Bundle Audit Committee 12 January 2024

1.1 09:30 - AC24.1 Welcome, introductions and apologies for absence
Audit Committee Agenda- Public Jan 24 V3

1.2 09:32 - AC24.2 Declarations of Interest on current agenda

1.3 09:34 - AC24.3 Draft minutes of the meeting held on 16 November 2023
AC24.1.3a Draft Minutes AC Public 16.11.23 - V5
AC24.1.3b Table of Actions

2.1 09:40 - AC24.4 AC Terms of Reference and Cycle of Business 24/25
AC24.2.1.1 Cover Paper for ToR for Audit (10.01.24) v3
AC24.2.1.2 Audit Committee ToR V0.02 Draft (reviewed 21.12.23 - untracked version
AC24.2.1.3 Audit Committee CoB 2024-25 v0.01 Working Draft (04.01.24) v1

2.2 09:45 - AC24.5 Corporate Governance Arrangements
a) Developing Committee Governance
b) Update on Policy on Policy consultation
c) Details of Breaches of SOs (late papers etc.)
d) Declarations of Interest/Gifts & Hospitality Implementation Plan Update
AC24.2.2a Cover Paper for Corporate Governance Report for AC
AC24.2.2b Appendix 1 - Breach log Audit January 2024
AC24.2.2c Appendix 2 - AC Report - Declarations of Interests Gifts and Hospitality V0.2

2.3 10:00 - AC24.6 Ombudsman Review
AC24.2.3 - Jan 2024 - Ombudsman Update Report

2.4 10:05 - AC24.8 Risk Management
a) Assurance report RMG
b) Corporate Risk Register
Board Assurance Framework
AC24.2.4a RMG Assurance and Corporate Risk Register
AC24.2.4b Board Assurance Framework AC Report

2.5 10:15 - AC24.9 Special Measures Report
a) Update on milestones and arrangements related to AC
AC24.2.5 Special Measures Report

3.1 10:25 - AC24.10 Review annual accounting progress and note financial accounting timetable
AC24.3.1 Review annual accounting progress and note financial accounting timetable

3.2 10:35 - AC24.11 SFI Conformance Report: period ending November 23
AC24.3.2 SFI Conformance Report period ending November 23

3.3 10:45 - AC24.12 Key Assumptions and Judgements 23/24 Annual Accounts

3.4 10:55 - AC24.13 Counter Fraud in Year Progress Report

4.1 11:05 - AC24.14 Internal and External Audit Tracker
a) Executive Medical Directorate
b) People Services
AC24.4.1a Tracker Report
AC24.4.1b Appendix 1 Audit Tracker - Proposed recommendations for Closure by
AC24.4.1c Appendix 2 Audit Tracker - Overdue Open Internal Audit recommendations
AC24.4.1d Appendix 3 Audit Tracker - Overdue Open External Audit recommendations
AC24.4.1e Appendix 4 Audit Tracker -Recommendations Awaiting Updates

4.2 11:30 - AC24.15 Internal Audit Progress Report
AC24.4.2a Internal Audit Progress Report Cover Sheet
AC24.4.2b Internal Audit Progress Report

4.3 11:35 - AC24.16 Any no assurance or limited assurance reports as a substantive item
a) Lessons Learnt
b) Decarbonisation
c) Waiting Lists
AC24.4.3a Final Internal Audit Report - Lessons Learnt
AC24.4.3b Internal Audit Report Final Decarbonisation
AC24.4.3c Final Internal Audit report - Waiting list mangement

5.1 11:45 - AC24.17 Auditor General's (external audit) update
AC24.5.1 Auditor General Exernal Audit Wales Update

6.1 11:50 - AC24.18 Briefings and update sessions (as appropriate)

7.1 11:55 - AC24.19 Summary of in Committee business to be reported in public

7.2 11:57 - AC24.20 Summary of Key Issues

7.3 11:59 - AC24.21 Items to Escalate to Board

7.4 12:00 - AC24.22 Date of Next Meeting
15th March 2024

Agenda for Audit Committee

Date 12 January 2024
Time 09:30 -12:30
Location Boardroom, Carlton Court
Chair Karen Balmer

Agenda item	Item	Lead	Action	Paper/Verbal
1.0 OPENING ADMINISTRATION				
1.1	Welcome, introductions and apologies for absence	Chair	Information	Verbal report
1.2	Declarations of interest on current agenda	Chair	Decision	Verbal Report
1.3	Minutes of previous meeting for accuracy & matters arising and review of summary action plan	Chair	Approval	Report
2.0 GOVERNANCE				
2.1	AC Terms of Reference and Cycle of Business 24/25	Acting Board Secretary	Approval	Report
2.2	Corporate Governance a) Developing Committee Governance b) Update on policies on policies consultation c) Details of Breaches of SOs (late papers etc.)Draft TOR for Board Committees d) Declarations of Interest/Gifts & Hospitality Implementation Plan Update	Acting Board Secretary	Assurance	Report
2.3	Ombudsman Review	Deputy Director of Quality	For Information	Report
2.4	Risk Management a) Assurance report RMG & Corporate Risk Register b) Board Assurance Framework	Head of Risk Management	Assurance	Report
2.5	Special Measures Report a) Update on milestones and arrangements related to AC	Director of Transformation & Improvement	Assurance	Report
3.0 FINANCE				

Agenda item	Item	Lead	Action	Paper/Verbal
3.1	Review annual accounting progress and note financial accounting timetable	Executive Director of Finance	Approval	Report
3.2	SFI Conformance Report: period ending November 23	Executive Director of Finance	Assurance	Report
3.3	Key Assumptions and Judgements 23/24 Annual Accounts	Executive Director of Finance	Assurance	Verbal
3.4	Counter Fraud in Year Progress Update	Head Of Local Counter Fraud Services	Assurance	Verbal
10 Min Break				
4.0 INTERNAL AUDIT				
4.1	Internal and External Audit Tracker a) Executive Medical Directorate b) People Services	Head of Risk a) Executive Medical Director/ b) Deputy Director of People	Assurance	Report
4.2	Internal Audit progress report	Head of Internal Audit	Assurance	Report
4.3	Any no assurance or limited assurance reports as a substantive item a) Lessons Learnt b) Decarbonisation c) Waiting Lists	Head of Internal Audit a) Executive Director of Nursing b) Interim Executive Director of Finance c)Executive Director of Operations	Assurance	Report
10 Min Break				
5.0 EXTERNAL AUDIT				
5.1	Auditor General's (external audit) update	Audit Wales	Assurance	Report
6.0 AUDIT COMMITTEE				
6.1	Briefings and update sessions (as appropriate)	Chair/ Acting Board Secretary/ Executive Director of Finance	Information	Verbal

Agenda item	Item	Lead	Action	Paper/Verbal
7.0 CLOSING BUSINESS				
7.1	Summary of in Committee business to be reported in public	Acting Board Secretary	Information	Verbal
7.2	Summary of Key Issues	Chair/ Acting Board Secretary	Information	Verbal
7.3	Items to Escalate to Board	Chair	Information	Verbal
7.4	Date of Next Meeting 15.03.2024	Chair	Information	Verbal

MEMBERS	
Name	**Title**
Karen Balmer	Independent Member, Chair
Dyfed Jones	Independent Member
Gareth Williams	Independent Member
In attendance	
Phil Meakin	Interim Board Secretary
Nick Lyons	Executive Medical Director/Deputy Chief Executive Officer
Russell Caldicott	Interim Executive Director of Finance
Andrea Hughes	Interim Director of Finance – Operational Finance
Chris Stockport	Executive Director Transformation and Strategic Planning
Nesta Collingridge	Head of Risk Management
Karl Woodward	Head of Local Counter Fraud Services
Dave Harris	Head of Internal Audit
Nicola Jones	Deputy Head of Internal Audit
Andrew Doughton	Audit Wales
Michelle Phoenix	Audit Wales Performance Lead
Matt Edwards	Audit Wales
Dave Harries	Head of Internal Audit
Simon Monkhouse	Audit Wales
Matt Joyce	Deputy Director of Quality
Adele Gittoes	Executive Director of Operations
Rhys Blake	Associate Director of Planned Care
Jason Brennan	Deputy Director of People

Betsi Cadwaladr University Health Board

Minutes of the Audit Committee held on 16 November 2023, Boardroom, Carlton Court, St Asaph

Present	
Name	**Title**
Karen Balmer	Independent Member, Chair
Dyfed Jones	Independent Member
Gareth Williams	Independent Member
In attendance	
Adele Gittoes	Interim Executive Director of Operations
Andrea Hughes	Interim Director of Finance
Andrew Doughton	Audit Wales Performance Audit Manager
Brenda Greenslade	Regional Risk Manager East (Observing)
Carol Shillabeer	Interim Chief Executive Officer
Chris Lynes	Deputy Executive Director of Nursing
Chris Stockport	Executive Director of Transformation and Strategic Planning
Danielle Hunt	Senior Risk Management Administrator (for minutes)
Dave Harries	Head of Internal Audit
Dyfed Edwards	Independent Member/Health Board Chair
James Risley	Deputy Executive Medical Director
Karen Higgins	Director of Primary Care
Karl Woodward	Head of Local Counter Fraud Services
Michelle Phoenix	Audit Wales Performance Lead
Nesta Collingridge	Head of Risk Management
Nicola Jones	Deputy Head of Internal Audit
Peter Greensmith	Assistant Director North Wales Dental Service
Phil Meakin	Acting Board Secretary
Rhys Blake	Associate Director of Planned Care
Russell Caldicott	Interim Executive Director of Finance

Agenda item	**Action**
OPENING BUSINESS	
AC23.109 Welcome introductions and apologies **AC23.109.1** The Chair of the Committee welcomed everyone to the meeting. **AC23.109.2** Apologies were received from the Executive Medical Director, for whom the Deputy Executive Medical Director deputised and the Executive Nurse Director for whom the Deputy Executive Director of Nursing deputised.	
AC23.110 Declarations of interest on current agenda	

AC23.110.1 There were no declarations of interest noted.	
AC23.111 Draft Minutes of the meeting held on 15 September 2023 and review of summary action log **AC23.111.1** The Committee received the draft minutes of the meeting held in September 2023 and these were confirmed as a true and accurate record. However, there was an action on the drafting in relation to the numbering and typos noted to be revised. **Action:** Minutes of the previous meeting to be updated in relation to comments around the numbering and typos. **AC23.111.2** The Acting Board Secretary summarised the detail upon the Action Log and invited comments. The table of actions was updated, along with the items for closure. **AC23.111.3** The Chair commented that the following items had previously been omitted from the Action Log. **Action:** Internal Audit Tracker – section to be added on which Committees are reviewing which recommendations and number of revisions made to the implementation dates **Action:** Audit Wales Performance Lead to be added as a member of Charitable Funds Committee	DH NC RC
ITEMS FOR APPROVAL OR ASSURANCE	
AC23.112 Details of Breaches of Standing Orders The Acting Board Secretary presented the item. **AC23.112.1** The Acting Board Secretary introduced the routine item and highlighted the importance of good governance arrangements and compliance in relation to the Health Boards Standing Orders. **AC23.112.2** Therein the report the Acting Board Secretary reported upon matters regarding current practice in line with the Model of Standing Orders, *namely;* • To note that papers are published 7 days in advance, rather than 10 *as stated in the Standing Orders*. • To also note that the publication of papers was likely to continue to breach the 10 day publication and continue as 7 days electronic publication. The Committee were asked to note and consider the point's raised within the report, along with the items of non-compliance and in particular the five breaches reported since January 2023 based on the 7-day publication.	

AC23.112.3 A discussion ensued and the Committee raised a number of questions and points. **AC23.112.4** The Chief Executive Officer (CEO) clarified the position of the Executives function, in relation to the screening of papers and the overall management of Executive business, it was noted that the screening of papers wasn't within scope. The CEO also made comment regarding the size and quality of proposed publications, along with the practicalities, quality and time constraints of reviewing the documents. **AC23.112.4** An Independent Member (IM - GW) provided comment on the 7 versus 10 day review as being reasonable and also commented on the Committee Chairs ability to have sufficient time to review the papers. The IM also highlighted that the Standing Orders had changed recently and were likely to change again. The IM also questioned the need to log with Welsh Government, or NHS Executive with regards to the periodic yearly review in order to reflect the updates required. **AC23.112.5** The IM (GW) explained concerns with regards to papers written some 3 weeks prior to Board and then potentially being out of date. It was also at this point noted, that if Committee Report content were shortened then that would ensure timely sign off by the Executives. The Audit Committee Chair (KB) also requested that papers are sent to the Chairs of Committees 10 days prior to the meeting to allow time to raise questions ahead of formal publication where necessary. **AC23.112.6** The Chair of the Health Board raised concerns in relation to the wider issues of breaches with regards to late publications and suggested the issue be raised with the Head of Corporate Affairs. **AC23.112.7** The Interim Executive Director of Finance also addressed the comments made by the IM and confirmed that reports developed 3 weeks in advance may not contain up to date financial information. The Interim Executive Director acknowledged the time limitations of reporting data within the current reporting framework. **AC23.112.8** The Head of Internal Audit raised concern relating to the logging of breaches with regards to the publication of Board and Committee papers. The Head of Internal Audit was concerned with the management response that was signed off by the previous Interim Board Secretary. The Head of Internal Audit concluded that the process of "sending a reminder" was not a robust internal control enhancement. **AC23.112.9** The Chair summarised that further work was ongoing and the Acting Board Secretary agreed to revisit the paper; in terms of quality, gate keeping and publication of papers. It was also noted that a discussion with Welsh Government was to be arranged with regards to standing orders and the forthcoming periodic review. It was clarified that papers would continue to be published 7 days prior to meetings and that the Standing	PH PM

Orders would not be updated to reflect. **Action:** The robustness of issues in relation to breaches of late publications to be reviewed by Head of Corporate Affairs taking into account Internal Audit's last report on breaches to work on strengthening the process. **Action:** Feedback to the Welsh Government, or NHS Executive with regards to the periodic yearly review in relation to the timeline of papers submitted to Committees.	
AC23.113 Corporate Governance Arrangements The Acting Board Secretary presented the report and appendices. **AC23.113.1** The Acting Board Secretary presented the paper to the Committee and verified that this report followed the report which was presented to the Board on 28th September 2023. The Committee were asked to note the progress and consider the updates provided. 1. Draft Committee work plans 2. Draft Terms of Reference for Committees and Advisory Groups 3. Corporate Calendars for 2023/24 and 2024/25 4. Corporate Governance Standing Operating Procedures 5. Board Induction Arrangements **AC23.113.2** The Acting Board Secretary clarified that the next step was to meet with Chairs and Executive Leads to review the suite of documents during November and December for onwards formal approval. **AC23.113.3** The Chair acknowledged the request to the Committee to note and consider the updates along with providing feedback to Board with regards to the remit of the Audit Committee, it was agreed that Information Governance would remain with PFIG. **AC23.112.4** IM (GW) agreed that Information Governance was not within the remit of the Audit Committee. The Committee further noted that the IM has taken the role of Chair of the Mental Health Act and Compliance Committee and the Meetings were forecasted as quarterly. The IM also summarised that further work was required with regards to Partnerships, People and Population Health Committee in relation to IMPT elements. It was also suggested to include a specific role or angle to include Primacy and Community Care along with early intervention focus. The consistency of abbreviations was highlighted (*in particular to* the Remuneration and Terms of Service Committee (REMCOM). Reference to the responsibility of strategic objectives and involvement of the Chair was made. The IM also confirmed to provide minor points in relation to meeting etiquette and desired requirements of Committee papers. The IM acknowledged the work of the Acing Board Secretary on the Induction progress to date and the improvements made.	

AC23.114 Risk Management The Head of Risk Management presented these items. **a) Board Assurance Framework (BAF)** **b) Corporate Risk Register** **AC23.114.1** The Head of Risk Management introduced the paper (a) and confirmed that the report had been received by the Quality Safety, Experience Committee (QSE) and Performance Finance and Information Governance Committee (PFIG). **AC23.114.2** The Committee recognised the work relating to the BAF which is currently aligned to strategic priorities but will be aligned to BCUHB's objectives once determined. **AC23.114.3** The Head of Risk Management drew attention to SP16 -Board Leadership and the corporate governance arrangements and actions; in relation to the progression of Independent Member recruitment and the Executive portfolio review. The Committee were asked to consider the approval of SP16. The Chair asked for clarification relating to the gaps in control and the public appointment process wording. The Acting Board Secretary clarified the position and agreed to update wording as noted. **AC23.114.4** The Head of Internal Audit commented in relation to *"the three lines of defence"* within the report and stated that Board and Committees should receive assurance, and not be part of the defence mechanism. The Head of Internal Audit also clarified the lines of defence and the expected contents. **AC23.114.5** The CEO provided an overview of the process of Board appointments which was an agenda item on the JET (Joint Executive Team). Independent Member recruitment was also discussed and the success in recruitment of IMs within the Health Board was raised. **AC23.114.6** The Committee noted and approved the BAF risk report - Appendix 2. **AC23.114.7** The Head of Risk Management introduced paper (b) and confirmed that the report had also been received by the QSE and PFIG Committees. It was explained that the report consisted of the work undertaken to consolidate all of the high and extreme risks. A short summary was provided to the Committee of the report content, along with suggestions to the work which was ongoing with Committees. **AC23.114.8** An IM (GW) raised the question in relation to the headings of the system (Datix) along with engagement and responses. The Head of Risk Management further clarified the headings and would be updated within a future version software. A further discussion ensued with regards	PH

to Tier 1 and Tier 2 risks along with extant data and their reviews. **AC23.114.9** The CEO summarised that the continual improvement and level work was recognised, along with recognition and importance of ongoing work priorities and milestones. The Head of Risk Management also outlined the detail and next steps required to progress. **AC23.114.10** The Committee were content with the current format and agreed to endorse the report and progress. The Committee had been assured with the progress to date. **Action:** Gaps in controls and Lines of defence to be updated on SP16**.**	NC
AC23.115 Special Measures Report The Executive Director of Transformation and Strategic Planning presented the item. **AC23.115.1 Special Measures Update** **a) Update on milestones and arrangements related to AC** The Executive Director of Transformation and Strategic Planning introduced and presented the item in relation to cycle 2. The report included the update on Special Measures, and the Executive Director outlined the progress to date on the deliverables associated to the Committee. The Committee acknowledged the detailed overview relating to standardisation and noted that since last meeting there was solid progress. **AC23.115.2** It was confirmed that the management response had been received regarding the Office of the Board Secretary review. **AC23.115.3** An IM (GW) commented upon 1.5 within the report and hoped that all Committees be operational upon commencement of the recruitment of the new IMs. **AC23.115.4** The Chair commented upon item 1.8 and of the recruitment and role of the Director of Corporate Governance. It was clarified that the job description was reviewed and noted at REMCOM and was out to advertisement. The report was to be updated in the next iteration to reflect the progress accordingly. **AC23.115.5** The Committee acknowledged the level of detail within the report relating to areas of challenge and process for independently assessing evidence, along with processes for how changes were being logged and managed. **b) Feedback from Independent Reviews – OBS Review** **AC23.115.6** The Acting Board Secretary provided the overview of the report in relation to the review, which was a record of the recent development session. It was confirmed that the report was to be published	

within the public domain which would include key themes. It was noted that an action plan had been included within the document and the Acting Board Secretary requested that the Committee note that the actions were also in relation to the special measure deliverables along with some separate additional items. The Acting Board Secretary requested that the Committee note the progress to date. **AC23.115.7** The Chair queried whether the Health Board Vice Chair could attend the Audit Committee. Best practice was clarified by the Acting Board Secretary which was taken from the NHS Wales Audit Committee Handbook that the vice chair could be a member of the Committee but it was not best practice for the Vice Chair to Chair the Audit Committee. The Acting Board Secretary agreed to review the content and quality of the report prior to public release. **AC23.115.8** The Committee agreed to endorse the feedback**.** **Action**: Review the quality of the report (OBS review) prior to public release.	PH
AC23.116 Review of amendments to SFIs & Breaches on SFIs and EASC and WHSSC The Interim Executive Director of Finance introduced the items. **AC23.116.1** The Interim Director of Finance summarised the highlights of the report which included the responsibilities, policies and procedures that were to be adopted by the Health Board. The Interim Director also presented the updates as noted therein Appendix 2 of the report. **AC23.116.2** The Audit Committee were asked to take assurance and consideration around the support, incorporation and adoption of the Standing Financial Instructions. The Audit Committee were also asked to support the incorporation and adoption of the Standing Orders for WHSSC and EASC as Schedules 4.1 and 4.2. **AC23.116.3** The Chief Executive Officer provided an explanation around the need to include an extra step in relation to single tender waivers, to ensure confidence and robustness with the process. The CEO agreed to feedback in relation to the Scheme of Reservation and Delegation (SORD) update. **AC23.116.3** A short discussion took place with regards to clarification and detail of SFIs. It was noted that the key requirements were noted and were being reviewed and monitored. A discussion ensured in relation to controls, the approach and procurement thresholds. **AC23.116.4** The Chair and Committee agreed to endorse the report.	

AC23.117 Amended Scheme of Reservation and Delegation (SORD) The Interim Executive Director of Finance presented the item. **AC23.117.1** The Interim Director of Finance summarised the report and provided an overview of the document; it was explained that the paper set out the decisions that are reserved for the Board and those that are then delegated down to the hierarchy the budget holders. It was confirmed that various updates had been made within Tables A, B and B2 of the SoRD and had been updated to reflect the changes from the 2023 Standing Financial Instructions review. **AC23.117.2** The Committee were asked to note the latest version of the SORD for onwards submission to the Health Board Meeting for approval. Once approved it was recognised that work would then be undertaken to update the relevant policies, procedures and the oracle hierarchical updates. **AC23.117.2** An Independent Member (GW) referred to the tables and updates to the documents along with referral limits. The Interim Director provided clarification to the IM in relation to the queries raised. The IM also requested clarification on the paper being presented to Committee and of the relevancy; the IM was provided with clarity around the limits and hierarchical delegations to Committees to receive documents. It was noted that the CEO was keen to review the detail and would work with the relevant officers to refine and review as required. It was agreed that the paper was to be presented at the next Health Board Meeting. **AC23.116.4** It was noted to endorse the report.	
AC23.118 Report on Single Tender Waivers and Losses & Special Payments Q4 22/23 The Interim Executive Director of Finance introduced the items. **AC23.118.1** The Chair referred to an earlier discussion around concerns raised in relation to Single Tender Waivers, and asked the Committee to note that this report which was for Q4 22/23 had not previously been brough to the Committee. The Interim Executive Director of Finance also emphasised that the report was historic and provided the explanation of the report detail to the Committee. **AC23.118.2** The Committee were asked to note the progress against the Single Tender Waivers & Single Quote Waivers implemented by the Health Board from the period January 23 to March 23 and along with the request to approve the Losses and Special Payments report from the same period. The committee approved accordingly. **AC23.118.3** The Head of Internal Audit informed the group that a meeting took place with the Director of Procurement and Deputy Director to go through the report and factual accuracy. The Head of Internal Audit	

summarised that all NHS Organisations submit Single Tender Waivers and Single Quote Waivers and there was a recommendation made to liaise with Welsh Government in terms of the current process, in order to try to reduce the numbers of single quotes. **AC23.118.4** Comment was made in relation to the understanding of procurement and grant status. An IM (GW) also provided an overview of his understanding of the requirements of open and transparent procurement / testing of the market. The CEO made comment and acknowledged the ongoing work with regards to the commissioning and contracting approach ahead. A discussion ensued in relation to the management, engagement and importance of the process. The Interim Executive Director of Finance assured the Committee of the appropriate engagement taking place. Further comment was made in relation to the important work with the Local Authority's and Partners, along with current processes in place, aspects of monitoring and value for money. **AC23.119.5** The Committee agreed to note and approve the reports presented.	
AC23.119 Dental Assurance Report The Assistant Director of North Wales Dental Service presented the paper. **AC23.119.1** The Assistant Director of North Wales Dental Service presented the paper and expressed that the monitoring and performance of dental contracts were rigorous and hard work undertaken by the Team in maintaining the contract management process and delivery. The report provided the update on the position regarding assurances relating to the delivery of and payment for Primary Care Dental Services. **AC23.119.2** The Assistant Director provided a summary to actual levels of service delivery. It was recognised there were between 25-30% of the population that were covered, dependent upon area and location. A further overview was expressed with regards to the context of the statistics. It was also stated that commissioning exercises were ongoing to replace lost activity and confirmed that work was ongoing with practices in order to increase the numbers of service delivery. Comment was made in relation to community dental services along with work being undertaken within cycle 3 special measures and the vision of including the maximisation opportunities and fixed structure formats. **AC23.119.3** The Committee noted the report and update.	
AC23.120 Internal and External Audit Tracker **AC23.120.1** The Head of Risk Management presented the report Update on the Internal and External Audit Recommendations Tracker Tool. **AC23.120.2** The Committee were asked to note the current position	

(October 2023) of outstanding audit recommendations and to take assurance in response to audit recommendations and proposed recommendations for closure. **AC23.120.3** The Head of Risk Management briefly talked through this paper and asked to note outstanding recommendations and consider the proposal of any closures from the Executives. The Head of Risk Management confirms in total there are 40 recommendations which are proposed for closure since August, however, still 57 remain as ongoing. The Head of Risk Management notes there is still some ongoing work to be made to the tracker itself and has received feedback with regards to this. **AC23.120.2** The Chair raised concern that Committee are not receiving the right level of assurance around some of the progress being made on the tracker. The Committee did not approve the paper 1A for closure and would like it to be presented again at the January meeting. The Chair requested that the reports be updated to include: • the original management response to the recommendation as it is hard to determine from the status update as to whether the actions agreed are being addressed • What year the audit was from • A column that provides "evidence" for example a link to a document / minutes / website so that there is a cross check that the action has been done – as a committee again the status update gives no evidence to underpin closure. (It was felt that not enough assurance was provided simply because in the OBS comments column an Exec Director has said approved / approved for closure. • Identification of who will check the evidence to verify / validate it • Full Names and job titles - names mentioned should include surname not simply Jason or Phil or whoever along with their job title. **AC23.120.3** An IM (GW) pointed out one thing specifically around number 90 on page 19 around the Charitable objectives and in the comment column it does not reflect the spends accurately. **AC23.120.4** The Acting Board Secretary has arranged for additional resources from within OBS team to make sure can progress this. **Action:** Internal and External Audit Tracker to be presented at the next meeting acknowledging feedback from IMs and incorporating additional info as requested by the Chair.	PM
AC23.121 Internal Audit progress report **AC23.121.1** The Head of Internal Audit briefly introduces the paper and noted two fundamental areas of Health Board delivery of services to its customers. The HoIA expressed his thanks to the Executive Team and	

CEO for the improved turnaround time. **AC23.121.2** The Deputy Head of Internal Audit raised awareness of two reports presented in Committee which were the GP OOH report and the Falls report. The Deputy Head of Internal Audit verifies they are making recommendations around compliance with policies and audit trails and documentation that's in place.	
AC23.122 Any no assurance or limited assurance reports as a substantive item **AC23.122.1** The Head of Internal Audit introduced the limited assurances GP OOH and Falls reports and invited Executives to speak to these reports, detailed below (section c and d of the minutes).	
AC23.123 Executive update on Internal and External Audit Tracker and Limited Assurance Reports **a) OBS update** **AC23.123.1** The Acting Board Secretary explained there are 21 actions noted with details of what they are in the paper. The Acting Board Secretary explained that approximately 10 of these actions can be closed and 11 are being progressed. **AC23.123.2** The Acting Board Secretary stated that some of the actions are grouped: 5 actions noted around declarations of interest, gifts and hospitality of which some are duplicated and out of these 5 there are 2 that can be closed and 3 that will be updated. The Acting Board Secretary also informs that there are some other actions that will come back with an update to around Chairs actions, the BAF and Corporate Governance Disciplines. **b) Operations update** **AC23.123.3** The Interim Executive Director of Operations briefly introduced this item and informed the group that in terms of updates she was unable to provide the level of assurance that this Committee requires. The Interim Executive Director of Operations advised that in relation to the review there is still some work to be done in conjunction with the IHC Directors. **c) GP OOHs report** **AC23.123.4** The Interim Executive Director of Operations introduced this paper before handing to Director of Primary Care. **AC23.123.5** The Director of Primary Care explained this paper was an internal audit of the peer review which took place in September 2022 and the peer review was of urgent primary care and OOH but this audit relates	

to OOH services only which is Pan BCU Services but hosted by East. **AC23.123.6** The Director of Primary Care gave assurance to the group of the 6 actions at the bottom of page 13 highlighting that 3 of them are now completed and the other 3 are in progress. **AC23.123.7** The Chair's observation of the actions is that all the target dates are October, however, the Director of Primary Care confirmed there are new dates for those actions. **d) Falls report** **AC23.123.8** The Deputy Executive Director of Nursing briefly introduced the report and highlighted the main areas of focus. The Deputy Executive Director described highlights around the first action and noted this will go to the Patient Safety Group on 30th November. The Deputy Executive Director assured the group there will be ratification before uploading onto BetsiNet and this action is currently on target being December 2023. The Deputy Executive Director also highlighted another issue around training and a Falls Management training Module 1A and 1B have been introduced in the Health Board which the compliance is currently around 93% in all areas. The Deputy Executive Director also highlighted one more issue with regards to training and that is the Patient Handling Training which is around 60% compliance due to challenges of releasing staff to attend. **AC23.123.9** An IM (GW) showed concern in relation to the highlights reported and would like to see great clarity over how much is to do with failure and how much to do with documenting what is happening. **AC23.123.10** The Head of Internal Audit drew attention to paragraph 2.15 of the report around RIDDOR's and the reporting of. The Head of Internal Audit was surprised that there's been over 1000 reported incidents but only 2 RIDDORS reported which are in West. The Head of Internal Audit believed with this information the Health Board is potentially at a significant risk of breaching statutory requirements due to not reporting within the 7 working days /not reporting at all. **AC23.123.10** The Committee sought an update from Health and Safety colleagues on assurances for RIDDOR reporting and the CEO had requested an update on all Health and Safety risks. **Action:** Committee to be provided with clarity on the lack of RIDDOR reporting and assurances to the CEO on all Health and Safety risks.	NC
AC23.124 Follow up Outpatients Management Response **AC23.124.1** The Chair asked the group for the paper to be noted as read and for focus on highlights to be presented.	

AC23.124.2 Interim Executive Director of Operations briefly introduced this paper and introduced the Associate Director of Planned Care. **AC23.124.3** The Associate Director of Planned Care presented the recommendations and gave an update on the work to address them. The Associate Director of Planned Care detailed a first recommendation of a strengthened clinical leadership of the programme of work alongside establishing a refreshed planned care programme and then detailed a second recommendation which was to address the outstanding recommendation from the 2015 report. **AC23.124.4** Audit Wales Performance Audit Manager noted the group that this report will be published after being reported to this Committee. **AC23.124.5** The Committee sought an updated management response for the Follow up Outpatients Management Response. **Action:** Management response for the Follow up Outpatients Management Response to be reviewed asap and updated for Audit Wales prior to publication	AG
AC23.125 Auditor General's (external audit) progress report AC23.125.1 The Audit Wales Performance Lead briefly introduced the report and noted one highlight of the intent to raise £123k in addition to standard Audit fee. The Audit Wales Performance Lead also noted that there has been ongoing post budget learning with the Interim Executive Director of Finance's team and found the current status on this is ongoing. The Audit Wales Performance Lead also reported that there is some background planning currently with regards to Charitable Funds Committee and the Audit work on this will commence in December 2023.	
AC23.126 National audit reports for information **a) National workforce data briefing** **AC23.126.1** The Chair asked the group to take this paper as read and informed the group it is for information. **AC23.126.2** An IM (GW) asked for follow up data from workforce colleagues about specific patterns, in particular growth in workforce across BCUHB and further clarity is required. It was agreed that this would be picked up by the People committee. Action: Workforce data and specific patterns around growth of particular groups and understanding our patterns to be presented to People committee.	

ITEMS FOR NOTING	
AC23.127 Briefings and update sessions (as appropriate) **AC23.127.1** The Chair and Interim Executive Director have nothing for noting. **AC23.127.2** The Acting Board Secretary wanted to note that communication is needed with other Committees (PFIG and QSE in particular) around some decisions and insights from this Audit Committee.	
CLOSING BUSINESS	
AC23.128 Summary of private in Committee business to be reported in public The Chair had nothing to note for this item.	
AC23.129 Summary of key issues **AC23.129.1** The Acting Board Secretary summarised feedback on papers, Committee decisions and actions noted in the meeting and a Chair's report to be produced to the Board in line with the minutes.	
Date of Next Meeting 12th January 2024	

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

	Lead Executive / Member	Minute Reference and Action Agreed	Original Timescale Set	Update	Revised timescale/ Action status (O/C)	RAG status
Actions from 13 January 2023						
1.	Board Secretary	**Charitable Funds - AC23.08.5G** The role of the Charity would be discussed at the Audit Committee Workshop in May.	15-May-2023	This action remains outstanding due to the change in membership. New date to be set	Action outstanding This has been scheduled for the March 2023 Audit Committee	
Actions from 15 May 2023						
1.	Executive Director of Finance	**Annual Report – AC23.62** The Executive Director of Finance to consider where is the best place for the Board to consider the topic of sustainability.	15 Sep-2023	Until all Committees are re-established this work will be continued through the PFIG Committee	Propose to monitor until Committees established	
Actions from 15 September 2023						
2.	Board Secretary	**AC23.81 Outstanding action on Charitable Funds Committee.** The Board Secretary to speak to the Head of Fundraising about how to progress things.		The November meeting has now occurred.		
4.	Board Secretary	**AC23.83 Annual Work Plan** The Board Secretary to facilitate an annual work plan for the Committee with the Chair of the Committee.		COB on the agenda Jan 2023 for approval.		

6.	Board Secretary	**AC23.86 Declarations of Interest/Gifts & Hospitality** Implementation Plan Update on Declaration of Gifts and Hospitality - The Board Secretary to report back in January on progress and compliance.	January 2024	Note that the Head of Corporate Affairs has been asked to develop implementation plan AC provided with an update in Jan meeting.		
7.	Board Secretary	**AC23.88 Policy on Policies** The Policy on policies needed to be clearer about what was reserved for the Board, in particular matters with legislative framework around them.	Nov 2023	Acting Board Secretary noted this will be coming to Audit Committee in January 2024		
8.	Board Secretary	**AC23.90 Internal Audit** – The Board Secretary to circulate Ombudsman's review and add to the next agenda.	Nov 2023	Acting Board Secretary with permission from Chair will circulate to Matthew Joyes and bring full report back in January 2024 Audit Committee		
9.	Board Secretary	**AC23.90.20 Clinical Audit** – Tier 1 National Audits - Board Secretary to review the dates of any recommendations.	Nov 2023	All Internal and External Audit actions are tracked, including Tier 1 and all dates are reviewed with owners as part of current process. Dates for the recommendations from the clinical audit report were reviewed by Head of Clinical Effectiveness on 06.12.2023 and are considered appropriate.		
10.	Board Secretary	**AC23.93 National Audit Report for information** - The Board Secretary to add digital inclusion to the Exec agenda and update the Audit Committee through the matter arising.	Nov 2023	Board Secretary has updated Executive Team work plan for inclusion by end of Nov 2023		
11.	Board Secretary	**Internal Audit Tracker –** section to be added on which Committees are reviewing which recommendations and number of revisions made to the implementation dates	Nov 2023	Completed and on the January 2023 meeting for review.		
Actions from 16th November 2023						
1.		Minutes of the previous meeting to be updated in relation to comments around	Jan 2024	Checked numbering and typos - complete		

		the numbering and typos.				
2.	Interim Executive Director of Finance	**AC23.111 Table of action** Interim Executive Director of Finance to invite to Michelle Pheonix for the future meetings of the Charitable Funds.	Jan 2024	Invite Sent		
3.	Head of Corporate Affairs	The robustness of issues in relation to breaches of late publications to be reviewed by Head of Corporate Affairs taking into account Internal Audit's last report on breaches to work on strengthening the process.	Jan 2024	Breach paper produced for AC and process is being monitored for robustness.		
4.	Acting Board Secretary	**AC23.112 Details of Breaches of SOs** Acting Board Secretary log with Welsh Government/NHS Exec (also Board Secretary forum) around Standing Orders as they will be reviewed in the next 12 months.	Jan 2024	PM has emailed Melanie Westlake of WG w/c 01.01.2024 with the observations from the Committee	Propose action to be closed, the SO's will not be updated within the next 6 months	
5.	Acting Board Secretary Head of Risk Management	**AC23.114 Risk Management a) Board Assurance Framework** Acting Board Secretary and Head of Risk Management to review the wording of the first control and review the lines of defence.	Jan 2024	Completed as well as other lines of defence reviewed for other BAF reports prior to submission to Board.		
6.	Acting Board Secretary	**AC23.115 Special Measures Report** Acting Board Secretary Review the quality of the report (OBS review) prior to public release.	Jan 2024	Completed prior to submission to Board.		
7.	Interim Executive Director of Finance	**AC23.117 Scheme of Reservation and Delegation** CEO to feedback in relation to the Scheme of Reservation and Delegation (SORD) update.	Jan 2024	The SoRD was approved by the Board on the 30th November and has been published on Betsinet. It will be reviewed again in 6 months.		

8.	Head of Risk Management	**AC23.120 Internal and External Audit Tracker** Head of Risk Management bring back paper to Audit Committee in January with all the feedback received from IMs, including the evidence that has been reviewed to give assurances, to also include a high/medium/low breakdown by Executives.	Jan 2024	On the Jan 2023 agenda and governance updated provided on all committee feedback.		
9.	Chief Executive Officer	**AC23.123 Executive update on Internal and External Audit Tracker and Limited Assurance Reports** **d)Falls report** CEO to pick up potentially having an overall assessment with Health and Safety to discuss all concerns including the reporting of RIDDOR.	Jan 2024	Head of Risk Management contacted Head of Health and Safety, Sue Morgan for a Health and Safety paper to CEO and position the recent reduction on RIDDOR submission to HSE and RIDDOR risk. Further Assurances provided to Head f Risk Management, IA and Chair on RIDDOR reportable falls. H&S risks to be presented at RMG in Feb and CEO To attend H&S meeting.		
10.	Executive Director of Operations	**AC23.124 Follow up Outpatients Management Response** Chair has recommended that in the next QSE there is a focus on follow ups. The committee sought an updated management response for the Follow up Outpatients Management Response.	Jan 2024	The Interim Executive Director of Operations has confirmed this has been completed.		
11.	Head of Local Counter Fraud Services	**PRIVATE – AC23.135 Review counter fraud progress reports** Chair to discuss report with Head of Local Counter Fraud report to include target dates for resolutions	Jan 2024	Head of Local Counter Fraud Services met with Chair to discuss and will update next report.		
12.	Acting board Secretary	**Review counter fraud progress reports to be on public agenda**	Jan 2024	Added for January.		

13.	Acting board Secretary	**PRIVATE – AC23.136 Review effectiveness of LCFS Specialist (through Counter Fraud Authority Quality Assessment)** Acting Board Secretary to check standing orders of publishing declaration of interest/conflicts of interest/gifts.	Jan 2024	PM has checked SO's in this regard and it clarifies that declarations should be received from staff on Band 8a and above.	Propose to keep open so that PM can check that this was the query to be resolved.	

Teitl adroddiad: ***Report title:***	**A Review of the Terms of Reference and Cycle of Business for the Audit Committee**
Adrodd i: ***Report to:***	Audit Committee
Dyddiad y Cyfarfod: ***Date of Meeting:***	Friday, 12 January 2024
Crynodeb Gweithredol: ***Executive Summary:***	The purpose of this report is to provide the Audit Committee with a proposed Terms of Reference and Cycle of Business for **review** and **endorsement.** As reported at the Health Board on 28 September 2023, one of the key Special Measures deliverables includes the requirement to "Establish /Re-establish Board Committees" and it was agreed at that meeting to review the Terms of Reference and Cycle of Business for all Committees (including Audit Committee) as one of the eight Committees and three Advisory Groups of BCUHB. A proposed Terms of Reference and Cycle of Business has been further developed in this paper using the following approach: - Utilising the outline remit of each Committee agreed on 28 September Health Board. - Considering and adopting the recommendations from the Office of the Board Secretary Review in 2023. - A review of Welsh Health Boards Terms of Reference. - A review of the Standing Orders for Health Boards - A review of Committee Handbooks – provided by Welsh Government. These proposed Terms of Reference and Cycle of Business for the Committees, including the Audit Committee have been developed and were noted and considered at the Audit Committee on 16 November 2023. In addition, at the Health Board on 30 November 2023 it was confirmed that the draft Terms of Reference would be developed in more detail with the Chair and Exec Lead for the Committee. This meeting took place on the 21 December 2023.

	The Acting Board Secretary would like to thank the Chair and Executive Lead for their help in developing the Terms of Reference and Cycle of Business and is asking the Committee to review and endorse the draft Terms of Reference to be presented to the Board to consider for approval on 25 January 2024. The proposed cycle of business will also be presented to the Board for noting.
Argymhellion: ***Recommendations:***	*The Committee is asked to:* • **Review and Endorse** the draft Terms of Reference for the Audit Committee. • **Review and Endorse** the Cycle of Business for the Audit Committee.
Arweinydd Gweithredol: ***Executive Lead:***	Phil Meakin - Acting Board Secretary
Awdur yr Adroddiad: ***Report Authors:***	Phil Meakin – Acting Board Secretary Supported by: • Nesta Collingridge – Head of Risk Management • Laura Jones – Special Measures Project Manager • Philippa Peake-Jones – Head of Corporate Affairs

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

Lefel sicrwydd: ***Assurance level:***	Arwyddocaol *Significant* ☐ 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):***	This work links to all strategic objectives of the Health Board as corporate Governance is a key enabler for them.
Goblygiadau rheoleiddio a lleol: ***Regulatory and legal implications:***	The Health Board is required to act according to its Standing Orders. This report contains information to allow the Health Board to conform to this.

	It is essential that the Board has robust arrangements in place for Corporate Governance and failure to do so could have legal implications for the Health Board.
Yn unol â WP7, a oedd EqlA yn angenrheidiol ac a gafodd ei gynnal? ***In accordance with WP7 has an EqlA been identified as necessary and undertaken?***	This is 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?***	This is 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)***	The nature of this paper has an impact on the way Corporate Governance is reported and managed in the Health Board. Risks related to Corporate Governance are reflected in the BAF and CRR and the development of this work will support better oversight and management of them.
Goblygiadau ariannol o ganlyniad i roi'r *argymhellion ar waith* ***Financial implications as a result of implementing the recommendations***	The effective and management of Governance has the potential to leverage a positive financial dividend for the Health Board through better integration of risk management into business planning, decision-making and in shaping how care is delivered to our patients thus leading to enhanced quality and less waste
Goblygiadau gweithlu o ganlyniad i roi'r argymhellion ar waith ***Workforce implications as a result of implementing the recommendations***	Failure to have effective Corporate Governance can impact adversely on the workforce. The development of a People Committee will strengthen arrangements for workforce related matters
Adborth, ymateb a chrynodeb dilynol ar ôl ymgynghori ***Feedback, response, and follow up summary following consultation***	An iteration of this paper will be received at the Health Board on 25 January 2024.
Cysylltiadau â risgiau BAF: (neu gysylltiadau â'r Gofrestr Risg Gorfforaethol) ***Links to BAF risks:*** *(or links to the Corporate Risk Register)*	The nature of this paper has an impact on the way the Board Assurance Framework will be reported and managed in the Health Board
Rheswm dros gyflwyno adroddiad i fwrdd cyfrinachol (lle bo'n berthnasol) ***Reason for submission of report to confidential board (where relevant)***	Not applicable

Next Steps:

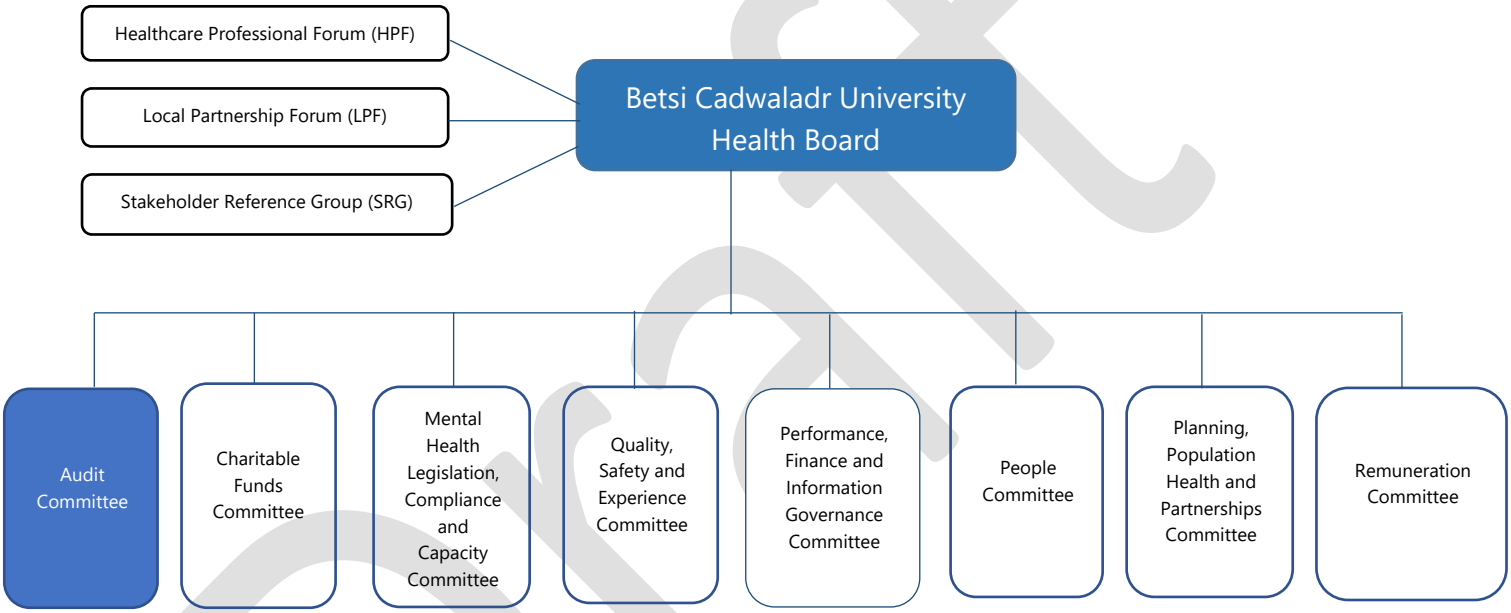
- The Acting Board Secretary to take the final draft of the Terms of Reference for formal approval at the Health Board on 25 January 2024.
- The Acting Board Secretary to take the final draft of the Cycle of Business for noting at the Health Board on 25 January 2024.

List of Appendices:

Appendix 1 – Draft Terms of Reference for the Audit Committee
Appendix 2 – Draft Cycle of Business for the Audit Committee

AUDIT COMMITTEE

TERMS OF REFERENCE



Version	Issued to	Date	Comments
V0.01 Draft	Audit Committee	16/11/23	Developed as a first draft for review with Committee Chairs and Lead Executives
V0.02 Draft	Meeting of Chair and Lead Execs of Audit Committee	11/12/23	Updated after a desktop review of all ToR against the requirements of the OBS Review and the Audit Handbook
V0.03 Draft	Audit Committee		Updated following roundtable meeting of the Chair and Lead Executive

1) Introduction

1.1 The Betsi Cadwaladr University Health Board (BCUHB) shall establish a Committee to be known as the Audit Committee. The Committee is an independent Committee of the Board and has no executive powers, other than those specifically delegated in these terms of reference. The detailed operating arrangements in respect of this Committee are set out below.

2) Purpose

The purpose of the Audit Committee is to;

2.1 Advise and assure the Board and the Accountable Officer on whether effective arrangements are in place, through the design and operation of the Health Board's system of assurance, to support them in their decision taking and in discharging their accountabilities for securing the achievement of the Health Board's objectives, in accordance with the standards of good governance determined for the NHS in Wales.

2.2 The Committee independently monitors, reviews and reports to the Board on the processes of governance, and where appropriate, facilitates and supports, through its independence, the attainment of effective processes.

2.3 Where appropriate, the Committee will advise the Board and the Accountable Officer on where, and how, its system of assurance may be strengthened and developed further.

2.4 The Committee's principal duties encompass the following:

2.4.1 Review the establishment and maintenance of an effective system of good governance, risk management and internal control across the whole of the organisation's activities, both clinical and non-clinical.

2.4.2 Seek assurance that the systems for financial reporting to Board, including those of budgetary control, are effective, and that financial systems processes and controls are operating.

2.4.3 Work with the all Committees of the Board to ensure that governance and risks are part of an embedded assurance framework that is 'fit for purpose'.

2.4.4 Receive an assurance on delivery against relevant Planning Objectives aligned to the Committee accordance with Board approved timescales, as set out in BCUHB's Annual Plan.

3) Responsibilities of the Committee and Delegated Powers

The Audit Committee shall provide advice, assurance and support to the Board in ensuring the provision of high quality, safe healthcare for its citizens, as follows:

3.1 Governance, Risk Management and Internal Control

3.1.2 The Committee shall review the adequacy of the Health Board's strategic governance and assurance arrangements and processes for the maintenance of an effective system of good governance, risk management and internal control, across the whole of the organisation's activities (both clinical and non-clinical) that supports the achievement of the organisation's objectives and designed to support the public disclosure statements that flow from the assurance processes, including the Accountability Reports.

This includes:

- the organisations ability to achieve its objectives,
- compliance with relevant regulatory requirements, standards, quality and service delivery requirements and other directions and requirements set by the Assembly Government and others,
- the reliability, integrity, safety and security of the information collected and used by the organisation,
- the efficiency, effectiveness and economic use of resources, and
- the extent to which the organisation safeguards and protects all its assets, including its people to ensure the provision of high quality, safe healthcare for its citizens.

3.1.3 In particular, the Committee will review the adequacy of:

- all risk and control related disclosure statements, together with any accompanying Head of Internal Audit documents and opinion, external audit opinion or other appropriate independent assurances, prior to endorsement by the Board;
- the underlying assurance processes that indicate the degree of the achievement of strategic and planning objectives, the effectiveness of the management of principal risks and the appropriateness of the above disclosure statements;
- the policies for ensuring compliance with relevant regulatory, legal and code of conduct and accountability requirements; and
- the policies and procedures for all work related to fraud and corruption as set out in Welsh Government Directions and as required by the Counter Fraud and Security Management Service.

3.1.4 In carrying out this work, the Committee will primarily utilise the work of Internal Audit, Clinical Audit, External Audit and other assurance functions, but will not be limited to these audit functions. It will also seek reports and assurances from directors and managers as appropriate, concentrating on the overarching systems of good governance, risk management and internal control, together with indicators of their effectiveness.

3.1.5 This will be evidenced through the Committee's use of an effective assurance framework to guide its work and that of the audit and assurance functions that report to it.

3.1.6 The Committee will seek assurance that effective systems are in place to manage risk, that the organisation has an effective framework of internal controls to address principal risks (those likely to directly impact on achieving strategic objectives), and that the effectiveness of that framework is regularly reviewed.

3.1.7 Monitor the assurance environment and challenge the build-up of assurance on the management of key risks across the year, and ensure that the Internal Audit plan is based on providing assurance that controls are in place and can be relied upon (particularly where there is a significant shift between the inherent and residual risk profile), and review the internal audit plan in year as the risk profile changes.

3.1.8 Seek assurance on delivery against Planning Objectives aligned to the Committee, considering and scrutinising the frameworks, charts/charters and action plans that are developed, supporting and endorsing these as appropriate.

3.1.9 Consider and recommend to the Board approval of any changes to the Risk Management Framework and oversee development of the Board Assurance Framework (BAF). The Committee will oversee associated BAF risks of the Committee.

3.1.10 The Committee will be responsible for reviewing the Health Board's Standing Orders and Standing Financial Instructions and Scheme of Delegation annually, (including associated framework documents as appropriate), monitoring compliance, and reporting any proposed changes to the Board for consideration and approval.

3.1.11 To receive annually a full report of all offers of gifts, hospitality, sponsorship and honoraria recorded by the Health Board and report to the Board the adequacy of these arrangements.

3.1.12 To review and report to the Board annually the arrangements for declaring, registering, and handling interests.

3.1.13 Approve the writing-off of losses or the making of special payments within delegated limits.

3.1.14 Receive an assurance on Post Payment Verification Audits through bi-annual reporting to the Committee.

3.1.15 Receive a report on all Single Tender Actions and extensions of contracts.

3.2 Internal Audit and Capital / PFI

3.2.1 The Committee shall ensure that there is an effective internal audit and capital/PFI function established by management that meets mandatory Internal Audit Standards for NHS Wales and provides appropriate independent assurance to the Committee, Chief Executive and Board.

3.2.2 This will be achieved by:

- review and approval of the Internal Audit Strategy, Charter, operational plan and more detailed programme of work, ensuring that this is consistent with the audit needs of the organisation;
- review of the adequacy of executive and management responses to issues identified by audit, inspection and other assurance activity, in accordance with the Charter;
- regular consideration of the major findings of internal audit work (and management's response), and ensure co-ordination between the Internal and External Auditors to optimise audit safety;

- ensuring that the Internal Audit function is adequately resourced and has appropriate standing within the organisation; and
- annual review of the effectiveness of internal audit.

3.3 External Audit

3.3.1 The Committee shall review the work and findings of the External Auditor and consider the implications and management's responses to their work. This will be achieved by:

- discussion and agreement with the External Auditor, before the audit commences, of the nature and scope of the audit as set out in the Annual Plan, and ensure coordination, as appropriate, with other External Auditors and inspection bodies in the local health economy;
- discussion with the External Auditors of their local evaluation of audit risks and assessment of the Local Health Boards/NHS Trusts and associated impact on the audit fee;
- review all External Audit reports, including agreement of the Annual Audit Report and Structured Assessment before submission to the Board, and any work carried outside the annual audit plan, together with the appropriateness of management responses; and
- review progress against the recommendations of the annual Structured Assessment.

3.4 Other Assurance Functions

3.4.1 The Committee shall review the findings of other significant assurance functions, both internal and external to the organisation, and consider the implications on the governance of the organisation.

3.4.2 The Committee's programme of work will be designed to provide assurance that the work carried out by the whole range of external review bodies is brought to the attention of the Board. This will ensure that the Health Board is aware of the need to comply with related standards and recommendations of these review bodies and the risks of failing to comply. These will include, but will not be limited to, any reviews by Inspectors and other bodies (e.g. Healthcare Inspectorate Wales, Welsh Risk Pool, etc), professional bodies with responsibility for the performance of staff or functions (e.g. Royal Colleges, accreditation bodies, etc).

3.4.3 The Audit and Risk Assurance Committee and the Quality, Safety and Experience Committee both have a role in seeking and providing assurance on Clinical Audit in the organisation. The Audit and Risk Assurance Committee will seek assurance on the overall plan, its fitness for purpose and its delivery. The Quality, Safety and Experience Committee will seek more detail on the clinical outcomes and improvements made as a result of clinical audit. The internal audit function will also have a role in providing assurance on the Annual Clinical Audit Plan.

3.4.4 The Audit and Risk Assurance Committee will also seek assurances where a significant activity is shared with another organisation and collaborative, in particular the NHS Wales Shared Services Partnership, Welsh Health Specialised Services Committee, Emergency Ambulance Services Committee and other regional committees. The Audit and Risk Assurance Committee will expect to receive assurances from internal audit performed at

these organisations that risks in the services provided to them are adequately managed and mitigated with appropriate controls.

3.5 Management

3.5.1 The Committee shall request and review reports and positive assurances from directors and managers on the overall arrangements for governance, risk management and internal control.

3.5.2 The Committee may also request specific reports from individual functions within the organisation (e.g. clinical audit), as they may be appropriate to the overall arrangements.

3.5.3 The Committee may also request or commission special investigations to be undertaken by Internal Audit, directors or managers to provide specific assurance on any areas of concern that come to its attention.

3.5.4 The Committee shall review the Annual Accounts and Financial Statements before submission to the Board, focusing particularly on:

- the ISA 260 report to those charged with governance;
- changes in, and compliance with, accounting policies and practices;
- unadjusted mis-statements in the financial statements;
- major judgemental areas;
- significant adjustments resulting from the audit;
- other financial considerations include review of the Schedule of Losses and Compensation.

3.5.5 The Committee should also ensure that the systems for financial reporting to the Board, including those of budgetary control, are subject to review as to completeness and accuracy of the information provided to the Board.

3.5.6 Assure the Board in relation to its compliance with relevant national practice, mandatory guidance, healthcare standards and duties, including Duty of Quality, Duty of Candour, Quality Standards and Quality Management ensuring the Board is supported to make strategic decisions through a quality lens.

4) Membership

4.1 Formal membership of the Committee shall comprise of the following:

MEMBERS
Independent Member (Chair)
2 x Independent Members (one of whom will be designated as Vice Chair)

4.2 The following should attend Committee meetings:

IN ATTENDANCE
Executive Director of Finance (Executive Lead)
Board Secretary
Other Attendees

Other Executive Directors as required by the Chair
Other Senior Managers as required by the Chair
Head of Internal Audit
Head/individual responsible for Clinical Audit
Local Counter Fraud Specialist
Representative of Auditor General (External Audit)

4.3 The membership of the Committee shall be determined by the Board, based on the recommendation of the Health Board Chair, taking into account the balance of skills and expertise necessary to deliver the Committee's remit, and subject to any specific requirements or directions made by the Welsh Government.

4.4 The Chair of the organisation should not be a member of the Audit Committee and will not normally attend. The Board Secretary and Executive Director of Finance will normally attend. The Chief Executive and other Executive Directors will attend whenever they are required to do so by the Committee Chair.

4.5 Membership of the Committee will be reviewed on an annual basis.

5) Quorum and Attendance

5.1 A quorum shall consist of no less than two of the membership and must include as a minimum the Chair or Vice Chair of the Committee, together with a third of the In Attendance members, including the Executive Director of Finance (or their nominated deputy) and the Board Secretary (or their nominated deputy)

5.2 Any senior officer of the Health Board or partner organisation may, where appropriate, be invited to attend, for either all or part of a meeting, to assist with discussions on a particular matter.

5.3 The Committee may also co-opt additional independent external 'experts' from outside the organisation to provide specialist skills.

5.4 Should any 'in attendance' officer member be unavailable to attend, they may nominate a deputy to attend in their place, subject to the agreement of the Chair.

5.5 The Committee may ask any or all of those who normally attend but who are not members to withdraw to facilitate open and frank discussion of particular matters.

6) Agenda and Papers

6.1 The Committee Secretary is to hold an agenda setting meeting with the Chair and/or Vice Chair and the Executive Lead (Executive Director of Finance / Board Secretary) at least six weeks before the meeting date.

6.2 The agenda will be based around the Committee work plan, identified risks, matters arising from previous meetings, issues emerging throughout the year, and requests from

Committee members. Following approval, the agenda and timetable for request of papers will be circulated to all Committee members.

6.3 All papers must be approved by the Executive Lead.

6.4 The agenda and papers will be distributed/published seven days in advance of the meeting.

6.5 A draft table of actions will be issued within two working days of the meeting. The minutes and table of actions will be circulated to the Executive Lead within seven days to check the accuracy, prior to sending to Members to review within the next seven days.

6.6 Members must forward amendments to the Committee Secretary within the next seven days. The Committee Secretary will then forward the final version to the Committee Chair for final review.

7) In Committee

7.1 The Committee can operate with an In Committee function to receive updates on the management of sensitive and/or confidential information.

8) Meetings

8.1 The Committee will meet bi-monthly and an annual schedule of meetings will be determined by the corporate calendar.

8.2 The Committee may be convened at short notice if requested by the Chair.

8.3 Any additional meetings will be arranged under exceptional circumstance and shall be determined by the Chair of the Committee in discussion with the Lead Director.

8.4 The Committee may, subject to the approval of the Health Board, establish sub-committees or task and finish groups to carry out on its behalf specific aspects of Committee Business.

