement with external providers is not consistent, resulting in contracts or agreements not being monitored.
3	Contractual	The form of contract is not appropriate and does not adequately protect the interests of the organisation. Contractual documentation has not been executed in a timely manner. The contract is not being applied as intended.
4	Cyber Security	There is no strategy for maintaining cyber security and/ or it is deficient.

Ref.	Theme	Definition / Examples
		The strategy/ plans are not implemented as intended and are therefore ineffective.
5	Financial Management & Control	Financial controls and management information requirements have not been properly considered. The financial controls or management arrangements are inadequate and/ or poorly applied, impacting the exposure to risk.
6	Governance	Inadequate / ineffective governance and oversight structures in place, which may include: · Absence of key roles and associated responsibilities to provide good governance. · Ineffective accountability and reporting structures with the absence of key scrutiny groups/ committees. General weaknesses in the internal control framework that are sufficient to impact the overall governance of the area audited.
7	Information & Data Quality / Accuracy	Systems, processes and procedures that support data accuracy/ quality are poorly designed or are not operating as intended, resulting in poor data quality. There is limited/ no guidance on the expected arrangements for data and information management. Insufficient records are maintained and/ or there are key gaps that would impact decision making. Information and/ or data is of an insufficient quality for monitoring, reporting and decision making.
8	Lessons Learnt	There are inadequate or no systems and processes in place to capture lessons learnt. Lessons learnt are not regularly shared/ reviewed within the organisation. There is clear evidence that the organisation has not learnt from prior experiences.
9	Performance Monitoring	There are no/ limited systems in place to capture performance information. The systems are ineffective in capturing the required information to manage performance. Performance information is not monitored and/ or shared. Corrective action to address performance issues is not determined or is ineffective.
10	Physical Security	There is no strategy/ plan to maintain physical security.

Ref.	Theme	Definition / Examples
		There is a lack of consideration of physical security needs (either current and/or future)
11	Planning, Delivery & Deadline Management	A lack of timescales or deadlines being set. Unmonitored scope creep results in missed deadlines, non-delivery of projects and/or tasks, overspends or negative impacts on the quality of the final output.
12	Policies & Procedures	There are no policies or procedures in place, or they are inadequate to manage the risk. Policies or procedures are overdue for review or do not reflect current operational and/or best practice.
13	Reporting	Reporting and escalation requirements not clearly defined, including what gets reported where and when. Defined reporting does not provide adequate information to support robust assurance, escalation and risk management. Reporting does not take place at the agreed frequency to the agreed fora in the agreed format, or there is a lack of evidence that reporting is taking place.
14	Resourcing	Organisational planning and management approaches do not incorporate consideration of demand and capacity. Demand and capacity inadequately considered. Lack of proactive review of resource to deliver plans or business-as-usual activities.
15	Risk Management	Inadequate/ ineffective risk strategy, appetite and/or management arrangements. The approach to risk management and/ or arrangements applied are not operating as intended.
16	Strategy	An appropriate strategy has not been developed to outline the vision of the organisation. The strategy is not an effective tool in achieving organisational objectives.
17	Training & Development	There is no defined strategy for training and development. Training needs have not been identified. There is no plan in place to address identified training needs.

Audit Committee Update – Betsi Cadwaladr University Health Board

Date issued: August 2024

Document reference: 4342A2024

Contents

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 7 May 2024.

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
Audit of the Health Board's Accounts	Russell Caldicott, Interim Executive Director of Finance	Audit of Financial Statements Report including the Opinion on the Financial Statements.	Completed.	July 2024.

Performance audit update

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

Exhibit 2 – Performance audit work

Area of work	Executive Lead	Focus of the work	Current status	Planned date for consideration
All Wales thematic work on Urgent and Emergency Care	Director of Therapies.	This work examines different aspects of the urgent and emergency care system in three parts: • Part One: Flow out of hospital (not applicable to the Trust). • Part Two: accessing urgent and emergency care. • Part Three: national arrangements and leadership structures.	Part One: Completed. Part Two: Report drafting. Part Three: Planning.	July 2024. November 2024. To be confirmed.
Structured Assessment – deep dive into financial efficiencies	Executive Director of Finance and Corporate Resources	Given the significantly challenging financial position across NHS Wales, this review is examining the approaches NHS bodies are taking in respect of achieving cost improvements, efficiencies, and financial sustainability.	Clearance – issued in draft.	November 2024.

Area of work	Executive Lead	Focus of the work	Current status	Planned date for consideration
Planned Care	Executive Medical Director	This work will be completed across all health boards and follows on from our national overview report on the planned care backlog in May 2022. Although we are still in the scoping phase, we intend to consider waiting list performance and arrangements to improve elective waits.	Set up held – progressing to fieldwork	January 2025.
Structured Assessment - core	Director of Corporate Governance / Board Secretary	This work will review the following core areas: • Board and committee effectiveness, cohesion, and transparency. • Corporate systems of assurance. • Corporate planning arrangements. • Corporate financial planning arrangements. This work will also seek to provide an update on the Trust's progress in addressing audit recommendations made in previous structured assessment reports.	Fieldwork.	January 2025.

Area of work	Executive Lead	Focus of the work	Current status	Planned date for consideration
Structured Assessment - deep dive review of investment in digital systems to support service resilience and transformation	Director of Digital Services	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.	Scoping.	To be confirmed.
Use of the strategic financial assistance provided by the Welsh Government for the 3.5-year period October 2020 to March 2024.	Executive Director of Finance and Corporate Resources	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.	Scoping.	To be confirmed.

Area of work	Executive Lead	Focus of the work	Current status	Planned date for consideration
Follow up review of quality governance arrangements	Executive Director of Nursing	This audit will examine progress in addressing issues identified in previous audit work. The scope of the work will be determined during the audit planning process.	Not yet started	To be confirmed.

Other relevant publications

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

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

Title	Publication Date
Community Pharmacy Data Matching Pilot	May 2024.
From firefighting to future-proofing – the challenge for Welsh public services	February 2024.
Board effectiveness follow-up – Betsi Cadwaladr University Health Board	February 2024.

Additional information

7   Audit Wales has not published any corporate documents since the last committee update.

8   There are no relevant Audit Wales consultations currently underway.

Teitl adroddiad: **Report title:**	Audit Wales Community Pharmacy Data Matching Pilot - Welsh Government Response
Adrodd i: **Report to:**	Audit Committee
Dyddiad y Cyfarfod: **Date of Meeting:**	Thursday, 12 September 2024
Crynodeb Gweithredol: **Executive Summary:**	Audit Wales and the NHS Wales Counter Fraud Service have undertaken a pilot exercise in Swansea Bay and Cwm Taf Morgannwg Local Health Boards to analyse community pharmacy dispensing data and provide insight to areas of high cost and potential fraud. The analysis focussed on three areas of risks around fraud and cost: Expensive items; Specials; and Higher cost formulations, and used a specially built interactive data tool that analysed data covering three years of dispensing to identify outliers. The extensive pilot involving almost 30% of pharmacies in Wales over a three-year period, found no evidence of systemic fraud or error, and considered the findings likely to be representative given the large sample size, the mix of pharmacies and prescriptions dispensed in the sample, and the duration of the field work. The Welsh Government acknowledge that the report therefore provides welcome assurance in this area of high spend and scrutiny. The Chief Pharmaceutical Officer at the Welsh Government intends to write to health boards providing information about both the interactive dashboard and the community pharmacy expensive items report, asking them to confirm what arrangements they will put in place to ensure the new tools are used to minimise the risk of fraud or error occurring within the health board.
Argymhellion: **Recommendations:**	*The Board is asked to note the content of the Welsh Government's response to Audit Wales' community pharmacy data matching pilot.*
Arweinydd Gweithredol: **Executive Lead:**	Lois Lloyd, Chief Pharmacist
Awdur yr Adroddiad: **Report Author:**	Andrew Evans, Chief Pharmaceutical Officer, Welsh Government