8.5 Meetings may be held in person where it is safe to do so or by video-conferencing and similar technology.

8.6 The Committee Secretary shall be determined by the Board Secretary.

9) Reporting

9.1 The Committee, through its Chair and members, shall work closely with the other Committees to provide advice and assurance to the Board through joint planning and co-ordination of Board and Committee business including sharing of information.

9.2 The Committee Chair, supported by the Committee Secretary, shall:

- Report formally, regularly and on a timely basis to the Board on the Committees activities.
- Bring to the Boards specific attention any significant matter under consideration by the Committee.
- Ensure appropriate escalation arrangements are in place to alert the Health Boards Chair, Chief Executive and/or Chairs of other relevant Committee, of any urgent/critical matters that may affect the operation and/or reputation of the Health Board.

9.3 The Committee will undertake an annual review on the effectiveness of its arrangements and responsibilities. The Office of the Board Secretary will lead this review.

10) Accountability, Responsbility and Authority

10.1 Although the Board has delegated authority to the Committee for the exercise of certain functions, as set out in these Terms of Reference, it retains overall responsibility and accountability for ensuring the quality and safety of healthcare for its citizens through the effective governance of the organisation.

10.2 The Audit Committee will seek assurance on an overall Clinical Audit plan, it's fitness for purpose and it's delivery. The role of the Audit Committee is to seek assurance on:
• Does the organisation have a plan - and is it fit for purpose?
• Is it completed on time?
• Does it cover all relevant issues?
• Is it making a difference and leading to demonstrable change?
• Is change supported by recognised improvement methodologies?
• Does the organisation support clinical audit effectively?

The Quality, Safety and Experience Committee will seek more detail on the clinical outcomes and improvements made as a result of clinical audit

10.3 The Audit Committee is directly accountable to the Board for its performance in exercising the functions set out in these terms of reference.

10.4 The requirements for the conduct of business as set out in the Health Boards Standing Orders are equally applicable to the operation of the Committee.

11) Review Date

11.1 These terms of Reference and operating arrangements shall be reviewed on at least an annual basis by the Committee for approval by the Board.

Audit Committee Cycle of Business
(March 2024 – March 2025)

Bwrdd Iechyd Prifysgol Betsi Cadwaladr University Health Board

Item of Business	Purpose	Lead	March 2024	May 2024	July 2024	September 2024	November 2024	January 2025	March 2025	Notes
Opening Business										
Apologies			✓	✓	✓	✓	✓	✓	✓	
Declarations of Interest			✓	✓	✓	✓	✓	✓	✓	
Minutes from the previous meeting			✓	✓	✓	✓	✓	✓	✓	
Matters arising & Table of actions			✓	✓	✓	✓	✓	✓	✓	
Report of the Chair: • Chair's action • Feedback from Board	This can be used as a placeholder if required (by exception)		✓	✓	✓	✓	✓	✓	✓	
Notification of matters referred from other Committees			#	#	#	#	#	#	#	
Strategic Priorities										
Review and oversight of process for establishing Strategic Plans for BCUHB			✓				✓			
Placeholder for consideration of issues arising from	Placeholder for requirement		#	#	#	#	#	#	#	

Audit Committee Cycle of Business
(March 2024 – March 2025)

Item of Business	Purpose	Lead	March 2024	May 2024	July 2024	September 2024	November 2024	January 2025	March 2025	Notes
the Strategic Planning Process or Plans										
					Issues Related to Key Risks					
Chair of Risk Management Group Assurance Report		Director of Corporate Governance / Head of Risk Management	✓	✓	✓	✓	✓	✓	✓	
Board Assurance Framework related to Committee		Director of Corporate Governance / Head of Risk Management	✓	✓	✓	✓	✓	✓	✓	
Corporate Risk Register related to Committee		Director of Corporate Governance / Head of Risk Management	✓	✓	✓	✓	✓	✓	✓	
Placeholder for any agenda items deriving from the BAF & CRR		Director of Corporate Governance	#	#	#	#	#	#	#	
Annual Risk Management Framework Review /Board Assurance Framework		Director of Corporate Governance / Head of Risk Management			✓					
					For Assurance					
					Corporate Governance					
Corporate Governance:		Director of Corporate Governance		✓						

Audit Committee Cycle of Business
(March 2024 – March 2025)

Bwrdd Iechyd Prifysgol Betsi Cadwaladr University Health Board

Item of Business	Purpose	Lead	March 2024	May 2024	July 2024	September 2024	November 2024	January 2025	March 2025	Notes
Review and Recommend Organisation's Annual Report										
Review Draft Annual Governance Statement		Director of Corporate Governance		✓						
Review of Amendments to Standing Orders		Director of Corporate Governance				✓				
Details of Breaches of SO's (late papers etc)		Director of Corporate Governance	✓	✓	✓	✓	✓	✓	✓	
Declarations of Interest and Gifts & Hospitality Report		Director of Corporate Governance		✓		✓		✓		
Annual Review of Gifts & Hospitality and DoI Registers		Director of Corporate Governance	✓							
Annual Review of Submissions on Database to capture externally commissioned reports etc. E.g. DU, CHC etc.		Director of Corporate Governance				✓				

Audit Committee Cycle of Business
(March 2024 – March 2025)

Item of Business	Purpose	Lead	March 2024	May 2024	July 2024	September 2024	November 2024	January 2025	March 2025	Notes
Audit Recommendations Tracker Other sources of assurance (audit reports, regulatory body reports, external reviews, shared services reports, ombudsman)		Director of Corporate Governance	✓	✓	✓	✓	✓	✓	✓	
Special Measures Progress Update on relevant areas		Director of Transformation & Improvement	✓	✓	✓	✓	✓	✓	✓	
Finance										
Finance: Review of Amendments to SFIs, Scheme of Delegation and SOs		Executive Director of Finance				✓				
Details of Breaches of SFIs, Scheme of Delegation and SOs		Executive Director of Finance	✓	✓	✓	✓	✓	✓	✓	
Post payment verification Progress Report		Executive Director of Finance		✓			✓			

Audit Committee Cycle of Business (March 2024 – March 2025)										
Item of Business	**Purpose**	**Lead**	**March 2024**	**May 2024**	**July 2024**	**September 2024**	**November 2024**	**January 2025**	**March 2025**	**Notes**
(Annual Report / Mid-Year Report)										
Financial Conformance report (inc review of losses & special payments, review of risks and controls and reporting of any SO breaches)		Executive Director of Finance	✓	✓	✓	✓	✓	✓	✓	
Review annual accounting progress and note financial accounting timetable		Executive Director of Finance						✓		
Review and Recommendation of audited annual accounts and financial statements		Executive Director of Finance			✓					
Internal Audit										
Internal Audit: Review Effectiveness of Internal Audit		Chair	✓	✓	✓	✓	✓	✓	✓	

Audit Committee Cycle of Business
(March 2024 – March 2025)

Item of Business	Purpose	Lead	March 2024	May 2024	July 2024	September 2024	November 2024	January 2025	March 2025	Notes
Head of Internal Audit Opinion and Annual Report		Internal Audit								
Review and approval of internal audit plan including Internal Audit Charter		Internal Audit								
Internal Audit Progress Report		Internal Audit	✓	✓	✓	✓	✓	✓	✓	
Internal Audit Reviews Limited/No Assurance Reports in Full		Internal Audit	#	#	#	#	#	#	#	
External Audit										
External Audit: Review Effectiveness of External Audit		Chair	✓	✓	✓	✓	✓	✓	✓	
Audit & Risk Committee Update		Audit Wales	✓	✓	✓	✓	✓	✓	✓	
Audit Wales Review Reports		Audit Wales							✓	
Audit Wales Annual Audit Report		Audit Wales	✓						✓	

Audit Committee Cycle of Business
(March 2024 – March 2025)

Bwrdd Iechyd Prifysgol Betsi Cadwaladr University Health Board

Item of Business	Purpose	Lead	March 2024	May 2024	July 2024	September 2024	November 2024	January 2025	March 2025	Notes
Audit Wales Audit Plan 2024 Review and approval		Audit Wales	✓							
Audit Wales Audit of the Financial Statements (ISA 260) Report (Including the letter of representation and Audit Opinion)				✓ **(in Extraordinary Meeting)**						
Structured Assessment			✓						✓	
Audit of Financial Statements Addendum Report (if required)			#	#	#	#	#	#	#	
National audit reports for information			#	#	#	#	#	#	#	
Counter Fraud										
Counter Fraud: Local Counter Fraud Report		Head of Local Counter Fraud	✓	✓	✓	✓	✓	✓	✓	
Agree Counter Fraud Annual Work Plan		Executive Director of Finance/ Head of Local Counter Fraud		✓						

Audit Committee Cycle of Business (March 2024 – March 2025)										
Item of Business	**Purpose**	**Lead**	**March 2024**	**May 2024**	**July 2024**	**September 2024**	**November 2024**	**January 2025**	**March 2025**	**Notes**
Review effectiveness of LCFS Specialist (through Counter Fraud Authority Quality Assessment)		Executive Director of Finance			✓					
Counter Fraud Annual Report		Head of Local Counter Fraud			✓					
Clinical Audit										
Clinical Audit: Clinical Audit Annual Plan		Executive Medical Director				✓				
Clinical Audit Annual Report		Executive Medical Director				✓				
Audit Committee										
Audit Committee: Plan How To Discharge Audit Committee Duties		Chair	✓	✓	✓	✓	✓	✓	✓	
Briefings And Update Sessions (As Appropriate)		Chair	✓	✓	✓	✓	✓	✓	✓	
Members Discussion with Head of Counter Fraud		Chair	✓	✓	✓	✓	✓	✓	✓	

Audit Committee Cycle of Business
(March 2024 – March 2025)

Item of Business	Purpose	Lead	March 2024	May 2024	July 2024	September 2024	November 2024	January 2025	March 2025	Notes
Committee Annual Report to Audit Committee		Secretariat							✓	
Review Committee Terms of Reference & Cycle of Business		Secretariat		✓					✓	
Closing Business										
Agree Items for referral to Board / other Committees		Committee Members	✓	✓	✓	✓	✓	✓	✓	
Review of Risks highlighted in the meeting for referral to Risk Management Group		Committee Members	✓	✓	✓	✓	✓	✓	✓	
Agree items for Chairs Assurance Report		Chair	✓	✓	✓	✓	✓	✓	✓	
Summary of Private Business to be reported in Public		Chair	#	#	#	#	#	#	#	
Review of Meeting Effectiveness		Committee Members	✓	✓	✓	✓	✓	✓	✓	
Date of Next Meeting		Secretariat	✓	✓	✓	✓	✓	✓	✓	

Audit Committee Cycle of Business (March 2024 – March 2025)										
Item of Business	**Purpose**	**Lead**	**March 2024**	**May 2024**	**July 2024**	**September 2024**	**November 2024**	**January 2025**	**March 2025**	**Notes**
Part B Rolling Programme of Ad-hoc Items										
TBC										
TBC										

Teitl adroddiad: ***Report title:***	**Corporate Governance Report for Audit Committee**		
Adrodd i: ***Report to:***	Audit Committee		
Dyddiad y Cyfarfod: ***Date of Meeting:***	Friday, 12 January 2024		
Crynodeb Gweithredol: ***Executive Summary:***	The purpose of this report is to provide Audit Committee with assurance on Corporate Governance matters in 1 report. This includes Section 1 – Developing Effective Committee Governance (Terms of Reference, Cycles of Business and Corporate Calendar) Section 2 - Policy on Policies-Feedback from consultation Section 3 - Details of Breaches of SOs (late papers etc.) Section 4 - Declarations of Interest/Gifts & Hospitality Implementation Plan Update		
Argymhellion: ***Recommendations:***	*The Committee is asked to:* **Section 1 – Developing Committee Governance** **Note, Review and take acceptable assurance** from the update on Developing Committee Governance, Inparticular the process undertaken to develop final Draft Terms of Reference and Cycles of Business. **Section 2 – Update on Policy on Policies Consultation** **Note** the update following a further feedback consultation on "Policy on Policies" **Section 3 – Breaches of Standing Orders Updates** **Note, review** and **receive acceptable assurance** on the details of Breaches of Standing Orders **Section 4 - Declarations of Interests/Gifts and Hospitality Implementation**. **Note, review and receive partial assurance on** the updated report on Declarations of Interests/Gifts and Hospitality Implementation.		
Arweinydd Gweithredol: ***Executive Lead:***	Phil Meakin - Acting Board Secretary		
Awdur yr Adroddiad: ***Report Authors:***	Phil Meakin – Acting Board Secretary Supported by: • Nesta Collingridge – Head of Risk Management • Laura Jones – Special Measures Project Manager • Philippa Peake-Jones – Head of Corporate Affairs • Jody Evans – Corporate Governance Officer		
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):***	This work links to all strategic objectives of the Health Board as corporate Governance is a key enabler for them.
Goblygiadau rheoleiddio a lleol: ***Regulatory and legal implications:***	The Health Board is required to act according to its Standing Orders. This report contains information to allow the Health Board to conform to this. It is essential that the Board has robust arrangements in place for Corporate Governance and failure to do so could have legal implications for the Health Board.
Yn unol â WP7, a oedd EqlA yn angenrheidiol ac a gafodd ei gynnal? ***In accordance with WP7 has an EqlA been identified as necessary and undertaken?***	This is 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?***	This is 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)***	The nature of this paper has an impact on the way Corporate Governance is reported and managed in the Health Board. Risks related to Corporate Governance are reflected in the BAF and CRR and the development of this work will support better oversight and management of them.
Goblygiadau ariannol o ganlyniad i roi'r *argymhellion ar waith* ***Financial implications as a result of implementing the recommendations***	The effective and management of Governance has the potential to leverage a positive financial dividend for the Health Board through better integration of risk management into business planning, decision-making and in shaping how care is delivered to our patients

	thus leading to enhanced quality and less waste
Goblygiadau gweithlu o ganlyniad i roi'r argymhellion ar waith ***Workforce implications as a result of implementing the recommendations***	Failure to have effective Corporate Governance can impact adversely on the workforce. The development of a People Committee as briefly outlined in this report will strengthen arrangements for workforce related matters
Adborth, ymateb a chrynodeb dilynol ar ôl ymgynghori ***Feedback, response, and follow up summary following consultation***	An iteration of this paper will be received at the Health Board on 25 January 2024.
Cysylltiadau â risgiau BAF: (neu gysylltiadau â'r Gofrestr Risg Gorfforaethol) ***Links to BAF risks:*** *(or links to the Corporate Risk Register)*	The nature of this paper has an impact on the way the Board Assurance Framework will be reported and managed in the Health Board
Rheswm dros gyflwyno adroddiad i fwrdd cyfrinachol (lle bo'n berthnasol) ***Reason for submission of report to confidential board (where relevant)***	Not applicable
Next Steps: • The Acting Board Secretary to take the final drafts of the Terms of Reference for all Committees to the Board (for their consideration to approve) on 25 January 2024 • The Acting Board Secretary to take the final draft of the Cycle of Business for noting at the Health Board on 25 January 2024.	
List of Appendices: *Appendix 1 – The report on Standing Order Breaches* *Appendix 2 – The full report on Declarations of Gifts and Hospitality*	

Corporate Governance Report for Audit Committee

1. Introduction and Background

The objective of this report is to give the Audit Committee an update on key Corporate Governance matters and to provide reassurance and assurance that progress is being made in the following areas.

- Concluding Committee Governance (Terms of Reference, Cycle of Business and Corporate Calendar)
- Policies on Policies-Feedback from consultation
- Details of Breaches of SOs (late papers etc.)
- Declarations of Interest/Gifts & Hospitality Implementation Plan Update

Section 1. Developing Effective Committee Governance for the Health Board.

1.1 At the last Audit Committee (November 2023) the Committee was provided with an update on Committee and Advisory Group Governance and this was also received at the Board in November 2023. This included links to Draft Terms of Reference and Draft Cycles of Business and a Corporate Calendar. The key development since the last update is that the appointment of Independent Members has allowed for all Committees to have a clear plan for being established with effective Corporate Governance arrangements supporting them.

1.2 It was agreed and noted at the above meetings that the Office of the Board Secretary would meet with Chairs and Executive Leads of those Committees in December and January to develop final Drafts of Terms of Reference for all Committees and Advisory Groups for the Board on 25 January 2024 to receive and consider for approval. In addition, a cycle of business for each Committee would also be received at the same Board meeting for noting.

1.3 The Corporate Calendar for the reminder of 2023/24 and 2024/25 has now been developed and shared with Board Members. It is proposed in this report that it is not necessary to reshare that information to give assurance to the Committee members. The Committee is asked to note that the Corporate Calendars are subject to amendments and that follow up work on securing diary invites in individual's calendars is underway.

1.4 It is not proposed to share that level of detail again in this paper (as this was provided at the last Audit Committee and the Board). However the table below seeks to give reassurance through providing a summary of key update information that can be verified by what has been received by Audit Committee members who Chair Committees. Other colleagues can request this information for assurance by emailing phil.meakin@wales.nhs.uk

1.5 The Committee is asked to note good progress on the process of meeting the Chairs and Executive Leads to develop final draft Terms of Reference and Cycles of Business and this is reflected in the table below. In addition and to give further assurance, many of the Committee Terms of Reference have been able to review these draft Terms of Reference and cycles of Business in an additional Committee meeting before the Board meeting on 25 January 2024. An example of this is this Committee (Audit) where they were received for noting and endorsement at this meeting today.

1.6 The report also notes that the three most recent Committees to be established/re-established have got the opportunity to shape the Committee's focus through "Introductory Committees" These allow for a discussion about the forward work programme and what the Committee wants to achieve. These could include identifying the significant issues that the Committees need to influence and/or how it can help inform and assure the Board on these matters.

Table 1 – Summary of Action Taken To Establish All Committees

	Terms of Reference developed with Chair and Exec Lead	Cycle of Business developed with Chair and Exec Lead	Board to receive final Draft TOR and COB	Committee In Place Established/Re-established	Notes
Audit Committee	Yes 21 Dec 2023	Yes 21 Dec 2023	25 January 24	Yes	
Charitable Funds Committee	Yes 18 Dec 2023	Yes 18 Dec 2023	25 January 24	Yes	
Mental Health Legislation Compliance and Capacity	Yes 22 Dec 2023	Yes 22 Dec 2023	25 January 24	Formally re-established on 11 January 2024	Management meeting took place on 13 December to allow continuity of compliance. Committee to receive TOR/COB ON 11 Jan 2024
Planning, Population Health and Partnerships Committee	Yes 14 Dec 2023	Yes 14 Dec 2023	25 January 24	Established on 10 January 2024	Introductory meeting on 10 January 2023 with TOR/COB
People Committee	Yes 8 Jan 2024	Yes 8 Jan 2024	25 January 24	Established on 12 January 2024	Introductory meeting on 12 January 2023 with TOR/COB
Quality Safety and Experience Committee	Yes 15 Dec 2023	Yes 15 Dec 2023	25 January 24	Yes	Committee also received on 19 Dec 2023
Remuneration Committee	Yes 19 Dec 2023	Yes 19 Dec 2033	25 January 24	Yes	Committee to receive on 23 Jan 2024
Advisory Groups **Please note that Terms of Reference are mandated form the NHS Wales Standing Orders**					
Healthcare Professionals Forum	Yes 18 Dec 2023	Yes 18 Dec 2023	25 January 24	Yes	
Local Partnership Forum	No To be arranged for February due to Ind Action	No To be arranged for February due to Ind Action	25 January 24	Yes	LPF meeting has been postponed but Terms of Reference will be shared with Chairs for comment ahead of 25 January.
Stakeholder Reference Group	Yes 18 Dec 2023	Yes 18 Dec 2023	25 January 24	Yes	Took to SRG on 4 Dec and Workshop arranged in late January to further develop work programme

Section 2. Update on Policy on Policies Review – Feedback from Consultation

2.1 The Health Board has a duty to ensure that appropriate policies and supporting procedures, protocols or guidelines (referred to collectively as written control documents) are in place to comply with legislation, enabling all employees/workers to fulfil their roles safely and competently.

2.2 The Health Board's Policy on Policies sets out the various roles, responsibilities and the route to be followed when developing or updating written control documents.

2.3 The Policy on Policies was originally developed in 2018 and was due for review in 2021. The revised Policy on Policies is appended at appendix 1. The Policy was discussed by the Executive Team on the 30/08/2023. The amendments and proposed approval route were agreed in principle and had been subject to a review at the Audit Committee held on 15/09/2023.

2.4 This feedback will now be taken to the Executive Team meeting on 14 January 2024 and then be reviewed at Audit Committee in March 2024. In order to keep agenda size to a minimum the policy has not been provided again but will be provided as part of a full set of documents to the March Audit Committee.

The main changes had been as follows (*following initial Consultation*):

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

2.5 Following the review at the Audit Committee held on the 15/09/2023 the Policy was then subject to further organisational Consultation

Feedback Received from Further Consultation

Feedback had been noted and received via Pharmacy Leads, ICU – Anaesthetics Lead and Womens Services. Feedback from this further consultation has been incorporated into a draft Policy via tracked changes which will be received for further consideration by the Executive Team on 14 January 2024. A snapshot of this feedback is provided below:

- *Page 19 table 2 –*
  - *Prescription chart approvals amended*
  - *Reference to BRAG/Shared Care Documentation*
- *Section 14.3 Updated to reflect Medicines related guidance and approvals.*
- *Supplementary Guidance - Updated to confirm Strategic approval details.*
- *Policy Template – Updated with Corporate Formatting requirements (Contents table, titles and reference / version control section.*
- *Document Submission Form – Updated and irrelevant sections removed.*
- *Section 5.3 - Local documents' further defined, and explicit governance/approval expectations described. This includes the new IHC structure and CEG.*

- *Section 14.3 - Clarified that local clinical documents may include aspects of medicines management.*
- *Section 7. Added 'cognitive aid' as a type of document.*
- *Section 9.1 - Reworded.*

2.6 In conjunction with the review of the Policy on Policies, work is also underway to address the number of documents past their review date and a proposal will be considered at the Executive Team in January 2023. The report to Executive Team will considering future reporting requirements to ensure organisational oversight which will include a summary of overdue documents to progress a 1.5 year programme review by agreeing criteria to prioritise by March 2024 – (number of out of date documents and impact assessments by relevant Executives and Leads).

2.7 Next Steps for Completing this Review

A formal paper will be provided to Executive Team Meeting on 17th January 2023 to approve the BCUHB Policy on Policies and consider the revised updates. Once approved, the document will be received at the Audit Committee in March 2024 with the objective of being a final review.

This paper to Executive Team will also highlight the work underway to review the existing library of written control documents and the development of a proposal for reporting documents past their review date. Again this document will be received at Audit Committee for review in March 2024.

Section 3 – Details of Breaches of Standing Orders (late papers)

3.1 This is a routine agenda item now for every Audit Committee. The most recent update is provided in Appendix 1. 7 breaches were recorded and following feedback at the last Audit Committee a follow was undertaken by the Head of Corporate Affairs to examine previous breaches that were not recorded. Therefore the Committee will see some dates in previous months that had not been reported.

3.2 As discussed at the last Audit Committee with the improvement in Corporate Governance provision (including effective forward plans and the implementation of a Standard Operating Procedure) there is a greater degree of influence to mitigate the number of breaches and a summary table will be produced that illustrates monthly trends related to breaches. Again, this will help influence the number of breaches. This will be reported from March 2024.

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

4.1 The purpose of this paper is to provide assurance and a position statement to the Audit Committee. A full report is provided in Appendix 2 of this Report as this was requested at the last Audit Committee. The paragraphs below provide a summary for this part of the paper.

4.2 The Board must ensure that the Health Board establishes and maintains a system for the declaration, recording and handling of Health Board officers' interests in accordance with the Values and Standards of Behaviour Framework.

4.3 A new electronic system widely used within the NHS was purchased from Civica called 'Declare' to capture all declarations. This was launched at the end of August 2023 and is available in both English and Welsh. This is being promoted to staff and managers to ensure that annual declarations are made and any gifts and hospitality are appropriately declared and Health Board is compliant.

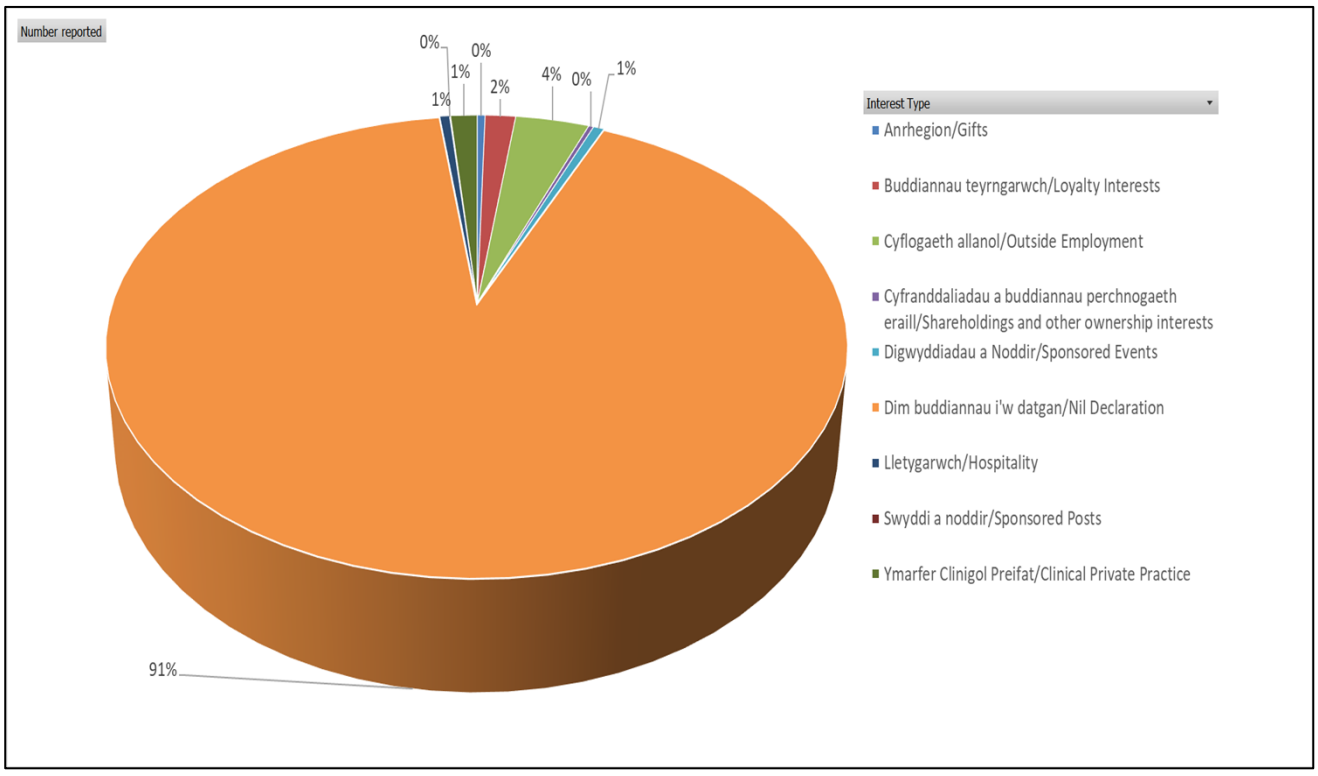
Link to Declare: [Betsi Cadwaladr University Health Board (mydeclarations.co.uk)]

4.4 A report was generated from the Declare System for this Audit Committee and the results of which are identified below . The Declare System generates raw data via Excel, which is then pivoted to create Tables of Data which can be requested and created to fit the needs of the Audit Committee Reporting Requirements.

4.5 The number of declarations reported to date total 1948, the majority of which are “Nil Declarations”

4.6 Whilst this number is large and indicates significant progress from a standing start we are very clear that more work needs to be done to report against the number of people expected to complete a return. This will be a focus for the next Quarter and it is proposed to bring an updated report to the Committee in March and May 2024.

	Number reported to date
Anrhegion/Gifts	8
Buddiannau teyrngarwch/Loyalty Interests	31
Cyflogaeth allanol/Outside Employment	75
Cyfranddaliadau a buddiannau perchnogaeth eraill/Shareholdings and other ownership interests	5
Digwyddiadau a Noddir/Sponsored Events	11
Dim buddiannau i'w datgan/Nil Declaration	1780
Lletygarwch/Hospitality	10
Swyddi a noddir/Sponsored Posts	1
Ymarfer Clinigol Preifat/Clinical Private Practice	27
Total Declarations Reported	**1948**



Audit Committee

January 2024

Record of Breaches of Publication of Committee Papers since last reported to Audit Committee in November 2023, not in accordance with Standing Orders

Meeting Date	Body	Standard	Issue/Reason for Breach	Details of papers
17.1.23	Partnerships People Population Health Committee	Publication of papers 7 days before meeting	3 follow on papers	BAF Winter Resilience Plan Primary Care
19.05.23	Quality, Safety & Experience Committee	Publication of papers 7 days before meeting	Public papers published 5 days before meeting	All
15.05.23	Audit Committee	Publication of papers 7 days before meeting	Public papers published 5 days before meeting	All
30.6.23	Performance, Finance & Information Governance Committee	Publication of papers 7 days before meeting	A late paper was added 2 days before the meeting in private session	Property disposals at Ala rd and Cilan Pwllheli
2.11.23	Performance, Finance & Information Governance Committee	Publication of papers 7 days before meeting	3 follow on papers	BAF CRR Integrated Performance report
14.11.23	Renumeration and Communication Committee	Publication of papers 7 days before meeting	Public papers published 6 days before meeting	Whole Agenda

Philippa Peake-Jones

Head of Corporate Affairs

16.11.23	Audit Committee	Publication of papers 7 days before meeting	2 follow on papers	Corporate Governance Report Special Measures Report

Philippa Peake-Jones

Head of Corporate Affairs

Teitl adroddiad: ***Report title:***	Declarations of Interests/Gifts and Hospitality
Adrodd i: ***Report to:***	Audit Committee
Dyddiad y Cyfarfod: ***Date of Meeting:***	Friday, 12 January 2024
Crynodeb Gweithredol: ***Executive Summary:***	The Board must ensure that the Health Board establishes and maintains a system for the declaration, recording and handling of Health Board officers' interests in accordance with the Values and Standards of Behaviour Framework. The purpose of this paper is to provide assurance and a position statement to the Audit Committee. A new electronic system widely used within the NHS was purchased from Civica called 'Declare' to capture all declarations. This was launched at the end of August 2023 and is available in both English and Welsh. This is being promoted to staff and managers to ensure that annual declarations are made and any gifts and hospitality are appropriately declared and Health Board is compliant. Link to Declare: Betsi Cadwaladr University Health Board (mydeclarations.co.uk)
Argymhellion: ***Recommendations:***	Gofynnir i'r Bwrdd The Committee is asked to take Partial Assurance from the report.
Arweinydd Gweithredol: ***Executive Lead:***	Phil Meakin, Interim Board Secretary and Associate Director of Governance
Awdur yr Adroddiad: ***Report Author:***	Philippa Peake-Jones – Head of Corporate Affairs Jody Evans – Corporate Governance 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* ☐	Derbyniol *Acceptable* ☐	Rhannol *Partial* ☒	Dim Sicrwydd *No Assurance* ☐
	Lefel uchel o hyder/tystiolaeth o ran darparu'r mecanweithiau / amcanion presennol *High level of confidence/evidence in delivery of existing mechanisms/objectives*	Lefel gyffredinol o hyder/tystiolaeth o ran darparu'r mecanweithiau / amcanion presennol *General confidence / evidence in delivery of existing mechanisms / objectives*	Rhywfaint o hyder/tystiolaeth o ran darparu'r mecanweithiau / amcanion presennol *Some confidence / evidence in delivery of existing mechanisms / objectives*	Dim hyder/tystiolaeth o ran y ddarpariaeth *No confidence / evidence in delivery*

Cyfiawnhad dros y gyfradd sicrwydd uchod. Lle bo sicrwydd 'Rhannol' neu 'Dim Sicrwydd' wedi'i nodi uchod, nodwch gamau i gyflawni sicrwydd 'Derbyniol' uchod, a'r terfyn amser ar gyfer cyflawni hyn: ***Justification for the above assurance rating. Where 'Partial' or 'No' assurance has been indicated above, please indicate steps to achieve 'Acceptable' assurance or above, and the timeframe for achieving this:*** **Partial assurance has been noted above because the system that has previously been invested in by the Health Board has only just been implemeneted and there needs to be a continued roll out of Information and engagement with it to ensure it is used effectively.**	
Cyswllt ag Amcan/Amcanion Strategol: ***Link to Strategic Objective(s):***	This report is purely administrative. There are no associated strategy implications.
Goblygiadau rheoleiddio a lleol: ***Regulatory and legal implications:***	This annual update is provided in order to comply with Standing Orders 8.1 – 8.7.
Yn unol â WP7, a oedd EqlA yn angenrheidiol ac a gafodd ei gynnal? ***In accordance with WP7 has an EqlA been identified as necessary and undertaken?***	Do/Naddo *Y/N* Os naddo, rhowch esboniad yn ymwneud â'r rheswm pam nad yw'r ddyletswydd yn *berthnasol* *If no please provide an explanation as to why the duty does not apply* Gweithdrefn ar gyfer Asesu Effaith ar Gydraddoldeb WP7 *WP7 Procedure for Equality Impact Assessments*
Yn unol â WP68, a oedd SEIA yn angenrheidiol ac a gafodd ei gynnal? ***In accordance with WP68, has an SEIA identified as necessary been undertaken?***	Do/Naddo *Y/N* Os naddo, rhowch esboniad yn ymwneud â'r rheswm pam nad yw'r ddyletswydd yn *berthnasol* *If no please provide an explanation as to why the duty does not apply* Gweithdrefn WP68 ar gyfer Asesu Effaith Economaidd-Gymdeithasol. *WP68 Procedure for Socio-economic Impact Assessment.*
Manylion am risgiau sy'n gysylltiedig â phwnc a chwmpas y papur hwn, gan gynnwys risgiau newydd (croesgyfeirio at y BAF a'r CRR)	(crynodeb o'r risgiau a rhagor o fanylion yma)

Details of risks associated with the subject and scope of this paper, including new risks(cross reference to the BAF and CRR)	This report is purely administrative. There are no associated risks.
Goblygiadau ariannol o ganlyniad i roi'r *argymhellion ar waith* ***Financial implications as a result of implementing the recommendations***	Scrutiny of this annual return (undertaken by Counter Fraud, Office of the Board Secretary and the Audit Committee) supports the mitigation of governance/financial risks associated with conflicts of interest and enables the Audit Committee to review and report to the Board upon the adequacy of the LHB's arrangements for dealing with offers of gifts, hospitality and sponsorship.
Goblygiadau gweithlu o ganlyniad i roi'r argymhellion ar waith ***Workforce implications as a result of implementing the recommendations***	Relevant staff are obliged to make declarations of interest and any gifts and hospitality received or declined.
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)***	
Camau Nesaf: **Gweithredu argymhellion** ***Next Steps:*** ***The continuation to Implement the agreed recommendations.***	
Rhestr o Atodiadau: ***List of Appendices:***	

Audit Committee - January 2024

Annual Declarations of Interests/Gifts and Hospitality

1. The Purpose of this Report:

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

This report sets out how we will manage two registers:

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

2. Board Member Responsibilities:

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

The Standing Orders also sets out that the Board Secretary, on behalf of the Chair, will maintain a register of Gifts, Hospitality and Sponsorship to record offers of gifts, hospitality and sponsorship made to Board members.

The Board must review these registers at least annually.

3. Previous Arrangements

The previous electronic system was introduced in 2016 to record declarations of interests, gifts and hospitality and rolled out across the Health Board. This was unsuccessfully maintained and manual forms had been used to collect declarations.

4. New Arrangements

Declarations made with a value of £25 or below were not included as the policy sets the threshold at any gift with an estimated value over £25.

All declarations will be reviewed by the Head of Counter Fraud Annually.

A new electronic system, widely used within the NHS was purchased from Civica called 'Declare'. This online portal is easy and quick to use and staff can log on using thier NHS email address. Support is available if required via the Office of the Board Secretary but guidance is also provided. This was launched on 31 August 2023 and is available in both English and Welsh.

Following a previous Internal audit, the new electronic forms also contain our counter fraud statement.

Now that the Declare system has been launched there will be a continuous drive to increase the compliance figures for declarations of interests with consistent monitoring. The Office of Board Secretary team are working with Civica, Communications team and Local Counter Fraud Services team to ensure staff make thier annual declarations of interest and Health Board is compliant.

5. Who do these new arrangements apply to?

These values and standards of behaviour will apply to all those conducting business by or on behalf of the Health Board, including Board members, HB Officers, Contractors and others, as appropriate. The following groups of people must make an annual declaration of interests:

- All Board Members
- Staff at Band 8C and above (or equivalent pay where staff are not on AfC pay grades)
- All staff who are in a position to influence the purchasing of goods and Services, anyone involved in payroll or payments of invoices or supplier arrangements, as well as fostering relationships with external organisations
- Any member of staff who are offered or takes any gift, hospitality or sponsorship.

6. When do declarations need to be made:

- Annually
- When something changes
- During any procurement activity
- In a meeting when the topic to be discussed is in line with your conflict
- Declarations should cover financial and personal interests and if in doubt, it should always be declared.

When an annual declaration is required, if nothing has changed, or there aren't any declarations to be made, a nil return must be made.

With regard to gifts, hospitality and sponsorship, a declartion must be made whenever it is offered to or by the HB. If it is offered it must be reported, even if the offer is declined.

7. Governance arrangements

Every Board member and HB officer has a personal responsibility to volunteer information in relation to offers of gifts, hospitality and sponsorship, including those offers that have been refused.

The Board Secretary, on behalf of the Chair and Chief Executive, will ensure the incidence and patterns of offers and receipt of gifts, hospitality and sponsorship are kept under active review, taking appropriate action where necessary.

Governance Leads are assigned for Directorates and declarations of interests are routed through these leads for approval/escalation. Following on from the

recommendations in a previous audit, all gifts and hospitality declarations are now also routed to the Office of the Board Secretary.

The Audit Committee will review and report to the Board upon the adequacy of the HB arrangements for :

- dealing with offers of gifts, hospitality and sponsorship".
- declaring, registering and handling interests

8. Where are they published:

The BetsiNet Intranet Pages have been updated and staff can access the portal via links provided as well as find guidance on declarations here:
Declarations of interest, gifts and hospitality (sharepoint.com)

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

9. Key Priorities for the next Quarter

- As the paper outlines there is a responsibility to capture all those conducting business by or on behalf of the Health Board, including Board members, Health Board Officers, Contractors and others, as appropriate.

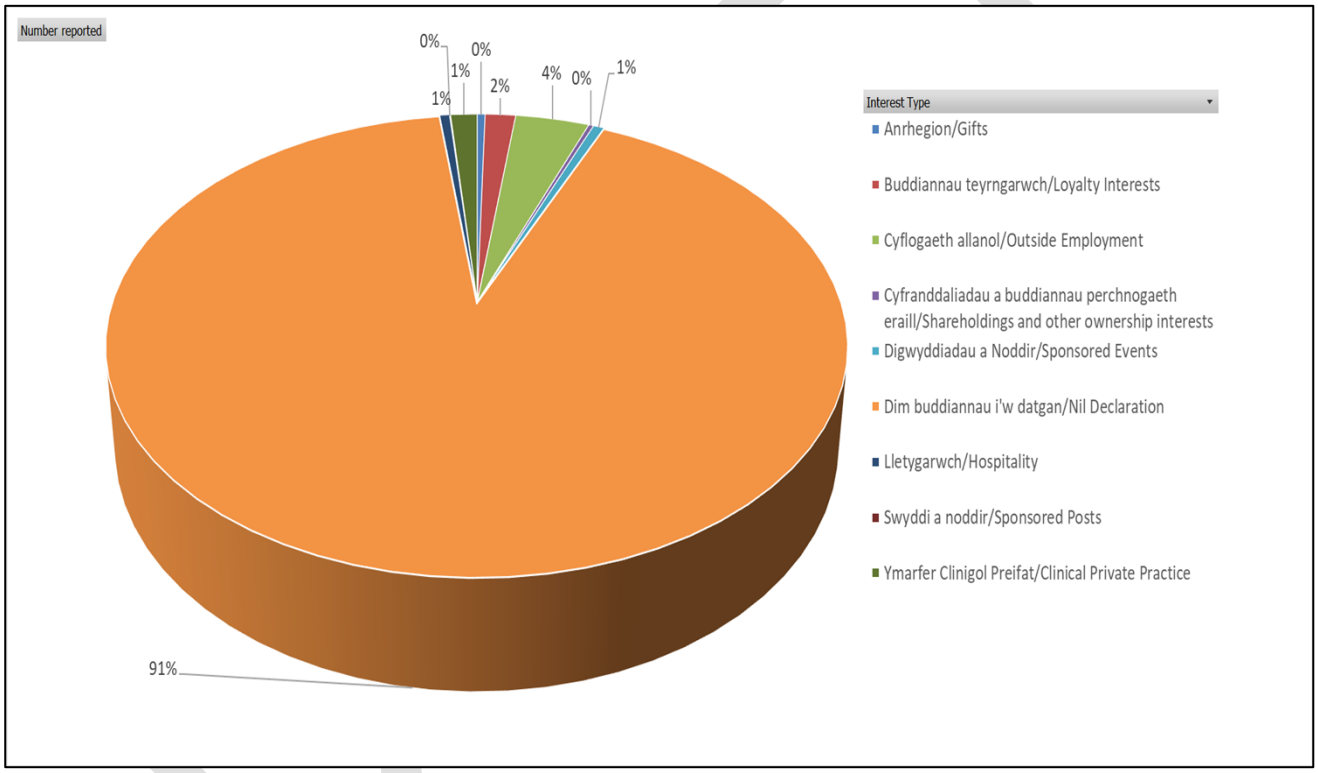
- To continue to make sure that there is visibility of compliance against our requirements under the Standing Orders by mobilising staff to comply fully with requirements.

- The report proposes that the Audit Committee continue to receive updates on progress from the implementation of the Declare system and reports on all groups.

- To note that following the approval of the draft brief for Standards of Business Conduct: Declarations of Interest, Gifts and Hospitality, the final audit brief has been issued to the Office of the Board Secretary. The review will commence in January 2024 / February 2024 with the debrief being held in February, along with a Final report back to Audit Committee in March 2024.

Declarations as at 28th December 2023

	Number reported to date
Anrhegion/Gifts	8
Buddiannau teyrngarwch/Loyalty Interests	31
Cyflogaeth allanol/Outside Employment	75
Cyfranddaliadau a buddiannau perchnogaeth eraill/Shareholdings and other ownership interests	5
Digwyddiadau a Noddir/Sponsored Events	11
Dim buddiannau i'w datgan/Nil Declaration	1780
Lletygarwch/Hospitality	10
Swyddi a noddir/Sponsored Posts	1
Ymarfer Clinigol Preifat/Clinical Private Practice	27
Total Declarations Reported	**1948**



The Declare System generates raw data via Excel, which is then Pivoted to create Tables of Data which can be requested and created to fit the needs of the Audit Committee Reporting Requirements.

Teitl adroddiad: ***Report title:***	Ombudsman Update Report			
Adrodd i: ***Report to:***	Audit Committee			
Dyddiad y Cyfarfod: ***Date of Meeting:***	12 January 2024			
Crynodeb Gweithredol: ***Executive Summary:***	This report provides the Committee with an update and assurance on the Ombudsman process			
Argymhellion: ***Recommendations:***	The Committee is asked to note this report.			
Arweinydd Gweithredol: ***Executive Lead:***	Dr Nick Lyons, Executive Medical Director			
Awdur yr Adroddiad: ***Report Author:***	Matthew Joyes, Deputy Director of Quality 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:***				
There is confidence in the process and data provided in the report however, the embedding of learning and improvement arising from Ombudsman cases remain an area of concern (as part of wider concerns about learning rather than specific to this process). This is being addressed through a range of measures including the actions aligned to Special Measures and the Board Assurance Framework.				
Cyswllt ag Amcan/Amcanion Strategol: ***Link to Strategic Objective(s):***	Quality			
Goblygiadau rheoleiddio a lleol: ***Regulatory and legal implications:***	The Duty of Quality is a statutory requirement under the Health and Social Care (Quality and Engagement) (Wales) Act 2020 – the			

	duty also includes new Health and Care Quality Standards. Instances of harm to patients may indicate failures to comply with the NHS Wales standards or safety legislation. The Ombudsman operates under the Public Services Ombudsman (Wales) Act 2019.
Yn unol â WP7, a oedd EqlA yn angenrheidiol ac a gafodd ei gynnal? ***In accordance with WP7 has an EqlA been identified as necessary and undertaken?***	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)***	BAF1.2
Goblygiadau ariannol o ganlyniad i roi'r *argymhellion ar waith* ***Financial implications as a result of implementing the recommendations***	N/A
Goblygiadau gweithlu o ganlyniad i roi'r argymhellion ar waith ***Workforce implications as a result of implementing the recommendations***	N/A
Adborth, ymateb a chrynodeb dilynol ar ôl ymgynghori ***Feedback, response, and follow up summary following consultation***	N/A
Cysylltiadau â risgiau BAF: (neu gysylltiadau â'r Gofrestr Risg Gorfforaethol) ***Links to BAF risks:*** *(or links to the Corporate Risk Register)*	BAF1.2
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*** N/A	
Rhestr o Atodiadau: ***List of Appendices:*** N/A	

Audit Committee – Ombudsman Update Report – January 2024

INTRODUCTION

This report provides the Committee with a short update and assurance on the role of the Ombudsman, the internal Health Board process, and a range of key issues of note for the Committee.

Regular reporting of Ombudsman activity is to the Quality, Safety and Experience (QSE) Committee via the Regulatory and Healthcare Law Assurance Report.

In discussion with the Committee Chair, it is proposed that going forward, an annual Regulatory and Healthcare Law Assurance Report is provided to this Committee providing assurance on process in support of the QSE Committee role to monitor activity and outcomes.

ROLE OF THE OMBUDSMAN

The Public Services Ombudsman for Wales (PSOW, or simply Ombudsman) can investigate complaints made by members of the public about public service providers in Wales. The Ombudsman was set up by the Public Services Ombudsman (Wales) Act 2005. This Act has been repealed and replaced by the Public Services Ombudsman (Wales) Act 2019 which came into force on 22 May 2019.

The Ombudsman investigates complaints from members of the public about alleged maladministration and service failure by the bodies in its remit. These include the Welsh Government, local authorities, local health boards and Police and Crime Commissioners.

The 2019 Act provides the Ombudsman with new powers, including the power to carry out own initiative investigations even where there is no complaint from a member of the public.

The 2019 Act also gives the Ombudsman new powers to prepare and publish a statement of principles about complaints-handling and permits the Ombudsman to publish model complaints handling procedures for bodies in its remit.

The Ombudsman is appointed by His Majesty the King following a nomination from Senedd Cymru.

INTERNAL PROCESS

A designated Ombudsman Liaison Officer is in post, within the Quality Assurance and Regulation Team of the Quality Directorate. This officer and the wider team act as the point of contact for the Ombudsman and facilitate all enquiries and investigations.

As part of the Special Measures programme, the Ombudsman process is under review alongside all of the associated quality and Putting Things Right (PTR) procedures (PTR is the legislative framework for complaint management in the Welsh NHS).

Contacts from the Ombudsman will normally enter the Health Board as initial enquiries. If the Ombudsman decides to take a case further, this would be done on the basis of an early resolution

or full investigation. An early resolution seeks to resolve the complaint rapidly and would always be the preferred approach where possible. In some cases, including allegations of serious harm, a full investigation would be undertaken by the Ombudsman.

On completion of a full investigation, the Health Board is given opportunity to provide any factual accuracy comments and will develop an action plan against the recommendations.

All actions are logged centrally and evidence collated from services. This evidence is shared with the Ombudsman who will only close a case upon their satisfactory review of the evidence.

Ongoing performance of the process is reported to the Regulatory Assurance Group, a sub-group of the Executive Quality Delivery Group. It is also reported in the Regulatory and Healthcare Law Assurance Report to the QSE Committee. An escalation process is in place to the Integrated Health Community (IHC)/Regional Service Medical Directors, and if necessary to the Executive Medical Director.

Executive oversight of the process is provided by the Executive Medical Director,

PUBLIC INTEREST REPORTS

Since the newly re-formed Committee came into being, the Ombudsman has issued three Public Interest Reports.

The first was issued in March 2023 and related to care at Ysbyty Glan Clwyd in April and May 2020 and concerned inadequate bowel care for the patient. The patient was in hospital mainly because of breathing problems. But while in hospital, they needed a specific type of bowel care. This did not take place as no skilled staff were available to do it, and nurses did not update doctors that it had not been done. The Ombudsman also found the Heath Board complaint investigation was not thorough or open enough The Ombudsman made a number of recommendations and all are in the process of being delivered.

The second was issued in September 2023. The Ombudsman launched an investigation after a complaint that the Health Board failed to provide appropriate and timely treatment to a patient after they were admitted to hospital with suspected appendicitis in August 2019 at Ysbyty Glan Clwyd. The Ombudsman upheld most parts of the complaint and was concerned that these events took a considerable toll on the patient's physical and mental wellbeing. The patient has been left with health and mobility problems. The Ombudsman made a number of recommendations and all are in the process of being delivered.

A third Public Interest Report was issued in November 2023. In this case the patient was seen at Ysbyty Glan Clwyd in January 2018, however it took 11 months before they had urgent surgery resulting in permanent sight loss in one eye and a need for lifelong treatment to manage pain and condition caused by the damage. The Ombudsman also criticised the delay in the complaint response. The Ombudsman made a number of recommendations which are now being delivered.

LEARNING FROM PSOW REPORTS

On receipt of all Ombudsman reports an action plan, based on the Ombudsman's recommendations, is developed by the Quality Assurance and Regulation Team and shared with the respective IHC/Service. Each completed investigation from the Ombudsman, regardless of whether it is a public interest report or not, is a case study in its own right. The relevant clinical team will provide a lessons learned document based on the case and in addition will provide a presentation that is shared at local clinical governance meetings/ quality and safety meetings. The agenda, minutes and slide set is then submitted to the Ombudsman as evidence of shared learning. Public interest reports are

similarly shared on a BCUHB-wide basis and will form part of the Organisational Learning Forum's agenda.

Future developments to improve the sharing of learning is the building of a central learning repository which will be a central portal managed by the Quality Directorate. All Ombudsman reports will be held in this repository but following a triage process will also be shared with a targeted staff population.

DATA REPORTING CONCERNS

In 2022 it was identified the Health Board had reported a different and lower figure in its Annual Reports to that reported by the Ombudsman in their Annual Letter (which is published publically). This issue was reported to Audit Wales by a member of the public.

This issue arose due to the Health Board not including decisions by the Ombudsman not to investigate or enquire into a matter (in effect providing only the numbers of actual enquiries and investigations, whereas the Ombudsman reported on all contacts regardless of outcome). The reports were also produced at different times of the year meaning some data was further refined following validation.

It was acknowledged the difference in reporting criteria may cause confusion to the public. In response, the Health Board and Ombudsman agreed to work together to ensure alignment of the reporting criteria and validation of the data across the two reports. This was undertaken in 2023 as part of this new process, and so for the most recent report, assurance can be taken that the data in both the Health Board Annual Reports and the Ombudsman fully aligns.

RELATIONSHIP MANAGEMENT

The Health Board has long maintained a positive and productive working relationship with the Ombudsman. This is undertaken at an operational level by the designated Ombudsman Liaison Officer working with the respective case officers, and through regular meeting between the Deputy Director of Quality Governance and the Ombudsman's Head of Complaints Standards (originally monthly, and recently reduced to quarterly).

Additionally, the Ombudsman meets personally with the Chair and/or Chief Executive annually.

The Ombudsman's Complaints Standards Team have provided training to staff in the Heath Board; the most recent session was on 28 September 2023 at Ysbyty Gwynedd targeted at senior clinicians and managers involved in Ombudsman investigations.

PERFORMANCE INDICATORS

At the time of writing, there are no responses to the Ombudsman which are overdue.

The Ombudsman measures responsiveness using a measure called Average Variance to Target (AVT). This is regularly shared with all health boards. The Health Board AVT is currently -3 (i.e. submissions are on average 3 days ahead of a deadline). The AVT has fallen since September 2023 by an average of 2 days. In order to increase performance, the Quality Assurance and Regulation Team are making changes to the monitoring and tracking of deadlines. To further assist with this, the team require continued support from IHCs and Regional Services to respond to requests from the Ombudsman in a timely manner.

At the time of writing, 67 cases were open with the Ombudsman including 5 initial enquiries, 9 early resolution proposals, 37 investigations (at various stages) and 12 open actions plans.

The Health Board has a higher referral, intervention and upheld rate in national benchmarking (see table below). This indicates there is a need to improve the approach to complaints within the Health Board (which would result in less people approaching the Ombudsman, and less intervention from the Ombudsman). As mentioned above, this work is part of the Special Measures programme.

	Population	Complaints Received	Complaints Received per 1000 residents (adjusted)	Complaints Closed	Within 30 days %	Referred to Public Services Ombudsman for Wales	Referred %	PSOW Cases Closed	PSOW Intervened %	Early resolution %	PSOW Upheld%
Aneurin Bevan University Health Board	591,225	1,502	5.08	1,459	78.27%	80	5.48%	94	37.23%	26.60%	8.51%
Betsi Cadwaladr University Health Board	698,369	1,218	3.49	1,181	44.20%	115	9.74%	119	35.29%	21.85%	13.45%
Cardiff and Vale University Health Board	496,413	2,215	8.92	2,180	79.86%	72	3.30%	74	22.97%	16.22%	1.35%
Cwm Taf Morgannwg University Health Board	445,190	1,520	6.83	1,103	85.77%	51	4.62%	61	29.51%	14.75%	13.11%
Hywel Dda University Health Board	385,615	1,187	6.16	1,147	67.65%	67	5.84%	69	36.23%	26.09%	10.14%
Powys Teaching Health Board	132,447	68	1.03	68	36.76%	10	14.71%	14	7.14%	0.00%	7.14%
Swansea Bay University Health Board	389,372	1,223	6.28	1,108	60.74%	65	5.87%	69	21.74%	15.94%	5.80%
Velindre University NHS Trust	-	107	-	98	98.98%	3	3.06%	4	0.00%	0.00%	0.00%
Welsh Ambulance Services NHS Trust	-	489	-	532	63.72%	20	3.76%	19	10.53%	10.53%	0.00%
Wales	3,138,631	9,529	6.07	8,876	70.54%	483	5.44%	500	30.60%	20.20%	9.00%

Teitl adroddiad: ***Report title:***	Corporate Risk Register Report			
Adrodd i: ***Report to:***	Audit Committee			
Dyddiad y Cyfarfod: ***Date of Meeting:***	Friday, 12 January 2024			
Crynodeb Gweithredol: ***Executive Summary:***	The purpose of this standing agenda item is to provide an update from the Risk Management Group (RMG) meeting on the 5th of December 2023 and present the Corporate Risk Register (CRR). The Committee provided with corporate risks to which Audit Committee has overall accountability for as well as an overview of outstanding corporate risks.			
Argymhellion: ***Recommendations:***	The Committee is asked to: 1. receive assurance from the Chair's report of the Risk Management Group The Committee is asked to consider: 2. the corporate risks to which the Committee has overall accountability. 3. consider which corporate risks should be included in papers to the Board.			
Arweinydd Gweithredol: ***Executive Lead:***	Phil Meakin, Acting Board Secretary			
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:N/A				

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):***	Links to the BAF detailed in respective CRR reports
Goblygiadau rheoleiddio a lleol: ***Regulatory and legal implications:***	It is essential that the Health Board has robust arrangements in place to assess, capture and mitigate risks, as failure to do so could have legal implications for the Health Board.
Yn unol â WP7, a oedd EqlA yn angenrheidiol ac a gafodd ei gynnal? ***In accordance with WP7 has an EqlA been identified as necessary and undertaken?***	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 ben 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)***	Links to the BAF detailed in respective CRR reports
Goblygiadau ariannol o ganlyniad i roi'r *argymhellion ar waith* ***Financial implications as a result of implementing the recommendations***	The effective and efficient mitigation and management of risks has the potential to leverage a positive financial dividend for the Health Board through better integration of risk management into business planning, decision-making and in shaping how care is delivered to our patients thus leading to enhanced quality, less waste and no claims.
Goblygiadau gweithlu o ganlyniad i roi'r argymhellion ar waith ***Workforce implications as a result of implementing the recommendations***	Failure to capture, assess and mitigate risks can impact adversely on the workforce.
Adborth, ymateb a chrynodeb dilynol ar ôl ymgynghori ***Feedback, response, and follow up summary following consultation***	Individual Executive Sign off of CRR reports
Cysylltiadau â risgiau BAF: (neu gysylltiadau â'r Gofrestr Risg Gorfforaethol) ***Links to BAF risks:*** *(or links to the Corporate Risk Register)*	See the individual risks for details of the related links to the Board Assurance Framework.

Rheswm dros gyflwyno adroddiad i fwrdd cyfrinachol (lle bo'n berthnasol) ***Reason for submission of report to confidential board (where relevant)***	N/A
Camau Nesaf: ***Next Steps:*** Completion of outstanding Corporate Risks Quarterly Submission of Corporate Risks to the Board	
Rhestr o Atodiadau: ***List of Appendices:*** Appendix 1 – Heat Map & Overview of Risk Scores Overview of Outstanding Corporate Risks Corporate Risk Register Report: **1. Leadership/Special Measures**	

1. Introduction

The purpose of this standing agenda item is to provide an update from the Risk Management Group (RMG) meeting on the 5th of December 2023 and present the Corporate Risk Register (CRR).

The Committee is provided with corporate risks to which the Audit Committee has overall accountability for, as well as an overview of outstanding corporate risks.

The Committee is asked to:

1. receive assurance from the Chair's report of the Risk Management Group

The Committee is asked to consider:

2. the corporate risks to which the Committee has overall accountability.
3. consider which corporate risks should be included in papers to the Board.

2. Risk Management Group Meeting Assurance Report Summary

RMG was held on the 5th of December 2023. The group heard from the Head of Risk Management on key changes that were received and approved at Audit Committee on the 16 November 2023 in relation to the revised Corporate Risk Register (CRR) and Board Assurance Framework (BAF).

The Group received the Risk Management Procedures which had been updated following the approval of the Risk Management Framework. The procedures have been cascaded out for consultation for two weeks (ending 15th of December, 2023) and feedback is being collated. The procedures were agreed in principle and changes will be highlighted to the Group following consultation outside of the meeting. This is due to the need to agree the procedures prior to the February meeting and have a guide for those which need to progress with the new changes in relation to the CRR and BAF.

An update was provided on the Risk Management Training Plan which is being developed to provide more comprehensive training over three levels according to staff's requirements. The Group heard this will encompass: risk management awareness (mandatory for all), operational risk management (for those key leads who manage risk registers) and strategic risk training (for the Board and senior staff who manage corporate and BAF risks).

Risk Register Reports were received from the: Office of CEO and Deputy CEO; Office of the Board Secretary; Office of the Nurse Director; Therapies & Health Sciences; Finance and Counter Fraud. All risk registers were relevant and had been recently reviewed.

Updates were received on the Risk Management Annual Work Programme. Five out of six actions on the 23/24 risk management annual workplan have been completed. There remain to be outstanding actions from 22/23 due to dependency on the Once for Wales

Risk Management Datix system, this is due to the system being delayed for roll out and actions dependent on the new system being adopted.

The second iteration of the Risk Management Performance Report Q2 was received at RMG. The report provided an overview of the Health Board's risk management performance, showing trends and practices across functions/services and regions. The purpose of this report is to communicate recommendations on how areas of improvement would be addressed.

The key elements highlighted in the report were:

- Improvement of the Health Board's risk maturity from novice to normalised.
- Potential under-reporting of risks in key functions within the Health Board such as Primary Care, Finance, Workforce and Organisational Development etc.
- The continuous improvement required to ensure risk titles and descriptions are suitable and action plans are functional (SMART) in risk mitigation.
- The report also highlighted the importance of utilising risk descriptors to support risk scoring and to ensure the risk had the proportionate level of management.
- All high risks (Tier 1) are being prioritised for quality assurance.

The report demonstrated positive momentum in many areas such as closure rates of medium risks and the RMG acknowledge progress compared to a couple of years ago. However, there are still areas that require additional improvement, most of which can be mitigated by further training, controls, and support from corporate risk team, champions and leads.

3. Corporate Risk Register Report Related to Audit Committee

One corporate risk is detailed in full in the report below and the Committee is asked to consider the reports for approval as the overall accountable Committee for the risk.

1. Leadership/Special Measures

Committees should take a view as to which Corporate Risks would be presented in the quarterly Board paper. This suggestion was well received at QSE, PFIG and Audit Committee. This aims to facilitate a more focused discussion the corporate risks (17 in total). **Therefore, the Committee is asked to review the corporate risks presented, consider for approval and indicate which reports should be presented to the Board.**

The following detail is provided:

- CRR Heat Map
- CRR Overview
- CRR Overview Outstanding Risks

Out of the 17 newly revised corporate risks, 8 risks remain outstanding to be fully developed and scores yet to be determined and full reports to be completed. The Heat Map illustrated below will be updated once all scores have been completed.

GIG CYMRU NHS WALES

Bwrdd Iechyd Prifysgol
Betsi Cadwaladr
University Health Board

Corporate Risk Register

Last updated 14 Dec 23

CRR Risk Heat Map

Impact							
	Catastrophic	5				Extreme • Financial Sustainability (PFIGC) • ICT Failure and Cyber (PFIGC) • Patient Safety-Falls (QSE)	Extreme • Failure to Embed Learning (QSE)
	Major	4				• Safeguarding (QSE) • People, Culture and Wellbeing (PFIGC) • Leadership/Special Measures (AC)	Extreme • Availability and Integrity of Patient Information (PFIGC) • Population Health (QSE)
	Moderate	3					
	Minor	2					
	Negligible	1					
			1	2	3	4	5
			Rare	Unlikely	Possible	Likely	Almost Certain
			Possibility				

Corporate Risk Register Overview

Possibility: Almost Certain				
Reference	**Title**	**Committee Oversight @Date Last reviewed**	**Current Risk Score**	**Progress**
Executive Director of Nursing and Midwifery				
CRR24-04	Failure to Embed Learning	QSE 19/12/2023	25	Six out of seven actions to support controls in relation to this risk are due in March 2024. Gaps in controls have been well identified and have further mitigations noted.
Executive Director of Public Health				
CRR 24-08	Population Health	PPPH (QSE) 19/12/2023	20	As per the previous population health corporate risks, action plans are progressing well within the control of the Health Board considering the funding constraints being the most notable gap in control. Due dates for some of the actions will be added but note the overall more long-term target date of 2026 to reduce the score to a target of 12.
Chief Digital and Information Officer				
CRR 24-07	Availability and Integrity of Patient Information	PPPH (PFIG) 18/01/203	20	

Impact: Catastrophic				
Reference	**Title**	**Committee Oversight @Date Last reviewed**	**Current Risk Score**	**Progress**
Executive Director of Nursing and Midwifery				
CRR 24-02	Patient Safety-Falls	QSE 19/12/2023	20	1 out of 6 actions have been completed, 2 to be progressed in Dec and remaining actions to be

				completed by February 2024 in order to reduce this score down to the target of 12.
Chief Digital and Information Officer				
CRR 24-17	ICT Failure and Cyber	PPPH (PFIG) 18/01/203	20	
Executive Director of Finance				
CRR 24-05	Financial Sustainability	PFIG	20	Risk Score has remained at 20 since opened in March 2023. Score to be reviewed once actions completed in March 24.
Possibility: Likely				
Reference	**Title**	**Committee Oversight @Date Last reviewed**	**Current Risk Score**	**Progress**
Executive Director of Nursing and Midwifery				
CRR 24-03	Safeguarding	QSE 19/12/2023	16	Five out of six actions to support controls in relation to this risk are due in March 2024 but this will not necessarily resolve the main gap in control around staffing resources. Gaps in controls have been well identified and have further mitigations noted.
Deputy Director of People				
CRR24-01	People, Culture and Wellbeing	PFIGC	16	
CRR24-16	Leadership/Special Measures	Audit Committee	16	New risk scoring 16, several actions due in March 2024 to reduce the risk score.

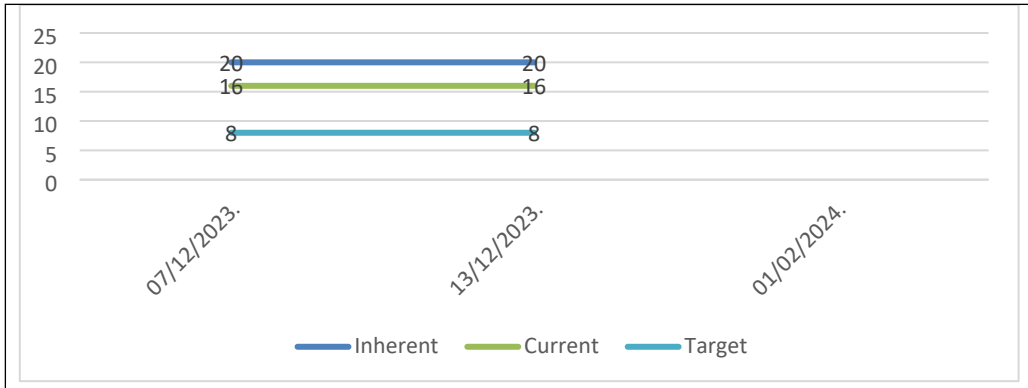
Corporate Risk Register Outstanding Risks

Risks Yet to Be Scored		
Executive Director Therapies & Health Science		
CRR 24-13	Timely Diagnostics	QSE
CRR 24-14	Harm from the Medical Devices/Equipment	QSE
Executive Director of Operations		
CRR 24-09	Community & Primary Care Provision	QSE
CRR 24-10	Unscheduled Care	QSE & PFIG
CRR 24-11	Planned Care	QSE & PFIG
CRR 24-12	Areas of Clinical Concern/Special Measures	QSE & PFIG
Deputy Director of People		
CRR 24-15	Health and Safety	People Committee (PFIG)
Executive Director of Finance		
CRR 24-06	Suitability and Safety of Sites	PFIG

CRR 24-16	**Leadership/Special Measures**			**Date Opened:** 07/12/2023
	Assuring Committee: (PPPH) Audit Committee			**Date Last Reviewed:** 13/12/2023
	Director Lead: Deputy Director of Workforce	**Link to Datix IDs**	**4480/3969**	**Date Last Committee Review:** 12/01/2024
		Link to BAF	**SP17**	**Target Risk Date:** 31/03/2024

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

Controls in place	Assurances	Additional Controls required	Actions and Due Date
1. People Committee is being scheduled to oversee delivery of the People Services agenda. 2. Cycles of special measures being closely monitored and reported upon. 3. Culture Change Steering Group will be reporting into Board via the CEO report 4. Local Integrated Health Communities & Pan Services People & Culture Committees 5. Draft Integrated Leadership Development Framework in place (forms part of special measures monitoring) 6. Draft OD plan in development (forms part of special measures monitoring) 7. Board Workshop with Professor Michael West on compassionate leadership 8. Suite of leadership conferences, networking and masterclasses on compassionate, inclusive leadership and engagement	1. Risks linked to CRR24-16 are reviewed and will be monitored via the People Committee, the Culture Steering Group and the People Services Senior Leadership Team. 2. Health Board progress reported through the People Committee to the Board and through the CEO report to the Board. 3. Work associated with this risk which links into the Special Measures Framework are monitored via the governance of the Framework and reported to Executive Team and Board	1. Integrated Leadership Development Framework 2. New approach to leadership and how to adopt it, aligned with the work on values and behaviours 3. Formal Culture Change Plan and accompanying Comms and Engagement plan 4. Examine the current pervasive culture: Final results from NHS Wales Staff Survey shared with all relevant managers and thematic analysis fed into Culture Change Plan 5. Revisit the values of the organisation 6. Develop a behaviours framework 7. Identification of resources to deliver the Culture Change programme	The strategic actions relating to this CRR recorded in the special measures cycle 3 milestones are; Integrated Leadership Development Framework socialised across the organisation for feedback 31/01/2024 Integrated Leadership Development Framework implementation plan presented to Executive Team 29/02/2024 Exploration of approach to leadership: Draft proposal of the approach and how to adopt it, aligned with the work on values and behaviours, presented to Executive Team prior to scheduling for review at Board 29/02/2024 OD Steering Group established 30/12/2023



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

Overall Assessment

Teitl adroddiad: ***Report title:***	Board Assurance Framework			
Adrodd i: ***Report to:***	Audit Committee			
Dyddiad y Cyfarfod: ***Date of Meeting:***	Friday, 12 January 2024			
Crynodeb Gweithredol: ***Executive Summary:***	As per the 23/24 Annual Plan Organisational Deliverables proposed risk descriptions have been provided and also the relationship with the proposed corporate risk register and Tier 1 risks.			
Argymhellion: ***Recommendations:***	The Committee is asked to **consider and approve** the BAF risks to which it has accountability for.			
Arweinydd Gweithredol: ***Executive Lead:***	Phil Meakin, Acting Board Secretary			
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: N/A ***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:	Appendix BAF report highlights the link between CRR.			

Link to Strategic Objective(s):	
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?***	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 ben 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)***	CRR and BAF paper prepared for committee
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***	N/A
Adborth, ymateb a chrynodeb dilynol ar ôl ymgynghori ***Feedback, response, and follow up summary following consultation***	BAF risks approved by Executives as the lead for the risk
Cysylltiadau â risgiau BAF: (neu gysylltiadau â'r Gofrestr Risg Gorfforaethol) ***Links to BAF risks:*** *(or links to the Corporate Risk Register)*	BAF paper which further links Tier 1 and CRR.

Rheswm dros gyflwyno adroddiad i fwrdd cyfrinachol (lle bo'n berthnasol) ***Reason for submission of report to confidential board (where relevant)***	
Camau Nesaf: ***Next Steps:*** 1. Submission to the Board. 2. Hold 1-1s for outstanding BAF risks and further develop controls, action plans etc. 3. Corporate Team to monitor and escalate any new BAF risks to Executives for review.	
Rhestr o Atodiadau: ***List of Appendices:*** Appendix 1- BAF Heat Map & Risk Overview Appendix 2 – Audit Committee BAF Risk Reports 1. Board Leadership and Governance	

Introduction/Background

1. The purpose of the Board Assurance Framework (BAF) is to inform and assure the Board with controls and action plans for identified high-extreme risks that relate to any possibilities of not delivering on the Annual Strategic Priorities of the Health Board. This will be aligned to Objectives once these have been reviewed.

   Where high risks emerge, Executives have provided Committees and the Board with a risk report which outlines controls and action plans in relation to achieving the deliverables on the Strategic Priorities. An overview is provided to the Committee in relation to the all the high risks identified, progress and score. Where the Committee have oversight, a BAF report has been completed.

   Executives have signed off their individual BAF risk reports prior to submission to Committee and the Board. **Committees are asked to review the report prior to approval at the Board.**

   Audit Committee has the overall accountability of two risk reports, one attached.

   1. Board leadership and governance

   Strategic Priority SP11 - Wider Delivery, scoring is currently being reviewed by the relevant lead prior to being signed off by the Executive if deemed high risk of non-delivery.

Summary

It is anticipated that out of the 19 Strategic Priorities, 10 are likely to be anticipated in the full BAF report and potentially high risk of failing to deliver on the strategic priorities. However, controls and action plans detail the work ongoing to mitigate and overall reduce this risk. The Board will be updated on progression of action plans and movement in score.

Three leads are outstanding in providing a score/report for their risk in relation to non-delivery.

Next steps

1. Ongoing monitoring of risks in relation to the Annual Plan Strategic Deliverables.
2. Risk scores for all to be monitored and Board to be provided with full BAF risk report.

Appendix 1-

BAF Heat Map & Risk Overview

Appendix 2 -

Audit Committee BAF Risk Reports

GIG CYMRU NHS WALES

Bwrdd Iechyd Prifysgol
Betsi Cadwaladr
University Health Board

Board Assurance Framework

Last updated 14 Dec 23

Appendix 1

BAF Risk Heat Map

Impact							
	Catastrophic	5			• SP1 – Population Health and Health Inequalities		• SP3 – Planned Care • SP18 – Quality, Innovation and Improvement
	Major	4			• SP12 – Workforce • SP17 - Organisational development	• SP9 – Women's Services • SP16 – Board Leadership & Governance	• SP5 – Cancer • SP13 – Digital, Data & Technology • SP10 – Children
	Moderate	3		• SP6 – Mental Health • SP8 – Learning Disabilities • SP19 – Social & Civic Leadership & Responsibility	• SP2 – Primary Care • SP15 – Partnerships		
	Minor	2		• SP7 – Substance Misuse			
	Negligible	1					
			1	2	3	4	5
			Rare	Unlikely	Possible	Likely	Almost Certain

Board Assurance Framework Risks Overview

Title	Score	Committee	Executive	Progress
Strategic Priority P1 Prevention and Health Protection	**15**	Quality, Safety and Experience Committee	Executive Director of Public Health	Approved by the Executive Director of Public Health
Strategic Priority P2 Primary Care	**9**	Performance, Finance and Information Governance Committee	Director of Primary Care	Confirmation of moderate risk score from the service
Strategic Priority P3 Planned Care	**25**	Performance, Finance and Information Governance Committee	Executive Director of Integrated Clinical Services	Draft risk being developed by the service to be reviewed.
Strategic Priority P4 Urgent and Emergency Care	**TBC**	Performance, Finance and Information Governance Committee	Executive Director of Integrated Clinical Services	Draft risk being developed by the service to be reviewed.
Strategic Priority P5 Cancer	**20**	Quality, Safety and Experience Committee	Executive Director of Integrated Clinical Services	Approved by the Executive Director of Integrated Clinical Services. Confirmation of funding required to reduce the score.
Strategic Priority P6 Mental Health	**6**	Quality, Safety and Experience Committee	Executive Director of Public Health	Confirmation of low risk score from the service
Strategic Priority P7 Substance Misuse	**4**	Quality, Safety and Experience Committee	Executive Director of Public Health	Confirmation of low risk score from the service
Strategic Priority P8 Learning Disability	**6**	Quality, Safety and Experience Committee	Executive Director of Public Health	Confirmation of low risk score from the service
Strategic Priority P9 Women's Services	**16**	Quality, Safety and Experience Committee	Executive Director of Integrated Clinical Services	Approved by the Executive. Score will be reduced once clarity on funding and steer from NHS Executive is received.
Strategic Priority P10 Children	**20**	Quality, Safety	Executive Director of	Draft risk developed by the service, approval

		and Experience Committee	Integrated Clinical Services	confirmation required from Executive Lead
Strategic Priority P11 Wider Delivery	**TBC**	Audit Committee	Executive Director Transformation And Strategic Planning	Score being reviewed.
Strategic Priority P12 Workforce	**12**	Quality, Safety and Experience Committee	Executive Director of Workforce	Confirmation of low risk score from the service
Strategic Priority P13 Digital, Data and Technology	**20**	Performance, Finance and Information Governance Committee	Director of Digital (Chief Digital Information Officer (CDIO)	Approved by Executive Director and reviewed at Committee
Strategic Priority P14 Estates and Capital	**TBC**	Performance, Finance and Information Governance Committee	Executive Director of Finance	Score being reviewed.
Strategic Priority P15 Partnerships	**9**	Quality, Safety and Experience Committee	Executive Director Transformation And Strategic Planning	Confirmation of low risk score from the service
Strategic Priority P16 Board leadership and governance	**16**	Audit Committee	Board Secretary	Reviewed by AC. Score will be reduced once IMs are onboarded
Strategic Priority P17 Organisational development	**12**	Quality, Safety and Experience Committee	Executive Director of Workforce	Score being reviewed.
Strategic Priority P18 Quality, Innovation and Improvement	**25**	Executive Director of Nursing and Midwifery	Executive Director of Nursing and Midwifery	Approved by the Executive Director of Nursing and Midwifery
Strategic Priority P19 Social and Civic leadership and responsibility	**6**	Quality, Safety and Experience Committee	Executive Director of Finance Executive Director of Workforce Executive Director of Public Health	Confirmation of low risk score from the service

Appendix 2

BAF SP16	**Executive:** Board Secretary		**Date Opened:** 19 October 2023
	Committee: Audit Committee		**Date Last Reviewed:** December 2023
	Strategic Priority: P16 Board leadership & governance	**Link to CRR:** Leadership/Special Measures **Link to Tier 1's:** 4480/3969	**Last Date Reviewed at Committee:** 16.11.23
			Target Risk Date: 31 January 2024 to review score. If progress made below then recommend a reduction to a score of 12 (3 x 4) by end of February 2024

There is a risk of failing to effectively strengthen the Board arrangements following special measures and implement critical governance, accountability, planning, and performance improvements.

Mitigations	**Gaps in Controls**	**Current Risk Score**
This refers to the process of reducing risk exposure and minimising its likelihood and/or lessening or making less severe its impact were it to materialise. Types of risk mitigations include the 5Ts (treat, tolerate, terminate, transfer or take opportunity). 1. The development and agreement of the Special Measures "**Governance and board effectiveness domain"** deliverables and milestones that give clarity on what needs to be delivered by when. This includes development of Board Development and Board Induction products to support Board arrangements. This is detailed in the action section. 2. Close working with Welsh Government on the recruitment of new Board members through the public appointment process. 3. Comprehensive response to the Board Effectiveness Review by Audit Wales that aligns to the Special Measures approach.	1. Welsh Government control the public appointment but progression updates are provided 2. The implementation of the review of the OBS is reliant upon following the organisational change policy and this will impact timescales for that part of the improvements 3. The appointment of some Executive appointments is reliant on the timely review of the Exec Portfolio review	Impact: 4 / Likelihood: 4 / Score: 16 Movement N/A

Actions and Due Date

	Target Date
SM Ref no C1-1.3: Implement phase 1 induction for all Board members	Nov-23
SM Ref no C1-1.4: Develop phase 1 Board development programme	Dec-23
SM Ref no C1-1.5: All committees with assigned IMs operational, including ToR, Corp Calendar and Workplans	Mar-24
SM ref no C1-1.6: Design Risk management framework and commence implementation	Dec-23
SM ref no C1-1.7: Permanent Chair/IM/CEO/Exec recruitment – dependent on Exec Portfolio Review and Senior HR Cases	Mar-24
SM ref no C2-1.8: OBS team – implement interim and design permanent structure	Dec-23
SM ref no C2-1.9: Policy management and implementation/audit approach	Oct-23
Feedback from Audit Wales follow up review – December 2023	Dec-23
Scrutiny of progress through Audit Committee	November 2023, January 2024 and March 2025
Assurance on progress through Board	November 2023, January 2024 and March 2026

Lines of Defence			Overall Assessment
1	**2**	**3**	If the above deliverables are put into place then a score of 12 could be achieved by March 2024 or earlier if new Committees and OBS Team are in place by February 2024 Next steps • Executive Team to review • Audit Committee to scrutinise on 12 January 2024 • Deliver plans as outlined above.
Special Measures meeting and assurances to committees on 90 day plan. OBS Team Meetings.	Acting Board Secretary providing recommendations and progress updates through the Executive Team meetings.	Internal Audit	

Teitl adroddiad: ***Report title:***	Special Measures Update			
Adrodd i: ***Report to:***	Audit Committee			
Dyddiad y Cyfarfod: ***Date of Meeting:***	12th January 2024			
Crynodeb Gweithredol: ***Executive Summary:***	The purpose of this paper is to provide an update on Special Measures, outlining the progress to date on the deliverables associated to this Committee.			
Argymhellion: ***Recommendations:***	The Committee is asked to **RECEIVE ASSURANCE** on the progress to date, acknowledging that a full cycle 2 closure assessment will be distributed by separate cover.			
Arweinydd Gweithredol: ***Executive Lead:***	Carol Shillabeer, Chief Executive (Accountable Officer) Dr Chris Stockport, Executive Director of Transformation & Strategic Planning (Lead Executive)			
Awdur yr Adroddiad: ***Report Author:***	Geraint Parry, Special Measures Programme			
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):***	To support Special Measures			
Goblygiadau rheoleiddio a lleol: ***Regulatory and legal implications:***	Not applicable			

Yn unol â WP7, a oedd EqIA yn angenrheidiol ac a gafodd ei gynnal? ***In accordance with WP7 has an EqIA been identified as necessary and undertaken?***	Not applicable
Yn unol â WP68, a oedd SEIA yn angenrheidiol ac a gafodd ei gynnal? ***In accordance with WP68, has an SEIA identified as necessary been undertaken?***	Not applicable
Manylion am risgiau sy'n gysylltiedig â phwnc a chwmpas y papur hwn, gan gynnwys risgiau newydd (croesgyfeirio at y BAF a'r CRR) ***Details of risks associated with the subject and scope of this paper, including new risks(cross reference to the BAF and CRR)***	Not applicable
Goblygiadau ariannol o ganlyniad i roi'r *argymhellion ar waith* ***Financial implications as a result of implementing the recommendations***	Not applicable
Goblygiadau gweithlu o ganlyniad i roi'r argymhellion ar waith ***Workforce implications as a result of implementing the recommendations***	Not applicable
Adborth, ymateb a chrynodeb dilynol ar ôl ymgynghori ***Feedback, response, and follow up summary following consultation***	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
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	

Audit Committee; 12th January 2024

Special Measure Update

1) Introduction

This report presents a brief update on Special Measures at the end of Cycle 2 (September to November 2023), along with early progress during the first weeks of Cycle 3 (December 2023 to February 2024).

The report provides a high-level overview of key business relating to this committee, including the one Independent Review under the remit of this committee. The November Board received a full report across all deliverables and milestones within Cycle 2, and a formal closure assessment for the cycle has also taken place and will be distributed to all Board members. At the time of writing Cycle 3 has only just begun with no milestone dates have yet become due; therefore this report represents a shortened version compared to previous iterations.

2) Background

The background to the Health Board escalation into Special Measures and the resultant organisational response has been covered in previous committees. The full Board meeting has also been receiving a detailed update across all deliverables and milestones to enable scrutiny.

3) Progress to date

Independent Reviews
A process is in place for the development and then delivery of recommendations associated to reviews received and there is one review under the remit of this committee, which is the Review of the Office of the Board Secretary (OBS).

Following the presentation of the Review of the OBS report to a development session of this committee in September and subsequent submission of the management response to formal committee, the report and management response have now been published for the public on our website as part of the November Board papers. This forms an important part of our transparent approach to respond to identified issues and demonstrating how we are changing the organisational culture, and we are now progressing with implementing the recommendations. High level requirements have been drawn out into Special Measures milestones, and reports against the wider action plan within the management response will also be reported to committee at regular intervals.

Overall, the Health Board is taking a thematic approach to the reviews to ensure we address the root causes of our issues, which are common across many of our areas. Thus far, the following 7 themes have been identified and these are being mapped to the most appropriate Executive Led Delivery Group to oversee delivery of the actions.

Themes from reviews received to date
1. Data, Intelligence & Insight Ensuring that there is an organisation wide approach with prioritised interventions into improving our data, intelligence and insight tools and capabilities. This will be a key enabler for sustainable improvement as well as supporting identification of future potential services of concern.
2. Culture Defining, engaging and committing to the long-term work necessary to improve the culture of the organisation. Integrated into our broader organisational development plan across Culture, Leadership and Engagement.
3. Risk Management Reviewing and refining our approach and appetite to risk, including how risks are identified, managed, mitigated, reported and monitored.
4. Patient, Family, Carer Involvement A single coordinated approach to maximise involvement and engagement with our patients and their families and carers, using their experiences to guide our ongoing service improvement.
5. Operating model Ensuring our operating model is designed to best deliver our strategic priorities, with clarity for everyone across all levels of the organisation on the roles and responsibilities, systems and processes within divisions and Pan BCU services.
6. Organisation Governance and compliance Ensuring organisation wide visibility and understanding of governance best practice and ensuring adherence to it.
7. Integrated Planning A well understood integrated approach to planning as a discipline, as well as contributions to our annual planning process.

Cycle 3 and Standardisation Phase Preparation

The plan for Cycle 3 (December 2023 to February 2024) has now been agreed by the Board and the relevant milestones for this committee are tabled at Appendix 1. As the Health Board reaches a greater position of stability a growing focus will be placed upon the 'Standardisation' phase that will follow. This phase, which is due to commence in April 2024, will be crucial in developing consistent standards across each of our geographical areas, reducing variation, and delivering continual improvement in our services.

Ensuring that Special Measures is incorporated into business-as-usual planning cycles is critical. Planning for 2024/25 is currently underway as part of the Integrated Medium-Term Plan (IMTP) for 2024 to 2027 and as such the Special Measures 'Standardisation' thinking is being incorporated into that process, and during December specific meetings have taken place with Welsh Government to discuss sustainability factors and readiness for transition.

4) Portfolio Management Office (PMO) Assessment

Overall Cycle 2 saw solid progress across a number of areas. In particular with regards to a well-functioning Board a number of recruitment activities have progressed, with a vice chair, 2 new permanent Independent Members (IM's) and a permanent CEO now in post, laying important foundations for 2024. Interviews for a permanent Chair have also taken place and an advert for a Director of Corporate Governance has closed. Further IM recruitment is also underway with appointments expected by the end of Cycle 3.

Building upon feedback from existing IM's a revised Board Induction programme has been developed and approved by the Chair, significantly enhancing the existing position. This is currently being tested and will be fully utilised as new appointments are made.

Corporate Governance arrangements are being strengthened with key findings from the OBS review around the Cycle of Business, Terms of Reference and Corporate calendar all progressing and regular updates have been provided to both committee and Board via a Corporate Governance Report in November, with further progress reports due in January. In addition to the OBS review itself, the overall Independent Review process has followed a structured approach and featured strongly in committee business with reports to development and formal sessions of the relevant committees. During this time interim arrangements for the functioning of the Office of the Board Secretary have been put in place, including bringing the Risk Management function into the directorate. Further strengthening on a permanent basis has been deferred into the new year following the appointment of a new Director of Corporate Governance.

5) Change Control

As part of Special Measures governance arrangements any proposed changes require approval through a change control process. This is approved through the Special Measures Senior Responsible Officer (SRO) before being submitted to the Board for final approval.

There are no further changes to advise the committee of at this stage. As the cycle 2 closure report is concluded a final assessment of any required changes will be undertaken and follow the agreed process if required.

6) Recommendations

The Committee is asked to **RECEIVE ASSURANCE** on the progress to date, acknowledging that a full cycle 2 closure assessment will be distributed by separate cover.

Appendix 1

Cycle 3 Milestones relating to Audit Committee

1. A well-functioning Board

Exec Lead	Milestone	Due Date	Why is it important to track
C1-1.5: All committees with assigned IMs operational			
Phil Meakin	1.5.7 Phase 2 - Approval at January Board of full and finalised Corporate Governance arrangements, as recommended in the OBS Review and highlighted below: 1. ToR for all Committees 2. Confirmed membership for each Committee 3. Cycle of Business for each Committee 4. Corporate Calendar for 2024/25	31/01/2024	Effective Corporate Governance of the Health Board, and as recommended within the OBS review
Phil Meakin	1.5.8 Findings from the Independent Review reports available received by each of the relevant Board Sub Committees.	29/02/2024	This enables transparent publication in the public domain and is an agreed process with WG and also
Phil Meakin	1.5.9 Committee Business Management Group (CBMG) re-introduced and scheduled to take place on a quarterly basis	29/02/2024	The Health Board's new governance arrangements will require effective coordination between Committees
C2-1.8: OBS team – implement interim and design permanent structure			
Phil Meakin	1.8.6 Director of Corporate Governance recruitment: Interviews held	31/12/2023	To strengthen the governance of the Health Board to become a well led organisation
Phil Meakin	1.8.7 Interim OBS structure agreed by CEO and Chair, and implementation has completed	31/01/2024	Improvements to Corporate Governance are required immediately to support the implementation of the Health Board's governance arrangements
C2-1.9: Policy management and implementation/audit approach			
Phil Meakin	1.9.4 The final "Policy on Policies" document approved at Audit Committee in January 2024	31/01/2024	Having this is an important step in improving the quality and consistency of all Policies across the Health Board
C3-1.10: Progress implementation of the risk management framework			
Phil Meakin	1.10.1 Risk Management Training reflecting the new Risk Management Framework design and tested	29/02/2024	Ensuring that our staff understand risk and their roles in relation to managing and mitigating risk is key to successful delivery of the framework.
Phil Meakin	1.10.2 Final format for the Board Assurance Framework agreed by Board Members (updated to include strategic objectives if available during Cycle 3)	29/02/2024	Strategic objectives are key to enable the BAF to be optimal
C3-1.11: Permanent IM/Exec recruitment – dependent Senior HR Cases			
Phil Meakin	1.11.1 3x Permanent IMs recruitment: Interview dates set (WG lead this activity – Board Secretary will link in for feedback on progress)	31/01/2024	Recruitment of a permanent Board is important to organisational stability and achieving the outcome of a well functioning Board.

Carol Shillabeer	1.11.2 Progress design of the revisions to the Executive Portfolio through discussion and implementation/recruitment commenced	29/02/2024	Having clearly defined roles and responsibilities and recruiting to a full complement of executive team members is key to achieving our aim of a well functioning Board.
C3-1.12: Implement phase 2 induction for all Board members			
Phil Meakin	1.12.1 Induction for Vice chair and x2 IMs recruited in November 2023 completed, using new Board Induction Programme	31/12/2023	Ensuring that new independent board members have a strong understanding of how the Organisational governance works is key to ensuring a well-functioning board and enabling IMs to discharge their responsibilities effectively
C3-1.13: Develop phase 2 Board development programme			
Phil Meakin	1.13.1 Phase 2 Board Development programme for 2024/25 reviewed at Executive Team	31/01/2024	During February 2024 new Board Members will be appointed. This may influence the precise nature of the Board Development Programme that is agreed.
Phil Meakin	1.13.2 Phase 2 Board Development programme for 2024/25 agreed with the chair through engagement with board members	29/02/2024	It's important that all Board Members with their varying backgrounds and experience have a common understanding of the BCU culture and leadership model, their role within it and the capabilities required to deliver it. They will then be able to fully discharge their responsibilities in ensuring the organisation delivers against its strategic priorities

2. A clear, deliverable plan for 2023/24

No Cycle 3 deliverables from Outcome 2 fall under the remit of this committee

3. Stronger leadership and engagement

No Cycle 3 deliverables from Outcome 3 fall under the remit of this committee

4. Improved access, outcomes and experience for citizens

Exec Lead	Milestone	Due Date	Why is it important to track
C1-4.6: Mental Health review of previous reviews – phase 2			
Teresa Owen	4.6.7 Copy of Royal College of Psychiatry MH&LD report received.	31/01/2024	Receiving this overarching report will be a key point in summarising historic concerns and providing a clear path for future improvements.
Teresa Owen	4.6.8 MH&LD/RCPsych Action Plan developed and scheduled for sign off via appropriate governance routes.	29/02/2024	Ensuring a timely response to issues raised in the reports will key to building confidence in our future plans.

5. A learning and self-improving organisation

No Cycle 3 deliverables from Outcome 5 fall under the remit of this committee

Teitl adroddiad: ***Report title:***	**Draft 2023/24 Annual Accounts Preparation Timetable**
Adrodd i: ***Report to:***	Audit Committee
Dyddiad y Cyfarfod: ***Date of Meeting:***	Friday, 12 January 2024
Crynodeb Gweithredol: ***Executive Summary:***	The purpose of this report is to provide an update on the preparation of the 2023/24 Annual Accounts process by providing a draft timetable. The timetable will be finalised by Welsh Government in Mid-March, including confirmation of the Draft Accounts and Final Audited Accounts submission dates. The team have regularly met with Audit Wales to confirm key matters leading up to production of Accounts, examples being the Health Board releasing provisions associated with aged 'Goods Received Notes' and Annual Leave Provision that related to exceptional days owing accumulated during the pandemic. Upon confirmation of the timetable the corporate calendar will be finalised (it is shared as draft currently) upon finalisation dates will be included for the following: • Draft Accounts to Audit Committee Accounts Workshop • Draft Accounts to Audit Committee • Final Accounts & ISA260 (Audit Wales Audit findings) to Audit Committee • Final Accounts to Board for endorsement • Annual General Meeting The intention is to subit the Draft Accounts and then present to members in the subsequent workshop, this report seeking agreement to this being a suitable process for oversight. The program of works and key tasks are defined within the attached chart, indicating task, lead officer, commencement and timeframes for conclusion. It is of note that the national timetable the Health Board will be required to submit the final audited accounts is yet to be confirmed. The submission for 2022/23 being 31st July, though discussions have been held that centre on the feasibility of bringing this forward (the draft timetable is based on a 31st July submission). An Audit Committee will be required approximately one week in advance of the submission deadline, and as such either there will be a requirement to move the date of committee scheduled in early July, or schedule an exceptional meeting for members to receive the findings of Audit Wales (ISA260) on the Annual Accounts submission for 2023/24.

<table>
<tr><td>Argymhellion:

Recommendations:</td><td colspan="4">The Audit Committee is asked to take assurance from the preparatory work undertaken by the Finance Department, engagement with Audit Wales and the granular level of planning to ensure the production of the Accounts, and the supporting reports, are completed on time.

The Audit Committee are asked to support the intention to submit the Draft Accounts, then receive a presentation on their content during the Annual Accounts workshop.</td></tr>
<tr><td>Arweinydd Gweithredol:
Executive Lead:</td><td colspan="4">Russel Caldicott, Interim Executive Director of Finance</td></tr>
<tr><td>Awdur yr Adroddiad:
Report Author:</td><td colspan="4">Andrea J Hughes, Interim Finance Director – Operational Finance</td></tr>
<tr><td>Pwrpas yr adroddiad:
Purpose of report:</td><td>I’w Nodi
For Noting
☐</td><td colspan="2">I Benderfynu arno
For Decision
☒</td><td>Am sicrwydd
For Assurance
☒</td></tr>
<tr><td>Lefel sicrwydd:

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

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

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

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

No confidence / evidence in delivery</td></tr>
<tr><td colspan="5">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:</td></tr>
<tr><td colspan="2">Cyswllt ag Amcan/Amcanion Strategol:

Link to Strategic Objective(s):</td><td colspan="3">This paper aligns to the strategic goal of attaining financial balance.</td></tr>
<tr><td colspan="2">Goblygiadau rheoleiddio a lleol:
Regulatory and legal implications:</td><td colspan="3">Statutory requirements for the Health Board to produce a set of Audited Annual Accounts for the Auditor General for Wales for the Welsh Government and for laying at the Senedd.</td></tr>
<tr><td colspan="2">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?</td><td colspan="3">Not necessary</td></tr>
<tr><td colspan="2">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?</td><td colspan="3">Not necessary</td></tr>
<tr><td colspan="2">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)</td><td colspan="3">BAF: 2.3 – Plan to reduce BCUHB’s Financial deficit, secure WG funding and retain WG’s strategic support</td></tr>
</table>

Goblygiadau ariannol o ganlyniad i roi'r *argymhellion ar waith* ***Financial implications as a result of implementing the recommendations***	None
Goblygiadau gweithlu o ganlyniad i roi'r argymhellion ar waith ***Workforce implications as a result of implementing the recommendations***	None
Adborth, ymateb a chrynodeb dilynol ar ôl ymgynghori ***Feedback, response, and follow up summary following consultation***	Not applicable
Cysylltiadau â risgiau BAF: (neu gysylltiadau â'r Gofrestr Risg Gorfforaethol) ***Links to BAF risks:*** *(or links to the Corporate Risk Register)*	See above
Rheswm dros gyflwyno adroddiad i fwrdd cyfrinachol (lle bo'n berthnasol) ***Reason for submission of report to confidential board (where relevant)***	Not applicable
Camau Nesaf: ***Next Steps:*** ***The report is for assurance – a final version will be available in Mid March.***	
Rhestr o Atodiadau: Draft Timetable Below	

DRAFT ACCOUNTS TIMETABLE - 2023/24			Open actions = 7		Overdue actions = 0																				
Programme Start		01/12/23	Future actions = 91		Closed actions = 3																				
						W6	W7	W8	W9	W10	W11	W12	W13	W14	W15	W16	W17	W18	W19	W20	W21	W22	W23	W24	W36
Action Ref	Task Title	Task Owner / Lead	Scheduled Start	Scheduled Closure Date	Status	1/1	8/1	15/1	22/1	29/1	5/2	12/2	19/2	26/2	4/3	11/3	18/3	25/3	1/4	8/4	15/4	22/4	29/4	6/5	29/7
1.00	**Audit Wales Meetings / Correspondence / Returns**	AH	**01-Dec-23**	**31-Jul-24**	**Open**																				
1.01	December - Preparatory meeting with Audit Wales	AH	01-Dec-23	31-Dec-23	Closed																				
1.02	January - Preparatory meeting with Audit Wales	AH	01-Jan-24	31-Jan-24	Future Action																				
1.03	March - Preparatory meeting with Audit Wales	AH	01-Mar-24	31-Mar-24	Future Action																				
1.04	Audit Enquiries letter provided by Audit Wales	Audit Wales	01-Feb-24	28-Feb-24	Future Action																				
1.05	Inflow updated with Audit Deliverables by Audit Wales	Audit Wales	01-Mar-24	31-Mar-24	Future Action																				
1.06	Audit Wales audit of the 2023-24 annual accounts, LMS, LFRs, WGA, Rem Report	Audit Wales	01-May-24	31-Jul-24	Future Action																				
1.07	Audit Wales to submit audited accounts, all returns, Annual Report sections (TBC) (Noon)	Audit Wales	31-Jul-24	31-Jul-24	Future Action																				
2.00	**Internal Pre- Accounts Preparation Tasks**		**01-Nov-23**	**31-Mar-24**	**Open**																				
2.01	Declarations of Interest meeting with Board Secretary	AH	01-Nov-23	31-Dec-23	Closed																				
2.02	Preparatory Discussion on production of the supporting Reports for the Accounts	SW	01-Dec-23	31-Dec-23	Open																				
2.03	Finance Department Annual Accounts Lunch and Learn sessions for all staff - December	SW	01-Dec-23	31-Dec-23	Closed																				
2.04	Finance Department Annual Accounts Lunch and Learn sessions for all staff - Feb and March	SW	01-Feb-24	31-Mar-24	Future Action																				
2.05	Annual accounts procedures and timetables circulated	SW	02-Jan-24	31-Jan-24	Future Action																				
2.06	Greenbury Senior Managers Remuneration submission to NHS Pension Agency	DR	01-Feb-24	28-Feb-24	Future Action																				
2.07	Declarations of Interested completed and agreed with Directors	PM / PPJ	01-Mar-24	31-Mar-24	Future Action																				
2.08	Year-end cash position managed	SW	01-Mar-24	31-Mar-24	Future Action																				
3.00	**Welsh Government Guidance**		**01-Dec-23**	**31-Mar-24**	**Open**																				
3.01	Draft Manual for Accounts issued by Welsh Government	Welsh Gov	01-Dec-23	31-Dec-23	Open																				
3.02	Responses on draft Manual for Accounts to Welsh Government	SW	01-Jan-24	31-Jan-24	Future Action																				
3.03	Final Manual for Accounts issued by Welsh Government	Welsh Gov	01-Mar-24	31-Mar-24	Future Action																				
4.00	**Inventory Counts**		**01-Dec-23**	**31-Dec-23**	**Open**																				
4.01	December Inventory count procedures and price lists lists issued	SW / CFO's	01-Dec-23	31-Dec-23	Open																				
4.02	Manual inventory counts undertaken at end of January	SW / CFO's	24-Jan-24	31-Jan-24	Future Action																				
4.03	Manual inventory counts undertaken at end of February	SW / CFO's	21-Feb-24	28-Feb-24	Future Action																				
4.04	Automated inventory counts at end of March	SW / CFO's	24-Mar-24	31-Mar-24	Future Action																				
5.00	**Agreement of Balances**		**02-Jan-24**	**31-Jan-24**	**Future Action**																				
5.01	Month 9 Agreement of Balances exercise for all NHS Wales organisations apart from WG	SW	02-Jan-24	31-Jan-24	Future Action																				
5.02	Month 11 informal Agreement of Balances exercise for all NHS Wales organisations apart from WG	SW	01-Feb-24	28-Feb-24	Future Action																				
5.03	Month 12 Agreement of Balances exercise for all NHS Wales organisations	SW	02-Apr-24	17-Apr-24	Future Action																				
6.00	**General Ledger / Accounts Preparation**		**05-Apr-24**	**10-May-24**	**Future Action**																				
6.01	Review draft position	MJ	05-Apr-24	05-Apr-24	Future Action																				
6.02	Day 5 Monitoring Return submission to Welsh Government	MJ	08-Apr-24	08-Apr-24	Future Action																				
6.03	M12 2023-24 general ledger closed	MJ	08-Apr-24	10-Apr-24	Future Action																				
6.04	GL download prepared	MJ	08-Apr-24	08-Apr-24	Future Action																				
6.05	Accounts working papers submitted to Financial Services	All	12-Apr-24	12-Apr-24	Future Action																				
6.06	Full Monitoring Return submission to WG (Noon)	MJ	26-Apr-24	26-Apr-24	Future Action																				
6.07	Unaudited accounts, LMS and LFRs (Excl LMS2 and LFR10)	SW	03-May-24	03-May-24	Future Action																				
7.00	**Centrally Managed Accruals and Provisions**		**29-Feb-24**	**24-Apr-24**	**Future Action**																				
7.01	Annual leave accrual	MJ	29-Feb-24	29-Feb-24	Future Action																				
7.02	Study Leave Accrual	MJ	29-Feb-24	29-Feb-24	Future Action																				
7.03	Clinical negligence & personal injury provision	NR	15-Apr-24	15-Apr-24	Future Action																				
7.04	Consultants relocation expenses provision	DR	15-Apr-24	15-Apr-24	Future Action																				
7.05	Employment Tribunals provision	SW	15-Apr-24	15-Apr-24	Future Action																				
7.06	Job banding appeals and reviews	CH	15-Apr-24	15-Apr-24	Future Action																				
7.07	Monthly expenses accrual	ZW	15-Apr-24	15-Apr-24	Future Action																				
7.08	Monthly pay accrual	ZW	15-Apr-24	15-Apr-24	Future Action																				
7.09	Permanent Injury Benefits / Pensions Accruals	NR	15-Apr-24	15-Apr-24	Future Action																				
7.10	Final Pay Control (FPC)	NR	15-Apr-24	15-Apr-24	Future Action																				
8.00	**Welsh Risk Pool**		**28-Mar-24**	**24-Apr-24**	**Future Action**																				
8.01	Welsh Risk Pool - Submission of DEL return	SW	08-Apr-24	08-Apr-24	Future Action																				
8.02	Welsh Risk Pool - First Submission Quarterly Return - AME	SW	10-Apr-24	10-Apr-24	Future Action																				
8.03	Welsh Risk Pool - Losses and special payment entries	SW	12-Apr-24	12-Apr-24	Future Action																				
8.04	Welsh Risk Pool - Second Submission Quarterly Return - AME	SW	12-Apr-24	12-Apr-24	Future Action																				
8.05	Welsh Risk Pool - resolution of queries	SW	15-Apr-24	15-Apr-24	Future Action																				
8.06	Welsh Risk Pool - Third Submission Quarterly Return - AME	SW	24-Apr-24	24-Apr-24	Future Action																				
9.00	**Accounts Payable - Year End Closure Tasks**		**28-Mar-24**	**18-Apr-24**	**Future Action**																				
9.01	Month 12 2023-24 Accounts Payable closed 3.00 pm	SW	28-Mar-24	28-Mar-24	Future Action																				
9.02	Month 12 2023-24 booking in open for two days for old year receipts	SW	02-Apr-24	03-Apr-24	Future Action																				
9.03	Month 1 2024-25 booking in open	SW	02-Apr-24	02-Apr-24	Future Action																				
9.04	Month 1 2024-25 Accounts Payable open	SW	02-Apr-24	02-Apr-24	Future Action																				
9.05	Initial OPO reports reviewed and uploaded	SW	02-Apr-24	02-Apr-24	Future Action																				
9.06	Accounts Payable Trial Balance breakdown saved on Finance Server 5.00 pm	SW	02-Apr-24	02-Apr-24	Future Action																				
9.07	Creditors balances to be issued by WHSSC (5pm)	SW	04-Apr-24	04-Apr-24	Future Action																				
9.08	Final OPO reports shared for review	SW	04-Apr-24	04-Apr-24	Future Action																				
9.09	Creditors statements issued by NHS Wales bodies (Noon) WHSSC 5pm	SW	04-Apr-24	04-Apr-24	Future Action																				
9.10	Creditors statements returned by WHSSC (Noon)	SW	08-Apr-24	08-Apr-24	Future Action																				
9.11	Creditors statements returned by NHS Wales bodies	SW	09-Apr-24	09-Apr-24	Future Action																				
9.12	Arbitration cases submitted to WG for any disputed Welsh NHS invoices	SW	15-Apr-24	15-Apr-24	Future Action																				
9.13	Welsh Government to issue LMS matrix (Afternoon)	Welsh Gov	18-Apr-24	18-Apr-24	Future Action																				
9.14	Submit LMS to Welsh Government (Noon)	ZW	18-Apr-24	18-Apr-24	Future Action																				
10.00	**Accounts Receivable - Year End Closure Tasks**		**02-Apr-24**	**18-Apr-24**	**Future Action**																				
10.01	Accounts Receivable receipting completed (Noon)	DR	02-Apr-24	02-Apr-24	Future Action																				
10.02	Month 12 2023-24 Accounts Receivable closed (Noon)	DR	03-Apr-24	03-Apr-24	Future Action																				
10.03	Run M12 Billing History Reports (Afternoon)	DR	03-Apr-24	03-Apr-24	Future Action																				
10.04	Month 1 2024-25 AR Open	DR	03-Apr-24	03-Apr-24	Future Action																				
10.05	Debtors balances to be issued to WHSSC (Noon)	DR	03-Apr-24	03-Apr-24	Future Action																				
10.06	Debtors statements issued to other NHS Wales bodies (Noon)	DR	04-Apr-24	04-Apr-24	Future Action																				
10.07	Debtors statements returned by WHSSC (Noon)	DR	08-Apr-24	08-Apr-24	Future Action																				
10.08	Debtors statements returned by NHS Wales bodies	DR	09-Apr-24	09-Apr-24	Future Action																				
10.09	Arbitration cases submitted to WG for any disputed Welsh NHS invoices	DR	15-Apr-24	15-Apr-24	Future Action																				
10.10	Welsh Government to issue LMS matrix (Afternoon)	Welsh Gov	18-Apr-24	18-Apr-24	Future Action																				
10.11	Submit LMS to Welsh Government (Noon)	AP	18-Apr-24	18-Apr-24	Future Action																				
11.00	**NHS Income and Expenditure Agreements**		**10-Apr-24**	**18-Apr-24**	**Future Action**																				
11.01	Issue - Income transactions statement to other WHSSC	SW / MJ	10-Apr-24	10-Apr-24	Future Action																				
11.02	Issue - Income transactions statement to other NHS Wales bodies	SW / MJ	11-Apr-24	11-Apr-24	Future Action																				
11.03	Sign-off date for agreement of income and expenditure with WHSSC (Noon)	SW / MJ	15-Apr-24	15-Apr-24	Future Action																				
11.04	Sign-off date for agreement of NHS Wales income and expenditure	SW / MJ	17-Apr-24	17-Apr-24	Future Action																				
11.05	Arbitration cases submitted to WG for any disputed Welsh NHS invoices	SW / MJ	15-Apr-24	15-Apr-24	Future Action																				
11.06	Welsh Government to issue LMS matrix (Afternoon)	Welsh Gov	18-Apr-24	18-Apr-24	Future Action																				
11.07	Submit LMS to Welsh Government (Noon)	NR	18-Apr-24	18-Apr-24	Future Action																				
12.00	**Annual Report inc Directors Statements and AO Responsibilities**		**28-Feb-24**	**03-May-24**	**Future Action**																				
12.01	Production of the Financial Statements and Notes	SW	28-Feb-24	03/05/2024	Future Action																				
12.02	Production of Remuneration Report	PPJ / DR	28-Feb-24	03/05/2024	Future Action																				
12.03	Production of Performance Report	ER / HSJ	28-Feb-24	03/05/2024	Future Action																				
12.04	Production of Annual Governance Statement	PM/PPJ	28-Feb-24	03/05/2024	Future Action																				
12.05	Production of Audit Response Letter - Those charged with Governance	RC/AH	28-Feb-24	03/05/2024	Future Action																				
12.06	Parliamentary Statements	SW	28-Feb-24	03/05/2024	Future Action																				

Teitl adroddiad: ***Report title:***	**Financial Conformance Report**
Adrodd i: ***Report to:***	Audit Committee
Dyddiad y Cyfarfod: ***Date of Meeting:***	Wednesday, 24 January 2024
Crynodeb Gweithredol: ***Executive Summary:***	This conformance report provides an update to the Committee on areas that relate to regulatory compliance or assurance and good practice expectations, the areas covered in this report are: • **Purchase orders that are non-compliant with SFI's (January 2023 to November 2023).** This data set relates to orders being raised after the invoice has been received. There has been a material reduction in non-compliance, with 328 order breeches during November 23, compared to 540 in May 23. A significant proportion of the orders are for known expenditure such as Locum and Agency spend or Healthcare services; however, the variable nature of the volume means that retrospective orders are produced. Each of the departments in which the breach arose, have been reminded of the SFI requirements and are required to take action to ensure future breaches do not re-occur. Reminder bulletins on financial instructions are included in Procurement communications and these remind staff that they must have approval before committing expenditure. Further reminders will be issued towards year end, as the data indicates this to be the period of greatest concern. • **E-Waiver System Developments and Single Waivers (September to November 2023)** The Finance Department have been re-developing the waiver system and following a period of user testing it is expected to be rolled out as a soft launch in December 2023. Key areas of improvement are system compliance with delegated limits contained within the Scheme of Reservation and Delegation (SoRD), better visibility of continuous (year on year) waivers; increased focus on retrospective requests; conditional approval to include automated reminders where further action is deemed necessary; and improved reporting. There has been a significant reduction in the number of approved waivers during the period September to November 23. Single Tenders – 12 approved, with 48 year-to-date compared with 87 for the same period last year. Single Quote – 1 approved, with 39 year-to-date compared with 46 for the same period last year.

	• **Receivables and conformance with payroll procedures** The Health Board has procedures in place to ensure that balances owed to the Health Board are invoiced promptly. Escalation procedures are in place to ensure that debtors are collected in a timely manner or highlighted for further action. As at 30th November 2023, there were 3,210 outstanding invoices, totalling £11.4m; of which, 565 invoices, totalling £3.8m, were less than 30 days old. The Health Board places great importance on the requirement for accuracy of payments made to staff, and is particularly concerned to ensure that staff are not under or overpaid. While underpayments should be detected reasonably promptly through staff action, there is a risk that overpayments can remain undetected over a period. For the period April – November 2023 there were 331 staff overpayments, with a gross value of £0.853m. Failure to complete forms on time remains the main cause of overpayments (164 cases). Staff overpayment breaches are included in service/area monthly management reports and discussed as part of the budget monitoring process in order to improve future compliance. As at 30th November 2023 the balance outstanding was £1.087m, compared to £0.948m at 31st March 2023. • **Payables and conformance with Public Sector Payment Policy (PSPP)** The Health Board aims to ensure that all balances are paid within 30 days of receipt of a valid payable invoice. Best Practice of 95% (by number) is set at 95%. The year-to-date (as at 30th November 23) achievement for non-NHS invoices by number is 94%. • **Losses and special payments (September to November 2023)** Losses and special payments should be exceptional in nature. The Health Board must administer losses in accordance with procedures set out by Welsh Government. Individual losses in excess of £50,000 require approval from the Welsh Government (£1,000,000 in the case of negligence claims). Clinical negligence claims account for the largest element of loss. Amounts in excess of £25,000 can be claimed from the Welsh Risk Pool Service in accordance with the risk pooling arrangements in place for NHS Wales. However, as the Welsh Risk Pool is funded from the NHS Wales healthcare budget these costs are still met by NHS Wales. Clinical negligence claims are managed by Legal and Risk Services and there were 285 active claims at the end of November 2023. Of these 122 matters were assessed as either probable or certain of settlement with a cumulative estimated value of £148m (before reimbursement from the Welsh Risk Pool).
Argymhellion:	The Audit Committee is asked to:

<table>
<tr><td>Recommendations:</td><td colspan="4">1. To note and discuss the below elements of performance
• Purchase orders that are non-compliant with SFI's (January 2023 to November 2023).
• E-Waiver System Developments and Single Waivers (September 2023 to November 2023)
• Receivables and conformance with payroll procedures (January 2023 to November 2023)
• Payables and conformance with Public Sector Payment Policy (PSPP) (January 2023 to November 2023)
2. Approve the Losses and Special Payments (September 2023 to November 2023)</td></tr>
<tr><td>Arweinydd Gweithredol:
Executive Lead:</td><td colspan="4">Russel Caldicott, Interim Executive Director of Finance</td></tr>
<tr><td>Awdur yr Adroddiad:
Report Author:</td><td colspan="4">Denise Roberts, Head of Capital, Business Improvement and Compliance
Andrea J Hughes, Interim Finance Director – Operational Finance</td></tr>
<tr><td>Pwrpas yr adroddiad:
Purpose of report:</td><td>I'w Nodi
For Noting
☒</td><td colspan="2">I Benderfynu arno
For Decision
☒</td><td>Am sicrwydd
For Assurance
☒</td></tr>
<tr><td rowspan="2">Lefel sicrwydd:

Assurance level:</td><td>Arwyddocaol
Significant
☒</td><td>Derbyniol
Acceptable
☐</td><td>Rhannol
Partial
☐</td><td>Dim Sicrwydd
No Assurance
☐</td></tr>
<tr><td>Lefel uchel o hyder/tystiolaeth o ran darparu'r mecanweithiau / amcanion presennol

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

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

Some confidence / evidence in delivery of existing mechanisms / objectives</td><td>Dim hyder/tystiolaeth o ran y ddarpariaeth

No confidence / evidence in delivery</td></tr>
<tr><td colspan="5">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:</td></tr>
<tr><td colspan="2">Cyswllt ag Amcan/Amcanion Strategol:

Link to Strategic Objective(s):</td><td colspan="3">This paper aligns to the strategic aim 1: Improving physical, emotional and mental health and wellbeing for all/improving the safety and quality of all services

BCUHB's SOs and financial requirements included are designed to ensure that expenditure is incurred for the purposes intended and aligned.</td></tr>
<tr><td colspan="2">Goblygiadau rheoleiddio a lleol:
Regulatory and legal implications:</td><td colspan="3">Areas of identified non-conformance highlight risk of failing to meet regulatory and legal</td></tr>
</table>

	requirements, and expected good practice. Mitigating actions are designed to manage highlighted risks effectively.
Yn unol â WP7, a oedd EqIA yn angenrheidiol ac a gafodd ei gynnal? ***In accordance with WP7 has an EqIA been identified as necessary and undertaken?***	None identified as necessary
Yn unol â WP68, a oedd SEIA yn angenrheidiol ac a gafodd ei gynnal? ***In accordance with WP68, has an SEIA identified as necessary been undertaken?***	None identified as necessary
Manylion am risgiau sy'n gysylltiedig â phwnc a chwmpas y papur hwn, gan gynnwys risgiau newydd (croesgyfeirio at y BAF a'r CRR) ***Details of risks associated with the subject and scope of this paper, including new risks(cross reference to the BAF and CRR)***	BAF: 2.3 – Plan to reduce BCUHB's Financial deficit, secure WG funding and retain WG's strategic support
Goblygiadau ariannol o ganlyniad i roi'r *argymhellion ar waith* ***Financial implications as a result of implementing the recommendations***	Unquantified lower financial risk
Goblygiadau gweithlu o ganlyniad i roi'r argymhellion ar waith ***Workforce implications as a result of implementing the recommendations***	None
Adborth, ymateb a chrynodeb dilynol ar ôl ymgynghori ***Feedback, response, and follow up summary following consultation***	Not applicable
Cysylltiadau â risgiau BAF: (neu gysylltiadau â'r Gofrestr Risg Gorfforaethol) ***Links to BAF risks:*** *(or links to the Corporate Risk Register)*	See above
Rheswm dros gyflwyno adroddiad i fwrdd cyfrinachol (lle bo'n berthnasol) ***Reason for submission of report to confidential board (where relevant)***	Not applicable
Camau Nesaf: **Gweithredu argymhellion** ***Next Steps:*** ***Implementation of recommendations*** • ***The report is for noting and, in the case of losses and special payments, approval***	
Rhestr o Atodiadau: ***List of Appendices:*** 1. Single Tender Waivers – September – November 2023 2. Singe Quote Waivers – September – November 2023	

Section 1 - Conformance with Procurement Procedures

a) SFI requirements

The Health Board's Standing Orders (SOs), incorporating Standing Financial Instructions (SFIs), set the minimum thresholds for quotes and competitive tendering. These thresholds reflect relevant regulatory requirements, and are summarised in the following table:

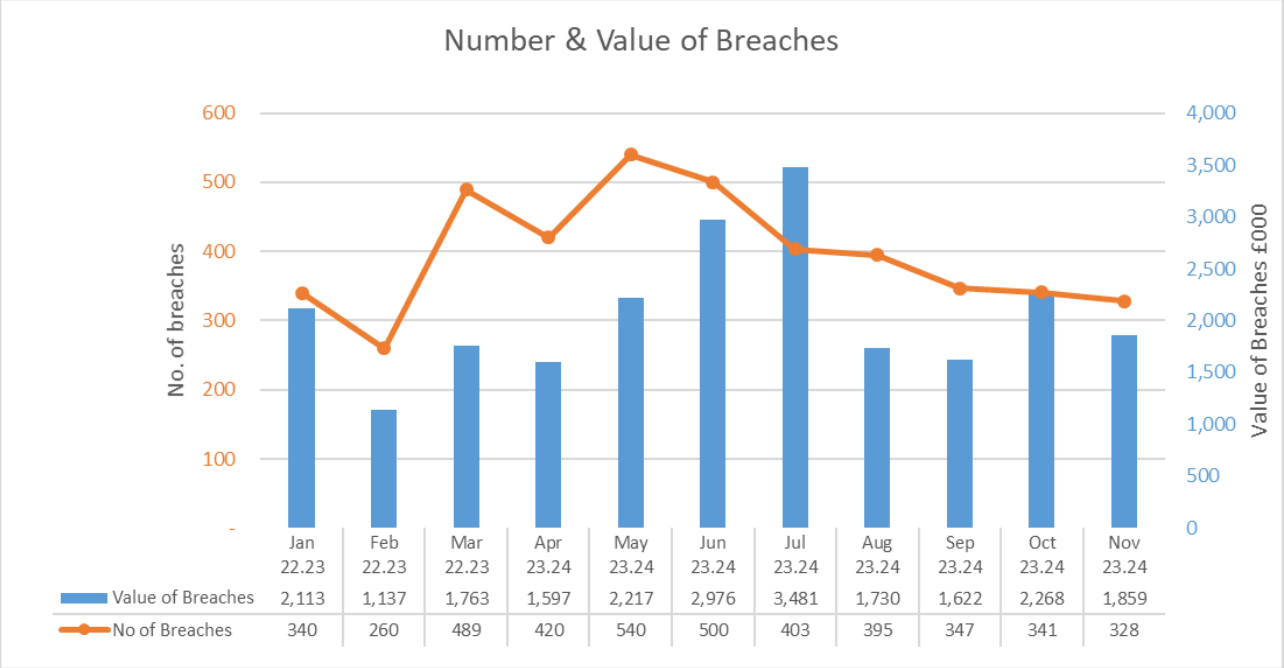
Contract Value(ex VAT)	Minimum Competition
<£5,000	At discretion of appropriate Director
£5,000-£25,000	3 written quotations
£25,000-OJEU threshold	4 tenders
Above OJEU threshold (currently £118,133)	5 tenders
Contracts between £500k and £1 million	WG Ministerial Approval for noting
Contracts above £1 million	WG Ministerial Approval required

Compliance with the SFIs promotes effective control, value for money and ensures that the Health Board operates in compliance with relevant legislation.

b) Purchase Orders

The use of a formal purchase order system is a key control to ensure expenditure is only committed following proper approval and all committed expenditure is recorded. The monthly trend in the graph below shows an improvement, with 328 breeches during November 23 compared to 540 back in May 23. A significant proportion of the orders are for known expenditure such as Locum and Agency spend or Healthcare services; however, the variable nature of the volume means that orders are retrospective placed once final quantities are known.