Pwrpas yr adroddiad: **Purpose of report:**	I'w Nodi *For Noting* ☒	I Benderfynu arno *For Decision* ☐	Am sicrwydd *For Assurance* ☒	
Lefel sicrwydd: **Assurance level:**	Arwyddocaol *Significant* ☐ Lefel uchel o hyder/tystiolaeth o ran	Derbyniol *Acceptable* ☒ Lefel gyffredinol o hyder/tystiolaeth o ran	Rhannol *Partial* ☐ Rhywfaint o hyder/tystiolaeth o ran	Dim Sicrwydd *No Assurance* ☐ Dim hyder/tystiolaeth o ran y ddarpariaeth

	darparu'r mecanweithiau / amcanion presennol *High level of confidence/evidence in delivery of existing mechanisms/objectives*	darparu'r mecanweithiau / amcanion presennol *General confidence / evidence in delivery of existing mechanisms / objectives*	darparu'r mecanweithiau / amcanion presennol *Some confidence / evidence in delivery of existing mechanisms / objectives*	*No confidence / evidence in delivery*

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

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

Cyswllt ag Amcan/Amcanion Strategol: *Link to Strategic Objective(s):*	Access to medicines
Goblygiadau rheoleiddio a lleol: *Regulatory and legal implications:*	e.e. Yr Awdurdod Gweithredol Iechyd a Diogelwch e.g. Health and Safety Executive
Yn unol â WP7, a oedd EqIA yn angenrheidiol ac a gafodd ei gynnal? *In accordance with WP7 has an EqIA been identified as necessary and undertaken?*	N/A
Yn unol â WP68, a oedd SEIA yn angenrheidiol ac a gafodd ei gynnal? *In accordance with WP68, has an SEIA identified as necessary been undertaken?*	N/A
Manylion am risgiau sy'n gysylltiedig â phwnc a chwmpas y papur hwn, gan gynnwys risgiau newydd (croesgyfeirio at y BAF a'r CRR) *Details of risks associated with the subject and scope of this paper, including new risks(cross reference to the BAF and CRR)*	CRR24-05 Financial Sustainability
Goblygiadau ariannol o ganlyniad i roi'r argymhellion ar waith *Financial implications as a result of implementing the recommendations*	Early identification and fraud reduction
Goblygiadau gweithlu o ganlyniad i roi'r argymhellion ar waith *Workforce implications as a result of implementing the recommendations*	NIL
Adborth, ymateb a chrynodeb dilynol ar ôl ymgynghori *Feedback, response, and follow up summary following consultation*	NIL
Cysylltiadau â risgiau BAF:	

(neu gysylltiadau â'r Gofrestr Risg Gorfforaethol) ***Links to BAF risks:*** *(or links to the Corporate Risk Register)*	
Rheswm dros gyflwyno adroddiad i fwrdd cyfrinachol (lle bo'n berthnasol) ***Reason for submission of report to confidential board (where relevant)***	Not applicable
Camau Nesaf: **Gweithredu argymhellion** ***Next Steps:*** ***Implementation of recommendations*** The health board's Chief Pharmacist's Office and Counter Fraud Team will review and confirm their arrangements to minimise risks of fraud and respond to the correspondence and bring back to the Audit Committee for assurance in due course.	
Rhestr o Atodiadau: ***List of Appendices:*** 1. Audit Wales Community Pharmacy Data Matching Pilot - Welsh Government Response	

Community Pharmacy Data Matching Pilot

May 2024

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Andrew Evans
Chief Pharmaceutical Officer
Cathays Park
Cardiff
CF10 3NQ
Reference: 4158A2024

Date issued: 23 May 2024

Dear Andrew

I am writing to share the findings from a community pharmacy data pilot project we have undertaken, working with NHS Counter Fraud Service Wales (NHS CFS Wales). Our aim was to analyse community pharmacy dispensing data at scale, to provide insight to NHS Wales on areas of high cost and potential fraud. We also saw this work as an opportunity to develop Audit Wales's expertise in fraud analytics techniques.

We chose community pharmacy as the focus of the pilot because it is an area of known fraud risk and does not appear to be scrutinised for fraud as much as some other NHS services.

Community pharmacy also involves considerable expenditure. NHS Wales spent a total of approximately £772 million on drugs, appliances and services related to community pharmacy activity in 2022-23. £162 million of this was for remuneration for the provision of community pharmacy services. The remaining £610 million was reimbursement for medicines and appliances purchased by pharmacies and dispensed against NHS prescriptions.

Our pilot covered Swansea Bay University Health Board and Cwm Taf Morgannwg University Health Board. We focused our analysis on three areas of known risks around fraud and cost: Expensive items; Specials; and Higher cost formulations.

We established and followed data governance procedures carefully, undertaking our work under the Auditor General's data matching powers set out in Part 3A of the Public Audit (Wales) Act 2004. We built an interactive data tool that analysed 31 million lines of data, covering three years of dispensing, and highlighted numerous outliers of interest. We highlighted these outliers to the two health boards involved.

The bullet points below summarise our conclusions:

- Our work did not find any immediate evidence of fraud, although we focused on a small number of fraud risks. While many of the outliers we flagged were known to the health boards in question, some were not. The health boards and NHS CFS Wales carried out further work to understand the issues underlying the outliers. We understand that two pricing errors were found, with a total overpayment value of £22,000, and NHS CFS Wales and NHS Wales Shared Services Partnership (NWSSP) are collaborating on how to reclaim these overpayments. Other outliers were deemed to be explainable and were not found to be cases of fraud or error.

- Our work has flagged a specific risk in relation to limited controls around the cost of Specials. No price restrictions are in place for certain Specials, presenting various opportunities for fraud or error. Although subject to various caveats, we estimate that during the three years covered by the pilot (April 2018 – March 2021), **approximately £700,000 could have been saved** in Wales if each instance of the highest cost dispensing of a Special was reduced to the Special's average dispensing cost. It is possible that our estimate may overstate the possible savings as we have included in our calculation some Specials that have a fixed price, and as such, no saving would be possible. It may also be the case that our estimate is understated because further savings could be possible by reviewing instances of dispensing that are of higher cost than the average but below the maximum cost.

- We flag inherent risks around contractors reimbursed large sums of money for dispensing activity in relation to Expensive items. The data tool identifies five contractors that dispensed more than £1 million of Expensive items during the period covered in the pilot. As a general principle, it may be advisable for health boards to carry out additional checks for contractors dispensing Expensive items at high levels such as this.

- We are aware of some work by NHS CFS Wales and a potential pilot by the Post Payment Verification (PPV) team at NWSSP that relate to identifying and reviewing fraud risks in community pharmacy dispensing activity. And we know that health boards' analysis of dispensing activity tends to focus on data from their health board alone. This approach may miss risks that could be identified by comparing their dispensing activity to other health boards. Also, processes for monitoring dispensing activity vary and a lack of capacity and resource can limit health boards' work. Overall, we concluded there is scope for more analysis of community pharmacy dispensing on a national basis for the purposes of detecting or preventing fraud and ensuring value for money.

We have decided to end the pilot and not develop the tool further. However, we have learnt valuable lessons and are looking for other areas of work in the field of fraud analytics. We also believe the NHS in Wales can learn from the work we have done. There is potential for others to adapt our tool, for example, to inform post-payment verification for dispensing. As such, we have provided our tool and wider learning from our approach to the PPV team at NWSSP. These staff are better placed to overcome the data governance complications we experienced and are also better placed to use the tool to explore outliers with health boards and dispensing contractors.

Any future approach to analysing dispensing data at scale would be greatly enhanced if other data sources could be joined up, particularly if users could access individual prescriptions. Health boards can access individual prescriptions via systems in place provided by NWSSP, but it would have been too complicated for us to access this data in the pilot. We have also learnt that subject matter knowledge, time and appetite from health boards, and multi-agency discussions, will be important to the success of any future fraud analytics approaches.

We are not making specific recommendations, but listed below are three questions that we believe NHS Wales, including its Directors of Pharmacy, should ask itself, given the findings of our pilot. I should be grateful if you could reply with details of any actions you intend to take in response to these issues:

- Are you satisfied with the current approaches in each health board, and across NHS Wales, to identify and investigate outliers in relation to high cost and risk of fraud for dispensing contractor activity?

- Are key lessons and best practice around these matters being shared between health boards? For example, are the health boards sharing examples of where fraud has been identified to make them aware of risks?

- Is there scope for the NHS in Wales to put extra cost-effective controls in place around the variable costs of Specials?

Appendix 1 provides more detail about our data matching pilot. **Appendix 2** summarises our main findings.