The value and number of breaches between January and November 2023 are detailed below:



Of the 'No PO (Purchase Order) No Pay' breaches, the 5 highest value orders for the period are as follows:

Division	Item Description	PO Amount £000's
Regional Services	OUTSOURCED PET-CT SCANNING AND AD HOC REPORTING CONTRACT 1ST JANUARY 2023 - 31ST DECEMBER 2023	650
Ysbyty Gwynedd	AGENCY LOCUM CONSULTANT COVER FOR GASTRO- DR KHALID BARAKAT, GMC 6045183. 07/06/2022- 31/03/2023 INCLUSIVE, AVG OF 40 HOURS/WEEK @ £160.00/HOUR. TOTAL PREDICTED APPROX £270,000 (42 WEEK PERIOD) EWAIVER 2022/23-972	270
Central Area	CALL DOWN PURCHASE ORDER FOR VACCINES FOR GP SURGERIES CENTRAL AREA FOR AUGUST TO OCTOBER 2023.	267
Ysbyty Gwynedd	ENDOSCOPY INSOURCING LISTS PAYMENT COVERING, INV-3298, 3351, 3381, 3382, 3411, 3439. INCORPORATING AUG 5-6, 12-13 (INCLUDING BSW), 19-20, 26-27 & 28 (BH)	258
Regional Services	F026 COUNTESS OF CHESTER FRAMEWORK PROVISION OF CT AND MRI SERVICES AT YSBYTY GLAN CLWYD AND WREXHAM MAELOR	257

The Divisions with the highest number of PO breaches are listed below:

Division	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	YTD
East	147	124	253	205	271	197	125	189	116	126	157	1386
Centre	142	67	143	96	107	97	98	101	100	82	79	760
West	51	28	61	117	94	59	55	71	57	57	44	554
Regional Services	14	4	25	48	84	33	28	23	20	27	79	342
MHLD	14	13	45	40	42	49	34	19	35	11	18	248

Each of the departments in which the breaches arose, have been reminded of the SFI requirements and to take action to ensure future breaches do not re-occur.

The Health Board's Oracle users are regularly reminded of the 'No PO No Pay' policy and that all staff must have approval before committing to expenditure. Reminder bulletins on procurement rules are issued in procurement communications. Further reminders will be issued towards year end, as the data indicates this to be the period of the greatest concern.

NHS Wales Shared Services Partnership and the Health Board are continuously reviewing processes and resolving 'invoices on hold' issues, through the Accounts Payable function.

c) E-Waiver Developments

Finance have been re-developing the waiver system, taking advantage of the features and functionality now available through the NHS Wales Microsoft 365 licence agreement. Following a period of user testing it is expected to be rolled out as a soft launch in December 2023.

This re-development has given Finance and NWSSP Procurement Services the opportunity to review the existing system and process, identify areas of weakness and propose opportunities to strengthen the Health Board's governance and control of requests to waive SFI requirements. Key areas of improvement are compliance with delegated limits contained within the Scheme of Reservation and Delegation (SoRD), better visibility of continuous (year on year) waivers; increased focus on retrospective requests; conditional approval to include automated reminders where further action is deemed necessary; and improved reporting.

Single Tender Waivers **(for items of expenditure above £25,000)**

It is normal practice to request bids from multiple suppliers. Where this is not possible, a single tender waiver should be obtained and approved ahead of expenditure being committed. Allowable rationale for a single tender waiver are:

- Follow-up work where a provider has already undertaken initial work in the same area (and where the initial work was awarded from open competition);

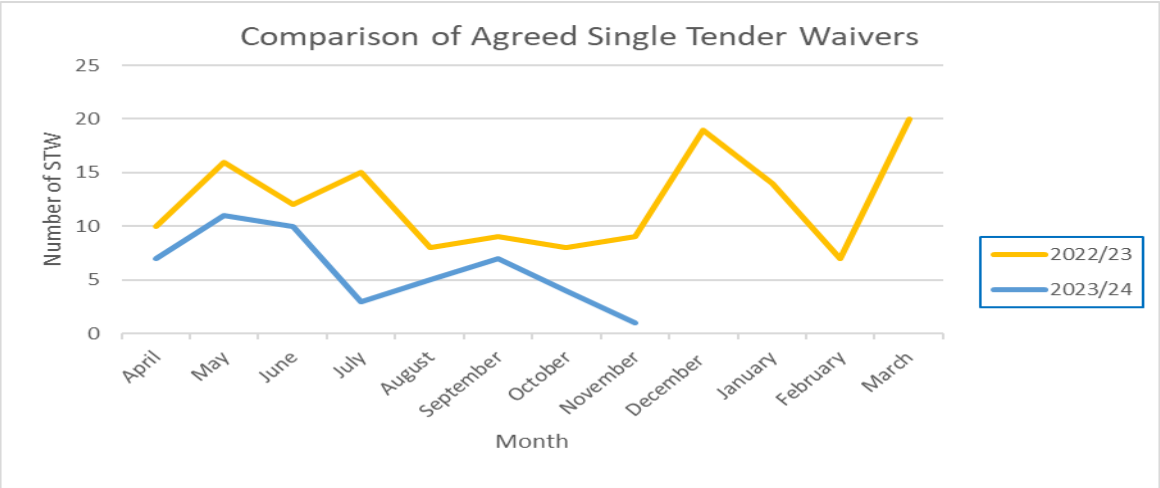
- A technical compatibility issue which needs to be met, e.g. specific equipment required, or compliance with a warranty cover clause;
- A need to retain a particular contractor for genuine business continuity issues (not just preferences); or
- When joining collaborative agreements where there is no formal agreement in place. Request for such a departure must be supported by written evidence from the Procurement Service confirming local agreements will be replaced by an all-Wales competition/National strategy.

The table below provides a summary of waiver activity for the period of September to November 2023, the year to date position and the comparator data for the same period last year.

Single Tender Waivers	2023/2024 Sept - Nov	2023/24 YTD	2022/23 YTD
Waivers Issued	18	73	88
Waivers Approved	12	48	87
Value of Approved Waivers	£0.9m	£3.8m	£5.9m
Waivers approval above EU Threshold	2	8	12
Cancelled Waivers	3	11	7

The number of approved waivers has significantly reduced when compared to the same period last year.

The chart below provides a monthly profile of the approvals to waive tender requirements during 2023/24, compared with 2022/23. Further information is detailed in **Appendix 1**.



Single Quote Waivers **(for items of expenditure between £5,000 and £25,000)**

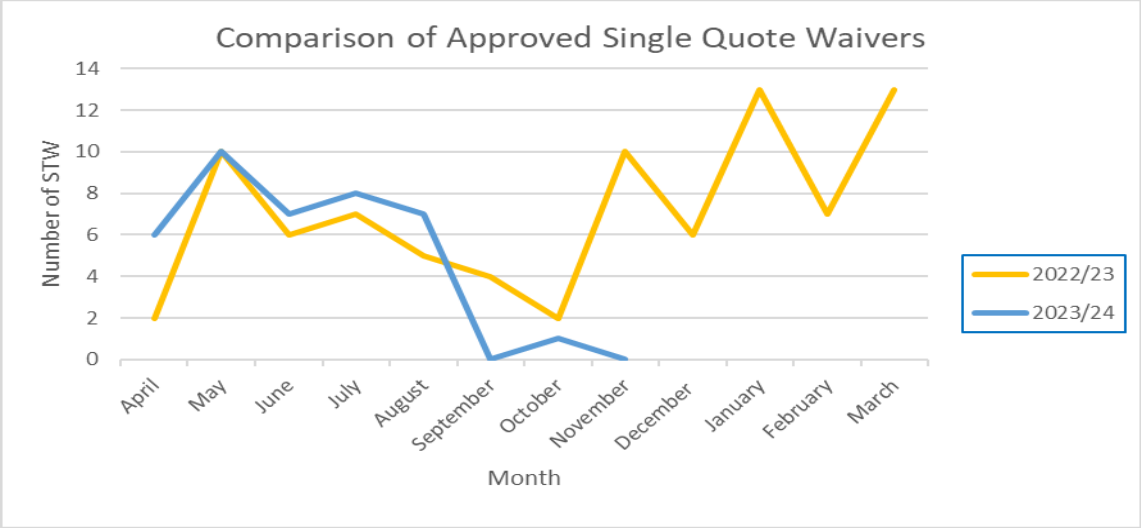
It is normal practice to obtain three quotes. Where this is not possible, then a single quote waiver should be obtained and approved ahead of expenditure being committed.

The table below provides a summary of waiver activity for the period of September to November 2023, the year-to-date position and the comparator data for the same period last year.

Single Quote Waiver	2023/2024 Sep - Nov	2023/24 YTD	2022/23 YTD
Waivers Issued	14	71	110
Waivers Approved	1	39	46
Value of Approved Waivers	£0.009m	£0.5m	£0.5m
Cancelled Waivers	4	10	1

The number of approved waivers has reduced when compared to the same period last year.

The chart below provides a summary of the approvals to waive quote requirements for 2023/24, compared with 2022/23. Further information is detailed in **Appendix 2**.



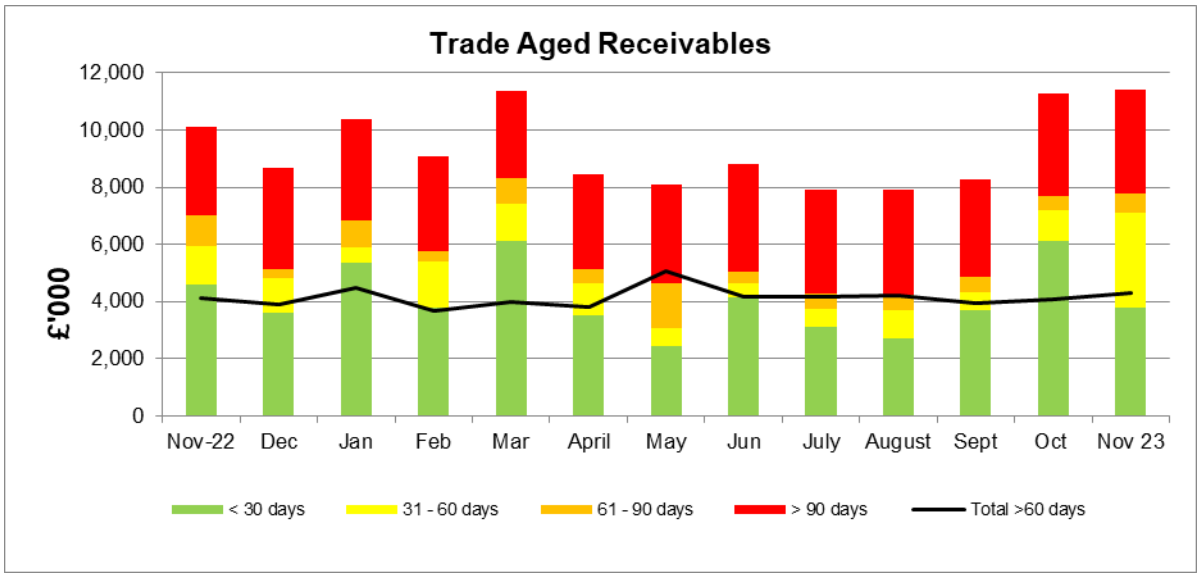
Section 2 – Receivables and Conformance with Payroll Procedures

a) Overview of Balances Owed

The Health Board has robust procedures in place to ensure that balances owed to the Health Board are invoiced promptly. Escalation procedures are in place to ensure that debtors are collected in a timely manner or highlighted for further action.

As at 30th November 2023, there were 3,210 outstanding invoices, totalling £11.4m, of which 565 invoices, totalling £3.8m were less than 30 days old.

The graph below shows the year-to-date trend in total debt and debt profile.



Provisions for bad and doubtful debts

The Health Board is required to maintain a bad debt provision against each outstanding invoice to cover the any future potential write offs. These provisions are calculated as a percentage of outstanding invoice values and are based on the type and value of each debt as well as historic collectability rates. Invoices are subject to further review on a quarterly basis to assess which bad debt provisions need to be increased to 100% due to specific risk of non-payment. All invoices that have been referred to the Health Board's debt recovery agents are automatically subject to a 100% bad debt provision.

Receivable balances over £10,000 and in excess of 6 months old as at 30th November 2023

The Health Board continues to contact a number of NHS and public sector organisations, escalating aged receivables and to seek specialist recovery advice when required. The table below provides an overview of debts over £10,000 and over 6 months old.

Customer	£000's	Number of invoices	Analysis and further action	Date debt raised
St David's Hospice	457	7	Invoices mainly relate to capital works completed at Ysbyty Penrhos Stanley prior to the Covid-19 pandemic. Whilst the Health Board agreed a re- payment profile with St David's Hospice in October 2022, which would protect the Hospice's cash flow and allow the debt to be repaid in full over 4 years, no payments have yet been received.	Dec 19 – Mar 22
St Helens & Knowsley Hospitals NHS Trust (now Mersey and West Lancashire Teaching Hospitals NHS Trust)	176	3	Recharge of specialist registrar rotation. Query regarding funding for placement, customer states they should not have been recharged. Query has been passed to area team to investigate and respond.	Sep 22 - Mar 23
NHS Cheshire and Merseyside ICB	133	1	Recharge for LAC placements, charges relate to various CCG's therefore there are delays as multiple approvals are required.	Jan23
Salary Overpayment	38	2	Overpayments have been referred to People Services who are liaising with the debtor.	Feb 22 & Apr 23
Overseas Patient	31	1	Overseas visitors charge for inpatient treatment which have been referred to a debt collection agency due to non-payment	Jul-22
Overseas Patient	28	1	Overseas visitors charge for inpatient treatment which have been referred to a debt collection agency due to non-payment	Sep-22
NHS South West London ICB	22	1	Recharge for non-contracted activity, query has been raised by customer as they believe the charges have been duplicated.	Jan-23
Overseas Patient	20	1	Overseas visitors charge for inpatient treatment which have been referred to a debt collection agency due to non-payment	Aug-22
Denbighshire County Council	20	1	Recharge for transformation grant. Council have disputed liability and this is now being dealt with by the Central IHC Finance Team.	Mar-20
Salary Overpayment	20	1	The employee repaid an initial £8,000 against this salary overpayment and agreed to set up a repayment plan for the remaining balance. As the initial instalment was never received, the invoice was referred to a debt collection agency for further action. The debtor has made an offer to repay the remaining balance over seven years, which has been rejected, and contact has been made to request an increase in the offer.	Mar-20
Pfizer Ltd	20	1	Recharge for high cost drugs. Pfizer have refused to pay as no PO was quoted on the invoice, the invoice has been referred to the Health Board's debt collection agency who are liaising with Pfizer's solicitors.	Mar-21
Salary Overpayment	20	1	The payroll department are investigating the overpayment, as the calculation could potentially be incorrect and a credit may be required.	Nov-21

Customer	£000's	Number of invoices	Analysis and further action	Date debt raised
NHS North East & North Cumbria ICB	19	1	Recharge for non-contracted activity. A part credit has been raised and payment is now awaited.	Feb-23
Private Patient	16	1	Charge for inpatient treatment, the invoice has been referred to the patient's insurance company.	Jun-22
The Walton Centre	15	1	Charge for radiology testing, a part credit has been raised, awaiting response if invoice can now be paid.	Apr-22
Salary Overpayment	14	1	Debtor has not responded despite numerous letters and reminders, if no response is received, the debt will be referred to a debt collection agency.	Jan-22
Salary Overpayment	12	1	Debtor has not responded to numerous chasing therefore the debt has been referred to a debt collection agency. The Health Board has now been advised that the debtor has entered into an Individual Voluntary Arrangement (IVA) and full recovery will be unlikely.	Sep-21
Salary Overpayment	11	1	Discussions are ongoing with the debtor who states they were not aware they were being overpaid at the time they received the salary. Certain benefits have been withdrawn due to the overpayment therefore talks are on-going.	Feb-23
Private Patient	10	1	Charge for chemotherapy drugs. The patient's insurance company have been contacted again and asked to make payment as a matter of urgency. There is a possible duplication of charges and a response is awaited from the income team.	Oct-20
Salary Overpayment	10	1	The debtor has not responded despite numerous letters and reminders and the debt has been referred to a debt collection agency who are trying to trace the debtor.	Nov-22
Salary Overpayment	10	1	An initial repayment plan that was agreed by Workforce and Organisation Development has ceased and the debt is therefore being referred back to WOD.	Mar-23

Note: English CCGs have been disestablished. New ICBs are legally responsible for their liabilities from July 2022.

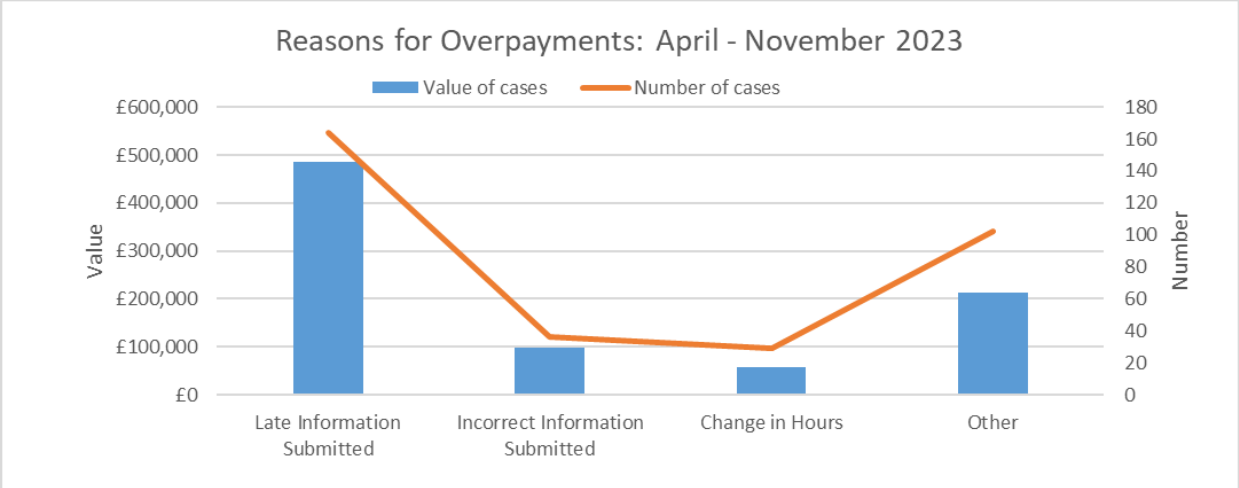
b) Staff Overpayments

The Health Board places great importance on the requirement for accuracy of payments made to staff, and is particularly concerned to ensure that staff are not under or overpaid. While underpayments should be detected reasonably promptly through staff action, there is a risk that overpayments can remain undetected over a period.

	2022/23 Jan - Mar	2023/24 Apr - Nov	2022/23 FYE
Number of Salary Overpayments	109	331	461
Value of Salary Overpayments	£0.233m	£0.853m	£0.671m

For the period April – November 2023 there were 331 staff overpayments, with a gross value of £0.853m.

Failure to complete forms on time remains the main cause of overpayments (164 cases). The reasons for the overpayments are detailed below.



Staff overpayment breaches are included in service/area monthly management reports and discussed as part of the budget monitoring process in order to improve future compliance.

Staff Overpayment Repayments

A robust and fair approach in the agreement of repayment periods is adopted to recover amounts as soon as possible, however, this can take a number of months especially where the error is attributed to the Health Board and immediate recovery would cause financial hardship.

As at 30th November 2023 the balance outstanding was £1.087m (31/03/2023 £0.948m). The debt, by collection stage, is detailed below:

	No. of Cases	% of Total Outstanding	Value of Total Outstanding
Agreed Instalment Plans	228	34%	£0.290m
Collection Agents	204	31%	£0.352m
In Dispute or Under Review	168	25%	£0.368m
Reminder Stage	33	5%	£0.68m
Invoice Stage	29	4%	£0.9m

The Health Board expects salary overpayments to be repaid either in a single amount or over the period that the overpayment occurred, with a maximum limit of six months. Where individual circumstances would not make this possible, consideration is given to longer repayment periods following completion of a household income and expenditure account. Repayment plans in excess of six months are reviewed with the debtor on a regular basis.

The extremely aged debts are there because either:

- Former organisations agreed the repayment plans or
- The HB is bound by legal orders applied on judgement or
- Senior officers agreed plans over the normal maximum repayment period of 36 months.

Section 3 - Conformance with Losses and Special Payments Procedures

Losses and special payments should be exceptional in nature and, where they do arise, are subject to additional scrutiny and reporting to the Audit Committee. The Health Board must administer losses in accordance with procedures set out by Welsh Government. Individual losses in excess of £50,000 require approval from the Welsh Government (£1,000,000 in the case of negligence claims).

The losses and special payments table below provides an overview of the losses incurred to November 2023. Clinical negligence claims account for the largest element of loss. Amounts in excess of £25,000 can be claimed from the Welsh Risk Pool Service in accordance with the risk pooling arrangements in place for NHS Wales. However, as the Welsh Risk Pool is funded from the NHS Wales healthcare budget these costs are still met by NHS Wales.

In common with the rest of the NHS, the Health Board has experienced an increase in the volume of claim activity within recent years and the table below provides information in relation to clinical negligence claims. Clinical negligence claims are managed by Legal and Risk Services and there were 285 active claims at the end of November 2023. Of these 122 matters were assessed as either probable or certain of settlement with a cumulative estimated value of £148m (before reimbursement from the Welsh Risk Pool). The table below shows the age profile of these claims.

57% of the caseload (163 matters) relate to claims in the early stages and whilst a significant number of these will be successfully defended, there are ongoing financial challenges. However, they are an indicator of future quality and require ongoing monitoring to ensure that any lessons are identified and actioned.

Year claim registered	No of claims
2023/24	26
2022/23	48
2021/22	50
2020/21	56
2019/20	51
2018/19	24
2017/18	8
2016/17	5
2015/16	5
2014/15	3
2013/14	1
2011/12	4
2010/11	1
2009/10	2
2008/09	1
Total claims	**285**

Losses and Special Payments

	Q4 22/23 £	Q1 23/24 £	Q2 23/24 £	Oct & Nov 23/24 £	Latest quarter analysis and further action
Medical Negligence					
Gross cost	2,378,506	6,304,445	3,352,279	3,666,560	
WRPS Reclaim	(1,983,851)	(5,823.346)	(3,008,695)	(3,271,473)	Payments were made on 249 cases, of which 42 came under the Redress Scheme.
Net Cost	394,655	481,099	343,584	395,087	
Personal Injury					
Gross cost	69,411	97.010	98,142	100,476	
WRPS Reclaim	(21,122)	(25.608)	(0)	(29,915)	Payments were made on 30 cases.
Net cost	48,289	74,402	98,142	70,561	
Loss of cash	200	1,000	0	570	Loss of cash from a patient's locker, the incident has been reported to the police and local counter fraud. Local counter fraud, finance and security will be visiting the ward to review the process.
Debtors written off	11,275	376	7430	0	Debtors are only written off as a last resort, after all means of collection have been exhausted. Debtors for Q3 are yet to be written off.
Loss or damage to equipment, property and stock	233,213	33,989	66,263	39,447	Relates to the loss of Pharmacy stock due to damage, breakages or expiry and obsolete stock written off. There are plans in place to improve this performance through introducing Pharmacy Automated Vending machines and aligning controls across the Health Board. A fridge failure resulted in the loss of £16k worth of vaccines reported in this figure.
Ex-gratia payments	179,027	19,154	23,076	15,266	Relates to 10 payments for loss/damage of patient's property and 6 ombudsman payments for delayed and unsatisfactory treatment.
VERS Payments	72,809	0	0	59,295	All payments are approved by the RATS Committee.
Total	**939,468**	**609,976**	**609,976**	**351,061**	

* The Welsh Risk Pool Service administers the risk pooling arrangement for negligence claims and reimburses amounts over £25,000.

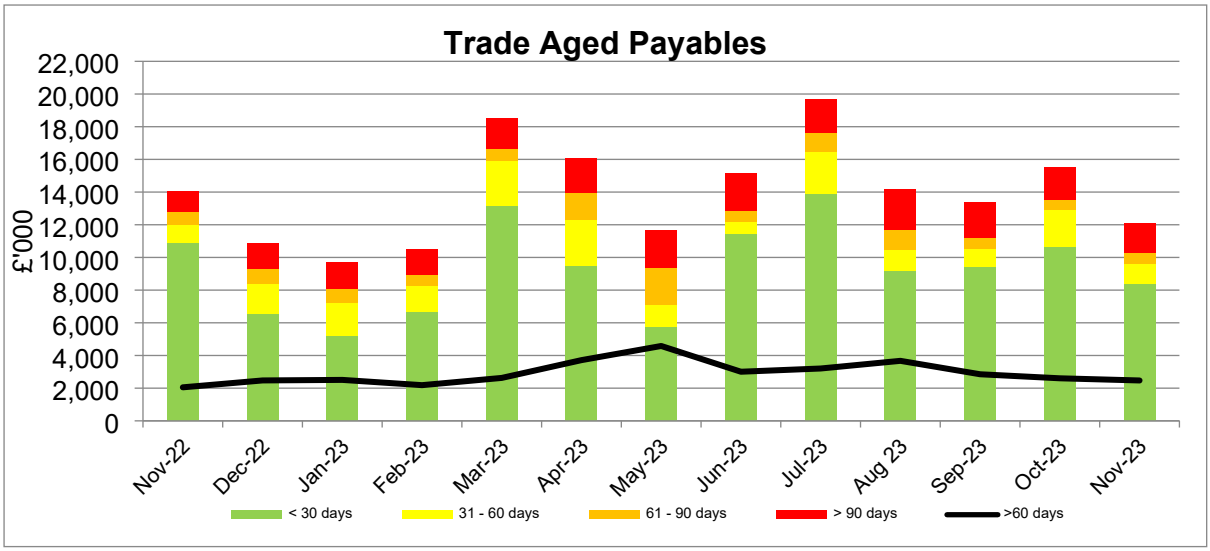
Section 4 - Conformance with Payable Procedures

PSPP Conformance

The Health Board aims to ensure that all balances are paid within a reasonable timeframe (or received for receivables), mainly within 30 days of receipt of a valid payable invoice (or issue of a receivables invoice). Best Practice of 95% (by number) is set for non-NHS invoices at 95%. The year-to-date (as at 30th November 23) achievement for non-NHS invoices by number is 94%.

High Value (£10,000 plus) Exceptions

The chart below provides an analysis of the trade payables by month.



The high-value (£10,000 plus) exceptions, over 6 months old, are listed in the table below. High value invoices are reviewed on a monthly basis and action is taken to resolve the disputes/queries.

Payable balances over 6 months old and over £10,000 as at 30th November 2023

Supplier	£000's	No of Invoices	Analysis and further action	Invoice Date
Flintshire County Council	127	1	The Head of Service has asked the Supplier as to confirm what services are being provided, awaiting response.	Mar-23
Linea Partners Ltd	118	8	Recharge for consultancy services - the Health Board is seeking legal advice as the contractual hours worked cannot be validated.	Jul 22 - Dec 22
Omnicell Ltd	103	2	Price queries raised with supplier, awaiting response.	Mar 22 & Jun 22
Medtronic Ltd	35	2	Supplier has been chased for a valid PO number, as PO quoted is incorrect.	Jan 23 & Mar 23
Anti-Ligature Shop Ltd	30	1	Work not fully complete, chased requisitioner for an update.	Apr 23
Johnson & Johnson Medical Ltd	24	1	Query over duplicate charges, credits have now been received, emailed Accounts Payable to see if these can now be paid.	Dec 22
Konica Minolta Business Solutions (UK) Ltd	12	1	Awaiting confirmation if invoice can be cancelled as it should have been paid via instalments.	Feb 23
Becton Dickson UK Ltd	12	1	Goods have not been received; supplier has been contacted to request a proof of delivery.	Sep 22
Wrexham University	11	1	Query raised regarding PO number, response awaited from requisitioner.	Mar-23
GN Hearing	11	1	Query raised with supplier as requisitioner has stated some items have been billed under a different invoice.	Nov 22

Appendix 1 - Approved Single Tender Waivers >£25K between 1st September – 30th November 2023

Ref No.	Date of Financial Approval	Area	Name of Supplier	Description	Rationale	Value	Supported By Procurement	Procurement Advice	Breached OJEU
2023/2024-1309	27/09/2023	IHC Centre (Area Team - Central)	IDOX	Lillie Patient Administration System for Sexual Health	Other (please specify) - Extension of existing Lillie contract is required as the contract is due to end on the 31st August 2023 and the service is unable to implement a new system prior to this date due to DDaT implementation timescales. The system will need to be upgraded from October 2023 to ensure continued access to support and maintenance, as V8 will be unsupported from 30.09.2023. Upgrade is included within costs below (Latest SBAR attached)	£26,103.66	Accept	Procurement can support this waiver as a procurement process for a new system has commenced with the All Wales Sourcing team. The Sexual Health team have ceased their own procurement for a new system until the AW solution is in place and this requirement is needed to ensure the continuation of service in the interim.	No
2023/2024-1332	06/09/2023	IHC West (Secondary Care - YG)	Mediteam	Agency Locum Consultant - Acute Medicine - YG	Other (please specify) - Off vend agency locum - have tried and failed to find on vend for this post. NB: this is to cover 1st October to 31st December 2023. ECR54181 awaiting approval for this period.	£75,600.00	Accept	This is a retrospective request consultant already in post and extension started. Procurement confirms this agency is not listed on any available frameworks; therefore, the only complaint route is either a Workforce recruitment exercise procurement or a waiver.	No
2023/2024-1340	28/09/2023	IHC West (Secondary Care - YG)	Royal National Institute for The Blind	Provision of an eye clinic liaison officer to support the Ophthalmic patients with sight loss. Crucial to the service and within the recommendations of the Royal College of Ophthalmologists meeting the AMD guidelines.	Genuinely one provider	£26,240.00	Accept	Original waiver 2023/2024-1252 rejected as Procurement could not support a 2-year period waiver where no market scoping had taken place and therefore suggested a 12-month agreement and during this time, a competitive process for a longer-term agreement is to be conducted.	No

Ref No.	Date of Financial Approval	Area	Name of Supplier	Description	Rationale	Value	Supported By Procurement	Procurement Advice	Breached OJEU
2023/2024-1342	27/09/2023	IHC Centre (Secondary Care - YGC)	FujiFilm UK Limited	Dell OptiPlex Radiology Reporting Workstation x 3	Genuinely one provider	£25,222.50	Accept	Procurement happy to support as FujiFilm are the only supplier. Machines need to be configured by FujiFilm prior to delivery and then additional applications to be added by BCUHB IT once delivered.	No
2023/2024-1345	06/09/2023	Secondary Care - Managed Clinical Support	Beckman Coulter Life Sciences	6 month extension to rental of Flow Cytometer and reagents for service continuity pending installation and commissioning of new equipment (delivered under BCU-OJEU-46049)	Interim arrangement pending tender	£88,745.69	Accept	Procurement support the use of a waiver as an appropriate route to market in this instance. A new contract has been awarded to another provider using a competitive tender, however, due to the time required to implement, this will not start until April 2024. It is not possible to award this extension via a compliant framework and as any new equipment would need to be validated before use an alternative provider is not practical, therefore a waiver is the appropriate route to market.	No
2023/2024-1348	15/09/2023	Secondary Care - Managed Clinical Support	LABORIE	Annual Maintenance of Image Processor & Cystoscopes Gynae Dept. in Wrexham Maelor & Ysbyty Gwynedd 01/09/23-21/08/24. The warranty has ended and no service contract was purchased when they were bought. EBME cannot maintain them.	Genuinely one provider	£25,017.30	Accept	Laborie are the OEM for this maintenance of equipment and have the necessary knowledge and expertise and access to spare parts, thus we are supporting this waiver.	No

Ref No.	Date of Financial Approval	Area	Name of Supplier	Description	Rationale	Value	Supported By Procurement	Procurement Advice	Breached OJEU
2023/2024-1352	02/10/2023	IHC East (Area Team - East)	Medi Team	Locum Consultant - N R - CAMHS remains in special measures, service see's our most vulnerable children &young people - essential post to ensure children are seen in time and managed appropriately.	Other (please specify) - Long standing recruitment issues to CAMHS Consultant posts, ongoing recruitment campaigns continue. Only provider with suitable candidate, ECR approved locum from August - end December	£83,187.20	Reject	This is a retrospective request; the consultant is already in post and extension started. Procurement confirms this agency is not listed on any available frameworks, for any future requirements the department will have to engage with procurement to perform a tender process.	No
2023/2024-1356	28/09/2023	Secondary Care - Managed Clinical Support	Werfern	Standing order for reagent to perform Immunology diagnostics. 6 month standing order to bridge gap whilst newly tendered equipment is implemented. Within budget allowance for diagnostic services.	Interim arrangement pending tender	£31,677.63	Accept	Procurement services support the use of a waiver in this instance as an interim solution whilst the new tendered Managed Service contract is implemented. There is no other compliant route to market to obtain the solution and therefore no other option is available.	No
2023/2024-1357	19/10/2023	IHC West (Area Team - West)	Medisure GPs	Agency GP	Follow on from previous waiver	£200,000.00	Reject	Procurement note that this request is retrospective and the post started on the 12th September. As this request is retrospective we are unable to influence the spend or confirm value for money through a competitive process. Procurement require the department to contact us ahead of organising agency posts so we can ensure the correct procedures & routes are been followed.	Yes

Ref No.	Date of Financial Approval	Area	Name of Supplier	Description	Rationale	Value	Supported By Procurement	Procurement Advice	Breached OJEU
2023/ 2024-1359	06/11/2023	Secondary Care - North Wales Cancer Services	Derwent Healthcare	Day chemotherapy treatment chairs The units had various chairs from various companies on trial and received patient feedback for them all. The clinical Teams and patient feedback on all other chairs trialled were not positive as regards to comfort and functionality. Comfortline2 therapy Chairs have been trialled for 12 months in the Alaw Day Unit for patients receiving chemotherapy treatment. The feedback from the clinical teams is that the chairs are good for patient cannulation and they have overall good functionality. The chairs that are in use have been extremely fit for purpose with positive feedback from patients. None of the other chairs provided the required specification for our patients.	Genuinely one provider	£46,920.00	Accept	Procurement supports this waiver on the basis that there are significant cost reductions by using this provider compared to framework pricing. There is saving of £416.71 per chair and a £5000.52 saving overall compared to the pricing available for alternative chairs available via the NHSSC framework. A further £1000 discount has been negotiated with the supplier. The Health Board are looking to standardise equipment across the acute sites moving away from beds to increase capacity for more patients to receive treatment. A trail was undertaken with various chairs from different providers and feedback provided by clinical teams was most positive for the ones provided from Derwent Healthcare as they best fit the specification required.	No

Ref No.	Date of Financial Approval	Area	Name of Supplier	Description	Rationale	Value	Supported By Procurement	Procurement Advice	Breached OJEU
2023/2024-1362	16/10/2023	IHC West (Area Team - West)	Pathway Software Ltd	Therapy Manager system - contract extension for 1 year from 1 April 2024 to 31 March 2025 Therapy Manager is the patient administration system/digital health record/diary management system used across BCU Therapies inpatients, outpatients and community with some 1500 users.	Genuinely one provider	£176,176.00	Accept	Procurement support this waiver on the basis that continuation of service is required whilst a replacement project takes place. Procurement are involved in the project board for a replacement system and have conducted an expression of interest market test for the Health Board. The replacement project is at options appraisal stage and therefore a tender would not be concluded in time ahead of the renewal. A VEAT notice has been published to notify the market that a contract is to be awarded with no competitive process. The Health Board have been using Pathway Software for the Therapy Manager Software since 2010 in such time a number of waivers have been submitted: STW.0562 – Oct'2010 STW.0691 – Mar'2011 STW.0714 - Mar'2011 STW.0939 – Feb'2012 2019/2020-157 – Mar'2020 2023/2024-1215 - Mar' 2023 Procurement advise that the Health Board need to move forward and complete the replacement project over the next 12 months ahead of the next renewal.	Yes

Ref No.	Date of Financial Approval	Area	Name of Supplier	Description	Rationale	Value	Supported By Procurement	Procurement Advice	Breached OJEU
2023/2024-1363	13/10/2023	Secondary Care - Managed Clinical Support	Clinisys ICE	ICE GP link system	Compatibility Issue (e.g. warranty cover clause or specific equipment)	£91,008.00	Accept	Procurement supports this waiver as an interim arrangement until the national system goes live for continuation of service. Previous waiver value approved was £36,410.87 and with this waiver the OJEU threshold will be exceeded therefore, a Voluntary Ex-Ante Transparency Notice will have to be published. As this is an embedded software, there is no viable alternative for support.	No

Appendix 2 - Approved Single Quote Waivers <£25K between 1st September – 30th November 2023

Ref No.	Date of Financial Approval	Area	Name of Supplier	Description	Rationale	Value	Supported By Procurement	Procurement Advice
2023/2024-1338	13/10/2023	IHC Centre (Area Team - Central)	VERTEC SCIENTIFIC LTD	SERVICE CONTRACT	Maintenance	£9,300.00	Accept	The Dexa Bone Densitometer is manufactured by Hologic and Vertec Scientific Limited have been appointed Hologic's UK Partner for the sale and servicing of such equipment. As the original equipment manufacturers agents, the above company has the technical knowledge and expertise to service the equipment in accordance with operating recommendations and instructions and can supply replacement parts, software updates and application support to enable the efficient operation of the equipment. Two days operator training are also included in the contract offering. It should be noted that a contract was let with a third party service provider for a similar model system in another health board many years ago and a range of problems were experienced in relation to engineer expertise which resulted in the involvement of Professor W D Evans, Head of Medical Physics and Clinical Engineering at Cardiff and Vale University Health Board. The contract was subsequently terminated and since this time, all Hologic bone densitometers used in NHS Wales have been serviced by Vertec Scientific Limited. For the above reasons the Waiver request is fully supported.

Teitl adroddiad: ***Report title:***	Update on Internal and External Audit Recommendations (Tracker Tool)			
Adrodd i: ***Report to:***	Audit Committee			
Dyddiad y Cyfarfod: ***Date of Meeting:***	12th January 2024			
Crynodeb Gweithredol: ***Executive Summary:***	The purpose of this report is to provide the Audit Committee with an update regarding the Health Board's position in the implementation of Internal Audit and External Audit recommendations.			
Argymhellion: ***Recommendations:***	The Committee is asked; • to note the current position (January 2024) of overdue audit recommendations. • take assurance that the Health Board has an appropriate tracking and reporting system in response to audit recommendations. • to consider proposed recommendations for closure.			
Arweinydd Gweithredol: ***Executive Lead:***	Acting Board Secretary, Phil Meakin			
Awdur yr Adroddiad: ***Report Author:***	Regional Risk Manager, Brenda Greenslade			
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:***				
Whilst there remain a number of recommendations that are significant and overdue, the Office of the Board Secretary (OBS) has more recently developed a **resourced system** to ensure detailed responses are collated, recorded and that agreements have been made that an update on actions. Guidance and support is provided to all recommendation 'Owners' and the final approval / signing off of				

recommendations is executed via the relevant Executive Director. Not all recommendations have been updated by leads or reviewed by Executives. A seperate appendix 4, was produced for oustanding updates.	
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:***	Compliance with Internal and External Audit requirements.
Yn unol â WP7, a oedd EqlA yn angenrheidiol ac a gafodd ei gynnal? ***In accordance with WP7 has an EqlA been identified as necessary and undertaken?***	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)***	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***	N/A 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***	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***	All 'Status Updates' are reviewed by the OBS well in advance (approx one month prior to the committee meeting) and an interim report is produced for each Executive detailing all of their outstanding recommendations. Status Updates that provide insufficient detail or that do not fully address the recommendation are flagged to the Board Secretary and the relevant Executive. The OBS then works with relevant leads to review and update. However, there may be some instances whereby the OBS is unable to contact relevant leads (absence / staffing / capacity etc.) and an up to date Status Update cannot be obtained. Recommendations all reviewed by individual Executives

Cysylltiadau â risgiau BAF: (neu gysylltiadau â'r Gofrestr Risg Gorfforaethol) ***Links to BAF risks:*** *(or links to the Corporate Risk Register)*	N/A other than those relating to individual audit reviews / recommendations
Rheswm dros gyflwyno adroddiad i fwrdd cyfrinachol (lle bo'n berthnasol) ***Reason for submission of report to confidential board (where relevant)***	
Camau Nesaf: **Gweithredu argymhellion** ***Next Steps:*** ***Implementation of recommendations*** The Tracker is presented to each quarterly meeting of the Audit Committee. The OBS continues to provide support and advice for recommendation owners / leads.	
Rhestr o Atodiadau: ***List of Appendices:*** • Appendix 1: Audit Tracker - Proposed recommendations for Closure by Executives • Appendix 2: Audit Tracker - Overdue Open Internal Audit recommendations • Appendix 3: Audit Tracker - Overdue Open External Audit recommendations • Appendix 4: Audit Tracker - Recommendations Awaiting Updates	

Key

Pending =Recommendation not due yet
Started= Recommendation actions have commenced
Marked as Implemented by Owner=Suggested as ready for closure by lead but not yet signed off by Executive
Final client approval= Recommended for closure by Executive and awaiting Committee endorsement
Awaiting Updates=Awaiting a recent progress update (requested monthly at present) by the lead

Introduction/Background

This report details the status of internal and external audit recommendations over the past six years, which are overdue high priority yet, still noted as incomplete.

All 'started' recommendations detailed below are overdue (Total=75)

Body of Report

External Audit recommendations

Reference	Recommendation Title	Assurance Rating	Audit Recs Made (Priority)			Audit Recs Implemented			Audit Recs Overdue (Agreed Timescale)			All Audit Recs Implemented
			H	M	L	H	M	L	H	M	L	
209	CHC Training Programme	Reasonable	0	1	0	0	1	0				✓
210	CHC Service Delivery	Reasonable	1	0	0	0	0	0	1	0	0	×
211	Governance, Accountability and Performance	Reasonable	1	0	0	1	0	0				✓
221	Recommendation 2 - Resources and Skills	Reasonable	0	0	1	0	0	1				✓
222	Recommendation 2 - Fraud Risks	Reasonable	0	1	0	0	1	0				✓
225	R3 - Audit Wales Structured Assessment 2020	Not Rated	1	0	0	1	0	0				✓
230	R1b - Structured Assessment (Phase 2) 2021	Not Rated	1	0	0	0	0	0	1	0	0	×
244	R1 - Structured Assessment 2019	Not Rated	1	0	0	0	0	0	1	0	0	×
245	R5 - Structured Assessment 2019	Not Rated	1	0	0	1	0	0				✓

There are 9 external audit recommendations. Six recommendations are recommended for closure and three remain open (started). Please see appendix 3, Audit Tracker - Open external audit recommendations.

Internal Audit Recommendations

There are 142 internal audit recommendations in total.
The full list of recommendations proposed for closure by Executives is in Appendix 1, and all open internal audit recommendations are in Appendix 2.

(Please note that the sub-categories of the overarching recommendations have been aggregated in data below and further details available in appendices.

Between 2017 and 2020 there are 2 internal audit recommendations on the tracker, both of which are high priority, with one proposed for closure and one open.

Reference	Recommendation Title	Assurance Rating	Audit Recs Made (Priority)			Audit Recs Implemented			Audit Recs Overdue (Agreed Timescale)			All Audit Recs Implemented
			H	M	L	H	M	L	H	M	L	
243	R1	Not Rated	1	0	0	0	1	0	0	0	0	✓
57	Reporting progress of Quality Improvement Strategy (QIS)	Limited	1	0	0	0	0	0	1	0	0	×

In 2021, there were 7 internal audit recommendations on the tracker, 4 high priority, one of which is proposed for closure and 3 open. 3 medium priority, 1 proposed for closure and two are open.

Reference	Recommendation Title	Assurance Rating	Audit Recs Made (Priority)			Audit Recs Implemented			Audit Recs Overdue (Agreed Timescale)		
			H	M	L	H	M	L	H	M	L
226-228	Continuing Healthcare Arrangements	Not Rated	3	0	0	1	0	0	2	0	0
72-73	Performance measure reporting to the Board – A	Reasonable	0	2	0	0	1	0	0	1	0
146-147	Women's Services Division – Sustainability of se	Reasonable	1	1	0	0	0	0	1	1	0

In 2022, there were 44 internal audit recommendations:

- 30 high priority, 11 of which are now proposed for closure, 18 started and 1 pending (not yet due).
- 13 medium priority, 6 of which are now proposed for closure and 7 started.
- 1 low priority recommendation proposed for closure.

Reference	Recommendation Title	Assurance Rating	Audit Recs Made (Priority)			Audit Recs Implemented			Audit Recs Overdue (Agreed Timescale)		
			H	M	L	H	M	L	H	M	L
59	Risk Management	Reasonable	0	1	0	0	1	0			
111	Impact Assessments	Reasonable	0	1	0	0	1	0			
114 - 118	Standards of Business Conduct: Declarations	Limited	3	2	0	0	0	0	3	2	0
119	Integrated Service Boards (ISB)	Limited	1	0	0	1	0	0			
120,121	Budgetary Control & Financial Reporting, includin	Reasonable	0	1	1	0	1	1			
123	Procurement & Tendering	Reasonable	0	1	0	0	0	0	0	1	0
127	Clinical Audit	Limited	0	1	0	0	1	0			
148,149	Employment of Medical Locum Doctors	Reasonable	1	1	0	0	0	0	1	1	0
150-152	Roster management	Limited	2	1	0	0	0	0	2	1	0
154,155	Establishment control – Leaver management	Limited	1	1	0	0	0	0	1	1	0
158 - 161	On-Call arrangements	Limited	4	0	0	0	0	0	4	0	0
165	Waste Management	Reasonable	0	1	0	0	1	0			
167	Speak out Safely	Reasonable	0	1	0	0	1	0			
170	Comisiynydd y Gymraeg/Welsh Language Comm	Limited	1	0	0	0	1	0			
173	Effective Governance: YWM	Limited	1	0	0	0	0	0	1	0	0
178	Effective Governance: YG	Limited	1	0	0	1	0	0			
183,185	Board and committee reporting	Limited	2	0	0	0	0	0	2	0	0
188	Chairs Action	Reasonable	0	1	0	0	0	0	0	1	0
235,240,241	Review of Eye Care Services	Not Rated	3	0	0	0	0	0	3	0	0
248	Recruitment of Substansive and Interim Executive and Senior Posts (ESP)	Limited	1	0	0	1	0	0			
308,309, 311-316	Waiting List Management	Limited	8	0	0	6	0	0	2	0	0
302, 305	Falls Management	Limited	2	0	0	2	0	0			

In 2023, there are 76 internal audit recommendations on the tracker:

- 52 high priority, 19 of which are proposed for closure, 1 marked as implemented by owner (not yet approved by Exec), 5 pending and 27 open.
- 24 medium priority recommendations, 11 proposed for closure, 3 marked as implemented by owner, 1 pending and 9 open.

Reference	Recommendation Title	Assurance Rating	Audit Recs Made (Priority)			Audit Recs Implemented			Audit Recs Overdue (Agreed Timescale)			All Audit Recs Implemented
			H	M	L	H	M	L	H	M	L	
169	Comisiynydd y Gymraeg/Welsh Language Comm	Limited	1	0	0	0	0	0	1	0	0	×
172,175	Effective Governance: YWM	Limited	2	0	0	1	0	0	1	0	0	×
184,186	Board and committee reporting	Limited	2	0	0	0	0	0	2	0	0	×
187,189,190	Chairs Action	Reasonable	1	2	0	0	1	0	1	1	0	×
193-6,198,19	Charitable Funds	Limited	4	2	0	2	0	0	2	2	0	×
202,203	Delivery of HB Savings	Limited	2	0	0	1	0	0	1	0	0	×
204	Management of Utilities	Substantial	0	1	0	0	1	0				✓
205-208	MH&LD	Reasonable	3	1	0	2	0	0	1	1	0	×
212	Digital strategy	Reasonable	1	0	0	1	0	0				✓
215,216	USC: Urgent Primary Care Centres - Business c	Limited	0	2	0	0	1	0	0	1	0	×
219	Public Health - Smoke free sites	Reasonable	1	0	0	1	0	0				✓
238	Review of Eye Care Services	Not Rated	1	0	0	0	0	0	1	0	0	×
246	Financial Control – Receipting of goods and year-	Reasonable	1	0	0	1	0	0				✓
247-249	Recruitment of Substantive and Interim Executive	Limited	3	0	0	2	0	0	1	0	0	×
250-254	Risk Management & Board Assurance Framewo	Limited	4	1	0	2	1	0	2	0	0	×
256,257	Planned Care Recovery & Transformation Group	Limited	2	0	0	0	0	0	2	0	0	×
258-260	Data analysis – Triangulation of data	Limited	3	0	0	0	0	0	3	0	0	×
261,262,264 265	Contracted Patient Services: Quality and Safety A	Limited	4	0	0	0	0	0	4	0	0	×
269,270	Performance Management – Quality and Perform	Limited	2	0	0	1	0	0	1	0	0	×
271,272	Recruitment Improvement Review	Substantial	0	2	0	0	2	0				✓
273	Hergest Unit Notice of Contravention (NoC) Actio	Limited	1	0	0	0	0	0	1	0	0	×
274	Cyber Security	Substantial	0	1	0	0	1	0				✓
275,276	Accounts Receivable	Reasonable	1	1	0	1	0	0	0	1	0	×
277-279, 281	Clinical Audit – Tier 1 National Audits	Limited	2	4	0	2	4	0				✓
284-289	GP Out of Hours	Limited	2	4	0	0	0	0	2	4	0	×
290-294, 297,299,301, 303,304,306	Falls Management	Limited	8	3	0	2	0	0	6	3	0	
310	Waiting List Management	Limited	1	0	0	0	0	0	1	0	0	

There are currently 13 internal audit recommendations for 2024 thus far, 11 of which are high priority with 1 proposed for closure, 2 pending and 7 started.
2 medium priority recommendation, 1 proposed for closure and 1 pending.

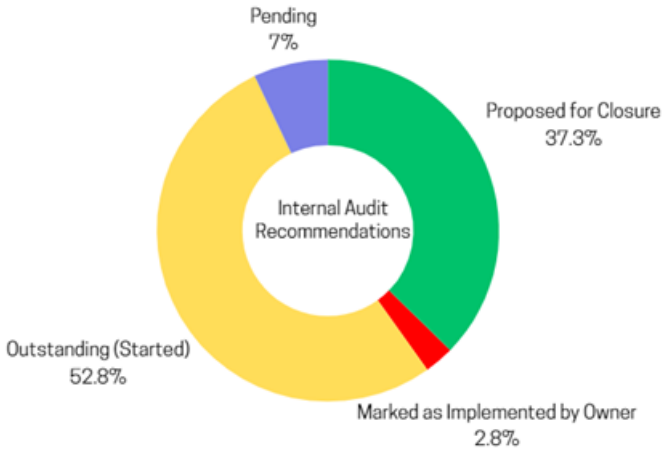
Reference	Recommendation Title	Assurance Rating	Audit Recs Made (Priority)			Audit Recs Implemented			Audit Recs Overdue (Agreed Timescale)			All Audit Recs Implemented
			H	M	L	H	M	L	H	M	L	
217,218	USC: Urgent Primary Care Centres - Business c	Limited	2	0	0	0	0	0				Pending 2024
220	Public Health - Smoke free sites	Reasonable	0	1	0	0	0	0				Pending 2024
263	Contracted Patient Services: Quality and Safety A	Limited	1	0	0	0	0	0				Pending 2024
266-268	Performance Management – Quality and Perform	Limited	2	1	0	0	1	0	0	0	0	Pending 2024
280	Clinical Audit – Tier 1 National Audits	Limited	1	0	0	1	0	0				✓
295,296,298, 300, 307	Falls Management	Limited	5	0	0	0	0	0				Pending 2024

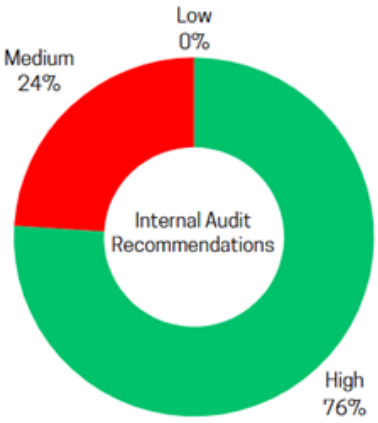
Outstanding Internal Audit Recommendations by Executive Lead

Executive		
Adele Gittoes	Interim Executive Director of Operations	20
Angela Wood	Executive Director of Nursing and Midwifery	19
Phil Meakin	Acting Board Secretary	14
Jason Brenan	Deputy Director of People	8
Russel Caldicott	Interim Executive Director of Finance	8
Chris Stockport	Executive Director Transformation and Strategic Planning	3
Ian Wilkie	Interim Director of MHLD	2
Teresa Owen	Executive Director of Public Health	1
Nick Lyons	Executive Medical Director	0
Dylan Roberts	Chief Digital and Information Officer	0
Total		**75**

Analysis

Internal Audit Recommendations:





Overall number of Internal Audit recommendations from 2017-2024 is 142

Total number proposed for closure by Executives is 53 (37.3%)
Total number open (started) is 75 (52.8%)
Total number pending (not yet due) is 10 (7%)
Total number marked as implemented by owner is 4 (2.8%)

Of the 75 open internal audit recommendations;

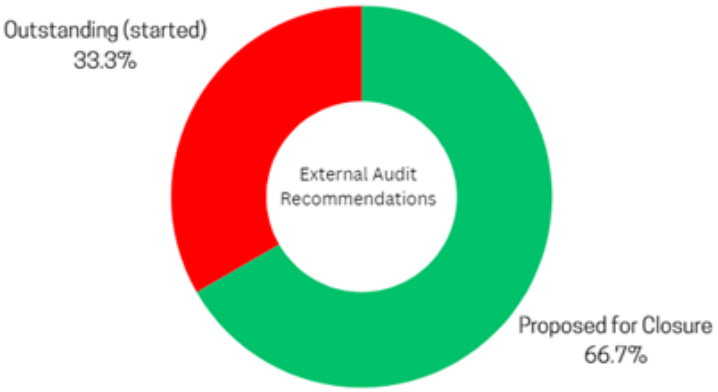
57 (76%) are high priority
18 (24%) are medium priority
All of which are overdue.

External Audit Recommendations:

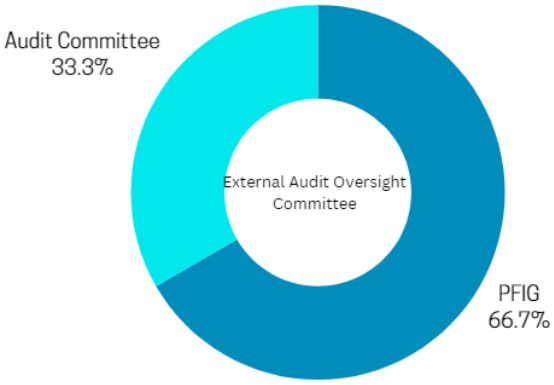
Overall number of External Audit recommendations from 2020 to 2023 is 9

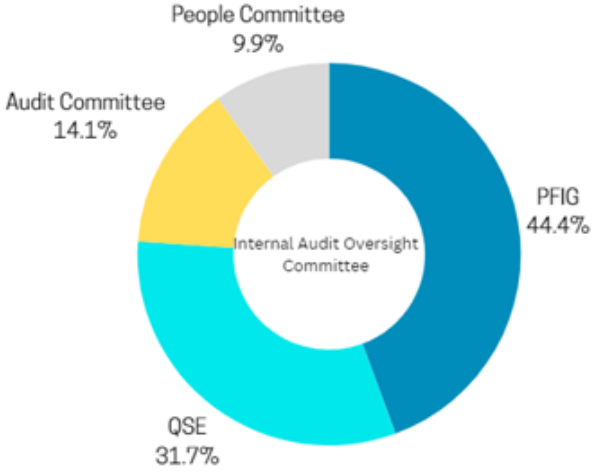
Total number proposed for closure is 6 (66.7%)
Total number open is 3 (33.3%)

All three of the outstanding external audit recommendations are high priority and overdue.



Recommendations categorised by oversight committees:





- A total of 26 recommendations, Appendix 4, responses from leads need further review and approval by the Interim Executive Director of Operations. This work is currently underway. However, 10 other recommendation updates aligned to the Interim Executive Director of Operations, relating to the Waiting List Management (9 recommendations) and one relating to the Structured Assessment 2019 have been updated and are included within the tracker.
- The Audit Committee will be updated with progress against the remaining 26 recommendations at the next Audit Committee in March 2024. On that occasion, the Audit Committee will receive the outstanding updates aligned to the Interim Executive Director of Operations only, with the complete tracker updated for the May 2024 Audit Committee as planned.

Governance Update of Tracking

Since the last Audit Committee in November 2023, work has been undertaken to develop and improve the tracker. Additional support has been provided the senior members of

OBS team to improving the structure and flow of the tracker, provide challenge around the quality of updates, and developing an internal Office of the Board Secretary quality assurance process. Work has also been undertaken on the formatting issues previously experienced with the tracker.

Following the loss of the tracking software, work has been undertaken to transfer the entire excel tracker (including those recommended for closure) on to a sharepoint site for robustness, efficiency and ease of access. This system will be fully embedded in March 2024.

The following are changes made in response to comments from the Audit Committee Chair:

- The original management response to the recommendation has now been included on the tracker, and follows the recommendation title and the recommendation itself.

- The audit year has also now been included on the tracker.

- The new process now includes three quality assurance checkpoints by the Office of the Board Secretary, with final approval by the Head of Risk Management.

- In relation to the process around recommendations put forward for closure where additional evidence to underpin closure is required, once received, this evidence is again reviewed by the team, and if not considered appropriate or sufficient, is challenged.

- In addition to the internal Office of the Board Secretary quality assurance process, every update provided by the action owner is referred to the final approval for review and approval, and once this approval is received, it is recorded on the tracker, and a copy of the approval saved on the Office of Board Secretary folder.

- At present, the closure evidence is available internally to the Office of the Board Secretary, and if the Audit Committee wishes to access this evidence going forward, samples can be made available for future meetings or on deep dives by Executives. Titles of evidence submitted will be requested for inclusion and reported going forward to improve the transparency of the evidence reviewed.

- The tracker appendix now shows the original implementation date, the latest revised implementation date, as well as the number of revisions since the original implementation date.

- Following audit tracker formatting issues at the last meeting, these have now been rectified.

- All recommendations have now been assigned to a committee so the tracker can be apportioned to a committee for oversight.

Conclusion

Out of the 151 recommendations there remain to be 60 high priority still open as opposed to 44 medium. However, 53 high recommendations are now proposed for closure and 24

medium by Executives. The majority of these are internal audit recommendations. Finance, Medical and Workforce in particular have progressed several of their recommendations for closure.

The majority of recommendations which remain open reside with Operations and Office of the Board Secretary. All responses have been reviewed and approved by Executives however 26 recommendations are outstanding and awaiting Executive sign off.