I have copied this letter to the Chairs of the Welsh Parliament's Public Accounts and Public Administration Committee, the Health and Social Care Committee, and the Finance Committee, for information. We intend to publish the letter on the Audit Wales website and share the findings with the audit committees of the two health boards in question, as well as with Community Pharmacy Wales and the NHS Wales Counter Fraud Steering Group.

Many thanks to you and your colleagues for their input to this project.

Yours sincerely

Adrian Crompton
Auditor General for Wales

Adrian Crompton
Auditor General for Wales

Appendices

1   About our data matching pilot

Context

1   Fraud and error present a significant challenge to public finances in Wales. We have previously estimated that fraud and error cost anywhere between £100 million and £1 billion each year to Welsh public services[1]. Given our role in auditing public expenditure, Audit Wales has a keen interest in actions to minimise public sector fraud. We facilitate the detection of fraud and error through the National Fraud Initiative, and we are keen to develop further data matching exercises.

2   Our Data Analytics team has been working with NHS CFS Wales colleagues on a pilot project using community pharmacy dispensing data. Community pharmacy is an area of considerable expenditure and with known fraud risks. NHS Wales spent a total of approximately £772 million on community pharmacy activity, covering both prescribing and non-prescribing costs in 2022-23. £162 million of this was for remuneration for the provision of community pharmacy services. The remaining £610 million was for reimbursement for medicines and appliances purchased by pharmacies and dispensed against NHS prescriptions. Simple application of the Public Sector Fraud Authority's estimate that between 0.5% and 5% of all government spending is lost to fraud and error[2] suggests the amount lost in relation to the £772 million[3] could range from £3.9 million to as much as £38.6 million.

3   We took an innovative approach, accessing data in a new way[4], analysing large amounts of data, and producing an interactive data tool that flagged outliers and formed the basis of facilitated discussions with health boards.

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1   Auditor General for Wales, Counter-Fraud Arrangements in the Welsh Public Sector, June 2019

2   Public Sector Fraud Authority, Cross-Government Fraud Landscape Annual Report 2022, March 2023

3   We calculated this figure using the NHS (Wales) Summarised Accounts Local Health Boards, NHS Trusts and Special Health Authorities in Wales. It is the sum of the 'cash limited' totals of 'Pharmaceutical Services' cost and the 'Prescribed drugs and appliances' cost in 'Table 2.1 Expenditure on Primary Healthcare Services'. 'Pharmaceutical Services' include non-prescribing costs, for example running costs and enhanced services of community pharmacies. 'Prescribed drugs and appliances' are mostly the cost of primary care prescriptions.

4   We accessed the data under the Auditor General's data matching powers provided under Part 3A of the Public Audit (Wales) Act 2004 for the purpose of assisting in the prevention and detection of fraud in or with respect to Wales.

4   Beyond an overall aim of preventing and detecting potential fraud and error, the aims of the pilot project were to:

- generate new insights into areas of high cost and potential fraud by analysing dispensing data at scale and by highlighting outliers;

- facilitate discussion between stakeholders to explore outliers and agree improvement actions;

- develop our expertise in fraud analytics techniques to apply to other projects; and

- report on our findings to provide assurance and food for thought on future actions regarding fraud analytics and prevention.

What we did

5   Working with NHS CFS Wales, we involved various other stakeholders and subject matter experts when developing our approach. These included NWSSP, Swansea Bay University Health Board, and Cwm Taf Morgannwg University Health Board, Community Pharmacy Wales[5], the NHS Wales Chief Pharmacists Group, the NHS Counter Fraud Authority in England, and NHS Scotland Counter Fraud Services.

6   To limit the size of the pilot, we included only two health boards in our analysis. We chose Swansea Bay University Health Board and Cwm Taf Morgannwg University Health Board for a number of reasons, including the availability of staff willing to participate in the pilot[6]. We are very grateful for their involvement.

7   This was the first pilot of its kind and, because Audit Wales is not part of NHS Wales, we do not have permissions to directly access certain data. NHS bodies requested that data sharing agreements be put in place. Unfortunately, while such agreements are encouraged by the Information Commissioner's Office, they would not be lawful in this situation, as they would fetter the Auditor General's access rights. We resolved this by drafting a 'Data Sharing Protocol'. The protocol helped ensure that data protection obligations were observed but without such unlawful fettering. And before requesting and receiving the source data from NWSSP, we sent privacy notices to more than 200 community pharmacy dispensing contractors covered in our scope (approximately 28% of the 712 community pharmacies in Wales in 2021-22[7]).

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5   Community Pharmacy Wales represents community pharmacies in Wales on NHS matters. Its main objective is to secure the best possible NHS service opportunities, remuneration and terms.

6   On 1 April 2019, the responsibility for providing healthcare services in Bridgend County Borough moved from Abertawe Bro Morgannwg University Health Board (the predecessor of Swansea Bay University Health Board) to Cwm Taf University Health Board (the predecessor of Cwm Taf Morgannwg University Health Board). By including these neighbouring health boards in our pilot, we ensured that our data covered the same sample of community pharmacies across all years.

7   StatsWales, Community pharmacies by LHB and year, 21 March 2024

8   Overall, the data governance aspects of the pilot, though necessary, were complicated and took a large amount of time to implement. They would also have been more time consuming had we involved more than two health boards.

9   We identified key areas of risk and focused on three markers of concern:

   a   **Higher cost formulations:** Different formulations (eg liquids, tablets, capsules, creams, branded and non-branded etc) of the same active substance[8] can vary widely in price. Higher cost formulations were involved in an NHS CFS Wales investigation that resulted in a criminal prosecution[9]. This came after a pharmacy had dispensed cheaper formulations, then claimed for more expensive formulations. We identified these items as a fraud risk, particularly in the case of hospital prescriptions. Hospital prescriptions are more likely than GP prescriptions to be handwritten and are therefore susceptible to being altered for fraudulent purposes.

   b   **Expensive items:** Items with a net ingredient cost[10] of £100 or more. In the investigation above, numerous prescriptions were for Expensive items. Therefore, we included this group of items as a potential indicator of fraud risk.

   c   **Special orders (Specials)**: Items requiring special preparation by a registered manufacturer. For many Specials – those not found in the Drug Tariff[11] – there is no restriction on their price. This presents a risk for potential high costs and/or fraud.

10   **Exhibit 1** provides an overview of the data we considered in the pilot.

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8   Active substances give medicinal products their therapeutic effect and are often referred to as active pharmaceutical ingredients.

9   NHS Wales Shared Services Partnership, Pharmacist struck off following conviction for £76,475 fraud, September 2020

10 Net ingredient cost refers to the 'cost (which the dispenser is reimbursed) of the drug before discounts and does not include any dispensing costs or fees. It does not include any adjustment for income obtained where a prescription charge is paid at the time the prescription is dispensed or where the patient has purchased a pre-payment certificate.'

11 The Drug Tariff is a document produced each month by NHS Prescription Services on behalf of the UK Government's Department of Health and Social Care. It specifies what amount of money (as net ingredient cost) a dispensing contractor will be reimbursed for dispensing an item included in the tariff, establishing a fixed price for each item found in the tariff each month.

Exhibit 1: dispensing data reviewed in the pilot, April 2018 – March 2021

Dataset	Approximate number of items	Approximate net ingredient cost of items
Formulations	30,785,000	£96.2 million
Expensive items	327,000	£70.6 million
Specials	19,000	£2.8 million

Note: The datasets are not mutually exclusive, items in one dataset may be found in another. The formulations data includes approximately 70 active substances, corresponding to approximately 1,170 formulations. Each formulation has a distinct combination of strength, form, and/or brand for the given active substance. We worked with NHS CFS Wales and the health boards to identify a range of active substances with formulations that are particularly expensive and/or of concern.

Source: NHS Wales dispensing data provided by NWSSP

11   We built an interactive data tool iteratively using Microsoft Power BI. The aim was to produce a tool that allowed the data to be explored quickly and easily to identify points of concern relating to anomalies, potential fraud, and areas of high cost.

12   Once the health boards had used the tool, we met with them and NHS CFS Wales to explore the issues arising. We presented a sample of outliers that we identified from using the tool, then the health boards provided initial responses to the outliers raised. Some of the outliers were easily explainable and were known by the health boards. Others were not known so the health boards and NHS CFS Wales carried out further work to understand the issues underlying the outliers.

2   Main findings from our data pilot

13   This section summarises our main findings under the following headings:

    a   The data tool flags clear outliers of potential concern;

    b   Variation in the cost of Specials suggests potential for savings;

    c   NHS Wales has limited controls in place for Specials;

    d   There are inherent risks around community pharmacy contractors that are reimbursed large sums of money for dispensing activity in relation to Expensive items;

    e   There is scope for more central analysis of risks around community pharmacy dispensing; and

    f   Our pilot has identified valuable learning for future fraud analytics approaches.

The data tool flags clear outliers of potential concern

14   We have used anonymised examples, taken from our interactive tool, to illustrate the key findings. The tool highlights many more outliers and examples than presented here. Further exploration of these outliers will depend on appetite from the health boards and NHS CFS Wales to use the tool. While we are flagging outliers as highlighted in the data tool, this does not necessarily mean that fraud or error is present or that there is definite potential for cost savings.

15   **Exhibit 2** shows a clear outlier suggesting a large cost discrepancy. It shows an item submitted for reimbursement in May 2020 costing £205 for one contractor but then costing £14,228 when submitted for reimbursement in June 2020 by a different contractor. We found that this was due to an error in the source data, and the correct cost was £1,428 not £14,228. The higher price was reimbursed to the contractor. NHS CFS Wales and NWSSP are now collaborating on how to reclaim the relevant overpayment. We present this outlier because it shows the potential for data tools such as ours to flag such discrepancies.

Exhibit 2: discrepancy* in net ingredient cost for a particular item submitted for reimbursement** by different contractors one month apart

*The £14,228 was paid to dispensing Contractor B rather than the correct cost of £1,428, an overpayment of £12,800. The error is being reviewed by NHS CFS Wales and NWSSP to consider what action to take regarding this overpayment.

**Reimbursement refers to the money contractors are reimbursed for the medication costs alone and does not include dispensing fees or other costs. The medication costs reimbursed may not be the same as the total net ingredient cost of the items dispensed by the contractor, with contractors often receiving deductions in the total net ingredient costs of items they have dispensed.

Source: Audit Wales analysis of NHS Wales dispensing data provided by NWSSP

16   **Exhibit 3** shows a clear outlier where contractor C has a large cost associated with Expensive items prescribed by hospital prescribers. Contractor C dispensed more than £580,000 worth of such items between April 2018 – March 2021, almost double the next nearest contractor. This is not necessarily unusual activity, with dispensing activity for hospital outpatient prescriptions depending, at least partly, on the policies and procedures of the health board in question.

17   **Exhibit 4** combines analysis of the **Exhibit 3** metric with the proportion of the total cost reimbursed to community pharmacy contractors that is accounted for by Expensive items prescribed by hospital prescribers. **Exhibit 4** shows that contractor C is an outlier in relation to both metrics. This provided greater weight to the argument that contractor C was displaying different dispensing patterns to other contractors. In this case, the relevant health board easily explained this outlier due to contractor C's proximity to a hospital, but this example illustrates the potential for detecting anomalous dispensing patterns using one or more metrics.

Exhibit 3: the five community pharmacy contractors that dispensed the highest total net ingredient cost of Expensive items prescribed by hospital prescribers, April 2018 – March 2021
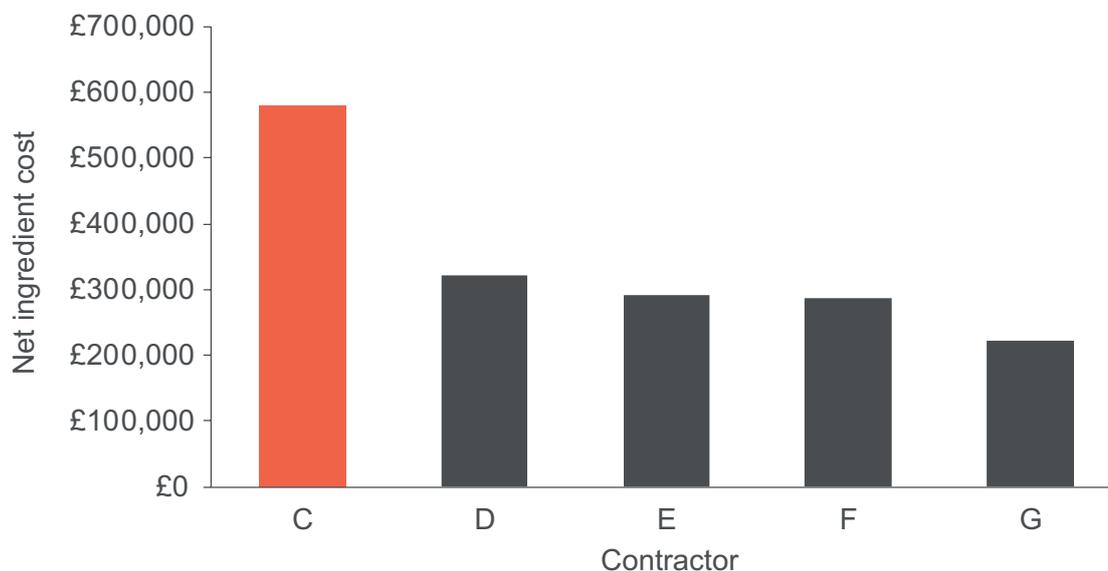
Source: Audit Wales analysis of NHS Wales dispensing data provided by NWSSP

Exhibit 4: comparison of two metrics of interest, applied to data for individual community pharmacy contractors, April 2018 – March 2021
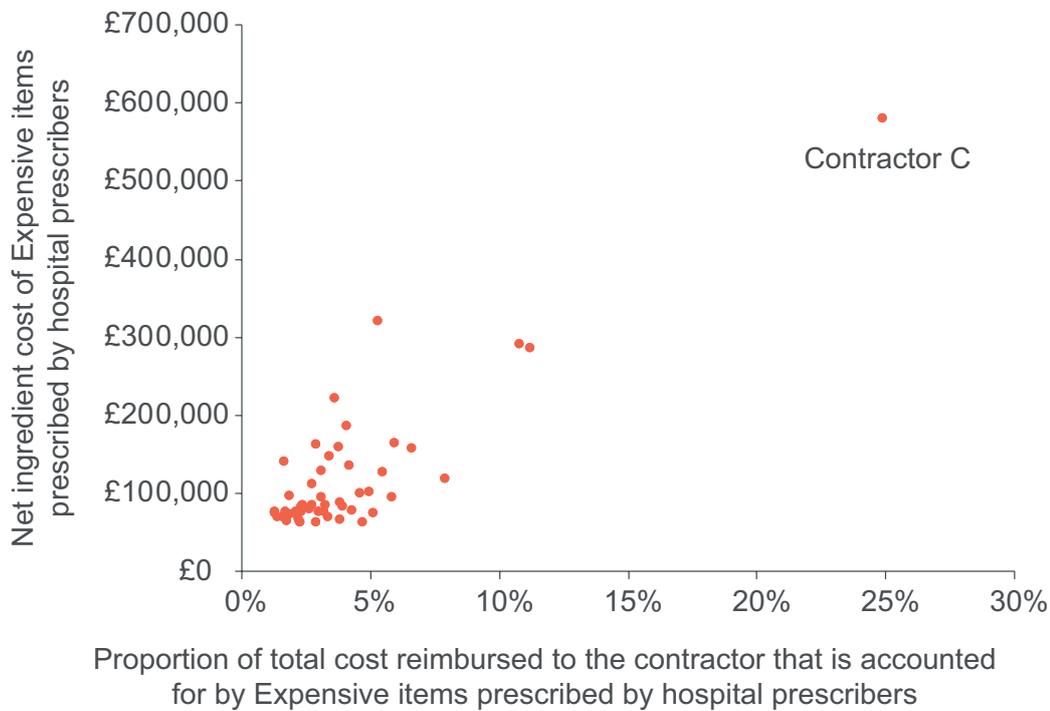
Note: Each orange dot represents an individual contractor, showing the 50 community pharmacy contractors with the highest total cost of Expensive items, in terms of net ingredient cost, prescribed by hospital prescribers.