AUDIT COMMITTEE

AUDIT TRACKER - PROPOSED RECOMMENDATIONS FOR CLOSURE

ID	Committee	Internal Audit / Wales Audit Office	Report Title	Year	Assurance Level	Priority	Recommendation Title	Recommendation	Management Response	Last status updates (September and October)	Latest status update	Action Owner	Final Approver	Recommendation State	Original implementation date	Revised implementation date	Number of Revisions	Actual Implementation Date	Date Final approved	For closure consideration at next Audit Committee?	Date Audit Committee approved closure
59	Audit Committee	Internal Audit	Risk Management	2022	Reasonable	Medium	Strategic Objectives	The Health Board revisits its strategic priorities, setting objectives that are measurable by a set timeline. Further review of its completion to ensure aspects identified within the findings around risk appetite/target risk and controls etc.	The BAF continues to evolve with the engagement and support of the full Board. With the refresh of 'Byw'n iach, Aros yn iach/Living Healthier, Staying Well' and all underpinning strategies, the Board will need to ensure a greater focus and consideration of strategic risks in the BAF as the Health Board looks to the future in delivering its strategies. This will be undertaken during the course of the year, ensuring that clearly articulated and measurable objectives are set, for achievement within a specific timeline. A review of the risk appetite/target risk score was undertaken at a Board Workshop on 27th April and further review/refinement will continue linked to the refresh of 'Byw'n iach, Aros yn iach/Living Healthier, Staying Well' as we move through the year.	Progress update required from Board Secretary and CEO - to be discussed at ET 08/11/2023.	The Executive Team and Committee members are sighted on the current version of the Board Assurance Framework which is aligned to Strategic Priorities in the Annual Plan and have taken the action to review the Health Board's Objectives. This work will start in Feb 24 and the Board Assurance Framework risks will be aligned to objectives. The Acting Board Secretary is proposing to close the action to reflect this update, but also to note that original action was 2022, and related to an earlier context, of which events have moved on.	Nesta Collingridge, Head of Risk Management	Phil Meakin, Interim Board Secretary	Final Client approved	31/03/2022	30/03/2024	2			Yes	
72	PFIG	Internal Audit	Performance measure reporting to the Board – Accuracy of information	2021	Reasonable	Medium	Reporting Accuracy	Whilst we recognise that first issue above was likely the result of a typing error, management must ensure that all data reported is accurate. To ensure consistency and transparency, changes to reporting methodology should be noted in the report and communicated to the reader.	Information reported to the Board in the Quality and Performance (Q&P) reports is currently extracted from a number of different data sources. Narrative to support the data is a combination of analysis by the Divisional/Programme leads and Performance Team Heads of Performance and Director of Performance. The current process is labour intensive and time consuming, the time between data being available and deadlines for producing the reports/completing the necessary internal governance clearance significantly limits the ability of the Performance Team to undertake quality assurance both in relation to the accuracy of the data included in each report as well as consistency between reports over time. The Board has requested the development of a new Integrated Quality and Performance Report (IQPR), this presents an opportunity to address the issues that are curtailing QA processes as well as to improve the content of the reports to ensure that the needs of the Board and subcommittees are met. Changes proposed include: Rationalising and automating the process of data collation and reporting - This will be supported by a process map of the current arrangements, which will enable the Health Board Informatics Team to develop a single performance data set. The Performance Team will work with the system developers in Informatics to harness Business Intelligence software with the aim of automating production of the 'front end' Board and Public facing reports. Once completed this new process should release Performance Team capacity to undertake detailed analysis of the information moving from performance reporting to performance monitoring and management, and should also provide more time to complete QA checks. Clear methodology for identifying areas of concern - The intention is to implement an assurance and risk scoring system that can be applied to each key metric (national and local) as well as the actions/outcomes identified in the Health Board Annual Plan. This will highlight the areas of greatest risk and/or lowest assurance which need to be brought to the attention of the Board. Additions and removals of items reported - Level of risk and assurance will change over time as a result of external factors as well as action taken by the service. The new IQPR will require a more dynamic approach to the items reported. It is recognised that the reasons for additions/removal of items from the report need to be open and transparent. It is intended that the new IQPR and the current reports, which will need to continue until the new report is in place will include a section where additions, removals and reasons for these changes are recorded. With regards to the development of the new IQPR, a Board workshop session took place on 27th April 2021 to discuss requirements. A plan comprising report specification and timescale will be produced for consideration by the CEO, Chairman and Executive Team in June 2021.	In line with the development of the IQPR, a further Board workshop has been held to explore the requirements of Committee Chairs in terms of assurance levels with reporting. As a result of these discussons, a proposed alternative dashboard has been developed which will be supported by a decision tree and supported via MS 365. This dashboard will be used to monitor performance via accountability meetings and narrative will be captured to support reporting into committees.	Additional assurance and evidence provided for closure: The implementation of the Integrated Performance Framework and the Integrated Performance Reports are well underway, having met in October and November 2023.	Edward Williams, Acting Director of Performance	Russell Caldicott, Interim Executive Director of Finance	Final Client approved	31/07/2021	31/12/2022	5		22/08/2023	Yes	
111	People Committee	Internal Audit	Impact Assessments	2022	Reasonable	Medium	Policies and Procedures	1.1a Health Board to clarify and document requirements regarding other Impact Assessments, and ensure information is embedded or signposted in key Health Board policy documentation (e.g. OBS1 Policy for the Management of Health Board Wide Policies, Procedures and other Written Control Documents, and F017 Policy for Revenue Business Case Development), and is accessible and visible to staff developing proposals / policies. Consideration should be given to an intranet page with the relevant resources and expertise signposted for staff. 1.1b Health Board to consider progressing and developing the Impact Assessment Gateway document for strategic and policy decisions including written control documents and development proposals to ensure statutory requirements are met.	The Office of the Board Secretary will review, develop and implement the Impact Assessment Screening Tool (IAST) in consultation with colleagues in strategy and planning, Equalities and other supporting functions. This review will take account of proportionality, recognising that some Impact Assessments are mandatory, some are of a technical nature (e.g. environmental impact assessments) and some are best practice. The review will also consider impact assessments that may become mandatory in the near future, such as the Health Impact Assessment, as well as being mindful of the principles of sustainable development contained within the Wellbeing of Future Generations Act. The review will also be further informed by the report of the Audit Wales review of Equality Impact Assessments across the Welsh public sector which commenced in October 2021 and for which the report is due in summer 2022. Once complete, associated key policies/documentation (Policy on Policies, Policy for Revenue Business Case Development etc.) will be updated to link back to the tool. The IAST will be uploaded to the Health Board's Policies and Procedures page on the staff intranet and can be linked back to from other key sites. The document will be subject to Health Board wide consultation (via the corporate bulletin, 'Draft documents for consultation intranet page' and targeted comms) and signed off by the Executive team.	The Integrated Assessment Screening Tool has been drafted in conjunction with relevant stakeholders/ corporate leads i.e. Equality Team, Welsh Language Team, Children's Services, Older Persons/Lead Nurse for Dementia, Safeguarding, Carers, Patient Experience, Finance and Transformation and Improvement Colleagues. The document is pending final review and comments with the Safeguarding Team and will then be sent on to Executives for final sign-off as per the Health Board's Policy on Policies. Following consideration the assessment is that a stand-alone intranet page is not necessary and would risk further confusion. Instead the IAST will be included on existing Equality/Policy/Business Planning intranet pages.	The tool is available on the Policies page on sharepoint and signposted to on the EqIA pages. A full review of how the tool has been taken up will need to be undertaken through the IHC People and Culture meetings and will form part of the Equality Maturity Matrix self-assessments scheduled for early 2024.	Ceri Harris, Head of Equality and Diversity	Jason Brannan, Deputy Director of People	Final Client approved	31/10/2022	31/03/2024	2	13/02/2023	30/08/2023	Yes	
119	Audit Committee	Internal Audit	Integrated Service Boards (ISB)	2022	Limited	High	ISB Governance Arrangements	The Health Board ensures Integrated Service Board governance arrangements are aligned with its own governance and planning frameworks, and is subject to regular review and scrutiny.	This action will be addressed as part of the review of the key documents supporting the embedding of the new Operating Model. These documents are the Scheme of Reserved Delegation development, the Performance and Accountability Framework, as well as the risk management policy	The revised Scheme of Delegation, together with the Risk Management Policy have been completed and were presented for sign off to the June Audit Committee. The revised Governance and Accountability Framework will be presented to the November Audit Committee. **October update** - The revised Scheme of Delegation, together with the Risk Management Framework have been completed and were signed off Sept 23. The revised Committee Framework will be presented to the November Audit Committee. Performance and Planning Frameworks were also approved.	All Frameworks have been approved at Board in September 2023. The Acting Board Secretary recognises that the new Operating Model has been implemented since this action was first put forward, therefore the context has now changed and been superceded by that implementation.	Nesta Collingridge, Head of Risk Management	Phil Meakin, Interim Board Secretary	Final Client approved	30/06/2022	30/09/2023	4		25/10/2023	Yes	
120	PFIG	Internal Audit	Budgetary Control and Financial Reporting, including COVID-19 financial governance	2021	Reasonable	Medium	Authorised Virements	Finance to ensure that effective manual processes are in place to ensure segregation of duties are being adhered to, including regular sampling of virements.	1) E-mail the Divisional Finance Teams to remind them of the importance of following due processes, with the process notes attached for information. (This action has already been carried out). 2) Sample 10% of virements on a month basis to test segregation of duties and authorisation of virements, calling CFO to account for any Breaches within their team.	Sampling of 10% of virements has been built into the regular monthly workflow processes, which incorporates calling CFOs to account for any breaches within their team.	Additional assurance and evidence provided for closure on sampling.	Michelle Jones, Head of Financial Reporting	Russell Caldicott, Interim Executive Director of Finance	Final Client approved	25/06/2022		0	08/06/2022	22/08/2023	Yes	
121	PFIG	Internal Audit	Budgetary Control and Financial Reporting, including COVID-19 financial governance	2021	Reasonable	Low	Questionnaire responses	Finance to review the findings of the audit questionnaire, and complete the planned rollout of divisional questionnaires commencing March 2022.	1) Finance to review the findings of the audit questionnaire and take on board any feedback. 2) Process for Divisional questionnaires to be sent out March 2022 onwards. This to be via a rolling process of 2 Divisions per month with a sample of 10-20 budget holders per Division. Feedback will be considered and steps taken to address any necessary actions which arise. (Questionnaires have been sent to a sample of budget holders in MH&LD & NWH Division in March and responses are currently being received and co-ordinated).	Questionnaire responses from the Audit questionnaires and the Finance questionnaires, where these have been received, have been reviewed.. As further responses are received these reviews will continue, and if necessary action plans to address any recurring themes will be drawn up.	Questionnaire feedback supplied for additional assurance and evidence provided for closure	Michelle Jones, Head of Financial Reporting	Russell Caldicott, Interim Executive Director of Finance	Final Client approved	24/06/2022		0	08/06/2022	22/08/2023	Yes	
127	QSE	Internal Audit	Clinical Audit	2022	Limited	Medium	Policy and process in place for clinical audit.	Review and update the policy and procedure document MD22, and include the governance structure within Appendix 1.	Management comment: Awaiting release of final operating model. The updated policy has been held in draft form, since September 2021, awaiting confirmation of the new organisation operating model and associated governance structures. The governance that underpins the new operating model, directly impacts on the roles and responsibilities embedded within the policy as well as providing necessary operational detail (included within the appendices). Agreed action - Subject to confirmation of the new operating model (and governance structure) in April 2022, the audit policy will be released for Health Board wide consultation May 2022, with view to agreement through Clinical Policies and Procedures Group (CPPG) / Clinical Effectiveness Group (CEG)/ Quality, Safety and Clinical Effectiveness (QSE) by September to accommodate Cycle of Business of these groups. The reviewed policy will outline all processes and current practice in relation to clinical audit activity within BCUHB and will reinforce its role within the quality framework in delivering quality improvement and quality control and will be formally communicated to staff.	The policy was approved at EDG (Quality) meeting. The remainder of the process to upload onto the Policies page on the intranet, and link to our Clinical Effectiveness webpage, and for the team to disseminate to local CEGs will now be implemented. **October update** - As referenced in Internal Audit report from October 2023 : 2.1 The Clinical Audit Policy and Procedure is available on the Health Board intranet site (BetsiNet). The QSE committee approved the latest version on 20 June 2023, and this was uploaded to BetsiNet on 6th July 2023. The document outlines the procedure for conducting clinical audits, including those required by the Welsh Government (Tier 1).	The Clinical Audit Policy has now been completed and ratified and uploaded on to the intranet after going through the relevant processes. The policy is on the Clinical Effectiveness page and promoted by the team each month in Local CEG meetings. We will be adopting of sharing direct to the IHC MDs on a monthly basis copying in HofCE and DEMD.	Joanne Shillingford, Head of Clinical Effectiveness	Nick Lyons, Executive Medical Director	Final Client approved	30/09/2022	30/04/2023	5	20/04/2023	08/08/2023	Yes	
165	PFIG	Internal Audit	Waste Management	2022	Reasonable	Medium	Non-compliance with Covid-19 operating procedure	Recommendations agreed to increase compliance with the Covid-19 SOP should be progressed and reviewed regularly to ensure implementation.	Estates and Facilities will continue with support from Senior Infection Prevention Leads, to increase compliance with the Covid-19 Standard Operating Procedure which will be reported through Infection Prevention Sub-Group.	Return to business as usual for the management of waste is now in place following a number of discussions and sessions with clinical and nursing team across the Health Boards Acute and Community Hospitals. On target for implementation by the end of August Compliance with the COVID19 SOP has now been achieve with oversight and reporting through the Infection Prevention Sub-Group which reports to QSE.	Return to business as usual for the management of waste is now in place following a number of discussions and sessions with clinical and nursing team across the Health Boards Acute and Community Hospitals. On target for implementation by the end of August Compliance with the COVID19 SOP has now been achieve with oversight and reporting through the Infection Prevention Sub-Group which reports to QSE.November update: Meetings have now been held with the IHC's and areas with plans put in place and waste audit's carried out on three sites including central IHC, Mold and Bryn Beryl. Additional evidence of closure provided.	Richard Daniel, Interim Director Capital and Estates	Russell Caldicott, Interim Executive Director of Finance	Final Client approved	31/08/2022		0	20/09/2022	22/08/2023	Yes	

167	People Committee	Internal Audit	Speak out Safely	2022	Reasonable	Medium	MDT Process log	1.1a Dates to be added into progress log i.e. 'date recorded' 'date of review' to enable tracking of concerns to outcomes. 1.1b Attendance at MDT meetings to be recorded to demonstrate meetings are quorate.	1.1a To add in details of recommendations in 1.1a into the MDT process log (process log updated and provided for reference). 1.1b Full names of attendees at MDT meetings will be captured on the process log (process log updated and provided for reference)	MDT process log has been updated as per recommendations and reviewed by Ossama Lotfy from the Audit Team and signed off as meeting the required standard. Action completed.	A record of the 'date recorded' and 'date of review' and also that attendance at meetings are logged. Additional evidence of closure provided.	Gareth Evans, Senior Organisational Development Manager	Jason Brannan, Deputy Director of People	Final Client approved	30/11/2022		0	12/12/2022	30/08/2023	Yes	
170	QSE	Internal Audit	Comisiynydd y Gymraeg/Welsh Language Commissioner: Dogfennau ar y Gwefan/ Documents on the Website	2022	Limited	High	Compliance with Welsh Language Standards (No.7) Regulations 2018 (Standards 39-43)	2.1a The Health Board must comply with the requirements of the Welsh Language Standards and ensure that information published on its website is consistent on both Welsh and English platforms. Controls to be implemented to ensure that the Welsh language is treated no less favourably than the English language. 2.1b Digital Communications Team to address the issues identified and review the Welsh website regularly to ensure consistency with the English website.	2.1a In response to recommendations 1.1, 1.2 and 1.3 recommendations have been made to resolve the current risk of non-compliance. These include: Establish a formal policy and guidance to support the management of BCU digital channels, including the website. Review current administration access to the BCU website and issue revised guidance and training where required. Recruit a dedicated translator for the Corporate Communications Team to manage all translation requests for the website, which will ensure content is published simultaneously and ensure amendments or additions to the website are subject to review and scrutiny prior to publishing. 2.1b Issues identified with the audited web pages that are managed by the Corporate Communications Team have been resolved. 2.1b Recruit a dedicated translator for the Corporate Communications Team to ensure all new or amended content is published in Welsh and English simultaneously on the website. 2.1b Establish a regular programme of audits with the Welsh Language Team to monitor the website on a monthly basis. 2.1b The Board Secretary to review and resolve issues relating to the publication of inconsistent Board/Committee papers and bundles.	1. Controls implemented include: a. BCUHB Website and Social Media Content Management Protocol; b. List of editors reviewed/refreshed and subject to periodic review; c. New content translation managed by the Communications team, regular audits of new and/or amended pages conducted (noting that some of the pages are devolved responsibility, i.e. the OBS page). 2. Outstanding action relates to reviewing existing historical content. External support has been commissioned, review underway, expected completion date end of September. **October update** - a. BCUHB Website and Social Media Content Management Protocol – Activated and implemented 10th August 2023 Policies and Written Control Documents - COM 01 - BCUHB Website and Social Media Content Protocol.pdf - All Documents (sharepoint.com); b. List of editors reviewed/refreshed and subject to periodic review – Editor listing reviewed and updated, work is ongoing to monitor periodically – August 2023; c. New content translation managed by the Communications team, regular audits of new and/or amended pages conducted (noting that some of the pages are devolved responsibility, i.e. the OBS page). Regular audits are planned and are conducted. 2. Outstanding action relates to reviewing existing historical content. External support has been commissioned, review underway, expected completion date end of September.	The support from the external company is now complete, and this concludes the actions relating to this recommendation. The draft report has been received back from the Auditors to confirm all actions have been completed and no further actions is required. This recommendation can now be closed.	Andrew Rogers, Head of Corporate Communications	Teresa Owen, Executive Director of Public Health	Final Client approved	31/12/2022	30/09/2023	3			Yes	
189	Audit Committee	Internal Audit	Chairs action	2022	Reasonable	Medium	Information provided to members / committees	All Board/Committee members should have access to the information provided with the request to ensure transparency and further scrutiny.	Investigate a SharePoint site for Chair's Actions which will enable all Chair's Actions to be reviewed by all IMs should they wish to do so.	Recommendation has been delayed due to OBS staffing issues and board member changes .	The Office of the Board Secretary Review has now been received and the recommendations from that will be taken forward. The reason why this has been marked as complete is that the corporate governance report now contains a routine capture of all Chair's Actions.	Philippa Peake-Jones, Head of Corporate Office	Phil Meakin, Interim Board Secretary	Final Client approved	31/01/2023	29/02/2024	1			Yes	
193	PFIG	Internal Audit	Charitable Funds	2022	Limited	High	Information provided to the board	1.1 Induction information provided to Board Members - review and issue to all, to include responsibilities, key information and how they are provided with assurance on the operation of the Charity. 1.2 Review the content and frequency of information provided to Trustees, including: More frequent Board of Trustee meetings. More frequent performance reporting (financial and qualitative, such as achievement of goals and objectives, fundraising data, Charity team activity). Assurance provided on meeting requirements of the Charity Commission. Information on any changes to guidance and how these are being applied within the Charity.	1.1 All Trustees will be reminded of their role and responsibilities and the charity's performance and how to access this information in a Trustees meeting setting. Liaise with the Office of the Board Secretary to review and Charitable Funds information included in induction for Board Members. All Trustees will receive a monthly update from the Charity Support Team on: Information from the Charity Commission to maintain a good level of knowledge and understanding of the Commission's guidance and regulation, and the their role as a Board member of the Corporate Trustee Spotlight on a Fund and Fund Advisor, so they are aware of the responsibilities and actions of those who are charged with overseeing different funds on behalf of the Corporate Trustee: Updates on grants awarded and grant impact, Review of internal and external communications. 1.2 A review of the content and frequency of information provided to Trustees will be tabled at the Charitable Funds Committee for discussion and reviewed at the Trustee meeting.	COMPLETED: Charity induction information prepared for new Board members. Request for in person (or Teams) 15 minute session with CFC Chair / Head of Fundraising be included in induction been approved. Information on charity activity is included in the IM and Exec updates and regular communications are included on the Betsinet page.	Charity induction information prepared for new Board members. Request for in person (or Teams) 15 minute session with CFC Chair/Head of Fundraising be included in induction been approved. Information on charity activity is included in the IM & Exec updates and regular communications are included on the Betsinet page. The info for the IMs provided for handbook: included in the 30/03/2023 Trustees meeting and the intro sent to the CEO, for example. BetsiNet information regularly updated for Trustee Board to keep abreast of developments, and additional information regarding governance now included on Charitable Funds Committee webpage - additional evidence provided.	Kirsty Thomson, Head of Fundraising : Awyr Las	Russell Caldicott, Interim Executive Director of Finance	Final Client approved	31/01/2023		0	04/05/2023	22/08/2023	Yes	
199	PFIG	Internal Audit	Charitable Funds	2022	Limited	High	Charity Objectives	The wording of the Charity's objectives should be reviewed to ensure it accurately reflects the spend of the charity i.e. staff and wellbeing support initiatives.	The charity objectives will be updated to ensure clarity of purpose in the 2023-28 strategy, due to be presented for approval at the December 2022 Charitable Funds Committee meeting, and ratification at the January 2023 Trustees meeting. The objectives will then be updated on the Charity Commission website, intranet, internet and the BCUHB Charitable Funds webpage.	Whilst the new strategy has not yet been finalised, the charity's objectives have been updated on all internal and external communications platforms, as required.	Whilst the new strategy has not yet been finalised, the charity's objectives have been updated on all internal and external communications platforms, as required, and further information provided as evidence.	Kirsty Thomson, Head of Fundraising : Awyr Las	Russell Caldicott, Interim Executive Director of Finance	Final Client approved	31/01/2023		0	24/04/2023	22/08/2023	Yes	
202	PFIG	Internal Audit	Delivery of Health Board Savings	2023	Limited	High	Effective governance and oversight arrangements to deliver savings	The Health Board, through its Executive, review the governance and assurance structure in the delivery of savings schemes.	The targeted delivery of operational savings has been progressed within the Health Board and delivered for the 2023/24 financial year.	**October update** - The Savings Plan process, including the associated requirement guidance and templates has been fully refreshed in 2023/24 and has been issued as part of the 2024/25 Annual Plan process. All savings schemes need to have approval sign off from: • The Programme Board, which includes the Programme Sponsor and Programme Finance Lead • Operational Lead (this may be a Clinical Lead) and budget holder(s), if different. • The IHC/ Service Directors in the scope of the scheme • CFO('s) in the scope of the scheme All Savings are reported to Welsh Government through the Monthly Financial Monitoring Return signed off by the Executive Director of Finance and CEO. Executive Committee, PFIGC and Board receive regular reports on the Savings Plans and delivery. Performance is also discussed at the Integrated Delivery Group.	Further evidence relating to BCU savings reporting provided as assurance for closure.	Andrea Hughes, Interim Director of Finance	Russell Caldicott, Interim Executive Director of Finance	Final Client approved	30/04/2023		0		25/10/2023	Yes	
204	PFIG	Internal Audit	Management of Utilities	2022	Substantial	Medium	Health Board EFPMS performance	Management to identify what actions are required to reduce consumption in the sites identified in order to meet the all Wales KPI for net energy consumption. Where actions are already planned i.e. as part of the Decarbonisation Energy plan, this should be clearly stated.	Operational Estates are working in partnership with Local Partnerships, Welsh Government Energy Services and Re-Fit Cymru in developing a framework to deliver the Health Board's Decarbonisation Action Plan relevant to Buildings. The framework will look at opportunity to invest in self generating energy sources i.e. Solar PV and energy reduction project by upgrading existing engineering infrastructure i.e. LED Lighting, HVAC etc. The project will be delivered over 2 phases with an estimated completion date for the framework by 2030.	Re:fit programme approved to proceed to Invitation to Tender in PFIG which will appoint an Energy Performance Contractor to support the Health Board	The paper had been ratified and agreed at PFIG. Additional evidence provided, and action can be closed.	Arwel Hughes, Head of Operational Estates - Interim	Russell Caldicott, Interim Executive Director of Finance	Final Client approved	30/06/2023		0	30/06/2023	22/08/2023	Yes	
205	QSE	Internal Audit	MH&LD	2023	Reasonable	High	PADR Compliance and WARRN training	Further progression is needed in order to achieve the overall divisional completion target of 85%. Focus is necessary to increase the uptake of training within areas of the division	Divisional PADR compliance rates to be an Agenda item in all local Operational Delivery meetings, with focus on staff who have - Never had a PADR (as at 31 st January 35 Divisional staff recorded); Never has a PADR Starter (as at 31st January 43 Divisional staff recorded); Out of date 24+months (as at 31 st January 35 Divisional staff recorded); PADR completed but not recorded (as at 31st January 4% (n76) noted). To ensure the Division meets the target compliance of 85% by 31/5/2023. Business Support Managers to include a detailed analysis of area PADR compliance data in the monthly Performance reports presented at the appropriate local Operational Delivery meeting. Head of Operations to discuss PADR compliance rates during local area Operational Delivery meeting, identify any barriers and support needed to ensure compliance of 85% is met by 31/5/2023 across all their area/regional teams. Escalation reports completed from each local Operational Delivery meeting, to include PADR compliance rates, formally presented and reported into MH&LD Service Finance Performance Delivery Group meeting (formally DSLT Finance and Performance meeting, Tier 2) to monitor and review progress. The Divisional Key Performance Indicators aligned to PADR to be scrutinised and any additional intervention discussed and agreed for areas under achieving. Reaffirm importance of and recording of PADRs within the MH&LD Staff Briefing. Include monthly PADR compliance rates in the Divisional Improvement Plan KPI data to show trajectory of improvement. WARRN TRAINING. Identify and book alternative accommodation to enable WARRN training sessions to accommodate 25 staff, instead of current 15 staff, to enable an increase in numbers of staff trained each month in order to increase training compliance from 62.5% to 85% by 30/9/2023. Provide monthly WARRN training compliance data, including analysis of individual area/department compliance, to HSE NOC Delivery Group meeting to enable monitoring, review and early identification of any barrier to delivery of meeting compliance target rate of 85% by 30/9/2023. Continue with delivery of twice monthly WARRN training sessions to ensure an additional 200 divisional staff complete WARRN training to meet 85% compliance. Set up a process to ensure new starters in the MH&LD Division are included in the monthly WARRN training sessions.	MH&LD Divisional PADR compliance report recording 85% PADR compliance across the Division. Report presented and shared at Operational Leadership Meeting and will be shared at the forthcoming Service People and Culture meeting due to be held on 3/7/23. PADR Compliance report attached. Update on WARRN training - MH&LD Divisional WARRN training compliance at 81% up to 18/6/23. WARRN training compliance report attached. Twice monthly training course continue to be held. MH&LD Divisional PADR compliance rate at 85% for two consecutive months (April 23 and May 23). Report attached as evidence. Action completed.	MH&LD Divisional PADR compliance remains above 85%, with October compliance recorded at 86.79%. MH&LD Divisional PADR compliance is presented at the MH&LD Service, People and Culture meeting, latest PADR report and Agenda embedded below. In addition PADR compliance is included in all local area Performance reports (embedded below) with Exception reports presented in MH&LD Divisional Finance and Performance meetings.	Adrianne Jones, MH&LD Operational Business Lead	Iain Wilkie, Interim Director MHLD	Final Client approved	30/04/2023		0	26/06/2023	31/08/2023	Yes	

208	QSE	Internal Audit	MH&LD	2023	Reasonable	High	Ockenden Recommendations	Management to review recruitment arrangements and ensure there is a clear recruitment strategy and plan in place to addresses the vacancies within the division and ensure stability of the management.	Business Support Managers to include a detailed analysis of area vacancies in the monthly Performance reports presented at the appropriate local Operational Delivery meeting. Head of Operations to discuss vacancy details during local area Operational Delivery meeting to identify any barriers and support needed to ensure timely progress with all recruitment activity across all their area/regional teams. Escalation reports completed from each local Operational Delivery meeting, to include vacancy levels, formally presented and reported into MH&LD Service Finance Performance Delivery Group meeting to monitor and review progress, to include deep dive analysis of vacancy data to enable understanding of current position and agreed plans to progress with vacancy reduction across the Division. The Divisional vacancy details scrutinised and any additional intervention discussed and agreed for areas with high number of vacancies. Divisional Accountability meetings with each area to be stood up to support the additional scrutiny and interventions required to vacancy position, recruitment processes and accuracy of data. Provide ongoing progress of the Just R Marketing campaign within the MH&LD Staff Briefing. Discussion of monthly Divisional Vacancy and Recruitment report at MH&LD Service People and Culture Delivery Group meeting. On-going progress with Just R Marketing campaign, talent pool process and further development of innovative approaches to address the number of vacancies across the Division. Creation of Quarterly report which will be presented at Operational Leadership Meeting (OLM) feeding into MH&LD Senior Leadership Team meeting to show impact and outcomes of the Just R Marketing campaign, to discuss and agree any further plans to address current vacancies across the Division. Ongoing progress and delivery of actions included in the Wellness, Work and Us Year 3 plan aligned to staff recruitment and retention, with creation of 36 month report to show impact, outcomes and recommendations aligned to addressing staff recruitment and retention. Continued monitor and review of Workforce work stream programme plan, recording and reporting impacts and outcomes of delivery. Development of a MH&LD Recruitment and Retention Strategy to ensure short, medium and long term focus on workforce recruitment and retention across all staff group within the Division. Review of all interim posts across the Division. Discuss and agree a plan to progress with substantive appointment to posts aligned to the MH&LD Operating Model.	The draft MH&LD Recruitment and Retention Strategy/Plan has been signed off and actions are progressing. Quarterly updates will be provided to MH&LD divisional SLT. Whilst some senior interim positions remain, these are longer term thus provide a greater level of stability than short term appointments, and a plan is in place for permeant recruitment. Therefore the proposal is to close this action.	MH&LD Divisional Recruitment and Retention plan developed and approved through respective Governance routes (copy provided for evidence). This ensure the Division has a clear recruitment plan in place to addresses the vacancies within the division. Just R 12 month recruitment plan ended September 2023 with transition plan agreed for utilising BCHUB External website and Social Media to continue showcasing the Division with the inclusion of microsite, live vacancies and talent pool vacancies. This provides a mechanism to support recruitment activities, as is part of the MH&LD Divisional Recruitment and Retention plan. Impact report on the Just R Campaign to evidence return on investment presented at the MH&LD Service, People and Culture Group meeting, and additional evidence provided.	Adrianne Jones, MH&LD Operational Business Lead	Iain Wilkie, Interim Director MHLD	Final Client approved	30/06/2023		0		31/08/2023	Yes	
209	PFIG	Wales Audit Office	Audit Wales CHC follow-up	2022	Reasonable	Medium	Continuing Health Care (CHC) Training Programme	The CHC Team, working with colleagues in Health Communities/Divisions/Pan-North Wales services agree a method to capture training needs analysis information upon which directed training can be planned and delivered.	Complete Learning Needs Analysis to identify training requirements and support the basis for planning further training activities, education approaches and methods; Learning Needs Analysis will expand on the Education Strategy and be coordinated through the CHC Strategic Joint Education Group (with LA partners). Mapping of training will capture relating framework, such as 117 aftercare. Innovative approaches to be considered and agreed (for CHC and Broadcare training) include multi-choice quizzes at the end of training modules, training videos, online feedback, Webinars, BetsiNet Newsfeed; continue to work with ESR to further develop accessible electronic CHC training modules; Improved data collection through group discussions, training needs assessment questionnaires/rolling review of feedback forms and surveys, skills and knowledge analysis, observations from lessons learned; Develop CHC Competency Framework by end of March 2023 with ambition to implement summer of 2023. CHC covers a diverse and specialised range of skills and the Framework will identify skills and knowledge required; Explore training appraisals within PADRs and make recommendations to the operational teams for implementation. Implement training module to communicate Lessons Learned from Appeals and Retrospective Claims to the wider Health and Social Care system; coordinate through the CHC Strategic Joint Education Group; Share training attendance registers with operational line managers across the wider Health Board to address any issues of non-attendance and develop an action plan; Embed CHC Foundation module into core 'business as usual' training as part of the 2023 rolling training programme; the Foundation module will be delivered on a monthly basis from January 2023 and publicised via the BetsiNet CHC page and via the CHC Strategic Joint Education Group.	Training has been prioritised during 2023. This includes shifting the perspective on CHC training to consider it as a core business activity rather than a 'nice-to-have'. TNA approach taken and resources developed in line with this; strategic goals defined; required skills and knowledge outlined; current skills evaluated; performance gaps identified; generic and bespoke sessions implemented. 2024 rolling programme being finalised and modules being updated in light of new D2RA pathways and feedback; All the above have supported establishing training needs. Incremental approach to competency framework adopted; first phase pre and post training self-assessment competency questionnaire implemented (it remains that learners need considerable coaxing to complete and this is an ongoing challenge with creative approaches being adopted); lessons learned module being finalised for roll out 2024; training attendance data is shared with IHC's and LA's; strategic joint education group with 6 NW LA partners continues and attendance at joint QAF Education, Training and Support Working Group secured (from October 23); CHC training reintroduced at Glyndwr and Bangor Universities post-Covid. **October update** - Revised Imp Date: 01/09/2023.	Confirmation that this item has been signed off following implementation of above listed actions. This item has also been signed off as a previous corporate risk. This recommendation can therefore be closed.	Jane Trowman, Head of Strategy and Health Planning	Chris Stockport, Executive Director Transformation and Strategic Planning	Final Client approved	31/03/2023	01/09/2023	1		28/11/2023	Yes	
211	PFIG	Wales Audit Office	Audit Wales CHC follow-up	2022	Reasonable	High	Governance, accountability and performance	The Health Board review the governance and accountability arrangements for CHC which brings together people, quality, performance and financial information.	Continuation of Contracts and Finance reports to PFIG. Continuation of Quality Assurance Framework update to Regional Commissioning Board and Regional Partnership Board. CHC reporting structures (Quality, Finance, and Performance) will be reviewed and there will be a recommendation made to the Executive team regarding a proposed governance and reporting structure for CHC. This will include a proposal that there is Executive Board agreement regarding the Exec lead for CHC, in line with the new Operating model. It will also help to formalise reporting, ensuring a quarterly report goes to a sub-group of the Board. Terms of Reference for CHC/Care Home Quality and Commissioning Group (SMT) will be reviewed. This will strengthen SMT membership in line with recent changes and establishment of IHCs. Further work will be carried out to align the IHC and corporate risk registers. The updated corporate risk register will then be issued for Executive sign-off. The CHC Operations Group TOR will be reviewed to ensure there is a strategic focus, as operational items are included in the Case Management Group remit.	Contracts and Finance reports to PFIG and QAF update to Regional Commissioning Board and Regional Partnership Board continues (complete). Corporate CHC will remain with Executive Director Transformation And Strategic Planning, and Commissioning with Finance and Contracts (complete). Revised ToR were approved at January 10th SMT meeting and circulated post meeting. Following this an updated meeting agenda, membership and reporting format has been introduced for Sept 5th SMT. (complete) IHC and corporate risk registers aligned. This will be part of monthly review in line with corporate risk register requirements. (complete) ToR updated and included in June CHC Ops Chair's report for SMT 04.07.23. The Agenda/reporting format will be reviewed in line with updated SMT Agenda introduced Sept 2023. (complete) **October update** - SMT Agenda re-focused Sept 2023 in line with Special Measures requirements and is focused on 3 elements; Safety and Quality, Performance & Finance and Contracting. A consolidated update is issued 1 week after SMT that can be used for information/update/escalation within corporate, IHCs and divisions. Revised Imp Date set to 30/09/2023	Action complete, and can be closed. Additional evidence provided as latest SMT update.	Jane Trowman, Head of Strategy and Health Planning	Chris Stockport, Executive Director Transformation and Strategic Planning	Final Client approved	31/03/2023	30/09/2023	1		28/11/2023	Yes	
212	PFIG	Internal Audit	Digital strategy	2023	Reasonable	High	Funding the implementation of the Digital Strategy	The Chief Digital and Information Officer, working with Finance colleagues: • identifies the costs associated in implementing the digital strategy. • ensures the budget report accurately reflects the funded establishment. • where funding is not available, the risks associated with cessation of the project is evaluated and formally reported to Committee.	Following the outcome of the IMTP and Capital submissions a plan the Digital Strategy year 23/24 plan will be reviewed and appropriate funding aligned, with a report to PPPH that includes the details about unfunded projects and the risks association with stopping those. Identify cost pressures and re-charges not currently within budget and establish the overarching budget baseline for 23/24.	A full review of the DDaT Budget has been undertaken and many previous cost pressures for 2022/23 have been funded. The DDaT IMTP submission has not been funded due to constraints across the Health Board. Some of the national projects and programmes did come with funding and some have brought additional pressures to the Health Board. A list of unfunded projects and the risks associated with non-delivery has been developed and is in the process of being reported to the PPPH Committee when it starts again. The costs of delivering the entirety of current Digital Strategy have not been fully quantified or funded and the risks associated with that are in the BAF with an accepted level of tolerance. 2.5. There is a risk that we won't achieve our strategic and operational objectives caused by having inadequate arrangements for the identification, commissioning and delivery of Digital, Data and Technology enabled change. 2.6 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. As a result DDaT are working on a re-baselining and revision of the Digital Strategy which following consultation will be ready in draft in early 2024.	The Chief Digital Information Officer has accepted this position as the Health Board are tolerating the risk which has been escalated to the Board and accepted. There is nothing further the Digital, Data and Technology Division can do to address this recommendation due to the Health Board's decision making in the current financial climate. Digital, Data and Technology Division will continue to put forward for all available funding in future years. Additional evidence provided for closure.	Andrea Williams, Head of Informatics Programmes Assurance and Improvement	Dylan Roberts, Chief Digital and Information Officer	Final Client approved	30/06/2023		0	30/06/2023	15/08/2023	Yes	
219	QSE	Internal Audit	Public Health - Smoke free sites	2023	Reasonable	High	Policy not up to date	Smoke free policy WP31 is progressed and agreed through the appropriate process as a matter of urgency to become compliant with legislation	Receive confirmation from the Board regarding position of smoking shelters across BCUHB in relation to legislation. Feedback to the WOD policy group on acknowledgment of their concerns and our position in line with legislation/ board decision and sign off. Once approved, submit policy to relevant approval groups for ratification. Once ratified, develop communications plan to promote revised policy across the organisation and add to BetsiNet policy pages. On-going review of management plan to ensure policy has been implemented. Review policy for any amendments regarding enforcement/compliance that develop throughout the year. Ensure BCUHB Smoke free Policy links with further policy development across each of the 3 acute hospital sites to support compliance with smoke-free legislation (including due diligence and reasonable steps). To include working with IHC's and Hospital Leads on developing, implementing and monitoring smoke-free hospital plans that support the wider BCUHB smoke free policy.	**October update** - Issue resolved around smoking shelters in relation to the policy and we will not be supporting smoking shelters across BCUHB premises. WP31 policy has been approved, signed off and has been disseminated and communicated across the health board. It is available via the workforce policy pages on Betsinet. A review of the policy will be made once all environmental officers have been employed and in place across the health board. PHW colleagues are working with the IHCs to implement a management plan in support of the policy. October 2023 - Item to be marked as green/completed, as the Smoke-free Policy has now been updated and approved through the relevant process, also with dissemination and comms taking place. The remaining work regards ensuring compliance of the Policy and it's review will be ongoing and involve a number of actions in working with staff, line managers, IHC's, recruitment of environment officers.	A considerable amount of work is ongoing in relation to review and engagement, and this forms part of the plan to work with the IHCs on the longer term management of the policy. Additional evidence provided to support closure.	Gavin Jones, Health Intervention Co-ordinator	Teresa Owen, Executive Director of Public Health	Final Client approved	31/10/2023		0		27/10/2023	Yes	
221	Audit Committee	Wales Audit Office	Audit Wales Follow up - counter fraud	2022	Reasonable	Low	Recommendation 2 Resources and Skills	The Executive Director of Finance reviews succession planning and service continuity arrangements in line with the Audit Wales report, factoring in other NHS Wales comparators.	The Executive Director of Finance and the Finance Director: Operational Finance have reviewed the structure of the department with the Head of NHS Counter Fraud Wales including benchmarking both the amount of resource and the structure with other Health Boards across Wales. This process will continue to be monitored with the Head of NHS Counter Fraud Wales and all options will be considered for the most appropriate structure and resourcing of the department.	Agreement reached to submit a re-banding for a Deputy Head of Counter Fraud post (B7) - awaiting outcome of evaluation awaited. This would bring the structure of the team in-line with recent changes to the LCFS Teams across Wales.	Re-banding of Deputy Head of Counter Fraud post accepted and submitted to payroll. Paper on future services presented through the Executive Directors of Finance All Wales meeting, and copy provided as additional evidence.	Andrea Hughes, Interim Director of Finance	Russell Caldicott, Interim Executive Director of Finance	Final Client approved	07/12/2022		0	07/12/2022	22/08/2023	Yes	
222	Audit Committee	Wales Audit Office	Audit Wales Follow up - counter fraud	2022	Reasonable	Medium	Recommendation 2 – Fraud Risks	Current ownership of fraud risks is reviewed and transferred for operational management and control where appropriate. The Counter Fraud Team works in partnership with the Risk Management Department to embed operational services ownership and identification of fraud risk in their day-to-day processes and any risks specific to the Counter Fraud team are reviewed on a regular basis.	The Director of Finance: Operational Finance has directed the Head of the Health Board's Local Counter Fraud Service to work with the Associate Director of Governance to agree the Agreed Management Action. Whilst the actions have individual action owners, the Associate Director of Governance will take responsibility to make sure they have been completed. Discussions have taken place with the Associate Director of Governance during November 2022 and have initially focused on the Management Actions which are required to be undertaken, to mitigate the Counter Fraud risks, to an acceptable level to achieve the Target Risk score – to allow the risks to be closed on the Risk Management system. The Associate Director of Governance will be tabling this at the BCUHB Risk Management Agenda Item in the BCUHB Health Board Leadership Team in January 2023 and the Risk Management Group in February to check and confirm that all actions have been taken. Associate Director of Governance to formally report to Audit Committee on a quarterly basis on the number of Fraud Risks which are being recorded by each of the Health Boards operational service departments.	The Board Secretary will now work with Finance Team and Fraud Team. This was agreed at the HBLT on the 3rd May 2023. Industrial Action took place and therefore Risk Management Group wasn't able to review actions of Counter Fraud risks were reviewed as part of the Risk Management Group in March 2023 and will be reviewed again in June 2023. In June 2023 they will have a bespoke agenda item	This action can be closed. The Risk Management Group met on 5th June 2024 and this agenda item was on the agenda. Regular meetings take place with both the Board Secretary and the Head of Risk Management. Counter Fraud is to be added to the cycle of business for RMG annually and a report was presented at RMG where it was noted the Fraud Risk Register needed to be updated, working with the risk team will now be business as usual. Additional evidence provided to support closure.	Phil Meakin, Associate Director of Governance	Russell Caldicott, Interim Executive Director of Finance	Final Client approved	31/12/2022	06/12/2023	2			Yes	

225	PFIG	Wales Audit Office	Audit Wales Structured Assessment 2020	2020	N/A	High	R3	Reporting progress against delivery of plans: Ensure that 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.	Update provided by Executive Director of Finance. An update has been provided to the board that includes NHS Wales Delivery Framework and narrative to articulate performance. The IQPF requires some further refinements in line with the development of the Integrated Performance Framework. However, assessment is that the rec can be closed.	IPR has now been agreed by the board and is being use in Health Boardmeetings. Additional evidence provided for closure	Edward Williams, Acting Director of Performance	Russell Caldicott, Interim Executive Director of Finance	Final Client approved	30/11/2020	31/12/2022	6		22/08/2023	Yes	
228	PFIG	Internal Audit	Continuing Healthcare Arrangements	2020	N/A	High	R8	While the Health Board strengthened leadership within its corporate CHC team during 2019, arrangements are currently ad hoc and temporary. The Health Board should seek to develop longer-term leadership to ensure improvement and robust central oversight of its CHC management.	A transition plan has been agreed to consolidate the corporate CHC leadership team. This team will now oversee CHC and the care home sector reporting into a substantive Assistant Director of Primary and Community services from 1 January 2021.	Agreed as complete on local CHC Audit Action Plan 07/03/23.	Confirmation was given by the Executive Director Transformation and Strategic Planning that he will remain the executive lead for Corporate CHC subject to any later/further review of Executive portfolios. An Acting Assistant Director for Care Homes and CHC Commissioning has been appointed, which has been extended to December 2024 to ensure continuity and leadership for the corporate team.	Kathryn Titchen, Commissioning Manager CHC	Chris Stockport, Executive Director Transformation and Strategic Planning	Final Client approved	31/01/2021	07/03/2023	9			Yes	
243	QSE	Internal Audit	Managing Medicines in Primary and Secondary Care	2016	N/A	High	R1	The Welsh Government, NHS Wales Informatics Service and all health bodies should agree a detailed, time bound plan for implementing electronic prescribing systems in secondary care, along with a clear process for monitoring the delivery plan.	The NHS Wales Informatics Service (NWIS) has established the Welsh Hospital Electronic Prescribing and Medicines Administration (WHEPMA) project to develop and implement the national plan for electronic prescribing in secondary care and the inaugural meeting of the project board was held on 23 November 2016. The project team is currently working with stake holders to define the exact scope of the project and the system requirements. Once this is complete the business case for procurement of a replacement hospital pharmacy system and an electronic prescribing and medicines administration solution will be completed by NWIS and considered by Welsh Government. Subject to the completion of the business case, it is expected that the procurement of these systems will be completed during 2018-19 with implementation beginning in the early part of 2019. Identify a BCU representative for the national project board and a medical, nursing and pharmacy link for the project by April 2017. National project to present the strategic outline business case to QSG/EMG by June 2017 prior to submission to WG. Establish a BCUHB implementation group by September 2017.	EMPA Board established. SRO Executive Director of Nursing and Midwifery - programme board chaired by deputy director of nursing and midwifery. Pre-implementation plan ongoing within programme timescales. Further programme update planned for January 2024	Evidence of Terms of Reference and notes of August health board programme board meeting (October note not yet available), and National Secondary Care programme board highlight report provided as additional evidence. 1. Electronic Prescribing and Medicines Administration (ePMA) Programme Board established (ToR and notes of recent meeting) 2. Senior Responsible Officer (SRO) and Programme Board chaired by Deputy Executive Director of Nursing and Midwifery. 3. Pre-implementation plan and programme milestones agreed by the Digital Transformation Medicines Portfolio and Welsh Government ePMA national board. 4. Health Board Business Case mid-drafting (November 2023) Additional Evidence Supports closure.	Lois Lloyd, Interim Chief Pharmacist	Nick Lyons, Executive Medical Director	Final Client approved	30/09/2017	31/01/2024	16			Yes	
245	PFIG	Wales Audit Office	Structured Assessment 2019	2019	N/A	High	R5	Reliance on temporary management staffing, 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.	The operating model commenced implementation from 1st August 2023, substantive posts identified and agreed there will continue to be vacancy / interims until substantive posts are recruited to.	This action was first published in 2019 and as such the context has since then changed. The context of the time was before the introduction of the New Operating Model. Since then, the New Operating Model has been introduced and all IHC appointments are now substantive. However, we recognise the ongoing focus on the reliance on interim management. The Health Board Remuneration Committee and Health Board has received updates showing a dramatic reduction in use of agency staff in senior roles, such that this action (from 2019) can be closed. The Executive Team and Remuneration Committee continue to focus on this matter.	Phil Meakin, Associate Director of Governance	Adele Gittoes, Interim Executive Director of Operations	Final Client approved	30/04/2020	01/10/2023	5			Yes	
246	PFIG	Internal Audit	Financial Control – Receipting of goods and year-end accruals	2023	Reasonable	High	Procurement guidance and training	Ensure all staff involved in procurement receive mandatory training in line with the requirements stipulated by the Chief Executive of NHS Wales. Review the evidence provided for Purchase Order 9705645 for £293,787 and ensure it is accounted for in the correct financial year.	In relation to training, we have to date focused on the provision of essential guidance and training on year-end processes for BCU colleagues in order the mitigate the risk of expenditure being accounted for across BCU in the wrong year at the 2022/23 year-end. Acknowledgement of this is welcome. The assessment of longer-training training needs and the delivery of an ongoing programme of training across BCU are addressed in the Financial Control Environment Action Plan. In relation to the specific Purchase Order 9705645 we confirmed that this was not accrued for in the 2022/23 year-end. It will be accounted for as appropriate in 2023/24.	Item 7 in the Financial Control Environment Action Plan, which is monitored fortnightly by WG in conjunction with Special Measures, includes a learning lessons process. The inclusion of the audit for the 2022-23 financial year provides assurance these lessons have been learned with balances endorsed as true and fair by Audit Wales.	Additional evidence of Oracle Refresher Workshop provided	Andrea Hughes, Interim Director of Finance	Russell Caldicott, Interim Executive Director of Finance	Final Client approved	31/07/2023	01/11/2023	1		22/08/2023	Yes	
248	People Committee	Internal Audit	Recruitment of Substantive and Interim Executive and Senior Posts (ESP)	2023	Limited	High	Standing Orders Compliance	The engagement of all interim/agency appointments must comply with the Standing Orders, Standing Financial Instructions and associated Delegated Matters/Scheme of Delegation and Standard Operating Procedure. Issues of non-compliance must be included in all relevant Performance and Accountability meetings with clear actions Minuted and officers held accountable for continual non-compliance.	2.1a A recent revision to the standard operating procedure F18, senior nonclinical agency interim engagements (v11) now incorporates a maximum contract length of 4 month for every request. Similarly, the Executive Director of Finance is now a co-approver of all new interim requests. A further addition will be made that will require a full contract value calculation to be undertaken by the requesting manager upon submitting the IAR, which will be validated against their SFI limits. This will require the requestor to liaise with their finance CFO to accurately quantify the total cost of the interim engagement. 2.1b Non-compliance with WG required processes, Standing Orders and SFIs will be reported to RTS (quarterly) and PFIG (monthly). Repeated noncompliance with process, by a single department, will be escalated to audit committee; the parameters of which will be defined in the response to point 3 below. Upon requesting an interim worker for a VSM post, the IAR form will be updated so the requestor will be asked to confirm they have been in contact with WG head of profession. The recruitment team will ensure all VSM posts are communicated to the relevant WG leads before any appointment is confirmed.	July rem com received the first report identifying compliance against SOP etc, September meeting will identify further escalation for repeated non-compliance into the AC. Areas of non-compliance are reported to the CEO and the Exec team	The format and content of the senior interim report was approved in September 2023, with an excerpt from the August 23 REMCOM meeting provided as further evidence.	Ali Mirza, Head of Strategic Recruitment	Jason Brannan, Deputy Director of People	Final Client approved	31/06/2023		0		30/08/2023	Yes	
249	People Committee	Internal Audit	Recruitment of Substantive and Interim Executive and Senior Posts (ESP)	2023	Limited	High	Remuneration and Terms of Service Committee – Reports for assurance	Management must ensure Committee Members are appropriately involved in determining the information they require for assurance and subsequent reporting/providing advice to the Full Board. As a minimum, any report to be submitted to the RATS Committee in relation to the appointment of an interim must incorporate assurance on compliance on key matters of control in Standing Orders, Standing Financial Instructions and Welsh Government instructions.	R&TS committee Terms of Reference is being updated and will be ratified in May 2023. The R&TS committee will define the required parameters of the reporting structure and make it's recommendations to board. A new reporting template for R&TS and the Executive Management Team will be implemented, to incorporate all JESP/VSM appointments, both interim and substantive, and whether the appointments are compliant with standing orders, SFIs and WG Instructions. In addition, the report will include details of permanent recruitment timeframes when a post has been filled by an interim.		The REMCOM terms of reference were approved, and have been provided as evidence. The senior interim report that was agreed in September 2023 will be provided to every meeting (bi-monthly) until further notice.	Ali Mirza, Head of Strategic Recruitment	Jason Brannan, Deputy Director of People	Final Client approved	30/09/2023		0			Yes	
250	Audit Committee	Internal Audit	Risk Management and Board Assurance Framework	2023	Limited	Medium	Risk Management department duties	The Strategy is updated to include the duties of the Risk Management Department.	The Risk Management Strategy to be revised to include the duties of the Risk Management Department.	The revised RM01 draft makes provision for Corporate Risk Management team duties and will be submitted to Sept Board 23 for review/approval. **October update** - The revised RM01 details the Corporate Risk Management team duties was approved at Sept Board 23.	The revised RM01 details the Corporate Risk Management team duties was approved at Sept Board 23. Additional Evidence provided to support closure.	Nesta Collingridge, Head of Risk Management	Phil Meakin, Interim Board Secretary	Final Client approved	30/08/2023	28/09/2023	1		25/10/2023	Yes	
251	Audit Committee	Internal Audit	Risk Management and Board Assurance Framework	2023	Limited	High	Oversight, scrutiny and challenge of CRR and BAF	The Health Board must ensure meetings within the governance structure take place as required, to allow adequate review and scrutiny of the risks facing the Health Board. Clarification is required on how often the Health Board and Audit Committee receive the CRR and BAF for review and scrutiny.	Review of the CRR review frequency (RM Strategy), within the Board and committee structure. The Health Board and Audit Committee to have a Cycle of Business to include the CRR and BAF for review and scrutiny (additional IA comments to the Management Response - We note the management action to consider where the CRR is reviewed, however management need to ensure these meetings take place to ensure sufficient scrutiny of the CRR).	The OBS Independent review is now complete, which included a review of Committee ToRs. This will influence the outcome of this rec and therefore a revised date has been set end of September pending CEO/Board review. The board is also pending appointment of permeant Members to enable committee meeting to take place. The TOR on receiveing the CRR and BAF will subsequently be set out in all TOR. **October update** - The revised RM01 details COB for BAF and CRR and was approved at Sept Board 23. All COB for committees /Board also reflect this change.	The revised RM01 details cycle of business for Board Assurance Framework and Corporate Risk Register and was approved at September Board 2023. All cycle of business for committees/Board also reflect this change. Additional Evidence provided to support closure.	Nesta Collingridge, Head of Risk Management	Phil Meakin, Interim Board Secretary	Final Client approved	30/08/2023	31/09/2023	1		25/10/2023	Yes	
253	Audit Committee	Internal Audit	Risk Management and Board Assurance Framework	2023	Limited	High	Escalation and de-escalation of risks	Clarification is required on the Committee approval process for the escalation and de-escalation of risks.	Review of the RM02 v3.9 to indicate the QSE approves the escalation/de-escalation of risks.	The escalation and de-escalation of risks is being reviewed in light of RM01 and RM02 where this process will be outlined, including in TOR for RMG. **October update** - The escalation and de-escalation of risks is being reviewed in light of RM01 and RM02. RM01 has now been approved. The Exec team have now updated their agenda to ensure the BAF and CRR are a standing agenda item on bi-monthly basis as well as risks to be escalted/de-escalated.	The escalation and de-escalation of risks is being reviewed in light of RM01 and RM02. RM01 has now been approved. The Exec team have now updated their agenda to ensure the Board Assurance Framework and Corporate Risk Register are a standing agenda item on bi-monthly basis as well as risks to be escalated/de-escalated.	Nesta Collingridge, Head of Risk Management	Phil Meakin, Interim Board Secretary	Final Client approved	30/08/2023	31/10/2023	1		25/10/2023	Yes	

266	PFIG	Internal Audit	Performance Management – Quality and Performance Reporting and Accountability Arrangements	2023	Limited	Medium	Performance report and measures	The Health Board continue with the improvement plan to review and update the quality performance report to ensure Committees are receiving appropriate, accurate and relevant information. This should assurance mechanisms in place through Board Committees, to ensure the Health Board are sighted on key areas of concern and are provided with assurance that Committees are considering all areas of performance.	The Health Board is reviewing its governance/assurance structures in line with Special Measures – this includes looking at the oversight / performance frameworks and associated reporting, processes and documentation. This will involve the gradual 'integration' of reporting on operational delivery, quality, safety and patient experience, workforce and finance by the end of March 2024. Alongside this includes a Review of the content, editorial ownership and quality of the information and data contained within all performance reporting it. This includes work with Informatics to ensure all Operating Framework Metrics, trajectories and other KPIs included in the Board Report have a documented processes and signoff for submission nationally, locally etc. Closer editorial management of the Performance Report now sits with the Director of Performance role. Effective Feb 2023 a summary/highlight report has been introduced to direct reviewers to key points of variation and from June 23 includes NHS Wales published Organisation Performance Reports and where relevant/available the comparative performance across all Wales' Board. Work continues alongside the revision of the Performance and Accountability Framework.	**October update** – The first iteration of the Integrated Performance Report (IPR) has been developed and shared at Integrated Performance Executive Delivery Group on 25/10/2023. This iteration will be presented at Performance, Finance and Information Governance Committee on 02/11/2023 as proof of concept. All pending changes identified at PFIG will be incorporated into the IPR before it's inaugural presentation at Health Board on 30/11/2023.	The first iteration of the Integrated Performance Report (IPR) has been developed and shared at Integrated Performance Executive Delivery Group on 25/10/2023. This iteration will be presented at Performance, Finance and Information Governance Committee on 02/11/2023 as proof of concept. All pending changes identified at PFIG will be incorporated into the IPR before its inaugural presentation at Health Board on 30/11/2023. Action complete, with the Health Board receiving at the meeting of the 1st December 2023 the Integrated Performance Report. However, continuous development and refinement of the report will continue. Additional evidence for closure provided.	Edward Williams, Acting Director of Performance	Russell Caldicott, Interim Executive Director of Finance	Final Client approved	31/03/2024		0			Yes	
269	PFIG	Internal Audit	Performance Management – Quality and Performance Reporting and Accountability Arrangements	2023	Limited	High	Accountability meetings (b)	Review current action tracker to determine whether actions are still relevant.	Action tracker to be reviewed for relevance by end of July 2023.	Recommended to close. Action Tracker reviewed/refreshed. Outstanding actions addressed and closed, refreshed arrangements to document the agreement of actions and outcome of each quarterly review will be done via accountability agreements (under the new Framework).	Accountability meetings now underway. Action to be closed. Monthly Integrated Performance Executive Delivery Group set up chaired by CEO, monthly meetings held every third Wednesday.	Edward Williams, Acting Director of Performance	Russell Caldicott, Interim Executive Director of Finance	Final Client approved	31/07/2023	29/02/2024	1			Yes	
271	People Committee	Internal Audit	Recruitment Improvement Review	2023	Substantial	Medium	Published documents	Management to ensure all published documents and guidance notes are relevant, up to date, and reflect current practice/requirements.	All BetsiNet pages that contain information and guidance on the recruitment process will be reviewed and updated, and any documents which are no longer relevant will be archived.	WOD in the process of reviewing library. This will be influenced by the new operating model / structure as the WOD team realigns to the IHCs	As identified in the audit, the recruiting managers guides on BetsiNet have been updated as per the new employment checks process implemented in September 2022 - additional evidence provided to support.	Ali Mirza, Head of Strategic Recruitment	Jason Brannan, Deputy Director of People	Final Client approved	30/06/2023	30/03/2024	1			Yes	
272	People Committee	Internal Audit	Recruitment Improvement Review	2023	Substantial	Medium	Board and Committee reporting	Management to review governance and reporting arrangements to ensure implementation and performance is subject to Health Board review and scrutiny.	A set of recruitment KPIs that can easily identify the Health Board's performance against target time-to-hire timeframes relating to Manager, NWSSP and People Services lines of responsibility, which can also be benchmarked against other Health Boards in Wales, will be included in the workforce performance report that is provided to PFIG committee. This will be supported with contextual information as to actions and issues relating to sustaining acceptable recruitment performance. Moreover, it is expected that the existing workforce BI dashboards, which contain relevant recruitment KPIs, will be utilised in local IHC reporting and oversight.	Recs implemented - KPIs now included in WOD to PFIG. Local IHC dashboard have been developed to provide and rela time info.	The KPIs have been approved by PFIG and have been in place since July 2023, and additional evidence has been provided to support this.	Ali Mirza, Head of Strategic Recruitment	Jason Brannan, Deputy Director of People	Final Client approved	30/06/2023		0		30/08/2023	Yes	
274	PFIG	Internal Audit	Cyber Security	2023	Substantial	Medium	Use of KPIs	KPIs should be developed that show the current security posture of the organisation	As noted in the report, the Cyber Security and Compliance Team have begun a piece of work to develop proposals for KPI's taking into consideration work being carried out nationally. The proposals will be developed ASAP, presented to the CDIO for implementation consideration by the end of Q3, 2023/24.	KPIs drafted, awaiting approval at the local DDaT ICT Governance and Security Group before onward submission to the CDIO. Whilst this is in train, work is also ongoing across Wales to develop standardised KPI and reporting nationally.	The Chief Digital Information Officer has approved the set of Cyber Security Key Performance Indicators, which take into account the requirements of the Network and Information Systems Regulations 2018 will now be implemented and reporting through the standardised governance arrangements via the ICT Security and Governance Group, which reports into the Information Governance Group and then upwards to the Performance, Finance and Information Governance Committee. (This reporting may revert to the Partnerships, People and Population Health Committee when meetings re-commence). Additional evidence to support closure provided	Sion Jones, Assistant Director/Chief Technology Officer	Dylan Roberts, Chief Digital and Information Officer	Final Client approved	01/09/2023	30/11/2023	1		29/11/2023	Yes	
275	PFIG	Internal Audit	Accounts Receivable	2023	Reasonable	High	Cash Deficit	The Health Board should ensure that any discrepancies between money banked and payments receipts be fully investigated and formally reported to establish reasons and prevent further occurrences.	The discrepancies identified between receipts and bankings have all now been confirmed as being timing differences, which were subsequently banked in all cases. Timing differences arise when cash is taken late in the day and therefore can only practically be banked the following day. Prompt action has been taken to meet with the Catering Manager in Denbigh and Ruthin where the audit findings were discussed and immediate changes to their banking processes have been enacted which will ensure any discrepancies arising from timing differences are explicitly followed through and secure banking confirmed as a matter of routine. Initial meetings have also been held with the Manager and Assistant Manager of YGC Catering, and we are now setting up more robust processes relating to the 'Midnight Till' and where cash is held over before being transferred to General Office. Turnover of cash is reducing due to the fact that card machines are now in the majority of our Community Hospitals. The General Office Manger continues to remind staff of the procedures to follow and actively provides re-fresh training to staff. A planned half-day targeted session with all Community Hospital General Offices is taking place in October, and this will be a further opportunity to reiterate the requirements set out in our procedures and to respond to any practical queries that they may have and to look at best practice.	Reviewed by Exec Director finance - close.	Further evidence to support closure provided.	Ronnie Bright, General Office Manager	Russell Caldicott, Interim Executive Director of Finance	Final Client approved	17/08/2023		0	17/08/2023	22/08/2023	Yes	
277	QSE	Internal Audit	Clinical Audit – Tier 1 National Audits	2023	Limited	Medium	Clinical Audit Plan	The Clinical Audit Plan for 2023/24 should be formally approved at the appropriate committee.	The Clinical Audit Plan for 2023/2024 was prepared and submitted initially to the Strategic Clinical Effectiveness Meeting on 14th February for discussion and agreement. Following this the Clinical Audit Plan was prepared and submitted to Quality, Safety and Experience Committee (QSE) on 7th March, the meeting was then stood down. The paper was then submitted to Quality Delivery Group (QDG) on 17th April, due to QSE not having any further dates to present at that time and due to changes in Board membership all of the Committees were not meeting at that time. It was therefore appropriate Nick Lyons signed it off as Executive Medical Director and Acting Chief Executive Officer at that time.	The Clinical Audit Plan went to QSE Committee in August and is incorporated into future cycle of business.	The Clinical Audit Plan for Tier 1 went to QSE Committee in August and is incorporated into future cycle of business from Strategic Clinical Effectiveness Group to be submitted when relevant. The quarterly reports show the current situation at that time of relevant published Tier 1 reports and where they are in the cycle process and any concerns are escalated to QDG and QSE where relevant. Processes are in place to flag up concerns on monthly basis within local Clinical Effectiveness Group with approach of sorting those concerns and avoiding escalation where possible. Due to local Clinical Effectiveness Groups running differently on each site, from November the Clinical Effectiveness Team sharing a monthly update to each IHC and Divisions sharing current position with regard to Tier1, Tier 2 and NICE - if any concerns or risks that need addressing, and these will be monitored and if no change escalated then escalated to Strategic CEG.	Joanne Shillingford, Head of Clinical Effectiveness	Nick Lyons, Executive Medical Director	Final Client approved	31/07/2023		0		31/08/2023	Yes	
278	QSE	Internal Audit	Clinical Audit – Tier 1 National Audits	2023	Limited	High	Clinical Audit participation	The Health Board to ensure resources are available to participate in audits in order to fully comply with the mandated audits.	On the next Strategic Clinical Effectiveness Group (CEG) agenda on 8th August a request was made that each local CEG discuss and identify resource gaps and how they come to that conclusion and bring back to CEG 12th September meeting relevant information for us to capture in Chairs Report to escalate to relevant Health Board meetings.	**October update** - Following on from Internal Audit Review one of the agenda items on Strategic Clinical Effectiveness Group 12th September was a request for each local CEG to discuss and identify resource gaps and how group come to that conclusion us to capture in Chairs Report to escalate to relevant Health Board meeting. Initially we have had updates on Tier 2 and are working through this, nothing has been raised on Tier 1 currently - we will escalate any concerns to QDG and QSE - this can be CLOSED	There is a process in place that concerns with resources for Tier 1 audits need to be brought to Strategic Clinical Effectiveness Group with what has been reviewed with regard to resources, that all options have been exhausted and the need to raise for support. Tier 1 is mandatory and it has been made clear that means BCUHB needs to be participating in these audits and making every attempt to do so. The Chair's report from SCEG will include details that need to be escalated to Quality Delivery Group if further support is needed to addres this. Additional evidence to support closure provided.	Joanne Shillingford, Head of Clinical Effectiveness	Nick Lyons, Executive Medical Director	Final Client approved	30/09/2023		0		16/10/2023	Yes	

279	QSE	Internal Audit	Clinical Audit – Tier 1 National Audits	2023	Limited	Medium	Validation of Data	Clinical Effectiveness Department liaise with the services to establish how the data is validated for each audit, this will enable the department to gain a better understanding of how the data is collected and validated.	Team are non-clinical and would not be able to validate this. At the next Strategic Clinical Effectiveness Group (CEG) agenda on 8th August we will request that when each Tier 1 audit is published that the area will need to validate how the data was collected. This will provide assurance and we can capture within our minutes and quarterly reports which will be submitted at relevant Health Board meetings. The Clinical Audit Facilitators will have this as one of a list of criteria when monitoring audits with IHCs and Divisions to note.	**October update** - The Clinical Audit Facilitators are working with all Tier 1 audits to clarify with each Clinical Audit Lead how the data has been validated and noting this to provide assurance within our our quarterly reports - This can now be CLOSED	Team are non-clinical and would not be able to validate this as each Tier 1 audit is published they will request detail from the area to validate how the data was collected. This will provide assurance and we can capture within quarterly reports which will be submitted at relevant Health Board meetings. The Clinical Audit Facilitators will have this as one of a list of criteria when monitoring audits with IHCs and Divisions to note. The Clinical Audit Facilitators are working with all Tier 1 audits to clarify with each Clinical Audit Lead to identify what validation takes place prior to data submission. This is being recorded on the departmental database and part of our team process to ensure we have all relevant information for reporting to Strategic CEG, QDG and QSE to provide assurance and if there are queries raised that escalation of this is followed. Additional evidence to support closure provided.	Joanne Shillingford, Head of Clinical Effectiveness	Nick Lyons, Executive Medical Director	Final Client approved	30/09/2023		0		16/10/2023	Yes	
280	QSE	Internal Audit	Clinical Audit – Tier 1 National Audits	2023	Limited	High	Progress reporting of Tier 1 audits (a)	The Health Board must ensure appropriate meetings within the governance structure take place as required and include clinical audit as an agenda point to allow adequate review and scrutiny of the issues affecting the Tier 1 process.	The quarterly reports that are produced from Clinical Audit Team capture which audits have been published in relevant quarter and includes all BCU identifiable data – plus process and completed actions and outstanding issues. These are followed up by Clinical Audit Facilitator at local CEGs. We have recently set up an Audit /NICE monthly meeting and we would capture any areas of concern that need taking to Strategic CEG to close the loop. A cycle of business (COB) has been developed to ensure relevant papers go to appropriate meetings.		In Clinical Effectiveness Department, we ensure through our processes that we monitor and review any issues effecting the Tier 1 process. These are raised with local Clinical Effectivness Groups to be aware and discussed how to manage. If failure to address these issues is not met then they will be escalated to Strategic Clinical Effectivness Group,to discuss and if cannot be addressed would be raised in Chairs Report to Quality Delivery Group for decision making. Clinical Audit Facilitator at local CEGs. Our new process is to share on a monthly basis to all IHCs and Divisions an update of current situation with Tier 1, Tier 2 and NICE Compliance nin the process and this is shared with Head of Clinical Effectiveness and Deputy Executive Medical Director. Within our CE team we have set up a monthly Audit /NICE monthly meeting and where we discuss areas of concern that need taking to Strategic CEG to close the loop. A cycle of business has been developed to ensure relevant papers go to appropriate meetings. Additional evidence to support closure provided.	Joanne Shillingford, Head of Clinical Effectiveness	Nick Lyons, Executive Medical Director	Final Client approved	31/03/2024		0			Yes	
281	QSE	Internal Audit	Clinical Audit – Tier 1 National Audits	2023	Limited	Medium	Progress reporting of Tier 1 audits (b)	To enhance accessibility of audit activity, improve timely reporting and keep track of the identified actions, the AMaT system needs to be developed further outside of the department and continue to be implemented throughout the Health Board.	We do currently update AMaT with all Tier 1 information and add on action plans however we need to review if beneficial to be using outside of department. Will look at piloting within couple of Tier 1 areas for feedback at relevant meetings.		All Tier 1 audit publications are uploaded onto AMaT (Audit Management and Tracking Software) as they happen and details and details entered into the Service Assessment form which note assurance/risk/level or actions to follow. The Audit webpage has information regarding the progress with the expected Service Assessment form and any approved forms are uploaded on to the system. All details are uploaded on to the webpage and it is being promoted regularly. Additional evidence to support closure provided.	Joanne Shillingford, Head of Clinical Effectiveness	Nick Lyons, Executive Medical Director	Final Client approved	31/12/2023		0			Yes	
282	QSE	Internal Audit	Clinical Audit – Tier 1 National Audits	2023	Limited	Medium	Learning from audits (a)	Ensure that the local service meeting minutes, which contain the lessons learned from the audits as specified within the service assessment of compliance form, are sent to the clinical effectiveness department as part of the assurance process.	Following recent meeting with Internal Auditor the Service assessment form was amended July 2023 to request evidence of discussions and how these are shared as part of the assurance process. Clinical Audit Facilitators will ensure that all details are completed before accepting the form as completed and the update will be included in the relevant quarterly report.	**October update** - The Clinical Audit Facilitators have developed a service assessment for that is sent to each Clinical Lead after each publication. This allows the Clinical Lead to note where discussions are held, which meetings information is fed back, how learning is shared. The process will not be closed until all the relevant evidence has been sent to Clinical Audit Facilitator to include in our Quarterly Reports. Additional evidence to support closure provided.	The Clinical Audit Facilitators have developed a Service Assessment of Compliance against Key standards (KPIs) form which is sent to the Clinical Audit Lead after each publication. This allows the Clinical Lead to note where discussions are held, which meetings information is fed back, how learning is shared. This information is then captured in the Quarterly reports and Annual report and also shared within local Clinical Effectiveness Groups (CEG). We review our processes regularly to ensure we are capturing as much as we can to share at relevant groups. On monthly basis we share an update with IHCs and Divisions on their current position with Tier 1 audits which shows the current position/progress also noting any concerns that need addressing. If this is not done through the relevant local Clinical Effectiveness Groups, then a paper would be produced to take to Stratgic Clinical Effectiveness Group to discuss further. Additional evidence to support closure provided.	Joanne Shillingford, Head of Clinical Effectiveness	Nick Lyons, Executive Medical Director	Final Client approved	23/07/2023		0		16/10/2023	Yes	
283	QSE	Internal Audit	Clinical Audit – Tier 1 National Audits	2023	Limited	High	Learning from audits (b)	Clinical Audit updates/Annual Clinical Audit Report to be presented to the Quality and Safety Committee to allow Health Board members the opportunity to challenge and approve the documents. The quarterly reports clearly tables and monitors the performance and progress of Tier 1 mandatory audits – the reports also note where there are lack of engagement or if reporting is late and these are picked up within the local CEGs by the Clinical Audit facilitators and captured in the following quarterly report whether improvements have been made or not and if needed noted in CEG and QDG so has mechanism in place to escalate when necessary.	All papers are on Cycle of Business (COB) and when to be presented at relevant meetings. As the QSE has stood down on a number of occasions, after being submitted at the Strategic Clinical Effectiveness Meeting, papers have been submitted at Quality Delivery Group for submitting in August. They will then go to QSE and Audit Committee now that dates have been re-established and agenda confirmed.	**October update** - Due to the QSE being stood down, at the time papers such as Clinical Audit Plan, Quarterly papers and Annual report were sent to Strategic Clinical Effectiveness Group and then to Quality Development Group. Now that QSE has been reinstated and meeting bi-monthly all those papers have been sent for information and approval . Also this will now be the process we follow to ensure that assurance and approval is received from all relevant groups. This can now be CLOSED	When reviewing the Cycle of Business for Strategic CEG, we took into account when the quarterly reports would be presented, at Strategic Clinical Effectiveness Group and then to Quality Delivery Group within our Chair's Report. The quarterly reports clearly tables and monitors the performance and progress of Tier 1 mandatory audits – the reports also note where there are lack of engagement or if reporting is late and these are picked up within the local CEGs by the Clinical Audit facilitators and captured in the following quarterly report whether improvements have been made or not and if needed noted in Strategic CEG and QDG so has mechanism in place to escalate when necessary. We constantly monitor our processes within the team to improve as necessary. Additional evidence to support closure provided.	Joanne Shillingford, Head of Clinical Effectiveness	Nick Lyons, Executive Medical Director	Final Client approved	30/09/2023		0		16/10/2023	Yes	

293	QSE	Internal Audit	Falls Management	2023	Limited	High	All Wales Falls and Bone Health Multifactorial Assessment (FBHMA) (Operation)	2.1a Staff should be reminded, through training, of the requirement to ensure the FBHMA and documentation pertaining to patient falls, provides sufficient information to fully understand the patients needs and requirements to minimise the risk of a potential fall. Compliance with this should be reviewed through existing audit mechanisms.	2.1a Health Board mandatory training Falls Prevention E learning module 1b relating to the FBHMA has been updated.		Good practice examples shared pan BCUHB alongside ongoing peer review process. In addition, as of January/February 2024 many staff will be required to update their Mandatory Training (which will be via the updated modules). IHC Leads will provide ongoing assurance of local Mandatory Training levels via the monthly Falls Steering Group.	Chris Lynes, Deputy Executive Director of Nursing	Angela Wood, Executive Director of Nursing and Midwifery	Final Client approved	31/08/2023		0			Yes	
297	QSE	Internal Audit	Falls Management	2023	Limited	High	All Wales Falls and Bone Health Multifactorial Assessment (FBHMA) (Operation)	2.1c Reminder to staff that all FBHMAs are to be completed upon patient transfer between wards. Compliance with this should be reviewed through existing audit mechanisms.	2.1c Training resources outlined 2.1a will include the re enforcement of when the FBHMA requires review and updating in line with national standard. The B6 Clinical MH Advisors now lead the patient risk assessment bedside learning programme (for falls and patient handling risk assessments) for the H&S team.		New Welsh Nursing Care Record upgrade flags on transfer to ward to complete Risk Assessments. A reminder to complete is also included in the training. The monitoring of compliance as stated is continually monitored and reviewed via existing ward metrics and now also with the peer reviews.	Chris Lynes, Deputy Executive Director of Nursing	Angela Wood, Executive Director of Nursing and Midwifery	Final Client approved	30/10/2023		0			Yes	
302	QSE	Internal Audit	Falls Management	2023	Limited	High	Training (Operation and Design)	3.1d Determine what training agency staff receive relating to patient falls and whether it is in line with training that the Health Board staff undertake and sufficient to ensure effective completion of falls documentation.	Scope of what training agency staff (58 external agencies part of the All Wales Framework) receive relating to patient falls and whether it is in line with training that the Health Board staff undertake and sufficient to ensure effective completion of falls documentation. - Temporary Staffing team for the Health Board to ensure the agencies have access to the Health Board e learning packages and are encouraged to complete; - the Health Board are amending and implementing the agency worker ward induction documentation to include familiarisation with risk assessments.		Monthly report now to be submitted to ward accreditation lead nurse to inform on falls training for agency workers. Additional evidence to support closure provided.	Clair Tipton, Head of Digital Workforce and Resourcing	Angela Wood, Executive Director of Nursing and Midwifery	Final Client approved			0			Yes	
305	QSE	Internal Audit	Falls Management	2023	Limited	High	Governance (Operation)	4.1b Lessons learned information included in Datix should be reviewed regularly to ensure learning is communicated/reported as appropriate, and to deter staff entering a full stop or a dash in the section.	4.1b Action 2 - The Health Board Patient Safety team will provide a weekly report from Datix of the previous weeks closed incidents to monitor quality of completion to be sent to IHC Directors of Nursing and IHC Governance leads to action locally this will be an ongoing process.		The Patient Safety Team provide a weekly report to IHCs/divisions that identifies incidents reported as moderate and above harm that have been closed without a management review/investigation or have gaps in lessons learned or have not followed process. These are re-opened by the Patient Safety Team and communication sent to the person who closed it and the governance lead. A monthly report is also sent for none and low severity incidents that have been closed without a management review. Additional evidence for closure provided.	Chris Lynes, Deputy Executive Director of Nursing	Angela Wood, Executive Director of Nursing and Midwifery	Final Client approved			0			Yes	
311	PFIG	Internal Audit	Waiting List Management: Review of the WG initiated Patient Validation Exercise, Risk Stratification and patient removal from lists	2022	Limited	High	Matter Arising 2 - Assessment of clinical risks relating to delays (Operation)	Patients who are identified as being overdue should be risk stratified as a priority. Records should be updated to confirm risk stratification has been completed and these should be reviewed on a regular basis to ensure there is minimal risk of patient harm	Action 4 - The Health Board recognizes the critical importance of risk stratification for overdue patients to minimize risk of patient harm. With the discontinuation of manual P value assignment under previous COVID protocols as noted in Actions 4 and 5, risk stratification now follows standing Welsh RTT guidance. A project is underway as part of the Planned Care Programme (see Action 7) to automate risk stratification based on referrals exceeding defined waiting time thresholds for their RTT classification. Automatic alerts will be generated for booking teams to facilitate urgent clinical review, re-prioritization, and escalation if needed. This multi-pronged approach will significantly strengthen oversight and proactive management of risk associated with overdue patients. Regular reporting will occur through the Planned Care Programme governance noted previously.		P value for risk stratification no longer in use – stood down as part of the removal of covid restrictions. Standing RTT classifications now apply – i.e. USC, Urgent, Routine.	Site Directorate General Managers	Adele Gittoes, Interim Executive Director of Operations	Final Client approved	30/04/2022		0			Yes	
312	PFIG	Internal Audit	Waiting List Management: Review of the WG initiated Patient Validation Exercise, Risk Stratification and patient removal from lists	2022	Limited	High	Matter Arising 2 - Assessment of clinical risks relating to delays (Operation)	Patients who are identified as being overdue should be risk stratified as a priority. Records should be updated to confirm risk stratification has been completed and these should be reviewed on a regular basis to ensure there is minimal risk of patient harm.	Action 5 - P value for risk stratification no longer in use – stood down as part of the removal of covid restrictions. Standing RTT classifications now apply – i.e. USC, Urgent, Routine.		P value for risk stratification no longer in use – stood down as part of the removal of covid restrictions. Standing RTT classifications now apply – i.e. USC, Urgent, Routine.	Site Directorate General Managers	Adele Gittoes, Interim Executive Director of Operations	Final Client approved	31/05/2022		0			Yes	
313	PFIG	Internal Audit	Waiting List Management: Review of the WG initiated Patient Validation Exercise, Risk Stratification and patient removal from lists	2022	Limited	High	Matter Arising 2 - Assessment of clinical risks relating to delays (Operation)	Patients who are identified as being overdue should be risk stratified as a priority. Records should be updated to confirm risk stratification has been completed and these should be reviewed on a regular basis to ensure there is minimal risk of patient harm.	Action 6 – Monitoring of routine RTT targets reported weekly to Welsh Government/NHS Executive). Weekly BCUHB Corporate access meeting monitors RTT performance and locally each IHC (Integrated Healthcare Communities) holds a weekly access meeting.		Monitoring of routine RTT targets reported weekly to Welsh Government/NHS Executive). Weekly BCUHB Corporate access meeting monitors RTT performance and locally each IHC (Integrated Healthcare Communities) holds a weekly access meeting.	Site Directorate General Managers	Adele Gittoes, Interim Executive Director of Operations	Final Client approved	31/03/2022		0			Yes	
314	PFIG	Internal Audit	Waiting List Management: Review of the WG initiated Patient Validation Exercise, Risk Stratification and patient removal from lists	2022	Limited	High	Matter Arising 2 - Assessment of clinical risks relating to delays (Operation)	Patients who are identified as being overdue should be risk stratified as a priority. Records should be updated to confirm risk stratification has been completed and these should be reviewed on a regular basis to ensure there is minimal risk of patient harm.	Action 7 – The Health Board recognizes the importance of aligned standardized removal reasons across all sites for consistency, improved analysis, and reduced errors or inconsistencies. Significant progress has already been made through the system consolidation actions updated below. Implementation of a single centralized Welsh Patient Administration System (WPAS) instance has established consistent removal coding structures across all Health Board sites and user groups. The migration to a unified WPAS platform with standardized data structures has eliminated the need for interim data alignment. By virtue of progress under Action 8 (action ID 315 in this tracker), removal reasons are now consistent organization-wide. With WPAS system convergence complete, the Health Board now has a single integrated structure for patient administration, referrals, waiting list management, and removals management. Standard operation procedures will reflect the centralized data system. This will further consolidate the gains from technical system consolidation to support consistency in removal reason usage. Progress will be monitored through Informatics governance.		A formal Planned Care Programme has been established which reports into an Executive Chaired Programme Board and ultimately onward to Executive Team. This board oversees progress against identified work streams and associated developments of which validation, booking and referral is a key programme of work. Operational progress around performance and delivery against RTT targets is monitored through weekly corporate access meeting. The recommendation will remain open until the automated, sustainable process is fully implemented by March 2024.	Site Directorate General Managers	Adele Gittoes, Interim Executive Director of Operations	Final Client approved	31/03/2022		0			Yes	
315	PFIG	Internal Audit	Waiting List Management: Review of the WG initiated Patient Validation Exercise, Risk Stratification and patient removal from lists	2022	Limited	High	Matter Arising 3 - Patients removed from waiting lists (Operation)	Standardisation of the reasons for removal should be developed to ensure consistency across the Health Board and enable analysis of reasons why patients are removed from waiting lists. This would also potentially reduce any inputting errors.	Action 8 – The Health Board has completed the implementation of a single instance of WPAS which closes this action.		The Health Board has completed the implementation of a single instance of WPAS which closes this action.	WPAS Standardisation lead	Adele Gittoes, Interim Executive Director of Operations	Final Client approved	May 2022		0			Yes	
316	PFIG	Internal Audit	Waiting List Management: Review of the WG initiated Patient Validation Exercise, Risk Stratification and patient removal from lists	2022	Limited	High	Matter Arising 3 - Patients removed from waiting lists (Operation)	Standardisation of the reasons for removal should be developed to ensure consistency across the Health Board and enable analysis of reasons why patients are removed from waiting lists. This would also potentially reduce any inputting errors.	Action 9 – As per action 8 (ID 315 in this tracker) – completed and closed.		As per action 8 (ID 315 in this tracker) – completed and closed.	WPAS Standardisation lead	Adele Gittoes, Interim Executive Director of Operations	Final Client approved	July 2022		0			Yes	

AUDIT COMMITTEE

INTERNAL AUDIT TRACKER

ID	Committee	Internal Audit (IA)/ Wales Audit Office (WAO)	Report Title	Year	Assurance Level	Priority	Recommendation Title	Recommendation	Management Response	Last status updates (September and October)	Latest status update	Action Owner	Final Approver	Recommendation State	Original implementation date	Revised implementation date	Number of Revisions	Actual Implementation Date	Date Final approved	For closure consideration at next Audit Committee?	Date Audit Committee approved closure
57	QSE	Internal Audit	Quality Improvement Strategy	2020	Limited	High	Reporting progress of Quality Improvement Strategy (QIS)	For the planned publication and launch of a new QIS for 2020 onwards, management should ensure the QIS: Is underpinned by a clear and concise implementation plan that records what actions/tasks are expected, by when and how success will be measured. Regular reports of progress should include clear performance and delivery per the implementation plan.	The planning of the new QIS is in progress currently and has built in a clear, concise and robust implementation plan with clear identified milestones, that will highlight progress against the clear aims of the QIS and its implementation. The new QIS will have clear mechanism for regular monitoring of progress/reporting against the aims of the QIS and the QIS implementation plan as agreed by QSE.	**September update**: The new Quality Strategy is being developed in line with the vision of the new interim CEO and aligned to the Special Measures programme, including the expected clinical governance review by the independent advisors appointed by Welsh Government. Therefore a provisional revised implementation date has been input as the 31st March 2024 pending discussion/ confirmation with the CEO and the Executive Director of Nursing to ensure alignment with the Special Measures programme.	This action remains on track and was subject to discussion at the Quality Governance Round Table Meeting with Welsh Government in November 2023, and forms part of the 2023/24 business plan for the Quality Governance Department.	Matthew Joyes, Assistant Director of Patient Safety and Experience	Angela Wood, Executive Director of Nursing and Midwifery	Started	01/08/2020	31/03/2024	11			No	
73	PFIG	Internal Audit	Performance measure reporting to the Board – Accuracy of information	2021	Reasonable	Medium	Standard Operating Procedure	Management to finalise and formally issue the RTT 26 Week Pathways Standard Operating Procedure. Ensure Risk Stratification controls and procedures are formally documented.	The RTT 26 Week Pathways Standard Operating Procedure is out for consultation and awaiting response from stakeholders. Previous feedback comments are being fed into the document and once all responses are reviewed the Standing Operating Procedure will follow the official sign off route via the Planned Care Board and Planned Care Transformation Group. The Head of Ambulatory Care post once filled will be responsible for owning and implementing the Standing Operating Procedure as best practice across BCUHB.	**October update -** The RTT 26 week SOP has been created and ratified, the education and training of this SOP has been conducted August 2021. However, since the creation of the document West have migrated onto WPAS from IPM and an Access Policy has been created that will supersede this document this is due to be sent for ratification November 2023. Sop provided as evidence to support update	Update required	Andrew Oxby, OPD Programme Support Manager	Adele Gittoes, Interim Executive Director of Operations	Started	02/08/2021	14/01/2022	4				
114	Audit Committee	Internal Audit	Standards of Business Conduct: Declarations	2022	Limited	High	Declarations of Interest Compliance	3.1 Governance leads to be reminded of their responsibility to review DOIs regularly and escalate non-compliance where required. 3.2 The Office of the Board Secretary to progress the options for reminding staff of declarations due via automatic emails.	3.1 Governance Leads will be issued monthly reports highlighting their teams' compliance with DOI submissions, which will form part of their monthly governance meetings, and escalated to the appropriate Execs Delivery Group on a bi-monthly basis. An automated approach to DOI management is being pursued via the MES Declare system, with the aim of ensuring that this is in place from the 1 st of April 2022. This will also be supported by a communications plan and a refreshed FAQ page As part of the planned communications plan, staff will be reminded of their obligations to disclose gifts and hospitality offered and received (onto the MES Declare system) under the Standards of Business Conduct Policy. This will also feed into the assurance monitoring by governance leads, which will include pursuing unauthorised declarations and escalate non-compliance of staff for known Gifts and Hospitality received, but which they have not declared.	The contract is now in place with Civica and implementation of the new system is underway following completion of the project set up documentation. Roll out due for week commencing 29/08/2023.	MS Declare is now live for both Declaration of Interests and Gifts and Hosptiality. All members of staff have been issued individual emails and log in details of how to make a declaration. The Declarations sharepoint site has been updated. Staff are reminded regulalry to submit and we have received a targetted email list of Band 8a and above to enable a personalised email from the Office of the Board Secretary office to be sent to these individuals. The action to remain open until the Declare System is fully embedded.	Philippa Peake-Jones, Head of Corporate Office	Phil Meakin, Interim Board Secretary	Started	30/06/2022	31/01/2024	3			No	
115	Audit Committee	Internal Audit	Standards of Business Conduct: Declarations	2022	Limited	Medium	Declarations of Interest Compliance	1.1 The Standards of Business Conduct policy is reviewed and updated where required, including further information: • Those roles below band 8c that require a declaration of interest • Responsibilities of Governance Leads to ensure compliance within their areas Medium Standards of Business Conduct Final Internal Audit Report Appendix A NWSSP Audit and Assurance Services 12 • Monitoring and reporting arrangements	Agreed, the policy has been updated with a view to incorporating best practice identified from the All-Wales Standards of business conduct Policy as well as the requirement for all staff to submit a declaration of interest annually.		The policy has been updated and is due for review in 2025. However, the policy will be reviewed again sooner than 2025 due to an audit this month, and the policy remains ambiguous. There is further work to be undertaken with Governance Leads to ensure they are aware of how to review Declaration of Interest. All staff have been targeted to complete a Declaration of Interest and Gift and Hospitality, however, further work will be undertaken, and Band 8a and above will also be targeted by an email from the Office of the Board Secretary. The action to remain open until the Declare System is fully embedded.	Philippa Peake-Jones, Head of Corporate Office	Phil Meakin, Interim Board Secretary	Started	30/06/2022	31/01/2024	1			No	
116	Audit Committee	Internal Audit	Standards of Business Conduct: Declarations	2022	Limited	High	Declarations of Interest System	2.1 The Office of the Board Secretary should seek confirmation from Finance that this information has been updated on a regular basis, to ensure compliance can be accurately monitored. 2.2 Exception reporting should be produced and reviewed regularly to highlight any issues with the data and the impact on compliance rates.	2.1 Agreed, however a new system is being put in place with effect from April 2022, which will be managed directly by the Office of the Board Secretary, and monthly updates from ESR will be incorporated onto the MES Declare system to ensure its accuracy and completeness. 2.2 Exception reports will be generated on a monthly basis on the new system, and automated alerts instigated on overdue submissions of staff with declarations over 6 weeks late.	The contract is now in place with Civica and implementation of the new system is underway following completion of the project set up documentation. Roll out due for week commencing 29/08/23. An update on compliance and progress will be provided to Audit Committee in January 2024.	The next report will be provided to Audit Committee in January 2024. The action to remain open until the Declare System is fully embedded.	Philippa Peake-Jones, Head of Corporate Office	Phil Meakin, Interim Board Secretary	Started	30/06/2022	31/01/2024	3			No	
117	Audit Committee	Internal Audit	Standards of Business Conduct: Declarations	2022	Limited	Medium	Gifts and Hospitality requirements	4.1 The guidance regarding the process of accepting/declaring gifts as well as Hospitality should be circulated/highlighted to staff on a regular basis, ensuring all staff are made aware of the policy as well as what they should do when accepting either gifts or hospitality. Those who oversee governance for gifts and hospitality should be encouraged to remind Directors/Assistant Directors of their role in approving hospitality prior to acceptance.	Agreed, a communications plan will be put in place to publicise the importance of disclosure of gifts and hospitality as part of the process of raising awareness on the requirements of the Standards of business Conduct Policy. (Consideration is also being given in relation to making the process of accepting / declaring gifts as well as Hospitality and the submission of an annual declaration of interests (even a Zero return), to be recorded as part of employees ' Annual appraisal process. The level of compliance can then be monitored from the systems where the Annual Assessment or PADR is recorded. The feasibility of this approach is being considered.)	This process will be automated on the MES Declare system (and will signpost to the staff intranet page with further info / Standards of Business Conduct Policy). Roll out of system due for week commencing 29/08/23. An update on compliance and progress will be provided to Audit Committee in January 2024.	This process was implemented when MES Declare went live. A report will be received at the Audit Committee in January 2024. The action to remain open until the Declare System is fully embedded.	Philippa Peake-Jones, Head of Corporate Office	Phil Meakin, Interim Board Secretary	Started	30/06/2022	31/01/2024	2			No	
118	Audit Committee	Internal Audit	Standards of Business Conduct: Declarations	2022	Limited	High	Monitoring and Reporting arrangements	The Office of the Board Secretary to consider the monitoring arrangements in place for declarations, gifts and hospitality to ensure these are reviewed on a regular basis. 5.2 Reporting to the Audit Committee to be updated to include current compliance rates for DOIs. Consideration should be given to more regular reporting if compliance rates are generally low.	5.1 DOI monitoring will take place monthly with scope incorporating: The completeness of the disclosures for decision makers, Quality assurance checks on submissions, Significantly out of date disclosures requiring escalation, Monthly update of ESR starters and leavers data, DOI disclosures requiring follow-up action. Gifts and hospitality declaration monitoring : Where appropriate, Governance Leads will also be assigned the same responsibilities for DOI reports to be monitored by the Office of the Board Secretary on a bi-monthly basis, with compliance rates to be reported to Audit Committee on a quarterly basis, by the Office of Board Secretary. The annual report on gifts and hospitality will be submitted to the Audit Committee in order to evidence compliance.	The OBS review will inform the Health Boards new Committee Structure and Audit Committee cycle of business will flow from this. A further review of the system is required post implementation to inform future reporting requirements (I.e. number of staff decs against KPIs etc.)	The system is now in place and a number of reports have been drawn down. The Board Secretary and Head of Corporate Affairs will review what data is required to be presented at the Meeting in January 2024. The action to remain open until the Declare System is fully embedded.	Philippa Peake-Jones, Head of Corporate Office	Phil Meakin, Interim Board Secretary	Started	31/05/2022	31/01/2024	3			No	
123	PFIG	Internal Audit	Procurement and Tendering	2021	Reasonable	Medium	E waiver system	Conditions or requests included as part of the approval of a waiver should be reviewed and actioned to ensure these are met.	3.1 We will investigate the possibility of updating the eWaiver system (as part of the 365 redesign) to include a follow up flag that we ensure caveats are noted and followed up if or when a waiver is renewed or extended.	Following a period of user testing the new system is now expected to go live at the end of August 2023. A communication plan for the launch is currently being developed to discourage use of STWs whilst promoting appropriate use of the new system. This is also subject to review fortnightly by WG as part of the Financial Control Environment Action Plan. Post implementation an assessment of impact will be conducted in September (revised date extended from March 2022 to end of September 2023). **October update** - Go live has been put back until November to allow time to incorporate some key governance updates in the waiver process.	Go live has been put back until November to allow time to incorporate some key governance updates in the waiver process. The eWaiver system has been reviewed and updated with the intention of using 365 functionality. Additional enhancements have been made in line with SFI and SORD (approved by Board 30/11/2023). Soft launch scheduled imminently (December 2023).	Denise Roberts, Head of Capital, Tax and Business Support	Russell Caldicott, Interim Executive Director of Finance	Started	31/03/2022	31/12/2023	9			No	
146	PFIG	Internal Audit	Women's Services Division – Sustainability of services	2021	Reasonable	Medium	Escalation of issues	Women's Division management to complete and submit the SBAR to the Health Board Chief Executive Officer. The outcome of the Executive level discussion with the Countess should be formally recorded at the appropriate Health Board forum. Concerns regarding quality of care must be escalated and the Health Board should undertake quality and safety audits to review issues raised.	SBAR Briefing Report: Re Continued Quality Assurances Concerns Relating to Maternity Services at the Countess of Chester Hospital prepared and present to the Health Board's, Chief Executive Officer on 22/10/2021. Letter highlighted local concerns about Maternity Services at the Countess of Chester drafted for the Health Board's Chief Executive Officer, for the attention of Cheshire CCG's Chief Executive Officer inviting a conversation to understand whether they share similar concerns and experiences to BCUHB, with regards to ongoing lack of quality assurances and in relation to specific clinical outcome measures in the Maternity Services they commission by the Countess of Chester Hospital NHS Foundation Trust. Update on actions taken by the Women's Division, in respect of the ongoing quality assurance concerns in the Maternity Service provided at the Countess of Chester, presented at the Women's Executive Accountability meeting on 5/11/21 and at Corporate PSQ on 9/11/21. Quality and Safety Audits and Assurances required during a pandemic and when formal contract management reporting resumes, to be formally and agreed with the Countess of Chester Provider Team on 24/11/21.	A further Paper to support the de-commissioning of the Service , as part of the 23/4 Savings and Quality agenda, is being prepared by the Service to be submitted to the Exec Team Meeting. **October update** - Section 6 depicts the roles and responsibilities of persons within the clinical audit process whilst Section 7 of the policy/procedure outlines the organisational structure.	Update required	Fiona Giraud, Director of Midwifery and Womens Services	Adele Gittoes, Interim Executive Director of Operations	Started	31/12/2021	28/08/2023	7				

147	PFIG	Internal Audit	Women's Services Division – Sustainability of services	2021	Reasonable	High	Finance and Contracting Arrangements	The Health Board to ensure controls are in place to verify activity, treatment, and intervention charges, or obtain sufficient assurance that the data provided by the Countess of Chester Hospital is fair and reasonable. Furthermore: Contracting to share monthly data with Women's to enable periodic review and reconciliation. The Women's Division to engage with the Contracting Team during the negotiation stages to explore future reporting requirements and whether the concerns raised could be addressed via the terms of the contract. Representative from Women's Division to attend and escalate issues and concerns via the monthly contract meeting between the Health Board and the Countess of Chester Hospital as required.	NHSE Guidance issued in response to the Covid 19 (March 2020 extended for 2021/22) pandemic which Welsh Government has adopted, stood down the requirement for a formal signed contract and contract management and reporting requirement, these will however be re-established once that guidance changes. Despite the guidance BCUHB Contracting Team has continued to meet with providers and data has been continued to be received during the pandemic. COCH implemented a new patient system in July 2021, there have been difficulties with the implementation which has resulted in BCUHB not receiving regular reports. This has been raised at meetings with COCH, formal correspondence has now been sent by the Contracting Team and a formal action plan requested for resolution. Activity data will continue to be validated for responsible commissioner and undertakes a series of validation checks regarding tariff and coding. Contracting to share monthly data with Women's to enable periodic review and reconciliation where queries arise these will be raised through the contract process once re-established formally by NHS England and Welsh Government and if required Clinical Audits will be pursued. Contracting have built links to Cheshire CCG as the lead commissioner for the main acute services at Countess of Chester and any significant assurance reports are now shared with the Health Board. BCUHB Contracting Team has continued to raise the ongoing concerns relating to commissioned Maternity Services during the pandemic albeit not within the formal process that existed previously when contract arrangements were fully operational. Contracting representation at the Women's Division Finance & Performance Group will continue and once received from Countess of Chester, monitoring reports will be presented and escalation issues captured to feed into formal contract meetings, representatives from the Division will be invited to Contract meetings as required to pick up service specific issues directly with the Provider. The next meeting with the Countess of Chester Foundation Trust is scheduled for 24th November 2021 and the service will be attending a pre meet on the 16th November 2021 to agree the clinical data and Quality Assurance Framework that will be expected by BCUHB whilst working outside of normal contracting arrangements, during a pandemic.	Contract information is being received from COCH and distributed, any queries are captured and raised at contract meetings as and when they may arise. Contracts team members attend divisional f&P meetings. **October update** - This item, Audit reference ID147, relates to ID4019/ Risk Score 12 which sits on the Women's Service's Risk Register and refers to the ongoing risk that pregnant women known to BCUHB, who access commissioned care via the maternity services at the Countess of Chester Hospital Trust, may not be receiving high quality patient centred safe care and optimal clinical outcomes.	Update required	Fiona Giraud, Director of Midwifery and Womens Services	Adele Gittoes, Interim Executive Director of Operations	Started	31/12/2021	30/05/2023	1	28/06/2023			
148	People Committee	Internal Audit	Employment of Medical Locum Doctors	2022	Reasonable	Medium	Justification Notes	All requests for recruitment of locum medical staff should be completed to a good level and include all necessary information and justification notes, which will facilitate an effective audit trail.	Clear guidance on minimum information required to be developed in liaison with Finance and Associate Medical Director Professional Standards (Office of the Medical Director 'OMD'). Quarterly compliance audit will be undertaken by WOD/Fin/OMD and included in Contract management information	This is now included in the monthly performance meeting and the initial report will start from 1st September 23. The delay in this is due to the implementation of a new booking system in August 2023.	Due to the changing financial position of the Health Board, the response to this action has been amended as the prior solution was not suitable. In October 2023, a new Rate Approvals group was put in place where services are required to submit detailed justification for high cost locum bookings. Linked to this, a new Temporary Medical Workforce Policy has been developed. The new policy is planned to be ratified in Q4 2023/24.	Nick Graham, Workforce Optimisation Advisor	Jason Brannan, Deputy Director of People	Started	30/06/2022	29/02/2024	6			No	
149	People Committee	Internal Audit	Employment of Medical Locum Doctors	2022	Reasonable	High	New Recommendation	The Health Board ensures there is a robust process to monitor the performance of the contract and this should be reflected in the Health Board Standard Operating Procedure/policy.	Tripartite Contract Management meetings to be arranged on a monthly basis. Tripartite Senior Contract Management meetings to be held quarterly.	The meetings are now in place and a dashboard is reviewed as part of these meetings which will be revised as required, any issues arising from the performance are discussed and actions agreed to rectify them as part of the contract management oversight. **October update** - This risk is a direct result of the Trust's inability to provide sufficient assurance on the quality of care which women known to BCUHB are receiving by them as a Provider. A high clinical intervention rate, the findings of a recent CQC Review (2022), recent Criminal Investigation relating to Neonatal Services and lack of timely KPI and Quality assurance reports to Commissioners is exacerbating the level of concern escalated numerous times to the Health Board.	The new BI dashboard is under development and due to be launched by January 2024.	Nick Graham, Workforce Optimisation Advisor	Jason Brannan, Deputy Director of People	Started	30/06/2022	30/01/2024	3	20/01/2023	30/08/2023	No	
150	People Committee	Internal Audit	Roster management	2022	Limited	Medium	Policies and Procedures	Policy WP28a requires a review, needs to include a reference to the E-timesheets also include the SOP within the documents to be read alongside the policy section on the first page. Draft SOP needs to be approved and activated.	Policy WP28a has been reviewed and is with Workforce Policy Group for consideration. Policy to be approved and deployed with a clear compliance audit schedule in place and commenced. Draft SOP to be reviewed to amend reference to unpaid break to acknowledge the risks associated on safe staffing in conjunction with Corporate Nursing Team. Interim SOP (with exception of paid break element) to be approved for a 3 months period to ensure clarity of process and accountability in intervening period.	Revised policy is now live with all relevant amendments enacted, the issue around breaks is now being managed by senior corporate nursing leads. **October update** - These concerns have been raised in a number of meetings with our BCUHB Contracting colleagues, and whilst some data is now being received we have again sought re-assurance on the 19th September in relation to Progress made against the findings of the CQC Report, assurance in relation to their Midwifery and Obstetric staffing, progress on their implementation of the Saving Babies Lives Care Bundle 3, approval of BCU patient pathways (those who don't follow the Birth Choices process) and how these are agree with the Health Board. These have been formally raised with the Countess and we await response.	The policy renewal took place but ongoing monitoring has shown that further work, led my the nurse optimisation team, is needed in relation to compliance with managing breaks. This is linked to the programme of work to move all nurses onto the e-Roster system to help applying a consistent approach to unpaid breaks accross the IHCs.	Nick Graham, Workforce Optimisation Advisor	Jason Brannan, Deputy Director of People	Started	31/07/2022	29/02/2024	2	14/12/2022	30/08/2023	No	
151	People Committee	Internal Audit	Roster management	2022	Limited	High	Submission of timesheets by agencies	Agencies are formally reminded of the requirement to submit timesheets within 48 hours to ensure roster managers have sufficient time to check these. Compliance with the submission of timesheets to be monitored and where there are continued delays this should be escalated via contract arrangements.	Formal letter to be issued to all agencies from Executive Director of Workforce and Organisational Development. Communication to be sent to all Heads of Nursing, Matrons and Ward Managers to emphasise requirement to lock down and record variations to working hours . Training sessions to be held again with Heads of Nursing, Matrons and Ward Managers to ensure understanding of requirements	Communication to all agencies has been issued. Communication to all Nursing Managers has been issued Training sessions have been put on for nursing teams on 2 separate occasions but have been poorly attended to date, this poor attendance has been flagged with AD for Nursing Workforce and further sessions are being arranged for September 22 with attendance now being made mandatory. All original actions and further actions have now been completed. **October update** - Additionally, we have recently identified some issues in terms of securing the Countess's input into SI's, PMRTs and responses to concerns, which is significantly impacting our ability to manage and progress our internal processes. This will be raised with the contracting team for discussion with the Countess at their next meeting.	It has been identified that furhter work with nursing is needed to improve compliance with the policy and locking of shifts in a timely manner.	Nick Graham, Workforce Optimisation Advisor	Jason Brannan, Deputy Director of People	Started	30/06/2022	29/02/2024	2	14/12/2022	30/08/2023	No	
152	People Committee	Internal Audit	Roster management	2022	Limited	High	Implementation of 1 hour breaks	The Temporary Staffing Team to regularly review 12 hour shifts on the system (prior to submission to payroll) and amend the break times as per the procedures. 3.2 Agencies are formally reminded of the requirement to input breaks according to the timesheets submitted, and reminded of the declaration included on the system where they are confirming the details entered are correct. 3.3 Roster managers to be formally reminded of the requirement to check shifts match timesheets/exception sheets before they are locked for payment. 3.4 The 12 hour shifts where the break has not been adjusted should be identified and steps taken to recover the overpayments. 3.5 The Temporary Staffing team should regularly check a sample of shifts on the system against paper timesheets retained by agencies.	(as per 1.2) Draft SOP to be reviewed to amend reference to unpaid break to acknowledge the risks associated on safe staffing in conjunction with Corporate Nursing Team. Revised SOP to be clear on responsibility within Nursing for amending working hours in line with Safe Care. Revised SOP approved by People and Culture Executive Delivery Group and implemented	All actions have been implemented as per the action plan. **October update** - Whilst this is an ongoing issue the Service has previously presented a Business Case to serve notice on the maternity contract at the Countess of Chester Foundation NHS Trust to Executive Management Group (EMG), Health Board Leadership Team (HBLT) and the previous three Chief Executive Officers (latest presentation was September 2022 at HBLT). The Service has undertaken significant engagement to shape the Decommissioning Business case dating back to 2018. This includes Board and Executive members, Women's Service Board Members, Clinical and Midwifery colleagues in addition to the Welsh Government. (A full chronology of engagement is available). Additionally, the Service has both raised concerns in terms of the care and limited assurance at the Countess and the proposed approach to de-commission services at regular Corporate Accountability meetings chaired by the latter three Chief Executive Officers.	The actions relating to this response were completed, however, it has been identifed that further improvements are needed to ensure roster users are followng the new SOP.	Nick Graham, Workforce Optimisation Advisor	Jason Brannan, Deputy Director of People	Started	31/08/2022	29/02/2024	2	14/12/2022	30/08/2023	No	
154	People Committee	Internal Audit	Establishment control – Leaver management	2022	Limited	High	Operational management compliance	Workforce and OD should progress the plans to improve leaver management as a priority, to ensure all employment controls are adhered to 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.	No 4 was piloted but did not work for IT teams, this was escalated via IT to a national group who is looking at a solution for the IT element of this. Further work to align with National changes to leaver management. **October update** - The Business Case has been refreshed in August 2023 and is with the Executive Team for consideration recommending a review of the current contract with effective change in April 2024.	No 4. - There remain technical issues to be resolved with the existing changes forms and self service function which has impacted the completion of this action. Whilst the ESR Self Service system sends the notifications to IT colleagues, it does not provide the details required. IT colleagues need to understand if the leaver requires their NADEX account to be terminated and leaving BCU is not always an indicator to terminate the NADEX as they may be moving to another NHS organisation in Wales or retiring and returning to BCU, the recent Pension changes will help address the retire and return staff members. A new all wales changes form (Staff Movemement Advice) is due for release in 2024 and will be expected to resolve this action.	Nick Graham, Workforce Optimisation Advisor	Jason Brannan, Deputy Director of People	Started	31/01/2022	31/03/2024	2	28/02/2022		No	

155	People Committee	Internal Audit	Establishment control – Leaver management	2022	Limited	Medium	Leaver data provided to areas/departments	Information on non-compliance with the leaver process should be included in monthly exception reports that are provided to areas/departments. Where non-compliance remains high action should be taken to improve compliance i.e. additional training and monitoring by Workforce and OD.	There are four interventions to assist with supporting the wider leaver management reporting process: 1. The monthly production of the ESR Leavers Report compared to the ESR Change Event Log by Division. This will highlight the number of leavers terminated in ESR after the leaving date, this will be grouped by month for high level numbers. 2. The monthly review of Establishment Control requests which highlight the EC request is relating to a team member being replaced. The check to be completed will be comparing the team member noted on the EC request with the ESR Leavers Report and follow up action with the EC requestor regarding why the team member hasn't moved departments or been terminated. 3. Both interventions above will ensure that non-compliance reporting is more targeted. The enhanced reports will be included in the monthly exception reports and shared with Heads of HR and with relevant Senior Leadership Teams. Each quarter the report will be aggregated and will include details of the supervisors who are repeat offenders. 4. Where there is a lack of compliance training and support will be put in place in conjunction with IT and IG to ensure managers are fully equipped to carry out the actions required.	This action has been implemented. It was not signed off earlier as it had dropped off the owners log due to a technical error with the system	1 - Complete 2 - Complete 3 - For re-review to ensure the data is being reviewed from within the Teams Channel and or included in Workforce BI Dashboard 4 - For re-review.	Nick Graham, Workforce Optimisation Advisor	Jason Brannan, Deputy Director of People	Started	31/01/2022	31/03/2024	1	28/02/2022	30/08/2023	No	
158	PFIG	Internal Audit	On-Call arrangements	2022	Limited	High	Review of on-call arrangements	1.1a The on-call review should be re-instated as a priority, to ensure arrangements match service requirements, and are reviewed considering changing needs as a result of changes due to VERS and the new Operating Model. 1.1b Management should consider the feedback from our questionnaire when reviewing on-call arrangements, and how these can be addressed. 1.1c Following completion of the review and update of guidance (see Matters Arising 2,3 and 4 below), this should be communicated to staff to ensure they understand their obligations and responsibilities for participating in the on-call rotas.	1.1a The on-call review will be restarted and will be led by the Interim Regional Director of Delivery (IRDD), supported by the Strategic Emergency Preparedness Response and Resilience (EPRR) lead. 1.1b Proposals will be presented to the Executive Team, for approval.	Full review underway with support from Workforce. Delays due to interim staff change over. Paper planned to Senior leadership Team by the end of September, then to Execs for the end of October. **October update** - T&F group implemented to review Bronze/Silver and Gold on call along with identifying themes from the on call. WG EPRR lead has been requested to share any all wales on call documentation to support resilience planning. Financial costs of IHC on call one area is still outstanding. Next steps - End of November SBAR to Operational Leadership team to agree on next steps for on call design.	Update required	Geraint Farr, Associate Director of Unscheduled and Emergency Care	Adele Gittoes, Interim Executive Director of Operations	Started	12/10/2022	31/10/2023	1				
159	PFIG	Internal Audit	On-Call arrangements	2022	Limited	High	Rota guidance/sustainabi lity	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.	The definitive rota and implementation was delayed due to the delay in implementation of the operating model. This was flagged as a potential risk when the audit response was given. The revised timescale is October 2023 to Execs / HBLT for agreement. **October update** - On review in September it was identified a lack on governacne arrangments around on call provision and Process, noting variances across BCUHB of staff on call. This is being addressed by the creation of a BCUHB On Call policy that will need to go via OLT (End of November) for ratificaiton prior to executives for sign off.	Update required	Geraint Farr, Associate Director of Unscheduled and Emergency Care	Adele Gittoes, Interim Executive Director of Operations	Started	01/07/2022	31/10/2023	1				
160	PFIG	Internal Audit	On-Call arrangements	2022	Limited	High	Compensatory rest and payment	Workforce policies to be reviewed and updated as necessary, including clear guidance on the requirement for taking compensatory rest. Guidance on compensatory rest and payment entitlement to be included on the staff intranet site and circulated to all staff included on on-call rotas. This should be done on a periodic basis to ensure new staff who are added to rotas are aware of their entitlements. Staff included in on-call rotas to be encouraged to take compensatory rest.	3.1a All on-call staff to be written to by the Interim Director of Regional Delivery, having agreed content of the letter with the Director of Workforce and OD, and Deputy CEO.	The compensatory rest policy is in the process of being confirmed, as there are many local differentiations in arrangements, and HR is reviewing the compensatory payments when we understand the intensity of the rotas, as per national/regulatory frameworks for payment. **October update** - No further update as of October 2023.	Update required	Geraint Farr, Associate Director of Unscheduled and Emergency Care	Adele Gittoes, Interim Executive Director of Operations	Started	11/07/2022	31/10/2023	1				
161	PFIG	Internal Audit	On-Call arrangements	2022	Limited	High	Training	The requirements of staff included in on-call rotas should be documented and staff provided with relevant information to ensure they are able to deal with expected issues whilst on-call i.e. key information about sites and services, as staff may not be familiar with the site they are responsible for during the on-call shift. Training should be provided to staff who are on the rotas to ensure they are aware of their responsibilities and possible scenarios of what they may have to deal with.	4.1a Programme of training to be reviewed. The programme will take into account the areas identified within the audit survey. 4.1b Manual to be developed with key information, and details for those on call. 4.1c All staff to receive training with a programme and timescale set for refresher training every two years. 4.1d Real time log to be introduced for all levels of on-call to aid action learning with a rolling process of review by the IRDD and Strategic EPRR lead.	Post implementation of policy, training programme to be implemented. Further considerations as to the recruitment to existing funded vacancies will be required for delivery. **October update** - Training process has commenced with 3 sessions completed in October 2023 regarding HFP and ambulance escalation. JESIP modeling has commenced for a training portfolio, along with development of a Training package on line for staff.	Update required	Geraint Farr, Associate Director of Unscheduled and Emergency Care	Adele Gittoes, Interim Executive Director of Operations	Started	12/12/2022	31/11/2023	1				
169	QSE	Internal Audit	Comisiynydd y Gymraeg/Welsh Language Commissioner: Dogfennau ar y Gwefan/ Documents on the Website	2022	Limited	High	Policy and Management of Website Information	1.1 Health Board to establish formal policy to support the management of the Health Board website (and other digital) content. 1.2 Management review website user administrator access privileges and establish controls to ensure amendments or additions to the Health Board website are subject to review and scrutiny prior to publishing. 1.3 Management to establish controls or monitoring arrangements to ensure that changes published on the English web pages are also actioned on the Welsh pages.	1.1 Establish a formal policy and guidance to support the management of BCU digital channels, including the website. 1.2 Review current administration access to the BCU website and issue revised guidance and training where required. 1.2 Commission support to conduct a review of the website to identify and rectify any discrepancies with existing Welsh/English content. This will be a six-month project to provide a robust review of the website. This will be funded by the Corporate Communications Team. 1.2 Recruit a dedicated translator for the Corporate Communications Team to: manage all translation requests for the website ensure content is published simultaneously link with Welsh Language team to maintain translation standards. This will ensure amendments or additions to the website are subject to review and scrutiny prior to publishing. The funding for the first 12 months of the post has been agreed, during which time a business case will be made for the post to be permanently established within the team. 1.2 All devolved editors will be contacted and reminded about the translation and publication requirements for the website and offered refresher training sessions. 1.3 Recruit a dedicated translator for the Corporate Communications Team to ensure all new or amended content is published in Welsh and English simultaneously on the website and resolve issues with delayed translation requests. 1.3 Establish a programme of audits to monitor the website on a monthly basis.	1. The protocol has been developed and signed off, approved by HBLT (1st March 2023) 2. Website user administration access privileges have been reviewed and controls implemented (list of editors reviewed, redundant users removed and all remaining users issued with protocol and user agreement. Refresher training also provided). 3. New content translation managed by the Communications team, regular audits of new and/or amended pages conducted (noting that some of the pages are devolved responsibility, i.e. the OBS page). 4. Whilst the original Management response indicated the recruitment of a dedicated translator for the Comms team, the team have been unable to recruit on two separate occasions. Financial circumstances now mean that funding is no longer available.	The draft report has been received back from the Auditors to confirm all actions have been completed. However, work is ongoing in order to undertake random checks on web pages to ensure continued compliance with protocol.	Andrew Rogers, Head of Corporate Communications	Teresa Owen, Executive Director of Public Health	Started	31/03/2023	31/01/2024	4			No	
172	PFIG	Internal Audit	Effective Governance: YWM	2022	Limited	High	Finance	Management to identify and progress savings schemes as a matter of urgency. Management ensure financial scrutiny is in line with the requirements laid out in the Operating Model.	A revised control total has been set for the EIHC. E IHC is an exemplar area for CHC savings. The Finance and Performance Sub Committee includes a duty to monitor progress with cost improvement programmes. Terms of Reference were signed off 16 November 2022.	East IHC Annual Plan has been signed off at IHC level (including oversight from the corporate plannng team). IHC F&P sub-group established as part of the new operating model. This will be subject to continuous review as well as part of the wider fianncial position (the saving guidance and templates are due for issue for the beginning of september).	Update required	Geraint Farr, Associate Director of Unscheduled and Emergency Care	Adele Gittoes, Interim Executive Director of Operations	Started	31/03/2023	31/10/2023	1				
183	Audit Committee	Internal Audit	Board and committee reporting	2022	Limited	High	Request and submission of papers and reports.	1.1 We recognise that the Health Board have recently implemented a Board/Committee Paper Assurance and Publication SOP. Management to ensure established timescales are met, monitor compliance, and escalate issues of significance to relevant Executive Leads, Chairs, and/or Board Secretary. 1.2 Management to consider publishing meeting and committee calendar on the Health Board website to encourage public engagement.	1.1 Agreed and as stated a Standard Operating Procedure for committee and board agendas is in place. 1.2 2023/24 Board and Committee meeting calendar will be published when finalised.	SOP in place. Calendar in final stages and hoped to be issued as final by September	The Corporate Calendar is now in place and work is ongoing to produce the calendar for 2024-2025. The SOP is implemented. Although the original (2022) recommendations have been met, this will be monitored and should stay open until the remaining Committees are scheduled to give additional assurance to the Audit Committee.	Philippa Peake-Jones, Head of Corporate Office	Phil Meakin, Interim Board Secretary	Started	31/12/2022	31/03/2024	2			No	