Source: Audit Wales analysis of NHS Wales dispensing data provided by NWSSP

18   **Exhibit 5** shows how the data tool allows users to explore how community pharmacy contractors perform in relation to multiple metrics, helping to flag contractors that warrant further analysis. The exhibit suggests contractors H and K could be of particular interest to review.

Exhibit 5: example of seven community pharmacy contractors reviewed against multiple metrics, April 2018 – March 2021

This exhibit is based on comparisons for contractors with some of the highest values for Metric 2. Higher values are highlighted in bolder colour.

Contractor	Expensive items		Specials		Higher cost formulations	
	Metric 1	Metric 2	Metric 3	Metric 4	Metric 5	Metric 6
H	£1,498,199	24%	£15,836	0.3%	£1,184,442	31%
I	£805,751	22%	£19,847	0.5%	£847,091	31%
J	£767,544	33%	£3,527	0.2%	£375,844	20%
K	£767,056	27%	£353,425	12.6%	£482,895	16%
L	£698,364	23%	£6,472	0.2%	£544,566	22%
M	£571,122	22%	£23,304	0.9%	£424,811	17%
N	£503,651	26%	£6,303	0.3%	£302,580	17%

Notes:

Metric 1 is the total net ingredient cost of all Expensive items dispensed by each contractor. Metric 2 is the proportion of the total cost the contractor is reimbursed for that is accounted for by Metric 1.

Metric 3 is the total net ingredient cost of all Special items dispensed by each contractor. Metric 4 is the proportion of the total cost the contractor is reimbursed for that is accounted for by Metric 3.

Metric 5 is the total net ingredient cost for all the items in the formulations dataset dispensed by the contractor. Metric 6 is the proportion of metric 5 that is accounted for by the higher cost formulation items identified that are dispensed by each contractor.

Source: Audit Wales analysis of NHS Wales dispensing data provided by NWSSP

Variation in the cost of Specials suggests potential for savings

19   As noted in **paragraph 9,** Specials not included in the Drug Tariff have no restriction on price. Our data tool highlights several cases where a particular Specials item has varied widely in price within a given month.

20   **Exhibit 6** shows a trend in the maximum and average net ingredient cost of dispensing a particular Specials item (Sucralfate 1-gram tablet)[12]. The costs vary greatly within each month, with instances of the price per tablet rising to nearly £13 in one month compared to an average of £3.56 for the same month. For each month of data, the differences between the maximum and average price indicate potential opportunities for cost savings. Where the cost is much greater than average, this might present cause for review to identify the potential for cost savings.

Exhibit 6: maximum and average net ingredient cost per tablet of Sucralfate 1-gram tablets dispensed by community pharmacy contractors, February 2020 to March 2021
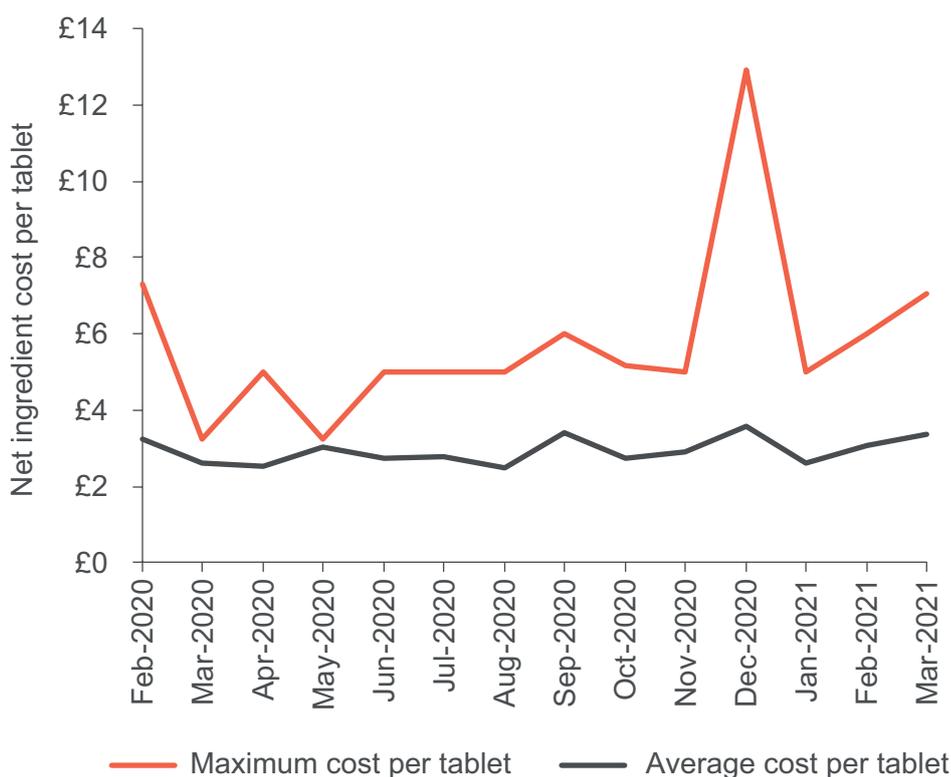

Note: Dates refer to date submitted for reimbursement, which may be different to the date of dispensing.

Source: Audit Wales analysis of NHS Wales dispensing data provided by NWSSP

12 Sucralfate 1g tablets were added to the Drug Tariff in March 2022, after we had completed our pilot. While we have highlighted this issue by using Sucralfate 1g tablets as an example, the general issue applies to all Specials items not named in the Drug Tariff.

21 We identified many other examples of variability in the maximum and average cost of Specials. For example, **Exhibit 7** shows an example where Contractor O submitted an item for reimbursement for £874, while other contractors had done so for £435 or less, for the same item (same medication, quantity, and strength) within the same month. This indicates an opportunity to potentially save £439 or more on this one item alone. NHS CFS Wales reviewed the prescriptions for these items. Price differences were due to different suppliers and pack sizes. The £874 claim price was identified as significantly different from the other claims, and a good example of a prescription that may require further verification work from the health board and/or the PPV team at NWSSP.

Exhibit 7: net ingredient cost of 112 tablets of Sucralfate 1g submitted for reimbursement in May 2018 by four community pharmacy contractors
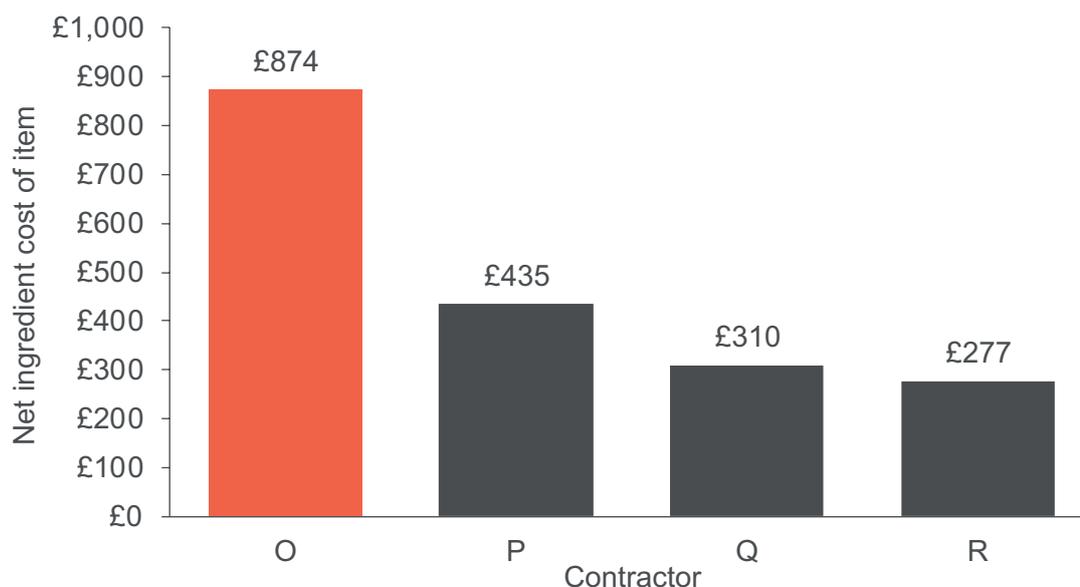
Source: Audit Wales analysis of NHS Wales dispensing data provided by NWSSP

22 The issues highlighted in **Exhibits 6 and 7** may present genuine potential for cost savings. However, without further investigation, working with the health boards, as well as someone with in-depth subject matter knowledge, to review individual prescriptions or invoices, we do not know which cases are normal behaviour, error, or fraud.