184	Audit Committee	Internal Audit	Board and committee reporting	2022	Limited	High	Submitted papers meet the Board / Committee requirements.	2.1 Management to ensure that papers and reports submitted to the BCU Board, Committees, or Advisory Groups are of the expected standard, meet the requirements of the Board / Committee and have been reviewed and quality checked prior to being submitted. Submissions to comply with Board / Committee Paper Assurance and Publication SOP. 2.2 Health Board to consider undertaking a root cause analysis of Board and Committee paper and report quality to determine whether there are underlying factors impacting the frequency of issues raised and determine appropriate solutions.	2.1 We will put in place three line of defence processes in assurance reporting, which will enable more focus on the requirements of the Board and its Committees, as well as the evidence required at an executive level to enable robust reports to be produced. This will also be incorporated within the Board and Committee effectiveness review and incorporated within the overall action plan, which be aligned to the Board development programme. 2.2 Accepted, root cause analysis to be undertaken as a result of the Board and Committee effectiveness review.	Update pending the outcome of the OBS review that will inform Committee type/ frequency of meetings and associated governance processes.	The Office of the Board Secretary Review has now been received and the recommendations from that will be taken forward. A SOP is now in place and will be monitored with regards to compliance and standards. The Office of the Board Secretary will develop a new report format and roll out training with regards to report writing. It is worth noting that the original action was completed, however the Acting Board Secretary wants to further improve report writing standards.	Philippa Peake-Jones, Head of Corporate Office	Phil Meakin, Interim Board Secretary	Started	30/03/2023	29/02/2024	1			No	
185	Audit Committee	Internal Audit	Board and committee reporting	2022	Limited	High	Reporting Breaches.	Management to establish controls and monitoring arrangements to ensure that all reporting breaches are captured and reported to the Audit Committee.	3.1 All staff will be reminded of the requirement to complete the breach log in relevant cases. Internal Audit observation: We do not believe the management action mitigates the risk of inaccurate reporting to Audit Committee.	Update pending the outcome of the OBS review that will inform Committee type/ frequency of meetings and associated governance processes.	The Office of the Board Secretary Review has now been received and the recommendations from that will be taken forward. The Audit Committee received a paper on Breaches at its November 2023 meeting, this will continously be monitored and reporting diligently monitored.	Philippa Peake-Jones, Head of Corporate Office	Phil Meakin, Interim Board Secretary	Started	31/12/2022	31/12/2023	1			No	
186	Audit Committee	Internal Audit	Board and committee reporting	2022	Limited	High	Cycles of Business and Terms of Reference.	4.1 Health Board/Committee Cycles of Business and/or Terms of Reference should be periodically reviewed and approved by relevant committees to ensure continued relevance. Approval should be recorded in relevant meeting minutes. 4.2 Management to consider publishing Board/Committee Terms of Reference and/or Cycles of Business on the Health Board website to promote public engagement and reintroduce the publishing of meeting minutes to improve accessibility.	4.1 Agreed. The ToR approved by Board in the September 2021 governance review are in the process of being reviewed and proposed to the committees and their approval will naturally be minuted. Committee Terms of reference will also be reviewed as part of the Board and Committee effectiveness review. 4.2 Agreed, these will be published on the website.	Process reviewed and revised, with Chair's Action as a standard agenda item for all Board meetings. Outstanding action is to update ToRs (pending OBS review).	The Office of the Board Secretary Review has now been received and the recommendations from that will be taken forward. Whilst there is more work to do this year, the original action has been completed.	Philippa Peake-Jones, Head of Corporate Office	Phil Meakin, Interim Board Secretary	Started	30/03/2023	31/12/2023	1			No	
187	Audit Committee	Internal Audit	Chairs action	2022	Reasonable	High	Process Design	The Health Board should adopt a formal process for documenting requests and approval of Chairs actions. Details captured could include: Unique identifier; Timelines (Issue raised locally/request made to OBS/authorisation granted by IMs and Chair); Financial impact/cost; Category; and Usual approval route and reasons why this has not been used. The OBS should ensure all approved Chair's actions are reported to the relevant Board/Committee meeting and sufficient detail is captured in the report and the minutes of the meeting. Consideration should be given to reviewing Terms of Reference for Board Committees and whether responsibilities for undertaking Chair's actions relating to Committee business is permitted.	1.1 The template will be amended as suggested to include the five additional fields. 1.2 Chair's Actions will be universally captured as part of the Chair's written report to the Board/Committee with effect from October 2022. 1.3 A review of the Terms of Reference for Board and Committees will be scheduled as part of the COB and Chair's Actions and will include the authority to undertake Chair's actions on behalf of the Board, as set out in the Scheme of Delegation	Recommendation has been delayed due to OBS staffing issues and board member changes .	The Office of the Board Secretary Review has now been received and the recommendations from that will be taken forward.	Philippa Peake-Jones, Head of Corporate Office	Phil Meakin, Interim Board Secretary	Started	31/01/2023	29/02/2024	1			No	
188	Audit Committee	Internal Audit	Chairs action	2022	Reasonable	Medium	Standard Operating Procedure	The SOP should be updated to reflect the detail of the process in place and consideration given to which IMs should be included in the approval of the request, where possible using their area of expertise.	The SOP will be updated to ensure alignment with the current practice for Chairs Actions, including the criteria applied for Independent member selection, taking into account expertise, and appropriate committee remit	Recommendation has been delayed due to OBS staffing issues and board member changes .	The Office of the Board Secretary Review has now been received and the recommendations from that will be taken forward.	Philippa Peake-Jones, Head of Corporate Office	Phil Meakin, Interim Board Secretary	Started	30/11/2022	29/02/2024	1			No	
190	Audit Committee	Internal Audit	Chairs action	2022	Reasonable	Medium	Lessons learned	4.1 There should be a periodic review of Chair's actions to determine the reason for the action and to establish if any changes need to be made to current processes/approval routes. 4.2 The Health Board should liaise with Board Secretaries/Office of Board Secretaries from HB3 and HB4, which may highlight areas where lessons can be learned to aid in reducing the number of actions.	4.1 The Board Secretary and Head of Corporate Affairs to review on a Yearly basis the Chair's Actions brought throughout the year. 4.2 Discuss at the national Board Secretaries forum what other organisations are doing and understand if there is the appetite for a once for all Wales approach to the Chair's Action Process.	Recommendation has been delayed due to OBS staffing issues and board member changes .	The Office of the Board Secretary Review has now been received and the recommendations from that will be taken forward. Data set for March review in Office of the Board Secretary calendar.	Philippa Peake-Jones, Head of Corporate Office	Phil Meakin, Interim Board Secretary	Started	31/01/2023	29/02/2024	1			No	
194	PFIG	Internal Audit	Charitable Funds	2022	Limited	High	Charitable Funds Committee	2.1 Review Membership of the Charitable Funds Committee in light of Executive changes, including the quoracy required for meetings and update Terms of Reference to reflect any revisions. We suggest a minimum 2 Executives and 2 Independent Members, recognising the wider pool of IM and Executives who are Board of Trustee Members. 2.2 Review responsibilities and objectives of Committee and consider the regular information provided including more qualitative data on the operation of the Charity, updating the Terms of Reference to reflect any revisions. 2.3 Undertake a review of the effectiveness of the Charitable Funds Committee, in line with the requirements of the Terms of Reference (2.1) of the Committee, including requirements of the Charity Commission.	2.1 New Terms of Reference to be approved by the BCUHB Chairman, the Chair of the Charitable Funds Committee and the Executive Team and submitted for approval by the Charitable Funds Committee and ratified by the Trustee Board. 31/01/23 Interim Board Secretary. 2.2 New Terms of Reference to be circulated to all Charity Team members for input to include fundraising, impact reporting and engagement planning and reporting as appropriate. 31/01/23 Interim Board Secretary: 2.3 Undertake an effectiveness review of the Committee via survey/interview of all Committee members and non-member regular attendees, and commit to a plan for reporting this and scheduling it in on an annual basis. More time to be allocated for measuring effectiveness at the end of the meetings, with specific questions considered in the 'Meeting Effectiveness' agenda item.	Following new Interim Board member appointments ToR review delayed. The intention is for the ToR to be signed off at CFC meeting Jan 2024 and ratified at the subsequent Audit Committee as necessary.	The draft CFC ToR is being presented for approval at the CFC 01/24 for ratification at the Trustees AGM 01/24.	Kirsty Thomson, Head of Fundraising : Awyr Las	Russell Caldicott, Interim Executive Director of Finance	Started	31/01/2023	31/03/2024	2			No	
195	PFIG	Internal Audit	Charitable Funds	2022	Limited	High	Strategy	The Charity Strategy should be presented to Board of Trustees for review and approval.	Charity Strategy to be submitted for approval to the December 2022 Charitable Funds Committee and presented for ratification at the January 2023 Trustees meeting.	The new Charity (and Charitable Partnerships) Strategy is due to be submitted to the Charitable Funds Committee for approval at the October with final ratification planned at November Board	The Charity Strategy was approved by the CFC on 03/10/23. The strategy will be ratified at the Trustees AGM 01/24.	Kirsty Thomson, Head of Fundraising : Awyr Las	Russell Caldicott, Interim Executive Director of Finance	Started	31/01/2023	31/01/2024	2			No	
196	PFIG	Internal Audit	Charitable Funds	2022	Limited	Medium	Policies and Procedures	4.1 Policies and procedures are reviewed to ensure any changes are reflected. Feedback from the Fund Advisor questionnaire should be incorporated when reviewing the procedures. 4.2 Training for Fund Advisors is reviewed and recommences as soon as possible.	4.1 Financial Procedures to be reviewed and submitted to the Charitable Funds Committee in March 2023 for approval. Engagement and Communications Procedures to also be drawn up for approval by the Charitable Funds Committee in March 2023. 4.2 New Fund Advisor training package and communications plan to be in place and resourced by April 2023.	Procedures update was delayed due to a decision to do a deeper dive into charity's finances. All procedures to be reviewed and submitted to the CFC for approval at the July 2023 CFC meeting and ratified as required by the Audit Committee in September. A new Fund Advisor training scheme is on track to be introduced by December 2023, but not as comprehensive as planned due to lack of capacity within the team.	The draft Charity Procedures are being presented for approval at the CFC 01/24. New Fund Advisor and Service / Area Charitable Funding Advisory Groups information and training to be introduced from 03/24.	Kirsty Thomson, Head of Fundraising : Awyr Las	Russell Caldicott, Interim Executive Director of Finance	Started	30/04/2023	31/03/2024	1			No	

198	PFIG	Internal Audit	Charitable Funds	2022	Limited	Medium	Expenditure	A process should be put in place to review the benefits/outcome of funding to ensure these have been realised and captured by the Charity.	A dedicated Grants Manager will be in post by March to ensure a more robust process can be put in place to track funding requests and monitor, evaluate and report funding outcomes and outputs for all charitable activity	COMPLETED. Dylan Evans, Grants and Data Manager, started in post from 27/03/23 and the development of a new grants management system, which includes new processes to capture more information, monitor and evaluate all charitable grants, is underway and due to be fully operational by the end of 2023.	The Grants and Data Manager responsible for implementing the actions relating to this recommendation is currently off work. Due to the subsequent reduced capacity in the Charitable Funds and Charitable Partnerships Support team, the actions have not been completed in the anticipated timescale. The revised timeline to improve the process to review the benefits/outcome of funding to ensure these have been realised and captured by the Charity is as follows: Complete: introduce new application summary template to highlight clear outcomes and outputs for all funding requests, which can be monitored and evaluated; Q3 2023/24 introduce new online application system for all funding requests and update guidance for all charitable funding applicants; Q4 2023/24 introduce a more sophisticated online system to monitor and record updates and evaluations from applicants to be included in Charitable Funds Committee reports and charity communications (subject to the approval of new systems Enthuse charity marketing platform, Donorfy CRM, and ProGrant / other grant management system by IT & IG). The process to review the benefits/outcome of funding to ensure these have been realised and captured by the Charity is included for noting in the January Charitable Funds Committee (CFC) papers and Grant Management is now a standing item within the Team Update paper submitted to the quarterly CFC meetings.	Kirsty Thomson, Head of Fundraising : Awyr Las	Russell Caldicott, Interim Executive Director of Finance	Started	30/09/2023	31/07/2024	1	04/05/2023	22/08/2023	No	
206	QSE	Internal Audit	MH&LD	2023	Reasonable	High	Ligature remediation funding was allocated appropriately	MHLD management ensure all ligature risk assessments remain 'live' and subject to regular scrutiny to mitigate/control identified risk.	Each MH&LD SLT to establish a local Ligature Reduction Group, chaired by the Head of Operations, Vice Chair Head of Nursing with an agreed standardised TOR signed of. To review TOR of the newly established Divisional Ligature Reduction Group, to ensure appropriate membership, meeting frequency and reporting of the group is discussed, agreed and signed off. The Chair of each MH&LD local Ligature Reduction Group to provide an exception report to the Divisional Ligature Reduction Group, covering the following: annual review status evidence of monthly review risk control and mitigation progress aligned to external review recommendations. The Chair of the Divisional Ligature Reduction Group to provide an exception report to the MH&LD Divisional Service Quality Group (formally MH&LD QSE meeting, Tier 2) and to the MH&LD Senior Leadership Team meeting (formally DSLT Business meeting, Tier 1) to provide assurance on key risks and mitigation plans related to high, medium and low risks to ensure all ligature risk assessments remain subject to regular scrutiny. Chair of the MH&LD Divisional Service Quality Group to provide a monthly assurance report into MH&LD Senior Leadership Team meeting including high risk anti-ligature works for any required capital expenditure. MH&LD Division to commission an external review of all MH&LD inpatient environments for ligature assessment to produce a report to identify high, medium and low risk ligature reduction work required across the Division. Each local Ligature Reduction Group to report on progress aligned to the external review report recommendations, included within Chairs exception report feeding into the Divisional Ligature Risk Reduction meeting. MH&LD Division to arrange an audit to check the governance arrangements for anti-ligature are implemented and consistently being met, with an exception report being fed into Divisional Ligature Reduction group highlighting any variance aligned to standards.	Progress has been made but further work required to strengthen arrangements (i.e. reporting, auditing). An evidence log will be presented to MH&LD Senior Leadership team 05/09/2023 with further actions agreed. **October update** - An evidence log has been developed and is available to view here: \\bcuestorage.cymru.nhs.uk\office of the board secretary\Board and Committees\Governance\Compliance\AC\Tracker Master\Additional evidence\Rec item 206 The outstanding actions are two ToR's to be formally signed, both scheduled for November 2023. The Health Board is still waiting for some of the commissioned external reports and then further work will be developed identifying high, medium and low risk. Once all the external reports are completed, they will be shared with all local areas to address, mitigate and discharge the findings through actions plans. This will also entail tri-partate working with Estates, Health and Safety and Governance colleagues. An audit to check the governance arrangement for anti-ligature is currently underway with the final report expected in November 2023. Expected date of final completion 31/12/2023.	The Division has received all external commissioned ligature reports and together with the internal ligature assessments are completing an analysis of high, medium and low scoring ligature items. The Division has held a meeting with Estates and Health and Safety to identify additional ligature items for capital investment/revenue. The Division has completed the fieldwork of the anti-ligature governance audit with a report expected early-mid December 2023.	Adrianne Jones, MH&LD Operational Business Lead	Iain Wilkie, Interim Director MHLD	Started	30/06/2023	31/12/2023	1			No	
207	QSE	Internal Audit	MH&LD	2023	Reasonable	Medium	Appropriate governance arrangements in place	ToRs require a review for signature and dates, OLM approval of draft ToR, development of a ToR for summit meetings. Formal reporting of information through the tiers is required, consideration needs to be given as using Divisional QSE as an exemplar. Cycle of business needs completion this will underpin any formal reporting requirements form the tiers.	Review TORs highlighted to ensure these are in place, dated and approved for the following meetings – MH&LD Summit meeting. MH&LD Finance and Performance Group MH&LD Clinical Strategy Group. To ensure, upon agreement of the revised Cycle of Business, all TORs are reviewed aligned to agreed Governance Framework of the new MH&LD Operating Model. Formal reporting throughout all meeting tiers to be implemented, with all meeting Agenda's amended aligned to agreed reporting structure. MH&LD Cycle of Business populated with each meeting Chair, secretariat, meeting frequency, TOR, Agenda template, minute template, RAID Log and either Chairs Assurance reports template or Exceptions report template included for reporting throughout tiered governance framework structure.	Weekly Governance Framework meeting continues to be held to progress with the development of the MH&LD Governance Framework. All Divisional meetings aligned to the Framework have been established, and the cycle of business and reporting schedule is at the final stages of development and implementation to ensure a robust governance framework across the Division. Outstanding action to final approve / sign off remaining ToRs following the implementation of several new delivery groups. **October update** - Governance Framework and Reporting Cycle continue to be developed. Slight delay caused by additional MH&LD meetings being stood up, and also confirmation of corporate reporting cycle which is still being developed i.e. Performance reporting. Delayed completion date of 31/12/23 expected.	MH&LD Governance Framework and Reporting Cycle developed and due for approval through respective governance routes. Due for presentation at Operational Leadership Meeting on 07/12/2023, and onward approval at Divisional Senior Leadership Team meeting on 12/12/2023. Once approved, evidence will be submitted and action closed.	Adrianne Jones, MH&LD Operational Business Lead	Iain Wilkie, Interim Director MHLD	Started	30/04/2023	31/12/2023	1			No	
216	PFIG	Internal Audit	USC: Urgent Primary Care Centres - Business case outcomes achieved	2023	Limited	Medium	Governance Frameworks and Communication Strategies	Governance frameworks, Communication Strategies, and supporting documents should be periodically reviewed and approved to ensure continued relevance and alignment with wider Health Board strategies. Evidence of scrutiny and approval should be retained.	Communication strategy to be drafted and reviewed in line with UPCC objectives. West UPCC Team to undertake Patient Satisfaction Survey as per East and Centre areas. Central UPCC Governance Framework to be reviewed and updated and signed off at Quality and Safety Group. Please refer to UPCC Peer review Action Plan – IA1	Communications strategy paused pending outcome of Urgent Care Review and proposed new model. Central UPPC Governance Framework to be updated and signed-off at August/ September Quality and Safety meeting.	Update required	Karen Higgins, Director of Primary Care	Adele Gittoes, Interim Executive Director of Operations	Started	31/05/2023	31/03/2024	1				
218	PFIG	Internal Audit	USC: Urgent Primary Care Centres - Business case outcomes achieved	2023	Limited	High	Benefits Realisation	2.1 Management to review UPCC capacity and establish measures that can be used to support the delivery of stated benefits. 2.2 The Health Board to ensure that where Business Cases and bids are received, clear measures are set out to assess benefits stated.	2.1 Work is being undertaken to develop suite of outcome measures and performance indicators, to appropriately measure impact of key primary care initiatives, including urgent primary care. Indicators will be used to support activity and performance management of UPCCs moving forward. 2.2 Business case guidance to require clear measures linked to identified benefits. East IHC Primary Care Team have undertaken additional courses recently around writing successful business cases .	Initial RBA training with primary care colleagues and wider teams to develop and confirm approach. USC Business Strategy being developed through USC and 6 Goals Programme Board, and will include development of population and performance scorecards and metrics as part of this work	Update required	Karen Higgins, Director of Primary Care	Adele Gittoes, Interim Executive Director of Operations	Started	01/01/2024		0				
226	PFIG	Internal Audit	Continuing Healthcare Arrangements	2020	N/A	High	R3	The Health Board's current work to drive consistency in the structure of its CHC teams should include work to ensure job descriptions reflect the roles required. These should be clearly articulated and understood by current and new CHC team members.	The CHC corporate team will lead the design of core structures for operational teams at Area and divisional level. This will include standardised job descriptions and structures on teams can work towards locally as opportunities allow within employment law.	Work has commenced but not completed. We are currently linking with national work on reviewing / agreeing competencies for each roles within CHC. Awaiting timescales for the National work. **October update** - Implementation date extended to 31st March 2024 as action is pending national work.	Implementation date extended to 31st March 2024 as action is pending national work.	Kathryn Titchen, Commissioning Manager CHC	Chris Stockport, Executive Director Transformation and Strategic Planning	Started	31/03/2021	31/03/2024	11			No	
227	PFIG	Internal Audit	Continuing Healthcare Arrangements	2020	N/A	High	R5	The Health Board's role as a contractor and commissioner of CHC is underdeveloped which causes inefficiencies and tensions amongst its staff and its providers. The Health Board should resume the work it began in 2019 to develop a CHC contracting and commissioning team with the capacity and capability to plan and deliver CHC more effectively and efficiently.	The Health Board accepts the need for the development of a new 'Commissioning Unit' with the responsibility for the strategic commissioning and performance management of all CHC and ICP placements. The Health Board has agreed in principle to adopt a 'Business Hub' model that will build on these principles, work has commenced to develop an outline business case.	Business Case for Clinical and Business Support Hub is being drafted. BC will go through the required committees in preparation for Board. Target completion date extended to 30/11/23.	Business Hub design principles have been prioritised and are being built into the current programme of work for Corporate CHC, Finance and Contracting. A weekly Corporate Provider Issues meeting has been established, with a monthly operational meeting to review themes, lessons learnt and identify areas for priority work. SOP provided as additional evidence. Action extended to 31st March 2024.	Kathryn Titchen, Commissioning Manager CHC	Chris Stockport, Executive Director Transformation and Strategic Planning	Started	30/04/2021	31/03/2024	9			No	
235	PFIG	Internal Audit	Review of Eye Care Services	2022	N/A	High	R2	Sub-regional variation of patient waits: Undertake analysis on sub-regional variation in waits, either by the Health Board's three main locality areas or by county of residence.	This links to recommendation 7 (Accountability for eye care service) so that a North Wales view can provide overview, guidance and management utilising the patient treatment list wait information that is already available supported by the dashboards that are in progress.	Detail now available on waiting list by Risk factor on a health board and locality basis. This is enabling a prioritisation of treatment, follow up and pathway management on clinical risk factors in addition to local improvement plans Audit of R1 data completeness/application of Wait Time Rules/SOS utilisation commenced: with aim to inform R1 Clinical and non-clinical validation plan. Snap audit has identified data completeness and application of Welsh Waiting Time rules learning. A "Data, Planning and Performance Improvement group" will be taking forward a plan to redress learning. Interim refresh of SOP (Standard Operating Procedures), Welsh Waiting time rules and patient information (to maximise their commitment to care pathway) commenced. **October update** - Note from Owner - No further update available to be provided.	Update required	Rhys Blake, Associate Director of Planned Care	Adele Gittoes, Interim Executive Director of Operations	Started	31/03/2022	31/08/2023	6				

238	PFIG	Internal Audit	Review of Eye Care Services	2022	N/A	High	R5	Efficiencies: Service efficiencies – develop a clear plan to improve service eye care service efficiency and productivity. Where relevant, this should be linked to wider service change/modernisation plans.	Transformation needs to be supported by continuous improvement. There are already key enablers identified with each of the sites/localities developing and agreeing key service productivity improvements pulled together from a pan North Wales to ensure standards are improved and across the Health Board.	To progress a clinically-led inception, Pan BCU Ophthalmology Plan: - A Continuous Improvement Network Steering Group to be formed within, Q2 2023 - This will deliver the inception, formulation and implementation of a plan that reflects National evidence-base, consensus good practice and the 5 clinical measure delivery for BCU HB.	Integrated Ophtalmology MDT Local Networks refreshed: with successful delivery of Integrated Retinopathy Pathways, Clinical engagement negatively impacted by continuance of long-term vacancies (Pan BCU Clinical Lead- 12 months. West Clinical Lead >36 months) and variation in appetite for Pan BCU/regional pathways. Shared vision is being supported by Office of Medical Director and Away Days in Q4.	Paolo Tardivel, Director of Transformation and Improvement	Chris Stockport, Executive Director Transformation and Strategic Planning	Started	31/03/2023	30/04/2024	3			No	
240	PFIG	Internal Audit	Review of Eye Care Services	2022	N/A	High	R7	Accountability for eye care services: Undertake a review of the accountability arrangements for eye care services with the aim of: • ensuring effective integration of services across acute sites; • achieving better integration of services with community optometry; and • eliminating inappropriate sub-regional variation of service delivery and improving service efficiency.	This will be encompassed within the stronger together work which will require the local integration of acute and primary care services with regards to the vertical pathways and processes whilst there is a North Wales responsibility and accountability for services and decision making to eliminate inappropriate sub-regional variation. It is anticipated that the introduction of a new Optometry reform contract will support change, strengthening relationships but also the opportunity to provide better accountability if delegated to the Health Board.	Work has commenced to review the current Eye Care Group and strengthen it's governance, remit and membership to oversee the development and delivery of an Integrated Eye Care service for the population of BCUHB..	Update required	Rhys Blake, Associate Director of Planned Care	Adele Gittoes, Interim Executive Director of Operations	Started	31/03/2022	30/11/2023	7				
241	PFIG	Internal Audit	Review of Eye Care Services	2022	N/A	High	R8	Eye care clinical leadership: Strengthen the clinical leadership structure, with a specific focus on responsibilities, and accountabilities for eye care services. As part of this, ensure that the optometry clinical leadership integrates into the existing clinical leadership structure.	Both North Wales Ophthalmology and Optometry Clinical leads are vital to developing and driving improvement. Recently these posts have become vacant and it is key to replace not only these posts but clinical leadership across sites and across the major sub-specialties; this matrix can be reviewed and tested. Vertical leadership creates potential silos whilst a more recent view of pan North Wales pathway leadership could be explored.	Requires explicit provision of dedicated clinical sessions to enable clinical leadership to be successfully discharged across the Health Board. So far, recruitment attempts have not been successful with just 1 session identified - such a role would need 2 minimum. **October update** - Discussions being had with potential internal candidates. If cannot appoint internally will seek to appoint externally reframing an existing clinical vacancy to include the role of clinical lead.	Update required	Rhys Blake, Associate Director of Planned Care	Adele Gittoes, Interim Executive Director of Operations	Started	31/03/2022	30/04/2023	5				
247	People Committee	Internal Audit	Recruitment of Substantive and Interim Executive and Senior Posts (ESP)	2023	Limited	High	Appointment of substantive JESP/VSM Posts	Management must ensure all appointments to JESP/VSM roles are fully compliant with Welsh Government instructions and Health Board Standing Orders. Management ensure that mandatory procurement training is in place for all Executive Directors and all staff involved in procurement, as required by Welsh Government Chief Executive, NHS Wales.	A new standard operating procedure, linked to a new WP1 safe recruitment policy, for all JESP/VSM appointments will be implemented. The new SOP will encompass reporting of compliance relating to Welsh Government instructions and Health Board standing orders, and will detail the lead officer for each area of responsibility. A new procurement training competence will be added to all JESP/VSM positions into ESR which will link to the training course needed to acquire the competence. This will be visible alongside all mandatory training for senior managers and enable effective reporting alongside all training requirements for the individuals.	Remuneration committee now receives monthly report to identify compliance with SOP, WG requirements and SFIs. WOD to identify process for procurement training for Executives and senior managers	The new SOP for VSM appointments has been approved through the policy development group and is expected to be ratified at the next REMCOM meeting in January 2024. The SOP became operational in August 2023 pending ratification. Procurement training for Executives has commenced and is due to be completed by the end of January 2024.	Ali Mirza, Head of Strategic Recruitment	Jason Brannan, Deputy Director of People	Started	31/07/2023	31/01/2024	2			No	
252	Audit Committee	Internal Audit	Risk Management and Board Assurance Framework	2023	Limited	High	Board Assurance Framework	The process for reviewing and updating the BAF should be documented and implemented. The BAF should be updated when objectives of the Health Board are agreed, to ensure focused actions. The sections of the BAF should be fully completed. The level of detail in action plans should be reviewed to ensure there is sufficient information included to provide assurance to members that appropriate actions are in place to address risks identified.	Document the process for reviewing and updating the BAF with implementation date. Ensure objectives of the Health Board is incorporated into the BAF with focused actions. It is paramount that all sections of the BAF be completed for robust scrutiny and assurance. (see action 3.4 below). Review the action plans to ensure sufficient information is included in the BAF with appropriate actions.	The BAF SOP will be updated following the TOR for all committees however the BAF has been updated for the Sept Board and the format is being revised to allow for more detailed action plans. **October update** - The BAF is on track and has been updated. A full report is due to be approved at the November Board.	The Board Assurance Framework has been completed along with action plans however is aligned to priorities and not objectives. This can be closed once objectives are reviewed in February.	Nesta Collingridge, Head of Risk Management	Phil Meakin, Interim Board Secretary	Started	30/08/2023	31/03/2024	2			No	
254	Audit Committee	Internal Audit	Risk Management and Board Assurance Framework	2023	Limited	High	Oversight and scrutiny of Divisions / IHCs	Review of all meetings attended across the three areas by the Risk Management Department is required. This will give a better understanding of what meetings are taking place as well as providing a more consistent and robust approach towards the Divisions/IHCs risk management arrangements. Clarification required on how the West IHC will provide assurance on its risk management arrangements without a IHC meetings Risk Management Group meeting taking place.	At the Risk Team Meeting, Regional Managers were asked to produce an excel spreadsheet of meetings which review and scrutinise risks for the rest of the year. Any cancellation of meetings and reasons why to be fed back during the Risk Team with repeat cancellation of meetings for escalation to the AD of Governance. Regional Manager West is working with West IHC to provide assurance on its risk management arrangements without the Risk Management Group meeting taking place. Meeting arranged with IHC Medical Director, Interim Head of Risk Management and Regional Manager West on the 1st June 2023 for further discussion and action (additional IA comments to the Management Response - Actions will need to be reviewed following the outcome of the meeting on 1st June 2023).	The risk team compiled a list of meetings but IHC West processes are due to be discussed in Oct RMG as they employee a local approach. IHC west meetings are currently outstanding and due for review following Oct RMG. **October update** - The risk team compiled a list of meetings for oversight but IHC West meetings are still due to be mapped. A meeting is in with IHC West to do this. IHC West did however presented their process for oversight at RMG in Oct and was approved as well as a view from internal audit.	All meetings have been mapped by the team but this needs to be signed off by the Head of Risk Management before closing.	Nesta Collingridge, Head of Risk Management	Phil Meakin, Interim Board Secretary	Started	30/08/2023	31/12/2023	2			No	
256	PFIG	Internal Audit	Planned Care Recovery and Transformation Group	2023	Limited	High	Planned Care Recovery and Transformation Group	It is evident that benefits of establishing the Group have not been realised - the Health Board needs to decide if reinstating the Group is the way forward to provide assurance to the Health Board and Welsh Government that the planned care programme is being successfully implemented. If Group meetings to resume, then its membership and terms of reference should be reviewed and updated to enable the Group meet its objectives with measurable deliverables being developed and reviewed regularly. Management should ensure there are sufficient resources allocated to the planned care agenda, to ensure the planned care programme is successfully implemented.	A draft revised programme is awaiting formalisation and there will be an inaugural meeting to launch the programme before the end of July. Programme resources have been identified and we are working to appoint individuals into lead roles.	Inaugural board meeting held. PID being finalised and GIRFT work to be aligned with this program. **October update** - PID being finalised reported on Agenda at Planned Care Programme Board. GIRFT work to be aligned with this programme.	Update required	Rhys Blake, Associate Director of Planned Care	Adele Gittoes, Interim Executive Director of Operations	Started	31/07/2023		0				
258	QSE	Internal Audit	Data analysis – Triangulation of data	2023	Limited	High	Triangulation of Data sets using consistent naming conventions	The Deputy Director of Quality: Continues to support the Quality Lead Manager develop the use of all data quality sets to inform Health Board wide reporting – This should be a priority. Ensures the standardisation of 'Location' within Datix, reviews the data associated with 'Do Not Use' and removes duplication of 'Categories', ensuring an appropriate audit trail where these are amended. Considers and progresses the findings within Paragraphs 2.3 to 2.5 inclusive of the Detailed Findings.	Following on from the re-alignment of the quality functions, a new Quality Insight and Systems Team is being created. New standard operating procedures for quality systems such as Datix are being developed which will include standardisation of analysis, reporting and dashboards. Working with the national Once for Wales RLDatix Team, a new locations and services hierarchy was implemented in April 2023 which aligns to national standards under the Once for Wales RLDatix programme and best practice. A change control process will be in place via the SOPs mentioned above. The findings from internal audit will be reviewed with the respective quality governance teams and findings will be shared with the executive-chaired Quality Delivery Group.	Work is in progress to develop dashboards. However, this is impacted by the National project. In the interim, Dashboards will be populated manually with a draft dashboard planned for submission to the QSE Committee in September. **October update** - A mock quality dashboard has been developed and is being tested and refined during Cctober and November for launch. A new Quality Systems Group is now inplace to ensure coordination across systems.	Draft Dashboard will be in place for end of November 2023.	Matthew Joyes, Assistant Director of Patient Safety and Experience	Angela Wood, Executive Director of Nursing and Midwifery	Started	31/08/2023	31/11/2023	1			No	
260	QSE	Internal Audit	Data analysis – Triangulation of data	2023	Limited	High	Quality, Safety and Experience Committee reporting	The Quality, Safety and Experience Committee Members stipulate all the data it requires for assurance purposes.	Following changes within the Board arising from Special Measures, the new members of the Committee are working with the Executive Director of Nursing and Midwifery (as executive lead for the QSE Committee) to revise the committee terms of reference and cycle of business. As a result, the reporting expectations and requirements will be revised. The special measures reviews of patient safety and quality governance systems by the Independent Special Advisors will also inform this work.	**October update** - A revised cycle of business was submitted to the QSE Committee for its meeting in October 2023.	This action to remain open until after the December QSE meeting, that way we can provide the final cycle of business and minutes as evidence to support closure.	Matthew Joyes, Assistant Director of Patient Safety and Experience	Angela Wood, Executive Director of Nursing and Midwifery	Started	30/09/2023	31/12/2023	1		27/11/2023	No	
261	QSE	Internal Audit	Contracted Patient Services: Quality and Safety Arrangements	2023	Limited	High	Process management	Management establish robust overarching Commissioning Assurance Framework, Policy, or relevant Standard Operating Procedure (SOP) to support the healthcare commissioning/contracting process. This should ensure that lines of escalation, roles, responsibilities, and requirements regarding the management and oversight of the quality aspect of services provided are clearly defined.	The Health Board will develop a Commissioning Assurance Framework (CAF) for the management of external healthcare contracts. This will set out the roles, responsibilities and processes and will cover not only the quality assurance of commissioned services but also the commissioning performance management, business intelligence/analysis and other professional services that input to contract management both where the health board is commissioner and provider. The Health Board will develop a training package for staff engaged in the contract management process to support the delivery of the CAF. (Note: the development of the CAF is likely to identify significant gaps in resource across functions in respect of meeting the organisational need identified in this audit, which would therefore be subject to a business case to achieve the required improvement in contract management practices including quality oversight).	Work is progressing, with input from the CEO, to develop the CAF. Issues and progress are being monitored by the Executive team as to resource implications. The items noted in the recommendation will be picked up as part of this	The Commissioning Assurance Framework has been placed on hold at the request of the CEO pending special measures independent review outcome recommendations. An update paper requested by the Executive Director of Finance regarding Healthcare Contracts and contract management was scheduled to be discussed at the Executive Team but has been paused pending the special measures review report. The paper outlined proposed contract management process and roles and responsibilities requesting Executives to approve the recommendation included in the report directing professional leads engagement.	Adrian Tomkins, Associate Director of Healthcare Contracting	Angela Wood, Executive Director of Nursing and Midwifery	Started	31/08/2023	31/01/2024	1			No	

262	QSE	Internal Audit	Contracted Patient Services: Quality and Safety Arrangements	2023	Limited	High	Contractual obligations	Management establish controls to ensure that all commissioned providers adhere to agreed contractual agreements and assess current contract review meeting arrangements to ensure appropriate levels of oversight and engagement.	The Health Board will, as part of the Commissioning Assurance Framework (CAF) mentioned above, establish roles, responsibilities and escalations for the review of contract performance, including contract meetings. The Health Board will ensure all agreements with Providers are backed up by a signed contract. The Health Board will review current contracts and ensure all Contracts include updated reporting requirements, schedules, timetables, and meeting requirements. The Health Board will review re-establish the internal monitoring of Provider reporting returns to include the escalation process should information not be provided. The Health Board will re-establish its internal Contract Assurance Group, reviewing the Terms of Reference to ensure the remit and representation are adequate to make the meeting effective.	Work is progressing, with input from the CEO, to develop the CAF. Issues and progress are being monitored by the Executive team as to potential resource implications.	The Health Board will, as part of the Commissioning Assurance Framework mentioned above, establish roles, responsibilities and escalations for the review of contract performance, including contract meetings. The Health Board will ensure all agreements with Providers are backed up by a signed contract. The Health Board will review current contracts and ensure all Contracts include updated reporting requirements, schedules, timetables, and meeting requirements. The Health Board will review re-establishing the internal monitoring of Provider reporting returns to include the escalation process should information not be provided. The Health Board will re-establish its internal Contract Assurance Group, reviewing the Terms of Reference to ensure the remit and representation are adequate to make the meeting effective.	Adrian Tomkins, Associate Director of Healthcare Contracting	Angela Wood, Executive Director of Nursing and Midwifery	Started	31/08/2023	31/01/2024	1			No	
267	PFIG	Internal Audit	Performance Management – Quality and Performance Reporting and Accountability Arrangements	2023	Limited	High	Procedures	1. Standard Operating Procedures should be in place for the process of collating information for the performance reports, including: - Roles and responsibilities (Performance staff, informatics, other staff providing data) - Data quality standards/consistent metrics/timescales - Data collation - process for receiving/extracting and collating data (including systems used and any training required for these) - Data validation – details of checks to be undertaken 2. Further work is required to provide assurance to the Board that the actions stated in performance reports are improving performance/outcomes.	1. The proposed establishment of a working group between Performance and Informatics colleagues is being developed – the first meeting of this meeting will focus on the process of external reporting of data, alignment with Wales Digital reporting guidance and other data definitions used within the NHS Wales Operating Framework and Welsh Government Aims. The remit of the Group will include all of the recommendations made in this report. 2. Agreed – The documents editor has the responsibility to ensure all avenues of intelligence and assurance are incorporated into the analysis and reporting including external assurance if available.	**October update** - Once the IPR is ratified at Health Board on the 30.11.2023, the Performance Intelligence and Assurance Directorate will produce the Standard Operating Procedures (SOPs) required to ensure efficient and accurate replication of the reports for updates as required. The SOPS will be tested and the Directorate will encourage a review by internal audit to ensure that they are robust and appropriate for a business continuity plan.	Once the IPR is ratified at Health Board on the 30/11/2023, the Performance Intelligence and Assurance Directorate will produce the Standard Operating Procedures required to ensure efficient and accurate replication of the reports for updates as required. The Standard Operating Procedures will be tested and the Directorate will encourage a review by internal audit to ensure that they are robust and appropriate for a business continuity plan.	Edward Williams, Acting Director of Performance	Russell Caldicott, Interim Executive Director of Finance	Started	31/03/2024		0			No	
268	PFIG	Internal Audit	Performance Management – Quality and Performance Reporting and Accountability Arrangements	2023	Limited	High	Accountability meetings (a)	The Health Board continue with the improvement plan to review and update Performance and Accountability Framework, ensuring meetings are scheduled regularly and the information discussed in performance meetings is captured, with expected outcomes clearly communicated to senior managers.	Agreed – Interim Director of Performance working closely with Interim CEO to agree/consult on direction of travel. Underway and first draft anticipated Q2, 2023/24.	**October update** - Accountability meetings (a) The Integrated Performance Framework (IPR) was ratified at Health Board on 28.09.2023. The Framework will enable the Performance Intelligence and Assurance Directorate and its partners to support the organisation in the delivery, monitoring, improvement and assurance regarding performance. The Framework outlines roles, responsibilities and expectations together with a structure and timeframe for performance governance mechanisms such as Integrated Accountability Reviews. The Acting Director of Performance Intelligence and Assurance is composing the Integrated Performance Intelligence and Assurance Strategy for 2023-27 and this will be presented at IPEDG in November 2023. The strategy will outline the implementation of the IPF including the Accountability processes, timelines, content and expectations. A test Accountability Review could be held in February 2024 as a learning session and then the 'real' reviews to be set up throughout 2024-2027.	Integrated performance Reviews have been put in place and will be held between 18th December 2023 and 22nd January 2024.	Edward Williams, Acting Director of Performance	Russell Caldicott, Interim Executive Director of Finance	Started	31/03/2024		0			No	
270	PFIG	Internal Audit	Performance Management – Quality and Performance Reporting and Accountability Arrangements	2023	Limited	High	Accountability meetings (c)	The process for reviewing actions should be revisited, to ensure actions from meetings are SMART, and progress is regularly provided (with reference to further detail in meeting minutes as required	This action will be aligned with the revised PAF process for Q2 Reviews, scheduled for Sept 2023.	**October update** - Accountability meetings (c) The Integrated Performance Intelligence and Assurance Strategy for 2023-27 will outline the communication routes with regards accountability reviews. This will include the structure and process around recording and communicating the actions and outcomes of the reviews. There will be a clear escalation process and pathway ensuring escalations reach the appropriate forum, e.g QSE, PFIG. They will also ensure timely communication and feedback to the services being held to account, with clear SMART actions. Progress of such actions will be monitored by the Performance Intelligence and Assurance Directorate outside of the reviews to ensure progress and updates are available at the next review.	The Integrated Performance Strategy for 2023-27 will outline the communication routes with regards accountability reviews. This will include the structure and process around recording and communicating the actions and outcomes of the reviews. There will be a clear escalation process and pathway ensuring escalations reach the appropriate forum, e.g QSE, PFIG. They will also ensure timely communication and feedback to the services being held to account, with clear SMART actions. Progress of such actions will be monitored by the Performance Intelligence and Assurance Directorate outside of the reviews to ensure progress and updates are available at the next review.	Edward Williams, Acting Director of Performance	Russell Caldicott, Interim Executive Director of Finance	Started	30/09/2023	31/01/2024	1			No	
286	PFIG	Internal Audit	GP Out of Hours	2023	Limited	Medium	Process Management (1.3)	Management to review implemented improvement actions to ensure they are operating as expected/having the desired impact.	Agree with recommendation. Management will review implemented improvement actions to ensure they are operating as expected/having the desired impact.	**October update** - This action is ongoing and in process. As actions are completed they will be monitored by the Primary Care Team. The outstanding actions will be monitored closely and will be reviewed when completed to ensure they are operating as expected.	Update required	Sefton Brennan, Head of Service GPOOH	Adele Gittoes, Interim Executive Director of Operations	Started	20/10/2023		0				
288	PFIG	Internal Audit	GP Out of Hours	2023	Limited	High	Data Discrepancy	Management to clarify reasons for data discrepancies and ensure internally produced Health Board Out of Hours data is accurate.	Agree with recommendation. Management will clarify reasons for data discrepancies and ensure internally produced Health Board Out of Hours data is accurate. The BCU team will work with the national team to agree on the content and presentation of the appropriate data sets.	**October update** - This action is ongoing and in process. A number of meetings have now been held between the BCU OOH team and the national team to review data and agree on reporting processes moving forward. Meetings will continue until all work has been completed which will be dependent on an agreed timeframe from the system provider Adastra – this will be monitored via the action plan.	Update required	Sefton Brennan, Head of Service GPOOH	Adele Gittoes, Interim Executive Director of Operations	Started	27/10/2023		0				
289	PFIG	Internal Audit	GP Out of Hours	2023	Limited	High	Board Assurance	Management to review governance and reporting arrangements and ensure that the outcome of the Peer Review and implementation of improvement actions are subject to Health Board oversight and scrutiny.	Agree with recommendation. Management will review governance and reporting arrangements and ensure that the outcome of the Peer Review and implementation of improvement actions are subject to Health Board oversight and scrutiny. A paper will be produced that clarifies the arrangements for sign off by the IHC and executive team.	**October update** - This action is ongoing and in process. Regular meetings are now in place for the Urgent Care Peer Review Improvement Group, and action plan has been revised and updated. The governance structure for Primary Care is in the process of being reviewed, so full confirmation about where this sits in accountability/scrutiny framework will be confirmed asap as part of overall review.	Update required	Rachael Page, Assistant Director of Primary Care	Adele Gittoes, Interim Executive Director of Operations	Started	27/10/2023		0				
290	QSE	Internal Audit	Falls Management	2023	Limited	Medium	Policy (Design)	1.1a The Policy requires review to ensure staff are provided with up to date requirements and guidance relating to falls. We understand this process is currently underway.	1.1a Policy NU06 The Prevention and Management of Adult Inpatient Falls will be: Review/consultation by Health Board Inpatient Falls Steering group		Draft Policy out for consultation with Falls Steering Group membership. To be presented / for ratification at BCUHB Patient Safety group on 30/11/23.	Chris Lynes, Deputy Executive Director of Nursing	Angela Wood, Executive Director of Nursing and Midwifery	Started	30/11/2023		0			No	
291	QSE	Internal Audit	Falls Management	2023	Limited	Medium	Policy (Design)	1.1a The Policy requires review to ensure staff are provided with up to date requirements and guidance relating to falls. We understand this process is currently underway.	1.1a Policy NU06 The Prevention and Management of Adult Inpatient Falls will be: Approval required by the Health Board Patient Safety Group		Draft Policy out for consultation with Steering Group membership. To be presented / for ratification at BCUHB Patient Safety group on 30/11/23.	Chris Lynes, Deputy Executive Director of Nursing	Angela Wood, Executive Director of Nursing and Midwifery	Started	30/11/2023		0			No	
292	QSE	Internal Audit	Falls Management	2023	Limited	Medium	Policy (Design)	1.1a The Policy requires review to ensure staff are provided with up to date requirements and guidance relating to falls. We understand this process is currently underway.	1.1a Policy NU06 The Prevention and Management of Adult Inpatient Falls will be: Health Board Clinical and Written Documents policy process for uploading, communication and replacing of the current version on BetsiNet.		Out for consultation with Steering Group membership. To be presented / for ratification at BCUHB Patient Safety group on 30/11/23. If approved by PSG, this action will then be completed.	Chris Lynes, Deputy Executive Director of Nursing	Angela Wood, Executive Director of Nursing and Midwifery	Started	31/12/2023		0			No	
294	QSE	Internal Audit	Falls Management	2023	Limited	High	All Wales Falls and Bone Health Multifactorial Assessment (FBHMA) (Operation)	2.1a Staff should be reminded, through training, of the requirement to ensure the FBHMA and documentation pertaining to patient falls, provides sufficient information to fully understand the patients needs and requirements to minimise the risk of a potential fall. Compliance with this should be reviewed through existing audit mechanisms.	2.1a How to guide/good practice guide to support Adult Inpatient with completion and quality of FBHMA to be developed and implemented across all Adult Inpatient wards;		Good practice examples shared pan BCUHB alongside ongoing peer review process.	Chris Lynes, Deputy Executive Director of Nursing	Angela Wood, Executive Director of Nursing and Midwifery	Started	30/11/2023		0			No	

295	QSE	Internal Audit	Falls Management	2023	Limited	High	All Wales Falls and Bone Health Multifactorial Assessment (FBHMA) (Operation)	2.1a Staff should be reminded, through training, of the requirement to ensure the FBHMA and documentation pertaining to patient falls, provides sufficient information to fully understand the patients needs and requirements to minimise the risk of a potential fall. Compliance with this should be reviewed through existing audit mechanisms.	2.1a In addition to the established Health Board monitoring mechanisms, an additional level of monitoring/coaching to improve the quality of the risk assessments will be implemented across the Adult Inpatient wards, this will be a peer review process completed by suitably trained registrant. This will be a pilot of 3 months, evaluate outcomes and present recommendation to the Strategic inpatient falls Group for sustainable model.		Good practice examples shared pan BCUHB alongside ongoing peer review process.	Chris Lynes, Deputy Executive Director of Nursing	Angela Wood, Executive Director of Nursing and Midwifery	Started	01/02/2024		0			No	
296	QSE	Internal Audit	Falls Management	2023	Limited	High	All Wales Falls and Bone Health Multifactorial Assessment (FBHMA) (Operation)	2.1b To reduce the inconsistent information amongst documentation, standardising of patient fall documentation should be considered.	The Welsh Nursing Care Record currently does not auto populate with patient detail such as mobility status form the admission assessment section into the FBHMA. This will be future enhancement to the Welsh Nursing Care Record on an all-Wales basis. To mitigate this risk: - the Health Board Training resources stress the requirement for using this detail to promote accurate and consistent patient profile.		Auto population dependent on All Wales schedule, however risk mitigated via training resources and peer review process.	Chris Lynes, Deputy Executive Director of Nursing	Angela Wood, Executive Director of Nursing and Midwifery	Started	01/02/2024		0			No	
298	QSE	Internal Audit	Falls Management	2023	Limited	High	Training (Operation and Design)	3.1a To review training compliance for all areas relating to Patient Handling training and ensure staff who require training undertake this as soon as possible.	Manual Handling (MH) is a Tier One risk on the BCUHB risk register scoring 16 requiring regular review of actions being completed. MH training compliance data cascaded monthly to respective IHC's/Division Director of Operations to include compliance, did not attend rates and available capacity for upcoming 2 months. Capacity within the MH training team to be optimised with focused recruitment drive for Band 6 posts (x3) supported by workforce.		The Manual handling Advisors are undertaking a monthly visit to wards identified as high risk for falls based on datix data. This programme is working well in Central and in the East and due to sickness there has been a delay with establishing this programme in the West. MH Trainers also attend wards to check compliances if training classes are cancelled or reduced size requiring only one trainer. It should be noted that the MH bedside learning programme is limited to the one visit a month, there are other teams that also provide this learning though and this may benefit from a coordinated response.	Sue Morgan, Head of Health, Safety and Security	Angela Wood, Executive Director of Nursing and Midwifery	Started	01/01/2024		0			No	
299	QSE	Internal Audit	Falls Management	2023	Limited	High	Training (Operation and Design)	3.1b Review Safeguarding training to include post falls management.	Internal training facilities to be identified by each IHC by December 2023. MH corporate team to progress contract arrangements for external training facilities to support capacity by December 2023.		Internal BCUHB training rooms have been identified in BCUHB sites including BYN, Abergele and the CTU in Wrexham. Moves are scheduled in to the diary to take place by the end of 2023.	Sue Morgan, Head of Health, Safety and Security	Angela Wood, Executive Director of Nursing and Midwifery	Started	30/12/2023		0			No	
300	QSE	Internal Audit	Falls Management	2023	Limited	High	Training (Operation and Design)	3.1c Consider a more formal training method for the bedside learning programme, and consider resources required to provide this to staff. Ensure records of training are kept.	Text messaging reminders for booked training session to be implemented to reallocate capacity from Did Not Attend (DNA) individuals. Health Board Falls Lead to make a formal request to the Safeguarding all Wales programme regarding consideration of safeguarding following recurrent falls.		Email reminders are being sent to staff four weeks prior to them attending their course and then a week before. Any delegates who do not attend (DNA) are sent a survey to establish the reason so that this can be captured in future training plans. The team are in the process of setting up the text message reminders. Level 2 training remains an eLearning package centralised to Welsh government, the package does not directly talk about falls but does support staff of when to consider an adult at risk. There is a guidance framework that is available for staff to refer to in relation to falls and safeguarding. This has also been adopted by the North Wales Safeguarding Board.	Chris Lynes, Deputy Executive Director of Nursing	Angela Wood, Executive Director of Nursing and Midwifery	Started	01/04/2024		0			No	
301	QSE	Internal Audit	Falls Management	2023	Limited	High	Training (Operation and Design)	3.1d Determine what training agency staff receive relating to patient falls and whether it is in line with training that the Health Board staff undertake and sufficient to ensure effective completion of falls documentation.	3.1d Falls lead to include Safeguarding matrix within the revised Falls Policy NU06 to support staff as to when to refer/engage Safeguarding following recurrent falls. Bedside learning programme to be recommended as a formal programme of training that will be implemented collaboratively with IHC Practice Development Nurses, Corporate Patient Safety team and Health and Safety team.		Safeguarding matrix included in updated policy (with Steering Group for consultation before going to BCUHB PSG for ratification on 30/11/23). Agencies provided with access to Falls training on NHS Wales e-learning site. Monthly monitoring in place for completions.	Clair Tipton, Head of Digital Workforce and Resourcing	Angela Wood, Executive Director of Nursing and Midwifery	Started	01/12/2023		0			No	
303	QSE	Internal Audit	Falls Management	2023	Limited	High	Governance (Operation)	4.1a The development of a standardised strategy that routinely identifies themes, trends, and lessons learned could enhance health boards' response to patient falls.	4.1a The revised Health Board policy NU06 outlines the following process for Inpatient falls to support identification of themes, trends and learning as follows: - Hot debrief on the ward following the fall for immediate learning and mitigation; - All falls are reviewed daily by local quality teams; - All falls are subject to focused review contained within Datix system; - All falls identified as harm being Moderate or above will have a Make it safe review within 72 hrs; - All falls identified as serious harm will have an executive led Rapid Learning Panel (RLP) which may then lead to an external investigation to identify potential additional learning opportunities. - The Health Board will communicate the revised policy NU06 via Health Board communication channels in addition core Health Board meetings. - Ongoing Monitoring will be via Patient Safety team.		Draft Policy out for consultation with Steering Group membership. To be presented / for ratification at BCUHB Patient Safety group on 30/11/23.	Chris Lynes, Deputy Executive Director of Nursing	Angela Wood, Executive Director of Nursing and Midwifery	Started	01/12/2023		0			No	
304	QSE	Internal Audit	Falls Management	2023	Limited	High	Governance (Operation)	4.1b Lessons learned information included in Datix should be reviewed regularly to ensure learning is communicated/reported as appropriate, and to deter staff entering a full stop or a dash in the section.	4.1b Action 1 - Each Integrated Health Community (IHC) Health Board has established weekly harms review meeting that includes Inpatient Falls, to improve the sharing of lessons learned the Health Board will develop a SOP to ensure standardised practice across the IHCs.		SoP to be developed.	Chris Lynes, Deputy Executive Director of Nursing	Angela Wood, Executive Director of Nursing and Midwifery	Started	30/12/2023		0			No	
306	QSE	Internal Audit	Falls Management	2023	Limited	High	Governance (Operation)	4.1b Lessons learned information included in Datix should be reviewed regularly to ensure learning is communicated/reported as appropriate, and to deter staff entering a full stop or a dash in the section.	4.1b Action 3 - The Health Board Patient Safety team will provide training and support to clinical teams to include best practice, lessons learned etc due to commence November 2023 and will be an ongoing programme of training and support across the Health Board.		Incident management training sessions have commenced face to face on the acute sites. Weekly dates are arranged up until end of March 2024 and include face to face and virtual sesssions. Training advertised on Betsinet, Nursing newsletter and disseminated to governance leads.	Chris Lynes, Deputy Executive Director of Nursing	Angela Wood, Executive Director of Nursing and Midwifery	Started	20/11/2023		0			No	
307	QSE	Internal Audit	Falls Management	2023	Limited	High	Governance (Operation)	4.1c Review the ward accreditation audits on the FBHMA to establish if the audits can include specific questions on detail that give a true reflection of the patient requirements.	4.1c The ward accreditation metrics are currently under review as part of the Health Board Ward Accreditation review. The revised metrics will be tested across the Health Board Inpatient wards to confirm the appropriateness and level of detail within the metric.		Aiming for April 2024 relaunch of Accreditation programme.	Chris Lynes, Deputy Executive Director of Nursing	Angela Wood, Executive Director of Nursing and Midwifery	Started	01/04/2024		0			No	
308	PFIG	Internal Audit	Waiting List Management: Review of the WG initiated Patient Validation Exercise, Risk Stratification and patient removal from lists	2022	Limited	High	WG initiated, locally delivered tranche 'patient' validation exercise - (Operation)	The governance spreadsheet required tighter controls to ensure the integrity of the data relating to access and who is populating the spreadsheet with information. Robust back- up arrangements should be established to ensure this key source of waiting list data is available in the event of corruption/data loss, resulting in patient harm – Options should be reviewed to move away from a spreadsheet to a more stable application	Action 1 - The Health Board recognises the need to improve upon and modernise the governance arrangements and management of validity of data and cleansing the waiting list. Funding was recognised as being required to address and strengthen the governance and management of the waiting lists.		The Health Board has now implemented WPAS (Welsh Patient Administration System) which provides us with a validation dashboard so we no longer use spreadsheets to manage data. The Health Board was successful in a bid against national planned care recovery and sustainability fund to strengthen booking processes and develop an in-house validation capability. This includes ongoing tranche validation work with plans to have a dedicated substantive validation team in place by start of 2023-24 financial year. At that point, validation will transition to business-as-usual rather than a cohort or tranche activity. Tranche validation work is currently underway together with recruitment of a substantive validation team that we anticipate being in post by the start of the new financial year. This action remains in progress. A revision has been made to the implementation date and it is anticipated that this will be complete by 31/03/2024 and will be business as usual.	Rhys Blake, Associate Director of Planned Care	Adele Gittoes, Interim Executive Director of Operations	Started	31/07/2022	31/03/2024	1			No	
309	PFIG	Internal Audit	Waiting List Management: Review of the WG initiated Patient Validation Exercise, Risk Stratification and patient removal from lists	2022	Limited	High	WG initiated, locally delivered tranche 'patient' validation exercise - (Operation)	The governance spreadsheet required tighter controls to ensure the integrity of the data relating to access and who is populating the spreadsheet with information. Robust back- up arrangements should be established to ensure this key source of waiting list data is available in the event of corruption/data loss, resulting in patient harm – Options should be reviewed to move away from a spreadsheet to a more stable application.	Action 2 - This project will use digital transformation in conjunction with process redesign to deliver significant and tangible improvements, removing much of the administration function – moving patient validation into business as usual rather than cohort or tranche activity. Phase 1 will be a proof of concept with one or more specialities. Funding is being sought via the WG (Welsh Government) who have engaged on the initiative with a view to scaling up pan-BCU (Due by 30/09/2022). The proof of concept to digitize and automate elements of the validation process is underway as part of the funded business case to establish a validation team.		As per response to Action 1 (tracker ID 308). Tranche validation work will cease at the end of this financial year (March 2024) and move to business as usual through a substantive in-house validation team. This action remains in progress.	Rhys Blake, Associate Director of Planned Care	Adele Gittoes, Interim Executive Director of Operations	Started	30/09/2022	31/03/2024	1			No	

310	PFIG	Internal Audit	Waiting List Management: Review of the WG initiated Patient Validation Exercise, Risk Stratification and patient removal from lists	2022	Limited	High	WG initiated, locally delivered tranche 'patient' validation exercise - (Operation)	The governance spreadsheet required tighter controls to ensure the integrity of the data relating to access and who is populating the spreadsheet with information. Robust back- up arrangements should be established to ensure this key source of waiting list data is available in the event of corruption/data loss, resulting in patient harm – Options should be reviewed to move away from a spreadsheet to a more stable application	Action 3 - Service validation model will be reviewed and redesigned as a component part of implementation of the substantive validation team, as part of the shift to business-as-usual processes under Action 1.		This action remains in progress to business-as-usual processes under Action 1 (referred to as ID 308 in this tracker).	Rhys Blake, Associate Director of Planned Care	Adele Gittoes, Interim Executive Director of Operations	Started	31/03/2023	31/03/2024	1			No	

AUDIT COMMITTEE

AUDIT TRACKER - OPEN EXTERNAL AUDIT RECOMMENDATIONS

ID	Committee	Internal Audit / Wales Audit Office	Report Title	Year	Assurance Level	Priority	Recommendation Title	Recommendation	Management Response	Last status updates (September and October)	Latest status update	Action Owner	Final Approver	Recommendation State	Original implementation date	Revised implementation date	Number of Revisions	Actual Implementation Date	Date Final approved	For closure consideration at next Audit Committee?	Date Audit Committee approved closure
210	PFIG	Wales Audit Office	Audit Wales CHC follow-up	2022	Reasonable	High	CHC Service Delivery	Executive Management review the delivery of CHC across the Health Board to ensure consistent approach to service delivery in line with the Framework. Services must remain local but opportunities for resilience and career development will be enhanced through a single CHC Team, accountable to one Executive Director and should be considered.	The newly established CHC Improvement Group includes representation from all CHC operational and corporate teams. This group will make short, medium and long term recommendations to the Executive Improvement Steering Group on future reconfiguration to provide local services and opportunities for career development. Organisational agreement on Exec Lead roles for CHC (operational and commissioning) as part of the Operating model. New Operating Model 'Stronger Together' – Outstanding Design, Clinical and Enabling Services and Functions – No 7 – Commissioning Unit. Secure funding for the establishment of the Business Support Hub pending medium to longer term recommendations from the CHC Improvement Group.	Group now changed to CHC Cross-cutting Schemes that reports up to SMT. Target completion date revised to 30/09/23. Exec Lead confirmed as Executive Director of Transformation and Strategic Planning. Temp Asst. Director of CHC to support the longer term arrangements has been extended and will work with confirmed Exec lead. **October update** - Implementation date to be extended as linking with national group looking at CHC cost cutting themes. Request to change imp date to: 31/03/2024.	There has been some progress against this action to ensure the Health Board is operating in line with the Framework. Key areas have been reviewed to ensure consistency across the 3 IHCs and Mental Health, and improved processes to provide greater assurance have been implemented e.g. Escalation Process and funding by exception. Further areas for focus have been identified and will be implemented and monitored as part of continued progress.	Jane Trowman, Head of Strategy and Health Planning	Chris Stockport, Executive Director Transformation and Strategic Planning	Started	31/03/2023	31/03/2024	1			No	
230	PFIG	Wales Audit Office	Structured Assessment (Phase 2) 2021	2021	N/A	High	R1b	Ensure improved focus on financial efficiency of services within finance reports. This could be achieved through periodic or thematic deep dives on financial efficiency, reporting on value-based healthcare progress, or as part of routine financial reporting.	The business case process is being updated and simplified and will include an assessment of: the relative efficiency of the specific service; what action has been considered to improve that efficiency ahead of the business case.	The review of the business case process is ongoing. It will need to take account of the potential changes that will be actioned through special measures and the indeendant planning review that include governance and budget allocation. The action will reflect a revised date to reflect the need for this clarity before the process can be concluded.	The independent planning review is due to conclude in the last quarter of the calender year. Part of the governance and planning reviews outcome will be the requirement to review the business case process from an IHC local level to that of an BCU wide business case level with scrutiny panels and committees defined.	Paolo Tardivel, Director of Transformation and Improvement	Chris Stockport, Executive Director Transformation And Strategic Planning	Started	31/01/2022	31/12/2023	5			No	
244	Audit Committee	Wales Audit Office	Structured Assessment 2019	2019	N/A	High	R1	Clinical strategy and service planning R1: Ensure that work to develop a clinical services strategy is delivered to planned timescales and includes a fundamental review of the shape and location of clinical services across all three main hospital sites. This work should focus on solving a number of service sustainability issues including: Medical staffing, vacancy gaps and on-call rota management. Service efficiency and affordability. Ability to meet forecasted growth in service demand. Mitigate the impact of unscheduled care on the effectiveness of wider services. Enabling sub-specialisation of clinical services, where beneficial.	A digitally enabled clinical strategy has been proposed and extensively discussed at health board meetings in September, October and November 2019. It sets out an ambitious approach to improving population health by focussing on prevention and systems changes, specifically establishing whole-system evidence based pathways; managed professional networks; and implementing a core bundle of digital healthcare technology, e.g. a digital health record. This strategy will disrupt traditional ways of working and enable greater digital literacy. It will build a system that focusses and measures outcomes and places less and less reliance on the site of care, moving to more accessible and personalised care. The strategy will reduce unwarranted variation in practice and outcomes, enhance specialisation and opportunities to improve research partnerships. The strategy will support prudent healthcare and improve the use of resources and maintain an affordable service that meets growth in demand. The Health Board is supporting the development of the strategy, with updates and the final implementation plan due by April 2020.	WG expectation is now that clinical services plans are developed by December 2023 at the latest. Work has continued on specific areas where sustainability is challenging, eg vascular, oncology. Further work now required to develop the more detailed overarching plan.	The clinical services plan will form a part of wider strategy development. Some elements will be developed in the annual plan for 2024/25 that is currently under development	Nick Lyons, Executive Medical Director	Phil Meakin, Interim Board Secretary	Started	31/07/2020	01/12/2023	11			No	