23   We estimate that for the two health boards reviewed, approximately
      £200,000 could have been saved over the three years covered in the pilot
      if each instance of highest cost dispensing of a Special for a given month[13]
      was reduced to its average cost for that given month. The calculation
      considers each month in isolation due to the cost for a Special potentially
      varying over the time of the pilot.

24   Using data from StatsWales[14] we determined the total net ingredient cost
      for medications for all of NHS Wales is approximately 3.5 times that of
      the two health boards. Extrapolating from the two health boards to all of
      NHS Wales using this figure produces an equivalent savings estimate of
      approximately £700,000.

25   These calculations are presented for illustrative purposes and are subject
      to certain caveats and a large degree of uncertainty. The calculations
      assume that it is reasonable to extrapolate the potential savings in the
      two health boards to all of Wales. The calculations also assume that all
      instances of the highest cost dispensing could be reduced, and so provide
      a potential saving opportunity. It is not clear from the data whether this is a
      reasonable assumption. It is also possible that our estimate may overstate
      the possible savings, given that we have included in our calculation
      some Specials that have a fixed price, and as such, no saving would be
      possible. Further information and investigation would be required to clarify
      the savings possible.

26   In addition, our calculations assume that it is reasonable to use just the
      highest and average cost of dispensing to estimate potential savings. We
      have used the highest and average cost because Specials are dispensed
      relatively infrequently, providing a limited number of dispensing instances
      to undertake the savings calculations each month for a given Special.
      However, it is possible that our estimate may understate the possible
      savings, given that it does not consider instances of dispensing that are
      higher than the average cost but below the maximum. Additionally, the
      average cost may not reflect good value. Reducing costs to below the
      average could identify further potential savings.

---

13 Highest net ingredient cost per unit of medication for medication for given month. The month
   being the date the item was submitted for reimbursement, which may be different from the
   date of dispensing.

14 StatsWales, Prescription items and cost by area and BNF chapter by year, 27 June 2023

NHS Wales has limited controls in place for Specials

27   The UK Government's Department of Health and Social Care decides which Specials to include in the Drug Tariff[15]. The Drug Tariff has changed over time, for example Part VIIID 'Arrangements for payment for Specials & Imported Unlicensed Medicines with Prices Determined Relative to a Commonly Identified Pack Size' was added in March 2022, introducing controls on payments for some additional Specials. We are not aware of any other fixed controls regarding the cost of Specials outside inclusion in the Drug Tariff.

28   Community pharmacies do not need approval from health boards before dispensing Specials. And health boards cannot direct contractors to use cheaper manufacturers unless specified in the Drug Tariff. Some health boards do review high-cost items to ensure they are appropriate. Health boards can also provide advice and support for the prescribers of Specials. The prescriber has responsibility to assess what is clinically appropriate for the patient and the dispensing contractor has responsibility to raise any clinical concerns.

29   Prices for Specials not found in the Drug Tariff can vary between different contractors, GP clusters of contractors, and health boards. Analysis of Specials costs across Wales, comparing health boards, may therefore highlight potential savings opportunities. We are not aware of such analysis being done.

30   Invoices for Specials specify what a manufacturer has charged a pharmacy contractor for a given item. They can be used to confirm that the contractor has claimed and been reimbursed for the correct amount. However, we are not aware of any requirement currently for contractors to submit invoices for Specials. And for invoices that are submitted, we are not aware of any routine inspection of them by NWSSP as part of the reimbursement processes to community pharmacy contractors for Specials. Review of these invoices in future analysis could highlight cases of error or fraud and lead to potential cost savings. Using a tool similar to ours could allow more informed decisions on which contractors to focus on.

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15 This control limits the amount the dispensing contractor can be reimbursed, in terms of the net ingredient cost of the item, for dispensing a Special in the Drug Tariff. This control is limited to this aspect in the supply of a Special. The dispensing contractor may have generated income or lost money depending on whether they paid more or less than the amount reimbursed to obtain the Special from the manufacturer. The contractor will also receive an additional dispensing fee for a Special.

31   As a result of our pilot highlighting concerns around the cost of Specials,
      NHS CFS Wales has discussed with the PPV team in NWSSP the
      potential for further work on dispensing risks. The PPV team has learnt
      from our approach to develop a dashboard to highlight data of concern
      as part of a pilot that may be carried out this year. The pilot would review
      prescription invoice claims for potential outliers, possible erroneous claims
      and potential incorrect data entry. Depending on the outcome, this may
      become a permanent check undertaken by the PPV team.

There are inherent risks around community pharmacy contractors that are reimbursed large sums of money for dispensing activity in relation to Expensive items

32   **Exhibit 8** shows the eight community pharmacy contractors in our dataset
      that dispensed the highest total cost (as net ingredient cost) of Expensive
      items. It shows that five contractors each dispensed more than £1 million
      of Expensive items during the period covered in the pilot.

Exhibit 8: the eight contractors in our dataset with the highest total net ingredient cost of all Expensive items dispensed, April 2018 – March 2021
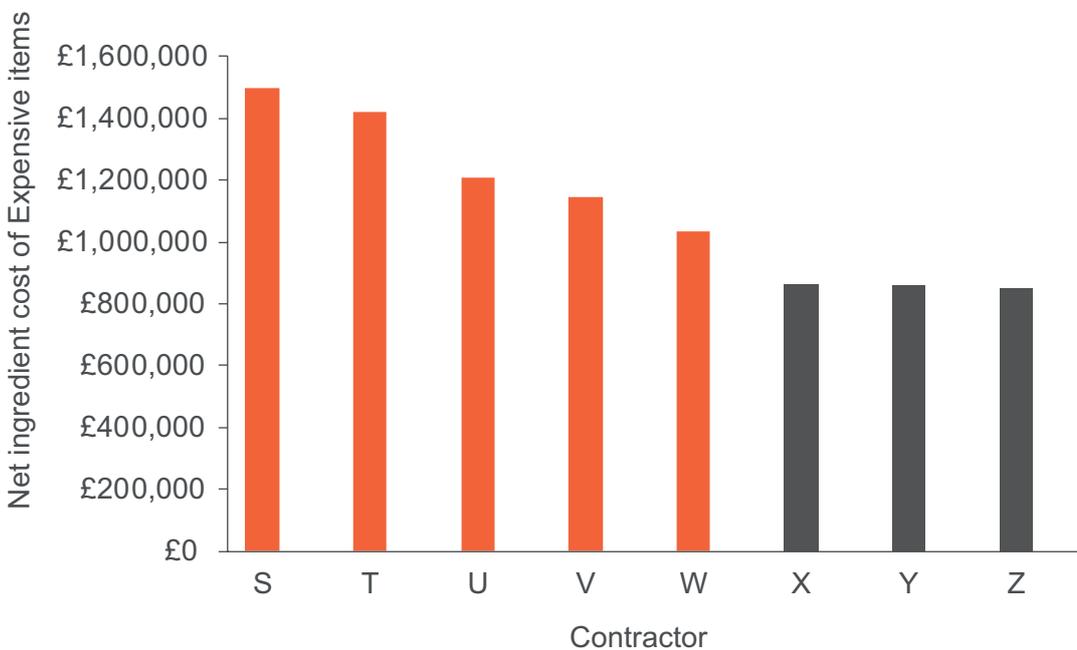
Source: Audit Wales analysis of NHS Wales dispensing data provided by NWSSP

33   The data tool provided value in enabling these and other contractors with large reimbursement costs, for the medication and appliances dispensed, to be identified quickly and easily alongside other information regarding risks related to contractors. The health boards may wish to review these contractors given the large sums of money reimbursed to these contractors for Expensive items. As a general principle, it may be advisable for health boards to carry out some additional checks of contractors with high levels of reimbursement costs for Expensive items, as well as high levels of costs overall, given the large sums of money involved and the potential to identify savings and instances of possible fraud.

There is scope for more central analysis of risks around community pharmacy dispensing

34   **Paragraphs 20 to 26** highlight scope for specific savings but our pilot focused on only three markers of concerns. Fraud can take place in other ways. For example, a contractor may claim to have dispensed items that have not been collected by patients, fraudulently claiming for the cost of items and dispensing activity that has not been completed.

35   Health boards have processes in place to monitor various aspects of dispensing activity, however, these vary between health boards. Relying on the work of individual health boards alone may also miss opportunities to identify areas of high cost and potential fraud across Wales. For example, a group of contractors may not present as anomalous in the health board alone but could be identified as anomalous when compared to all contractors in Wales.

36   A lack of capacity and resource in health boards can limit health boards' work in interrogating risks around community pharmacy dispensing data. Processes can depend on the knowledge and availability of an individual member of staff, which poses succession planning risks, as well as risks around a single point of failure. The complexity of analysis required and the volume of data involved add further disincentives for health boards to carry out this work.

37   We have not been made aware of any analytical work to review community pharmacy dispensing fraud risks for NHS Wales other than work undertaken by NHS CFS Wales, the potential PPV pilot mentioned in **paragraph 31** and the analysis carried out by individual health boards in isolation. NHS CFS Wales has reviewed areas of risk around community pharmacy such as the initial investigation that informed our pilot, as well as reviews of out of pocket expenses. We concluded that more centrally supported work to detect and prevent fraud in dispensing activity, as well as to ensure value for money, could be beneficial.

Our pilot has identified valuable learning for future fraud analytics approaches

38   We have learnt valuable lessons from our pilot, including:

    a   **It is feasible to analyse entire populations of data** – Our approach and our interactive tool allowed us to focus on known risks and made it possible to explore millions of data items. This could allow much more in-depth analysis than more limited, sampling approaches.

    b   **Subject matter knowledge and multi-agency discussions are vital** – The analysis of specific risks was most effective when health board staff were in discussion with NHS CFS Wales and Audit Wales. These discussions brought together a blend of local and subject matter knowledge, as well as specialist fraud and data skills. Without detailed subject matter knowledge related to the everyday realities of community pharmacy and dispensing practices, it was sometimes difficult for us to fully understand the risks and issues.

    c   **Time and appetite are necessary in health boards to make use of data tools** – Our approach relied on health board staff having time to explore the data tool. Without this, future tools may not be used fully, and opportunities to identify and respond to concerns may be missed.

    d   **It would be beneficial to join up our pilot data with other data sources** – Any future approach to analysing dispensing data at scale would be greatly enhanced if other data sources could be joined up, particularly if users could access individual prescriptions. This would allow efficient exploration of outliers, with all data being in one place. The lack of data on individual prescriptions was a barrier in our pilot project. Health boards can access individual prescriptions via systems in place provided by NWSSP but it would have been too complicated for us to access this data in the pilot because we are not an NHS organisation and the data governance requirements would have been substantial.

39   Our work did not find any immediate evidence of fraud, although our work focused on a small number of fraud risks. While many of the outliers we flagged were known to the health boards in question, some were not. The health boards and NHS CFS Wales carried out further work to understand the issues underlying the outliers. We understand that two pricing errors were found, with a total overpayment value of £22,000, and NHS CFS Wales and NWSSP are now collaborating on how to reclaim these overpayments. Other outliers were deemed to be explainable and were not found to be cases of fraud or error.

40   We have decided to end the pilot and not develop the tool further. This is mainly due to the complexities of delivering such a project as an external organisation to the NHS in Wales (see **paragraphs 7 and 8).** However, we will build upon the learning from the pilot and look to undertake new fraud analytic projects, including one using a data matching approach to explore whether patients are accurately registered in GP lists.

Archwilio Cymru
Audit Wales

We welcome correspondence and telephone calls in Welsh and English.

Rydym yn croesawu gohebiaeth a galwadau ffôn yn Gymraeg a Saesneg.

Prif Swyddog Fferyllol
Chief Pharmaceutical Officer

Llywodraeth Cymru
Welsh Government

Adrian Crompton
Auditor General for Wales
Audit Wales
1 Capital Quarter
Cardiff
CF10 4BZ

By email

19 July 2024

Dear Adrian,

Community Pharmacy Data Matching Pilot

Thank you for your letter of 23 May and the accompanying report describing the findings and recommendations of Audit Wales' community pharmacy data matching pilot. Given the scale of public expenditure on medicines and pharmaceutical services, tackling fraud and error is of considerable importance and I am grateful to you and your colleagues for taking the time to investigate risk in the community pharmacy sector so thoroughly.

I am particularly pleased this extensive pilot involving almost 30% of pharmacies in Wales over a three-year period, found no evidence of systemic fraud or error. I consider these findings are likely to be representative given the large sample size, the mix of pharmacies and prescriptions dispensed in the sample, and the duration of the field work. The report therefore provides welcome assurance in this area of high spend and scrutiny.

Whilst not making specific recommendations, you ask three questions NHS Wales, should ask itself, given the findings of your pilot.

Are you satisfied with the current approaches in each health board, and across NHS Wales, to identify and investigate outliers in relation to high cost and risk of fraud for dispensing contractor activity?

As I have set out above the report provides a great deal of reassurance that auditors were unable to find any evidence of systemic fraud or error within the community pharmacy

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sector. Of course, we cannot be complacent given there may be some types of fraudulent activity which were not investigated by the pilot or fraud may be occurring in health boards other than those included in the sample.

There are examples of significant fraudulent practice having occurred in the community pharmacy sector such as those described in the report. It is reassuring that these historic cases were identified by health boards working closely with NHS Counter Fraud Services, through checks and balances which pre-date the pilot.

The pilot identified risks in three main areas: pricing errors, expensive items and specials.

On pricing errors, between 6 million and 7 million prescriptions in Wales are processed for payment by the NHS Wales Shared Services Partnership every month. Prescription payment accuracy is consistently high with an error rate of only around 1 per 1000 prescriptions processed.   Where processing errors occur, they are as likely to result in underpayments to pharmacies as they are in overpayment by the NHS. Audit Wales' work only considered overpayments and it is therefore likely that further investigation of errors would cancel out any potential savings for the NHS over time. The level of pricing accuracy is agreed between the NHS and Community Pharmacy Wales on behalf of pharmacy contractors we do not therefore propose to take any further actions to address under and overpayments. It will however remain possible to make corrections in respect of individual errors on an ad hoc basis.

Turning to expensive items, I agree additional checks by health boards are likely to improve how risks are managed in this area. Whilst I am aware health boards may undertake some checks on expensive prescriptions already, such checks generally focus on the prescriber of the medicine rather than the pharmacy which dispensed it. I agree with your assessment that health boards would have greater assurance if additional checks on pharmacies dispensing large numbers of expensive prescriptions were undertaken. We will therefore take three actions to improve the work health boards undertake in this area.

Firstly, we have commissioned the Wales Analytical Prescribing Support Unit (WAPSU) to develop an interactive expensive items dashboard which can be accessed by health boards and used to identify expensive prescriptions issued by general practitioners and hospital outpatient departments in their area. The dashboard allows health board users to access aggregated and individual prescription data including the individual prescription images retained by the NHS Wales Shared Services Partnership.

Secondly, we will work with the NHS Wales Shared Services Partnership to develop a monthly report detailing expensive items dispensed by pharmacies in each health board area and make this report routinely available to health boards.

Finally, we will write to health boards providing information about both the interactive dashboard and the community pharmacy expensive items report, asking them to confirm what arrangements they will put in place to ensure the new tools are used to minimise the risk of fraud or error occurring within the health board.

Are key lessons and best practice around these matters being shared between health boards? For example, are the health boards sharing examples of where fraud has been identified to make them aware of risks?

I agree there are likely to be significant benefits arising from sharing lessons learned and best practice between health boards. We will therefore write to the Head of NHS Counter Fraud Services in Wales and the Directors of Pharmacy of each health board asking what arrangements might be put in place to facilitate such information sharing.

Is there scope for the NHS in Wales to put extra cost-effective controls in place around the variable costs of specials?

Specials are often considerably more expensive than licenced medicines, due to the bespoke nature of the product and include costs of sourcing raw materials, manufacturing, quality control, or importing products and distribution.

The nature of specials make them much more liable to price fluctuations arising from changes to the prices of raw materials or from an urgent need for a special to be manufactured where a surcharge may be payable for faster delivery.

Action has been taken over a number of years to reduce the cost of specials to the NHS. In 2011, standard reimbursement prices were introduced for the most commonly prescribed manufactured specials (for example liquids, creams and ointments made to an individual formula). Between 2018 when Audit Wales began its fieldwork, and 2023 the total annual spend on these medicines fell by more than 50% (from £1.01 to £0.48m per year) as a result of the changes.

More recently in March 2022, further changes were made to reduce the cost of unlicensed, imported medicines by incentivising pharmacy contractors to source these medicines at the cheapest price possible, reducing variation and excessive prices that do not reflect the cost of manufacturing the special. In the first year following these further changes costs fell by 5% (from £0.65m to £0.62m).

The reimbursement costs of specials have been subject to scrutiny for a number of years including as part of a Department of Health and Social Care consultation in 2019. Various approaches including requiring pharmacy contractors to obtain quotes from several manufacturers, seeking central approval to place orders, and a national specials' procurement service, have all been proposed and discounted as being unlikely to result in significant cost savings.

Given the changes made since Audit Wales' fieldwork, the previous consultation and analysis of options, and the significant reduction in cost in recent years, I do not consider the same potential exists to make the savings estimated by Audit Wales in future years. However, there continues to be potential for health boards to review individual prescriptions for high cost specials which could be replaced with a lower cost standard licensed preparation. The interactive expensive items dashboard developed by WAPSU will support health boards to identify additional opportunities to query the prescribing of expensive unlicensed specials.

I trust this information demonstrates the steps we are taking to ensure fraud is identified and wherever possible prevented in the community pharmacy sector in Wales. The additional actions we will take as a direct result of the data matching pilot will serve to strengthen health boards' approach further and I am grateful to you and your colleagues for your interest and assistance in this important area.

I am copying this letter to the Chairs of Senedd Cymru's Public Accounts and Public Administration Committee, Health and Social Care Committee, and Finance Committee, for information.

Yours sincerely

Andrew Evans FRPharmS
Prif Swyddog Fferyllol/Chief Pharmaceutical Officer
Llywodraeth Cymru/Welsh Government

Cyfarfod a dyddiad: Meeting and date:	Audit Committee
Cyhoeddus neu Breifat: Public or Private:	Public
Teitl yr Adroddiad Report Title:	Summary of business considered in private session to be reported in public
Cyfarwyddwr Cyfrifol: Responsible Director:	Pam Wenger, Director of Corporate Governance
Awdur yr Adroddiad Report Author:	Philippa Peake-Jones, Head of Corporate Affairs
Craffu blaenorol: Prior Scrutiny:	None
Atodiadau Appendices:	None

Y/N to indicate whether the Equality/SED duty is applicable	N

Argymhelliad / Recommendation:

The Committee is asked to note the report.

Ar gyfer penderfyniad /cymeradwyaeth For Decision/ Approval		Ar gyfer Trafoda eth For Discussi on		Ar gyfer sicrwydd For Assurance		Er gwybodaeth For Information	✓

Sefyllfa / Situation:

To report in public session on matters previously considered in private session.

Cefndir / Background:

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

Asesiad / Assessment

The Committee considered the following matters in private session:

18 July 2024

- Details of Breaches of SFIs, Scheme of Delegation and SOs

Audit Committee – Annual Cycle of Committee Business

(1st April 2024 to the 31st March 2025)

The Annual Cycle of Committee Business has been developed to help plan the management of Committee matters and facilitate the management of agendas and committee business. The Annual Cycle of Committee Business will be complemented by a "Non-Routine Committee Business (Forward Work Plan)" for 'one-off' Ad-hoc items raised during the course of meetings.

The role of the Committee is set out in the Health Board's standing orders and the Terms of Reference, both of which are available here:

The **Audit Committee** meets bi-monthly.

Committee Chair	Members	In Attendance	Preliminary matters to be included on agenda:
Karen Balmer	Rhian Watcyn Jones	Russell Caldicott, Executive Director of Finance (Executive Lead) Pam Wenger, Director of Corporate Governance	Welcome & Apologies Declarations of Interest
Committee Vice Chair Urtha Felda	Dyfed Jones	**Other Attendees** Other Executive Directors as required by the Chair Other Senior Managers as required by the Chair Dave Harries, Head of Internal Audit Head / Individual responsible for Clinical Audit Local Counter Fraud Specialist Andrew Dalton, Representative of Auditor General (External Audit)	Unconfirmed minutes of meeting held on xxxx Matters Arising & Action Log

AGENDA ITEM	MAY (Q1)	JULY (Q2)	SEPTEMBER (Q3)	NOVEMBER (Q3)	JANUARY (Q4)	MARCH (Q4)
PRELIMINARY MATTERS						
GOVERNANCE						
Review the Board Assurance Framework		█	█	█	█	
Review the Risk Management System	█	█	█	█	█	█
Audit Tracker Report	█	█	█	█	█	█
Deep dive into specific risks and assurances (where delegated)	█		█	█	█	█
Note Business of other Committees and review Inter-relationships			█	█	█	█
Review Draft Annual Report, Accounts and Annual Governance Statement (inc timetable and plans)	Final Draft					Draft
Receive other Sources of Assurance		█	█	█	█	
Review Speaking Up / Whistleblowing Arrangements			█			
Review Fit and Proper Person Tests						█
Review other Reports and Policies (as appropriate)	█				█	
Review Ministerial Directions and Welsh Health Circulars	█			█		
Details of Breaches of SO's (late papers etc)	█					
Declarations of Interest and Gifts & Hospitality Report	█			█		
Annual Review of Gifts & Hospitality and DoI Registers				█		
FINANCIAL FOCUS						
Conformance Report	█	█	█	█	█	█
Review Annual Accounts and Financial Statements (inc the External Audit Opinion)	June meeting may be required					
Review Risks and Controls around Financial Management		█			█	

NB: The Annual Cycle of Business has been developed in line with the HFMA NHS Audit Committee Handbook March 2024

AGENDA ITEM	MAY (Q1)	JULY (Q2)	SEPTEMBER (Q3)	NOVEMBER (Q3)	JANUARY (Q4)	MARCH (Q4)
Review Changes to Standing Orders, Standing Financial Instructions and other Key Governance Documents		■			■	
Review Changes to Accounting Policies / Significant Judgements		■			■	
Review Exception Reporting			■			■
INTERNAL AUDIT						
Review and Approve Annual Internal Audit Plan						■
Review and Approve Annual Internal Audit Terms of Reference						■
Annual Review of the Effectiveness of Internal Audit					■	
Review Internal Audit Progress Reports		■	■	■	■	■
Receive Annual Internal Audit Report and Associated Opinions	■					
EXTERNAL AUDIT						
Agree External Audit Plans and Fees					■	
Review the Effectiveness of External Audit			■	■		
Review External Audit Progress Reports	■	■	■	■	■	■
Review the External Auditor's Report to those charged with Governance		■				
Receive / Consider the External Auditor's Annual Audit Letter		June meeting may be required				
COUNTER FRAUD						
Review and Approve the Annual Workplan for Counter Fraud Activity						■
Review Counter Fraud Progress Reports		■	■	■	■	■
Review the Organisation's Annual Self-Assessment against NHSCFA's Standards	■					
Review the Effectiveness of those carrying out Counter Fraud Activity					■	
Receive the Annual Report on Counter Fraud Activity	■					
ANNUAL REPORTING						
Committee Annual Report to Board						■
Review Committee Terms of Reference						■
FOR INFORMATION						
Summary of Business to be Reported from Private	■	■	■	■	■	■
Review Committee Workplan	■	■	■	■	■	■
Review Committee Cycle of Business	■	■				
CLOSING BUSINESS						
Agree Items for Referral to Board / Other Committees	■	■	■	■	■	■
Review of Meeting Effectiveness	■	■	■	■	■	■
Date of Next Meeting	■	■	■	■	■	■
Resolution to Exclude the Press and Public	■	■	■	■	■	■
PRIVATE AGENDA						
Private Discussions with Internal and External Auditors (and LCFS)		■				

NB: The Annual Cycle of Business has been developed in line with the HFMA NHS Audit Committee Handbook March 2024

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
24.08.24	Email from Andrea Hughes on 24.08.24	Andrea Hughes	Counter Fraud Policy – was due to Sept meeting but not ready	Counter Fraud Policy to go to Committee	Andrea Hughes	Russell Caldicott	05.11.24	
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	
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	