AUDIT COMMITTEE

AUDIT TRACKER - RECOMMENDATIONS AWAITING UPDATES

ID	Committee	Internal Audit (IA)/ Wales Audit Office (WAO)	Report Title	Year	Assurance Level	Priority	Recommendation Title	Recommendation	Management Response	Last status updates (September and October)	Latest status update	Action Owner	Final Approver	Recommendation State	Original implementation date	Revised implementation date	Number of Revisions	Actual Implementation Date	Date Final approved	For closure consideration at next Audit Committee?	Date Audit Committee approved closure
73	PFIG	Internal Audit	Performance measure reporting to the Board – Accuracy of information	2021	Reasonable	Medium	Standard Operating Procedure	Management to finalise and formally issue the RTT 26 Week Pathways Standard Operating Procedure. Ensure Risk Stratification controls and procedures are formally documented.	The RTT 26 Week Pathways Standard Operating Procedure is out for consultation and awaiting response from stakeholders. Previous feedback comments are being fed into the document and once all responses are reviewed the Standing Operating Procedure will follow the official sign off route via the Planned Care Board and Planned Care Transformation Group. The Head of Ambulatory Care post once filled will be responsible for owning and implementing the Standing Operating Procedure as best practice across BCUHB.	**October update -** The RTT 26 week SOP has been created and ratified, the education and training of this SOP has been conducted August 2021. However, since the creation of the document West have migrated onto WPAS from IPM and an Access Policy has been created that will supersede this document this is due to be sent for ratification November 2023. Sop provided as evidence to support update	Update required	Andrew Oxby, OPD Programme Support Manager	Adele Gittoes, Interim Executive Director of Operations	Started	02/08/2021	14/01/2022	4				
146	PFIG	Internal Audit	Women's Services Division – Sustainability of services	2021	Reasonable	Medium	Escalation of issues	Women's Division management to complete and submit the SBAR to the Health Board Chief Executive Officer. The outcome of the Executive level discussion with the Countess should be formally recorded at the appropriate Health Board forum. Concerns regarding quality of care must be escalated and the Health Board should undertake quality and safety audits to review issues raised.	SBAR Briefing Report: Re Continued Quality Assurances Concerns Relating to Maternity Services at the Countess of Chester Hospital prepared and present to the Health Board's, Chief Executive Officer on 22/10/2021. Letter highlighted local concerns about Maternity Services at the Countess of Chester drafted for the Health Board's Chief Executive Officer, for the attention of Cheshire CCG's Chief Executive Officer inviting a conversation to understand whether they share similar concerns and experiences to BCUHB, with regards to ongoing lack of quality assurances and in relation to specific clinical outcome measures in the Maternity Services they commission by the Countess of Chester Hospital NHS Foundation Trust. Update on actions taken by the Women's Division, in respect of the ongoing quality assurance concerns in the Maternity Service provided at the Countess of Chester, presented at the Women's Executive Accountability meeting on 5/11/21 and at Corporate PSQ on 9/11/21. Quality and Safety Audits and Assurances required during a pandemic and when formal contract management reporting resumes, to be formally and agreed with the Countess of Chester Provider Team on 24/11/21.	A further Paper to support the de-commissioning of the Service , as part of the 23/4 Savings and Quality agenda, is being prepared by the Service to be submitted to the Exec Team Meeting. **October update -** Section 6 depicts the roles and responsibilities of persons within the clinical audit process whilst Section 7 of the policy/procedure outlines the organisational structure.	Update required	Fiona Giraud, Director of Midwifery and Womens Services	Adele Gittoes, Interim Executive Director of Operations	Started	31/12/2021	28/08/2023	7				
147	PFIG	Internal Audit	Women's Services Division – Sustainability of services	2021	Reasonable	High	Finance and Contracting Arrangements	The Health Board to ensure controls are in place to verify activity, treatment, and intervention charges, or obtain sufficient assurance that the data provided by the Countess of Chester Hospital is fair and reasonable. Furthermore: Contracting to share monthly data with Women's to enable periodic review and reconciliation. The Women's Division to engage with the Contracting Team during the negotiation stages to explore future reporting requirements and whether the concerns raised could be addressed via the terms of the contract. Representative from Women's Division to attend and escalate issues and concerns via the monthly contract meeting between the Health Board and the Countess of Chester Hospital as required.	NHSE Guidance issued in response to the Covid 19 (March 2020 extended for 2021/22) pandemic which Welsh Government has adopted, stood down the requirement for a formal signed contract and contract management and reporting requirement, these will however be re-established once that guidance changes. Despite the guidance BCUHB Contracting Team has continued to meet with providers and data has been continued to be received during the pandemic. COCH implemented a new patient system in July 2021, there have been difficulties with the implementation which has resulted in BCUHB not receiving regular reports. This has been raised at meetings with COCH, formal correspondence has now been sent by the Contracting Team and a formal action plan requested for resolution. Activity data will continue to be validated for responsible commissioner and undertakes a series of validation checks regarding tariff and coding. Contracting to share monthly data with Women's to enable periodic review and reconciliation where queries arise these will be raised through the contract process once re-established formally by NHS England and Welsh Government and if required Clinical Audits will be pursued. Contracting have built links to Cheshire CCG as the lead commissioner for the main acute services at Countess of Chester and any significant assurance reports are now shared with the Health Board. BCUHB Contracting Team has continued to raise the ongoing concerns relating to commissioned Maternity Services during the pandemic albeit not within the formal process that existed previously when contract arrangements were fully operational. Contracting representation at the Women's Division Finance & Performance Group will continue and once received from Countess of Chester, monitoring reports will be presented and escalation issues captured to feed into formal contract meetings, representatives from the Division will be invited to Contract meetings as required to pick up service specific issues directly with the Provider. The next meeting with the Countess of Chester Foundation Trust is scheduled for 24th November 2021 and the service will be attending a pre meet on the 16th November 2021 to agree the clinical data and Quality Assurance Framework that will be expected by BCUHB whilst working outside of normal contracting arrangements, during a pandemic.	Contract information is being received from COCH and distributed, any queries are captured and raised at contract meetings as and when they may arise. Contracts team members attend divisional f&P meetings. **October update** - This item, Audit reference ID147, relates to ID4019/ Risk Score 12 which sits on the Women's Service's Risk Register and refers to the ongoing risk that pregnant women known to BCUHB, who access commissioned care via the maternity services at the Countess of Chester Hospital Trust, may not be receiving high quality patient centred safe care and optimal clinical outcomes.	Update required	Fiona Giraud, Director of Midwifery and Womens Services	Adele Gittoes, Interim Executive Director of Operations	Started	31/12/2021	30/05/2023	1	28/06/2023			
158	PFIG	Internal Audit	On-Call arrangements	2022	Limited	High	Review of on-call arrangements	1.1a The on-call review should be re-instated as a priority, to ensure arrangements match service requirements, and are reviewed considering changing needs as a result of changes due to VERS and the new Operating Model. 1.1b Management should consider the feedback from our questionnaire when reviewing on-call arrangements, and how these can be addressed. 1.1c Following completion of the review and update of guidance (see Matters Arising 2,3 and 4 below), this should be communicated to staff to ensure they understand their obligations and responsibilities for participating in the on-call rotas.	1.1a The on-call review will be restarted and will be led by the Interim Regional Director of Delivery (IRDD), supported by the Strategic Emergency Preparedness Response and Resilience (EPRR) lead. 1.1b Proposals will be presented to the Executive Team, for approval.	Full review underway with support from Workforce. Delays due to interim staff change over. Paper planned to Senior leadership Team by the end of September, then to Execs for the end of October. **October update** - T&F group implemented to review Bronze/Silver and Gold on call along with idenifying themes from the on call. WG EPRR lead has been requested to share any all wales on call documentation to support resilience planning. Financial costs of IHC on call one area is still outstanding. Next steps - End of November SBAR to Operational Leadership team to agree on next steps for on call design.	Update required	Geraint Farr, Associate Director of Unscheduled and Emergency Care	Adele Gittoes, Interim Executive Director of Operations	Started	12/10/2022	31/10/2023	1				
159	PFIG	Internal Audit	On-Call arrangements	2022	Limited	High	Rota guidance/sustainability	The following should be documented for on-call rotas: Minimum staff numbers; Seniority/experience mix; Timelines for preparation and issuing of rotas; Frequency and type of each employees commitment is equitable; Process for staff being added to the rota when commencing an applicable senior role; Process for staff being removed from the rota, ensuring the impact this will have on other staff is considered, with reasons approved at an Executive level. Any staff removed from the rota should be reviewed regularly to determine if they can be put back on it.	2.1 On-call document, covering the recommendations above will be issued to all staff.	The definitive rota and implementation was delayed due to the delay in implementation of the operating model. This was flagged as a potential risk when the audit response was given. The revised timescale is October 2023 to Execs / HBLT for agreement. **October update** - On review in September it was identified a lack on governacne arrangments around on call provision and Process, noting variances across BCUHB of staff on call. This is being addressed by the creation of a BCUHB On Call policy that will need to go via OLT (End of November) for ratificaiton prior to executives for sign off.	Update required	Geraint Farr, Associate Director of Unscheduled and Emergency Care	Adele Gittoes, Interim Executive Director of Operations	Started	01/07/2022	31/10/2023	1				
160	PFIG	Internal Audit	On-Call arrangements	2022	Limited	High	Compensatory rest and payment	Workforce policies to be reviewed and updated as necessary, including clear guidance on the requirement for taking compensatory rest. Guidance on compensatory rest and payment entitlement to be included on the staff intranet site and circulated to all staff included on on-call rotas. This should be done on a periodic basis to ensure new staff who are added to rotas are aware of their entitlements. Staff included in on-call rotas to be encouraged to take compensatory rest.	3.1a All on-call staff to be written to by the Interim Director of Regional Delivery, having agreed content of the letter with the Director of Workforce and OD, and Deputy CEO.	The compensatory rest policy is in the process of being confirmed, as there are many local differentiations in arrangements, and HR is reviewing the compensatory payments when we understand the intensity of the rotas, as per national/regulatory frameworks for payment. **October update** - No further update as of October 2023.	Update required	Geraint Farr, Associate Director of Unscheduled and Emergency Care	Adele Gittoes, Interim Executive Director of Operations	Started	11/07/2022	31/10/2023	1				
161	PFIG	Internal Audit	On-Call arrangements	2022	Limited	High	Training	The requirements of staff included in on-call rotas should be documented and staff provided with relevant information to ensure they are able to deal with expected issues whilst on-call i.e. key information about sites and services, as staff may not be familiar with the site they are responsible for during the on-call shift. Training should be provided to staff who are on the rotas to ensure they are aware of their responsibilities and possible scenarios of what they may have to deal with.	4.1a Programme of training to be reviewed. The programme will take into account the areas identified within the audit survey. 4.1b Manual to be developed with key information, and details for those on call. 4.1c All staff to receive training with a programme and timescale set for refresher training every two years. 4.1d Real time log to be introduced for all levels of on-call to aid action learning with a rolling process of review by the IRDD and Strategic EPRR lead.	Post implementation of policy, training programme to be implemented. Further considerations as to the recruitment to existing funded vacancies will be required for delivery. **October update** - Training process has commenced with 3 sessions completed in October 2023 regarding HFP and ambulance escalation. JESIP modeling has commenced for a training portfolio, along with development of a Training package on line for staff.	Update required	Geraint Farr, Associate Director of Unscheduled and Emergency Care	Adele Gittoes, Interim Executive Director of Operations	Started	12/12/2022	31/11/2023	1				

172	PFIG	Internal Audit	Effective Governance: YWM	2022	Limited	High	Finance	Management to identify and progress savings schemes as a matter of urgency. Management ensure financial scrutiny is in line with the requirements laid out in the Operating Model.	A revised control total has been set for the EIHC. E IHC is an exemplar area for CHC savings. The Finance and Performance Sub Committee includes a duty to monitor progress with cost improvement programmes. Terms of Reference were signed off 16 November 2022.	East IHC Annual Plan has been signed off at IHC level (including oversight from the corporate planning team). IHC F&P sub-group established as part of the new operating model. This will be subject to continuous review as well as part of the wider fianncial position (the saving guidance and templates are due for issue for the beginning of september).	Update required	Geraint Farr, Associate Director of Unscheduled and Emergency Care	Adele Gittoes, Interim Executive Director of Operations	Started	31/03/2023	31/10/2023	1				
173	PFIG	Internal Audit	Effective Governance: YWM	2022	Limited	High	Clinical Audit	3.1a The list of Tier 3 audits should be shared with the East Clinical Effectiveness Group to ensure audits are focused on the risks within the site and that there is no duplication of audits/efforts across the site. This would also provide opportunities for work across more than one division/locality. 3.1b Results and lessons from Tier 3 audits should documented and 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 East Clinical Effectiveness Group and a process put in place to ensure that relevant learning/feedback is shared across the site and potentially the Health Board.	The East Clinical Effectiveness Group is established in the new governance plan and includes both the YWM and Community Services Medical Directors, so is already happening. The Director of Nursing for East chairs this and the T3 audits are shared in this forum, as are the results and recommendations. The imminent commencement of a newly appointed EIHC Medical Director will enable, as part of the wider team, a robust, structured approach to developing and delivering the action plans.		Update required	Emma Jane Hosking, Hospital Site Medical Director/Consultant Anaesthetist	Adele Gittoes, Interim Executive Director of Operations	Pending	23/11/2022		0	23/11/2022			
175	PFIG	Internal Audit	Effective Governance: YWM	2022	Limited	High	Risk Management	5.1a The Risk Register requires review to ensure that risks are accurate and appropriate actions/dates are included. 5.1b Management to review consistency of reporting in accordance with the revised Operating Model/governance structure.	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.	We have fully integrated within the IHC governance framework	Update required	Ian Donnelly, Acute Care Director	Adele Gittoes, Interim Executive Director of Operations	Final Client approved	31/03/2023		0	30/11/2022	05/09/2023	Yes	
178	PFIG	Internal Audit	Effective Governance: YG	2022	Limited	High	Clinical audit	The list of Tier 3 audits should be shared with the QSCE to ensure there is no duplication of audits/efforts across the Ysbyty Gwynedd. This would also provide opportunities for work across more than one division/locality. Results and lessons from Tier 3 audits should be shared across the Health Board. Noting that divisions/localities are responsible for Tier 3 audits, we would suggest the learning/feedback is provided to the QSCE and the Clinical Effectiveness Team and a process put in place to ensure that relevant learning/feedback is shared across the site and potentially the Health Board. Management should ensure that staff contribute to Tier 2 audits where required, in order to progress the Health Board's Clinical Audit Plan.	A full list of Tier 3 audits will be Shared via the next Quality Safety and Clinical Effectiveness at Ysbyty Gwynedd, to ensure that these are appropriately focussed and do not duplicate effort. Lessons learned from Tier 3 Audits to be a major item from discussion at the December 2022 QSCE, with all Directorates represented on a multi-disciplinary basis to ensure cross fertilisation of ideas and feedback. A report to be produced to consolidate this feedback to be shared via the Health Board level meeting in early 2023. All appropriate staff encouraged to participate in Tier 2 audits and contribute to clinical audit, where possible being given allocated time for this, via a joint letter from the clinical members of the new IHC Leadership Team (Medical, Nursing	The Quality Local Delivery Group across the West IHC has now been established and met for the first time in February 2023. A further meeting is scheduled for Wednesday 22nd March 2023. A cycle of business has been agreed and a programme of audit established. This will formally report through the Quality LDG in May 2023. The IHC Medical Director is also currently the chair of the Health Board Clinical effectiveness Committee, and will take any learning for wider dissemination to that forum. A new Organisational Learning Forum, chaired by the Executive Director of Nursing, has also been established, and the West IHC is represented by its Director of Nursing. Implemented as per update comments 21st March 2023.	Update required	Janw Hughes-Evans, Interim Area Nurse Director West	Adele Gittoes, Interim Executive Director of Operations	Final Client approved	31/12/2022	31/03/2023	2	21/03/2023	05/09/2023	Yes	
215	PFIG	Internal Audit	USC: Urgent Primary Care Centres - Business case outcomes achieved	2023	Limited	Medium	Data reconciliation	3.1 Management to ensure reconciliation of reported performance information to source data is documented and retained. This could be incorporated within existing working documents. 3.2 Health Board to consider using UPCC engagement data to target promotion of the service to GP Practices that have low referral rates / have not used the service.	3.1 Review of reconciliation data for West and inaccuracies corrected. Confirm management arrangements for reconciliation and retention of performance data for Central IHC UPCC in line with findings and recommendations. Please refer to UPCC Peer review Action Plan – IA2. 3.2 Continuous review of GP practices that have not used the service and meetings/discussions to take place where necessary. Continuous attendance at Practice Managers/Cluster Meetings to promote and provide update of engagement. Review of ED referrals in the West to understand limitations, and consider relocation if proximity to ED is identified as an issue. Please refer to UPCC Peer review Action Plan – IA2	3.1 - Data reconciliation of West data completed and master copies available. 3.2 - continuous review of GP practices not utilising the service is on-going and practices contacted directly for discussion 3.2 - Review of ED attendances - SBAR submitted to Area Directors for West for discussion, other options to be explored before final decision is made	Update required	Chris Couchman, Associate Director of Primary Care	Adele Gittoes, Interim Executive Director of Operations	Final Client approved	31/05/2023		0	24/05/2023	05/09/2023	Yes	
216	PFIG	Internal Audit	USC: Urgent Primary Care Centres - Business case outcomes achieved	2023	Limited	Medium	Governance Frameworks and Communication Strategies	Governance frameworks, Communication Strategies, and supporting documents should be periodically reviewed and approved to ensure continued relevance and alignment with wider Health Board strategies. Evidence of scrutiny and approval should be retained.	Communication strategy to be drafted and reviewed in line with UPCC objectives. West UPCC Team to undertake Patient Satisfaction Survey as per East and Centre areas. Central UPCC Governance Framework to be reviewed and updated and signed off at Quality and Safety Group. Please refer to UPCC Peer review Action Plan – IA1	Communications strategy paused pending outcome of Urgent Care Review and proposed new model. Central UPPC Governance Framework to be updated and signed-off at August/ September Quality and Safety meeting.	Update required	Karen Higgins, Director of Primary Care	Adele Gittoes, Interim Executive Director of Operations	Started	31/05/2023	31/03/2024	1				
217	PFIG	Internal Audit	USC: Urgent Primary Care Centres - Business case outcomes achieved	2023	Limited	High	UPCC Models	The Health Board should consider the future model of the UPCCs to ensure appropriate resources and accommodation are available to provide a consistent service that is accessible to all patients.	Future model for Urgent Primary Care being developed currently, led by the Director of Primary and Community Care and Deputy Executive Medical Director for Primary Care. The future model will be established as part of this work. Please refer to UPCC Peer Review Action Plan – IA3		Update required	Karen Higgins, Director of Primary Care	Adele Gittoes, Interim Executive Director of Operations	Pending	01/01/2024		0				
218	PFIG	Internal Audit	USC: Urgent Primary Care Centres - Business case outcomes achieved	2023	Limited	High	Benefits Realisation	2.1 Management to review UPCC capacity and establish measures that can be used to support the delivery of stated benefits. 2.2 The Health Board to ensure that where Business Cases and bids are received, clear measures are set out to assess benefits stated.	2.1 Work is being undertaken to develop suite of outcome measures and performance indicators, to appropriately measure impact of key primary care initiatives, including urgent primary care. Indicators will be used to support activity and performance management of UPCCs moving forward. 2.2 Business case guidance to require clear measures linked to identified benefits. East IHC Primary Care Team have undertaken additional courses recently around writing successful business cases .	Initial RBA training with primary care colleagues and wider teams to develop and confirm approach. USC Business Strategy being developed through USC and 6 Goals Programme Board, and will include development of population and performance scorecards and metrics as part of this work	Update required	Karen Higgins, Director of Primary Care	Adele Gittoes, Interim Executive Director of Operations	Started	01/01/2024		0				
235	PFIG	Internal Audit	Review of Eye Care Services	2022	N/A	High	R2	Sub-regional variation of patient waits: Undertake analysis on sub-regional variation in waits, either by the Health Board's three main locality areas or by county of residence.	This links to recommendation 7 (Accountability for eye care service) so that a North Wales view can provide overview, guidance and management utilising the patient treatment list wait information that is already available supported by the dashboards that are in progress.	Detail now available on waiting list by Risk factor on a health board and locality basis. This is enabling a prioritisation of treatment, follow up and pathway management on clinical risk factors in addition to local improvement plans Audit of R1 data completeness/application of Wait Time Rules/SOS utilisation commenced: with aim to inform R1 Clinical and non-clinical validation plan. Snap audit has identified data completeness and application of Welsh Waiting Time rules learning. A "Data, Planning and Performance Improvement group" will be taking forward a plan to redress learning. Interim refresh of SOP (Standard Operating Procedures), Welsh Waiting time rules and patient information (to maximise their commitment to care pathway) commenced. **October update** - Note from Owner - No further update available to be provided.	Update required	Rhys Blake, Associate Director of Planned Care	Adele Gittoes, Interim Executive Director of Operations	Started	31/03/2022	31/08/2023	6				
240	PFIG	Internal Audit	Review of Eye Care Services	2022	N/A	High	R7	Accountability for eye care services: Undertake a review of the accountability arrangements for eye care services with the aim of: • ensuring effective integration of services across acute sites; • achieving better integration of services with community optometry; and • eliminating inappropriate sub-regional variation of service delivery and improving service efficiency.	This will be encompassed within the stronger together work which will require the local integration of acute and primary care services with regards to the vertical pathways and processes whilst there is a North Wales responsibility and accountability for services and decision making to eliminate inappropriate sub-regional variation. It is anticipated that the introduction of a new Optometry reform contract will support change, strengthening relationships but also the opportunity to provide better accountability if delegated to the Health Board.	Work has commenced to review the current Eye Care Group and strengthen it's governance, remit and membership to oversee the development and delivery of an Integrated Eye Care service for the population of BCUHB..	Update required	Rhys Blake, Associate Director of Planned Care	Adele Gittoes, Interim Executive Director of Operations	Started	31/03/2022	30/11/2023	7				

241	PFIG	Internal Audit	Review of Eye Care Services	2022	N/A	High	R8	Eye care clinical leadership: Strengthen the clinical leadership structure, with a specific focus on responsibilities, and accountabilities for eye care services. As part of this, ensure that the optometry clinical leadership integrates into the existing clinical leadership structure.	Both North Wales Ophthalmology and Optometry Clinical leads are vital to developing and driving improvement. Recently these posts have become vacant and it is key to replace not only these posts but clinical leadership across sites and across the major sub-specialties; this matrix can be reviewed and tested. Vertical leadership creates potential silos whilst a more recent view of pan North Wales pathway leadership could be explored.	Requires explicit provision of dedicated clinical sessions to enable clinical leadership to be successfully discharged across the Health Board. So far, recruitment attempts have not been successful with just 1 session identified - such a role would need 2 minimum. **October update** - Discussions being had with potential internal candidates. If cannot appoint internally will seek to appoint externally reframing an existing clinical vacancy to include the role of clinical lead.	Update required	Rhys Blake, Associate Director of Planned Care	Adele Gittoes, Interim Executive Director of Operations	Started	31/03/2022	30/04/2023	5				
256	PFIG	Internal Audit	Planned Care Recovery and Transformation Group	2023	Limited	High	Planned Care Recovery and Transformation Group	It is evident that benefits of establishing the Group have not been realised - the Health Board needs to decide if reinstating the Group is the way forward to provide assurance to the Health Board and Welsh Government that the planned care programme is being successfully implemented. If Group meetings to resume, then its membership and terms of reference should be reviewed and updated to enable the Group meet its objectives with measurable deliverables being developed and reviewed regularly. Management should ensure there are sufficient resources allocated to the planned care agenda, to ensure the planned care programme is successfully implemented.	A draft revised programme is awaiting formalisation and there will be an inaugural meeting to launch the programme before the end of July. Programme resources have been identified and we are working to appoint individuals into lead roles.	Inaugural board meeting held. PID being finalised and GIRFT work to be aligned with this program. **October update** - PID being finalised reported on Agenda at Planned Care Programme Board. GIRFT work to be aligned with this programme.	Update required	Rhys Blake, Associate Director of Planned Care	Adele Gittoes, Interim Executive Director of Operations	Started	31/07/2023		0				
257	PFIG	Internal Audit	Planned Care Recovery and Transformation Group	2023	Limited	High	Reporting	Review the mechanisms for reporting, ensure requirements have been clearly established and expectations communicated with the relevant Groups/Committee.	Reporting arrangements will be published once finalised with the programme initiation arrangements.	Planned Care Board established with ToR approved. **October update** - TOR have been updated to be re-submitted for ratification at Planned Care Programme Board November 2023	Update required	Rhys Blake, Associate Director of Planned Care	Adele Gittoes, Interim Executive Director of Operations	Marked as Implemented by Owner	31/07/2023		0				
284	PFIG	Internal Audit	GP Out of Hours	2023	Limited	Medium	Process Management (1.1)	Management to develop robust written control documents to support operational processes and strengthen governance arrangements.	Agree with recommendation. Management will develop robust written control documents to support operational processes and strengthen governance arrangements. Much of this will be incorporated into 1.2 Terms of Reference.	**October update** - This action is completed. A terms of reference has been finalised and regular meetings are in place. These meetings will be minuted and all actions added to the action plan for the group.	Update required	Rachael Page, Assistant Director of Primary Care	Adele Gittoes, Interim Executive Director of Operations	Marked as Implemented by Owner	13/10/2023		0			Yes	
285	PFIG	Internal Audit	GP Out of Hours	2023	Limited	Medium	Process Management (1.2)	Management to establish a Terms of Reference for the Peer Review Group, ensuring the role, remit, reporting, and escalation requirements for the Group are clearly defined, and consider maintaining meeting minutes/action log to promote transparency and document decision-making.	Agree with recommendation. Management will establish a Terms of Reference for the Peer Review Group, ensuring the role, remit, reporting, and escalation requirements for the Group are clearly defined, and consider maintaining meeting minutes/action log to promote transparency and document decision-making.	**October update** - This action is completed.This action is completed. A terms of reference has been finalised and decision making is documented. Minutes from monthly meetings will be recorded and an action plan is in place.	Update required	Rachael Page, Assistant Director of Primary Care	Adele Gittoes, Interim Executive Director of Operations	Marked as Implemented by Owner	13/10/2023		0			Yes	
286	PFIG	Internal Audit	GP Out of Hours	2023	Limited	Medium	Process Management (1.3)	Management to review implemented improvement actions to ensure they are operating as expected/having the desired impact.	Agree with recommendation. Management will review implemented improvement actions to ensure they are operating as expected/having the desired impact.	**October update** - This action is ongoing and in process. As actions are completed they will be monitored by the Primary Care Team. The outstanding actions will be monitored closely and will be reviewed when completed to ensure they are operating as expected.	Update required	Sefton Brennan, Head of Service GPOOH	Adele Gittoes, Interim Executive Director of Operations	Started	20/10/2023		0				
287	PFIG	Internal Audit	GP Out of Hours	2023	Limited	Medium	Progress Update Log	Management to ensure that responsible officers and completion dates assigned to improvement actions are documented. We are aware that the Progress Update Log is currently being reviewed – management should consider the appropriateness and current utilisation of the Evidence field within the Update Log.	Agree with recommendation. Management will ensure that responsible officers and completion dates assigned to improvement actions are documented. Management will consider the appropriateness and current utilisation of the Evidence field within the Progress Update Log.	**October update** - This action is completed. Completion dates and improvement actions are now monitored via the action plan for the group. Responsible officers have been identified for each action. The evidence field and update log are incorporated onto the action plan.	Update required	Rachael Page, Assistant Director of Primary Care	Adele Gittoes, Interim Executive Director of Operations	Marked as Implemented by Owner	13/10/2023		0			Yes	
288	PFIG	Internal Audit	GP Out of Hours	2023	Limited	High	Data Discrepancy	Management to clarify reasons for data discrepancies and ensure internally produced Health Board Out of Hours data is accurate.	Agree with recommendation. Management will clarify reasons for data discrepancies and ensure internally produced Health Board Out of Hours data is accurate. The BCU team will work with the national team to agree on the content and presentation of the appropriate data sets.	**October update** - This action is ongoing and in process. A number of meetings have now been held between the BCU OOH team and the national team to review data and agree on reporting processes moving forward. Meetings will continue until all work has been completed which will be dependent on an agreed timeframe from the system provider Adastra – this will be monitored via the action plan.	Update required	Sefton Brennan, Head of Service GPOOH	Adele Gittoes, Interim Executive Director of Operations	Started	27/10/2023		0				
289	PFIG	Internal Audit	GP Out of Hours	2023	Limited	High	Board Assurance	Management to review governance and reporting arrangements and ensure that the outcome of the Peer Review and implementation of improvement actions are subject to Health Board oversight and scrutiny.	Agree with recommendation. Management will review governance and reporting arrangements and ensure that the outcome of the Peer Review and implementation of improvement actions are subject to Health Board oversight and scrutiny. A paper will be produced that clarifies the arrangements for sign off by the IHC and executive team.	**October update** - This action is ongoing and in process. Regular meetings are now in place for the Urgent Care Peer Review Improvement Group, and action plan has been revised and updated. The governance structure for Primary Care is in the process of being reviewed, so full confirmation about where this sits in accountability/scrutiny framework will be confirmed asap as part of overall review.	Update required	Rachael Page, Assistant Director of Primary Care	Adele Gittoes, Interim Executive Director of Operations	Started	27/10/2023		0				

Teitl adroddiad: ***Report title:***	Internal Audit Progress Report 1 November to 31 December 2023		
Adrodd i: ***Report to:***	Audit Committee		
Dyddiad y Cyfarfod: ***Date of Meeting:***	12 January 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 Board and required in accordance with the Welsh Government NHS Wales Audit Committee Handbook – Section 4.5 Reviewing internal audit assignment reports. The progress report summarises five assurance reviews finalised since the last Committee meeting in November 2023, with the recorded assurance as follows: • Substantial assurance (green) – none; • Reasonable assurance (yellow) – three; • Limited assurance (amber) – two; • Unsatisfactory (red) – none; and • Advisory (grey) – none. The report also details the reviews with reports issued as draft and work in progress. Through review planning discussions with management and identifying key progress for follow-up, we have identified four reviews for deferment from the Internal Audit plan for consideration by Committee, these being: • Follow up - Recruitment of substantive and interim executive and senior posts. • Follow up – Contracted Patient Services: Quality and Safety arrangements. • Charitable Funds. • Wrexham Maelor Continuity – Phase one.		
Argymhellion: ***Recommendations:***	The Committee is asked: • To receive the progress report. • To consider and approve deferment of the four reviews identified to the 2023/24 internal audit plan. • To approve inclusion of the Orthopaedics Project, Llandudno General Hospital in the plan for 2023/24.		
Arweinydd Gweithredol: ***Executive Lead:***	Interim Board Secretary		
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 EqlA yn angenrheidiol ac a gafodd ei gynnal? ***In accordance with WP7 has an EqlA 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	N/A other than those relating to individual audit reviews / recommendations.

Workforce implications as a result of implementing the recommendations	
Adborth, ymateb a chrynodeb dilynol ar ôl ymgynghori ***Feedback, response, and follow up summary following consultation***	The progress report is produced independently of management. The progress report has been shared with the Interim Board Secretary.
Cysylltiadau â risgiau BAF: (neu gysylltiadau â'r Gofrestr Risg Gorfforaethol) ***Links to BAF risks:*** *(or links to the Corporate Risk Register)*	N/A other than those relating to individual audit reviews.
Rheswm dros gyflwyno adroddiad i fwrdd cyfrinachol (lle bo'n berthnasol) ***Reason for submission of report to confidential board (where relevant)***	N/A
Camau Nesaf: **Gweithredu argymhellion** ***Next Steps:*** ***Implementation of recommendations*** The 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 • Appendix 2: Lessons Learnt • Appendix 3: Decarbonisation	

Betsi Cadwaladr University Local Health Board

Audit Committee
Internal Audit Progress Report

1st November to 31st December 2023

NWSSP Audit and Assurance Services

GIG CYMRU NHS WALES
Partneriaeth Cydwasanaethau
Gwasanaethau Archwilio a Sicrwydd
Shared Services Partnership
Audit and Assurance Services

GIG CYMRU NHS WALES
Bwrdd Iechyd Prifysgol Betsi Cadwaladr University Health Board

Contents

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

Disclaimer notice - please note:

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

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

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

Introduction

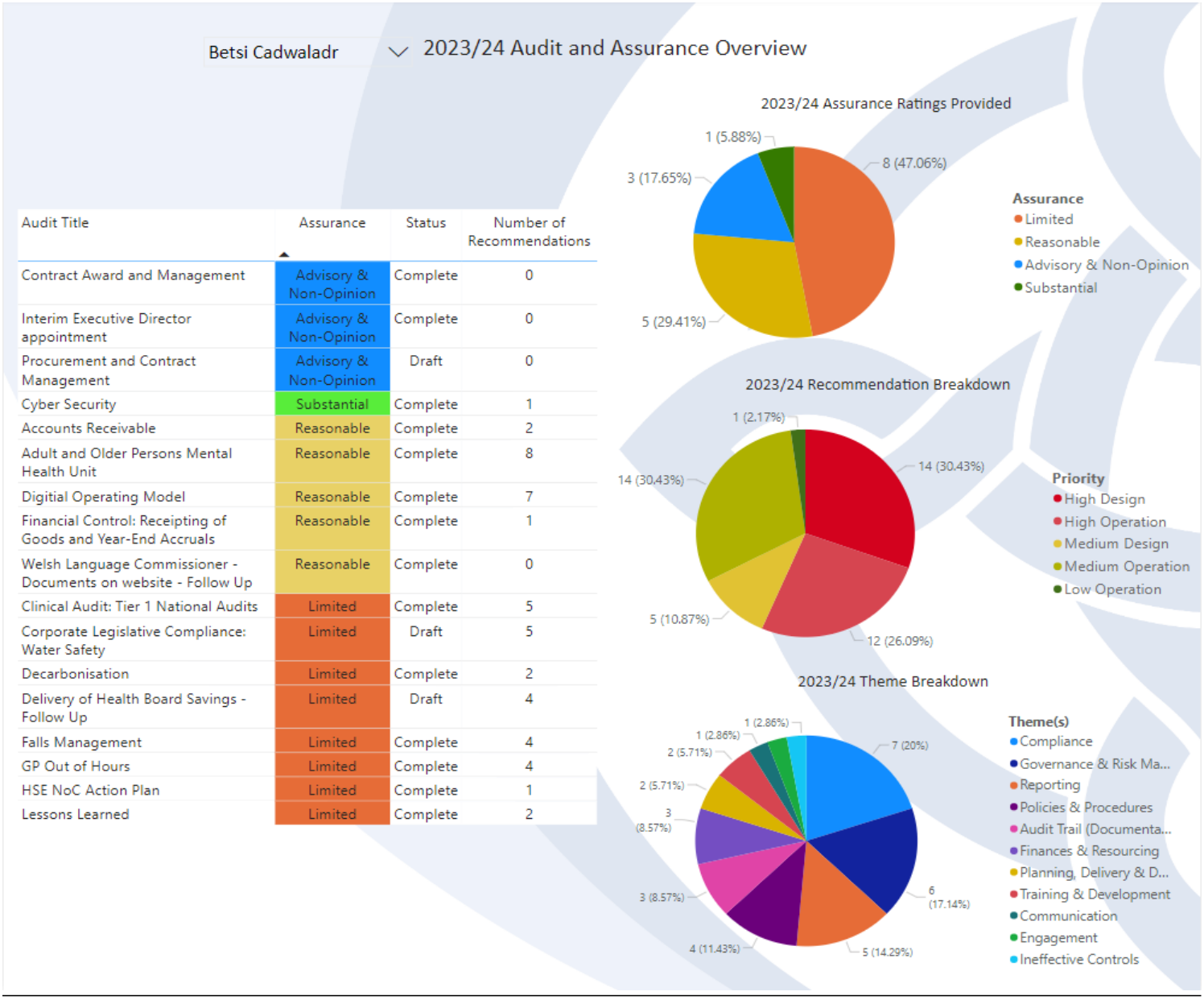
1. This progress report provides an update to the Audit Committee in respect of the assurances, key issues, and progress against the Internal Audit (IA) Plan for 2023-24.

Reports Issued

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

3. In reviewing the 2023/24 draft and final reports issued to date, image 1 details the high-level information from the reviews.

Image 1: Extract from the NHS Wales tracker for Betsi Cadwaladr ULHB at 31 December 2023



Audit Title	Assurance	Status	Number of Recommendations
Contract Award and Management	Advisory & Non-Opinion	Complete	0
Interim Executive Director appointment	Advisory & Non-Opinion	Complete	0
Procurement and Contract Management	Advisory & Non-Opinion	Draft	0
Cyber Security	Substantial	Complete	1
Accounts Receivable	Reasonable	Complete	2
Adult and Older Persons Mental Health Unit	Reasonable	Complete	8
Digitial Operating Model	Reasonable	Complete	7
Financial Control: Receipting of Goods and Year-End Accruals	Reasonable	Complete	1
Welsh Language Commissioner - Documents on website - Follow Up	Reasonable	Complete	0
Clinical Audit: Tier 1 National Audits	Limited	Complete	5
Corporate Legislative Compliance: Water Safety	Limited	Draft	5
Decarbonisation	Limited	Complete	2
Delivery of Health Board Savings - Follow Up	Limited	Draft	4
Falls Management	Limited	Complete	4
GP Out of Hours	Limited	Complete	4
HSE NoC Action Plan	Limited	Complete	1
Lessons Learned	Limited	Complete	2

- Theme definition is included at Table 6.

Executive Summaries

Lessons Learnt	BCU-2324-06	10 November 2023
Report opinion:	Limited	

Purpose: To consider whether there are robust processes and controls in place to support the management of learning within Health Board Integrated Healthcare Communities (IHCs) and pan-North Wales services, and to review operational compliance with Make it Safe (Plus) principles.

Overview

The significant matters which require management attention include:

- There are no Health Board policies, guidance documents, or Standard Operating Procedures (SOP) in place to support the management of lessons learnt.
- Established processes and governance arrangements are not consistent across all IHCs and services.
- There are no formal processes in place to review the effectiveness of implemented learning.
- Make it Safe (Plus) requirements are not formally documented.
- There is significant variation in the quality and detail of Make it Safe (Plus) and lessons learnt information recorded in Datix.

Objectives		Assurance
1	Integrated Health Communities and pan-North Wales services have established robust process to capture, manage, and share lessons learnt from sources including claims, concerns, and incidents. Operational processes comply with relevant policies and Make it Safe principles.	Limited
2	There is evidence to demonstrate opportunities for learning are implemented, and outcomes are reviewed to ensure effectiveness to limit future occurrence.	Limited
3	Lessons learnt are subject to robust governance arrangements with clear lines of accountability, reporting, escalation, and evidence of outcome sharing within Integrated Health Communities and pan-North Wales services. Information management and reporting structures support the identification of common themes and to promote learning across services.	Limited

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

Key Matters Arising		Objective	Control Design or Operation	Recommendation Priority
1	The Health Board does not have a formal policy, SOP, guidance notes or other formal written	1,2,3	Design	High

	control document in place to support the management of learning. Established working practice varies by IHCs and pan North Wales services, and there are no formal processes in place to review the effectiveness of implemented learning. We also found variation in the quality of information recorded in Datix.			
2	Each IHC and service reviewed have established processes to manage Make it Safe (Plus) reviews. However, we cannot confirm compliance as the principles and requirements of Make it Safe (Plus) have not been formally documented. As with lessons learnt, we found significant variation in the quality and consistency of information recorded in Datix and were unable to extract robust performance data from the system.	1	Design	High

Digital Operating Model	BCU-2324-08	20 November 2023
Report opinion:	Reasonable	

Purpose: To review what steps have been taken to develop proposals for a new operating model in delivering Digital, Data and Technology (DDaT) Services at the Health Board.

Overview

Work is underway on developing a new Digital Strategy, and the development of an updated Digital Operating Model is progressing. The governance structures had been improved, with the formalisation of the Chief Clinical Information Officer and Chief Nursing Information Officer roles, although we note the Board turnover has impacted on governance.

An assessment of the required skills and capabilities within Digital has been undertaken and a plan to develop missing skills is in place. A roadmap for delivery of an updated operating model is in place and work is ongoing in some areas to redefine organisational processes. We note that the delivery of a successful digital model will need cultural change throughout the organisation, and the Digital Directorate is working on this.

The matters requiring management attention include:

- Ensuring the Board is fully aware of digital and its capabilities;
- Ensuring the relationships between DDaT and the service enable integrated planning;
- Enabling a funding model that is appropriate for the organisation's digital ambitions;
- Ensuring greater links between the Transformation Team and DDaT.

Objectives		Assurance
1	Control and Governance	Limited
2	Operating Model	Limited
3	Roadmap	Reasonable
4	Digital Processes	Reasonable
5	Technology	Reasonable

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

Key Matters Arising		Objective	Control Design or Operation	Recommendation Priority
1	Governance	1	Operation	Medium
2	Business Relationships	2,4	Operation	High
3	Funding	3	Operation	High
4	National Systems	3	Operation	Medium
5	Transformation Team	4	Operation	Medium
6	Equipment Refresh	5	Operation	Medium
7	Cloud Strategy	6	Operation	Medium

Decarbonisation BCU-2324-11 7 December 2023

Report opinion: Limited

Purpose: To determine the adequacy of management arrangements to ensure compliance with the requirements of the Welsh Government's decarbonisation strategic delivery plan and ensure that the UHB has appropriate controls and management arrangements in place to achieve the same.

Overview

The significant matters which require management attention include:

- Decarbonisation is not reported into existing organisation accountability and reporting frameworks for 2023.
- An appropriate decarbonisation reporting structure which monitors the progress of the action plan within the Health Board is not currently in place.

- Due to the existing status of actions the Decarbonisation Action plan risks falling further behind schedule and failing to achieve the key deliverable decarbonisation activities.

	Objectives	Assurance
1	Governance – To obtain assurance that appropriate governance arrangements have been established.	Limited
2	Localised Strategies – To ensure that a tailored decarbonisation strategy and action plan has been developed in accordance with available legislation and guidance.	Reasonable
3	Funding Strategy – There is an appropriate funding strategy targeting discretionary, EFAB and All-Wales funding.	Reasonable
4	Monitoring & Reporting – To ensure appropriate monitoring and reporting arrangements are in place.	Limited
5	Project Delivery: To obtain assurance that projects included within the 2023/24 funding commitments have been successfully delivered, and that appropriate arrangements are in place to secure available funding during 2024/25.	Limited

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

	Key Matters Arising	Objective	Control Design or Operation	Recommendation Priority
1	There is no reporting of decarbonisation into existing organisation accountability and reporting frameworks. Currently no decarbonisation reporting structure which monitors the progress taking place	1,4	Design	High
2	Risk of the Decarbonisation Action plan falling behind schedule and failing to achieve the key deliverable decarbonisation activities.	5	Operation	High

Adult and Older Persons Mental Health Unit BCU-SSu-2324-12 12 December 2023

Report opinion: Reasonable

Purpose: To evaluate the progression and delivery of the development of an Adult and Older Persons Mental Health Unit at Glan Clwyd Hospital against the key business case objectives and to assess the adequacy of the systems and controls in place to support the successful delivery of the project.

Overview

Whilst the forecast outturn cost remained on budget, the assessment was based on a schedule of accommodation from 2021. Accordingly, the cost impact of design development and changes after the approval of the Outline Business Case (OBC) had not been included. A pre-tender estimate was not prepared prior to requesting costs from the Supply Chain Partner (SCP). There is therefore potential for the SCP Target Cost to vary significantly to this original assessment.

During the design development it was identified that the site-wide electrical infrastructure was insufficient to meet the demands of this and other projects in development. It was suggested that this was known prior to the project progressing but had not been shared with project staff. Key cost and time assumptions had been significantly impacted by this.

Development of the FBC (Full Business Case) had also been delayed because of seasonal restrictions on the timing of ecology surveys. These matters should have been known and anticipated.

Market testing delays had resulted in an anticipated late submission of the Target Cost report.

The UHB (University Health Board) continued to experience issues in the timely and appropriate execution of contractual documentation with a number signed late or remaining incomplete.

Objectives	Assurance
1 Project Performance	Limited
2 Follow Up	Substantial
3 Governance Arrangements	Reasonable
4 Approvals	Reasonable
5 Financial Monitoring/Reporting	Reasonable
6 Contractual Appointments	Limited
7 Design	Reasonable
8 Planning	Reasonable

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

Key Matters Arising	Objective	Control Design or Operation	Recommendation Priority
1 Cost reporting	2	Operation	Medium

	Key Matters Arising	Objective	Control Design or Operation	Recommendation Priority
2	Provision of a costed risk register	3	Operation	Medium
3	Timely sign-off of contracts	6	Operation	Medium
4	Timely sign-off of design sheets	7	Operation	Medium
	Future Matters arising			
5	Electrical Infrastructure	4	Operation	High
6	Contracts should be executed prior to the commencement of works / duties.	6	Operation	Medium
7	Undertaking of surveys	8	Operation	Medium

Follow-up: Welsh Language Commissioner - Documents on the Website

BCU-2324-17

12 December 2023

Report opinion: Reasonable

Purpose: To establish progress made by management to implement agreed actions arising from the previous internal audit [report BCU-2223-04 refers], which concluded limited assurance over the arrangements in place for website compliance with Welsh Language Standards.

Overview

Considerable progress has been made by management to address the previous report findings, including publication of a Website and Social Media Content Protocol, regular audits of amended pages on the website, and the use of an external provider to undertake a full review of the website.

Arrangements are in place to monitor changes on the website, with demonstrated regular review of audits.

One action was not fully completed due to difficulties in recruiting to a translator post. This action is considered obsolete as, given the difficulties, management have relied on alternative controls in place, recognising there may be some delays in information being translated. The protocol agreed by the Executive team includes allowance for when emergency / time critical information is to be published/translated.

The external review of the website was completed in November. These are being taken forward by the Communications Team. This action has been marked as completed, noting issues have been identified and the team are working through these.

	Previous Matters Arising	Previous Priority Rating	Direction of Travel	Current Priority Rating
1	Process in place for the management of Welsh information on the external Health Board website.	High	⇧	Closed
2	Compliance with the requirements of Welsh Language Standards.	High	⇧	Closed

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
Special Measures – Contract and Procurement Management	Draft report – Factual accuracy matters have been addressed and revised report issues 20 November 2023 – we await management approval.	31 October 2023	N/A – Actions raised with no response required for Internal Audit.
Follow-up: Delivery of Health Board Savings	Draft report has been issued – Factual accuracy meeting held 12 December 2023.	30 November 2023	3 January 2024
Corporate Legislative Compliance: Water Safety	Draft report issued.	13 December 2023	15 January 2024

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

Table 2: Reviews in progress

Review	Draft report due:
Health and Safety	January 2024
Effective Governance: Womens	January 2024
Effective Governance: Central IHC	January 2024
Digital Health Record (Cito) – Patient Records Transition Programme	January 2024

Review	Draft report due:
Operating Model	January 2024
Follow up of Internal Audit Recommendations	Ongoing - report as required
Discharge Arrangements – Discharge to Recover then Assess (D2RA) Pathways	February 2024

6. Audit briefs have been issued/agreed for the following reviews:
   - Records Management – Fragmented Care records.
   - Standards of Business Conduct.
   - Corporate Legislative Compliance: NHS (Appointment of Consultants) (Wales) (Amendment) Regulations 2005.

Contingency/Organisational Support/Advice

7. Internal Audit supports the Health Board through providing advice and guidance on areas of control, new systems, and processes.
8. 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

9. The additional support provided to the Health Board with focused reviews is channelled through contingency.
10. As new risks are identified in year, the Board Secretary and internal audit consider the planned reviews against the emerging high-level risks.
11. As part of developing the audit briefs and considering the status of reviews, we noted the following reviews cannot be followed-up in full due to agreed management action plan timelines not implemented in time for this financial year or processes had yet to progress to enable a review in line with the approved plan:

Table 3: Audit reviews recommended for deferral or removal from the 2023/24 plan

Audit Title	Reason for requesting deferral / removal from plan
Follow up - Recruitment of substantive and interim executive and senior posts	Following publication of the Welsh Government *Rapid Review of Interim appointments to Executive posts at Betsi Cadwaladr University Health Board* it includes an action plan with implementation dates ranging from February to April 2024 inclusive. To eliminate duplication, we will combine the follow-up of both our and Welsh Government reports into one as they are very much interdependent – We have agreed this approach in principle with both the Chief Executive and Deputy Director of People, subject to ratification by the Audit Committee.

Audit Title	Reason for requesting deferral / removal from plan
	We recommend deferring the review to May 2024 to enable the April 2024 timeline to pass and undertake a whole system review of appointments that would include follow-up of both agreed action plans.
Follow up – Contracted Patient Services: Quality and Safety arrangements	The review of agreed actions has identified two key actions are not scheduled for completion until March 2024 and therefore would not have been completed in time for a follow-up review this financial year. We recommend deferring the review to Quarter 1 2024/25 to enable the agreed action plan timelines to pass and undertake the follow-up then.
Charitable Funds	The Executive Director of Finance has requested that this review be delayed until April 2024 to enable them to close the year end position and formerly adopt the revised policies and procedures developed. We support this delay in order that we undertake a review of internal controls in operation against revised policies and procedures. We recommend deferring the review to Quarter 1 2024/25 to enable management to implement revised policies and procedures as requested by Executive Lead.
Wrexham Maelor Continuity Phase one	The Executive Director of Finance has requested that this review be delayed to confirm approval of the business case. There is also no Senior Responsible Officer / Programme Board in place at this time. We will continue to monitor progress at the project to ensure timely rescheduling of the audit. We recommend deferring the review and as an alternative, we propose to progress the audit of the Orthopaedics project in Llandudno.

12. The following tables detail the planned performance indicators (Table 4) captured by Internal Audit in delivering the service and the planned delivery of the core internal audit plan (Table 5) with the assurance provided.

13. Table 4 is reporting a positive status across all indicators. Figures are based on fifteen reports/briefing papers issued as final (or requiring no response) to date.

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	Green	93%	80%	v>20%	10%<v <20%	v<10%

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

Table 5 – Core Plan 2023-24 (April 2023 to March 2024)

Planned output	Outline timing	Status	Assurance (including draft report assurance opinions)
Special Measures - Contract and Procurement management review	October 2023	Draft report issued.	Not Applicable
Financial Control: Receipting of goods and year-end accruals	April 2023	Final report issued.	Reasonable
Accounts Receivable	June 2023	Final report issued.	Reasonable
Clinical Audit: Tier 1 National Audits	June 2023	Final report issued.	Limited
Falls management	June 2023	Final report issued.	Limited
Lessons learnt	July 2023	Final report issued.	Limited
Cyber security	April 2023	Final report issued.	Substantial
Digital Operating Model	June 2023	Final report issued.	Reasonable
GP Out of Hours (Deferred from22/23)	June 2023	Final report issued.	Limited
Decarbonisation	September 2023	Final report issued.	Limited
Adult and Older Persons Mental Health Unit (IAAP)	April – September 2023	Final report issued.	Reasonable
Corporate Legislative Compliance: Water Safety	June 2023	Draft report issued.	Limited
Hergest Unit Notice of Contravention (NoC) Action Plan	June 2023	Final report issued.	Limited
Procurement and Contract management arrangements	June 2023	Briefing paper issued.	Not Applicable
Interim Executive Director appointment	September 2023	Briefing paper issued.	Not Applicable
Follow up - Delivery of HB Savings	October/ November	Draft report issued.	Limited

Planned output	Outline timing	Status	Assurance (including draft report assurance opinions)
	2023		
Follow up - Welsh Language Commissioner - Documents on the Website	August 2023	Final report issued.	Reasonable
Follow up of Internal Audit Recommendations	October 2023 – March 2024	Review in progress.	
Health and Safety	October 2023	Review in progress.	
Effective Governance - Integrated Health Community – Central	October 2023	Review in progress.	
Discharge arrangements / patient flow management	October 2023	Review in progress.	
Operating model	November 2023	Review in progress.	
Standards of Business Conduct – Declarations of Interest, Gifts and Hospitality	December 2023	Brief agreed – Review to commence in January/ February 2024	
Digital Health Record (Cito) – Patient Records Transition Programme	November 2023	Review in progress.	
Womens Services	November 2023	Review in progress.	
Corporate Legislative Compliance: NHS Appointment of Consultant Regulations 2005	November 2023	Brief agreed.	
Budgetary Control	December 2023	Planning meeting rescheduled by management to 4 January 2024.	
Follow up - Recruitment of substantive and interim executive and senior posts	December 2023	Deferral requested.	Recommendation to Audit Committee for deferral.
Charitable Funds	January 2024	Deferral requested.	Recommendation to Audit Committee for deferral.
Follow up – Contracted Patient Services: Quality and Safety arrangements	January 2024	Deferral requested.	Recommendation to Audit Committee for deferral.
Deprivation of Liberty Safeguards (DoLS)	January 2024	Planning meeting booked.	
Board Assurance Framework and Risk Management	February 2024	Planning meeting booked.	

Planned output	Outline timing	Status	Assurance (including draft report assurance opinions)
Records Management – Fragmented Care records	February 2024	Brief agreed.	
Grievance procedure and case management	February 2024	Planning meeting booked.	
Wrexham Maelor Continuity	October 2023 – March 2024	Deferral requested.	Recommendation to Audit Committee for deferral.
Workforce Strategy: Operational implementation (Deferred from 22/23)	June 2023	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
1	Cyber & Data Management	Management of IT systems and data is inadequate, access rights are not monitored or maintained which may compromise cybersecurity.
2	Communication	Information is not communicated clearly internally within teams, or externally with partners, forums, or wider stakeholders.
3	Compliance	Non-compliance with relevant policies, procedures, standards, applicable laws and regulations, and government instructions. No formal compliance monitoring and issue escalation.
4	Policies & Procedures	Inadequate or lack of policies and procedures in place.
5	Audit Trail (Documentation)	There are missing or partially completed documents, or the quality of documents is not sufficient. A lack of document retention, unretrievable documents/data or inappropriate audit trail.
6	Engagement	Lack of engagement with staff, partners, and wider stakeholders. Engagement with external providers is not consistent, resulting in contracts or agreements not being monitored.
7	Governance & Risk Management	Formal governance routes are inadequate, ineffective, or there is a lack understanding of them. This may affect the ability to identify, assess and manage risk.

Ref.	Theme	Definition
8	Ineffective Controls	The necessary control(s) to mitigate risk(s) do/does not exist, is ineffective, or there are gaps which result in inefficiencies.
9	Reporting	The adequacy, quality, or accuracy of reporting is insufficient for assurance, or there is a lack of assurance mechanisms and central oversight in place. No formal reporting, escalation, and scrutiny processes are established, all of which may affect the ability to make decisions.
10	Finances & Resourcing	There are inadequate resources to deliver required tasks, a lack of resource management, monitoring, or funding. Financial viability and sustainability need to be properly considered and maintained.
11	Review	Whilst work is in progress and when it is completed, reviews are not undertaken regularly (or at all) to ensure quality, effectiveness and that the desired outcome is achieved or is on target to be achieved. Best practice is not reviewed or considered, lessons learned are not monitored or documented which may impact development and lead to repeated mistakes.
12	Physical Security	No consideration and actions to protect against current and future threats.
13	Planning, Delivery & Deadline Management	A lack of timescales or deadlines being set, or unmonitored scope creep resulting in missed deadlines, non-delivery of projects and/or tasks, overspends, or negative impacts on the quality of the final output.
14	Training & Development	A lack of training, opportunities to complete training, or training materials within teams; this may lead to gaps in knowledge and over reliance on certain staff members.
15	Contractual	Awaiting definition.
16	Strategy	Awaiting definition.
17	Other	If there is no correlation between a recommendation and one of themes outlined, this option can be selected to help monitor the accuracy of the list provided and to identify potential additional themes.

Lessons Learnt
Internal Audit Report

November 2023

Betsi Cadwaladr University Health Board

GIG CYMRU NHS WALES
Partneriaeth Cydwasanaethau
Gwasanaethau Archwilio a Sicrwydd
Shared Services Partnership
Audit and Assurance Services

GIG CYMRU NHS WALES
Bwrdd Iechyd Prifysgol Betsi Cadwaladr University Health Board

Contents

Review reference:	BCUHB-2324-06
Report status:	Final
Fieldwork commencement:	31 July 2023
Fieldwork completion:	12 October 2023
Debrief meeting:	*Various debrief discussions with key staff during review*
Draft report issued:	12 October 2023
Management response received:	10 November 2023
Final report issued:	10 November 2023
Auditors:	Rhys Jones, Principal Auditor Nicola Jones, Deputy Head of Internal Audit Dave Harries, Head of Internal Audit
Executive sign-off:	Angela Wood, Executive Director of Nursing and Midwifery
Distribution:	Mandy Jones, Deputy Executive Director of Nursing Chris Lynes, Deputy Executive Director of Nursing Matthew Joyes, Deputy Director of Quality Reena Cartmell, Director of Nursing Quality Assurance and Learning Tracey Radcliffe, Head of Patient Safety Sarah Musgrave, Lead Manager - Learning Phil Meakin, Interim Board Secretary
Committee:	Audit Committee

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

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

Executive Summary

Purpose

The review has considered whether there are robust processes and controls in place to support the management of learning within Health Board Integrated Healthcare Communities (IHCs) and pan-North Wales services, and to review operational compliance with Make it Safe (Plus) principles.

Overview

We have issued limited assurance on this area. The significant matters which require management attention include:

- There are no Health Board policies, guidance documents, or Standard Operating Procedures (SOP) in place to support the management of lessons learnt.
- Established processes and governance arrangements are not consistent across all IHCs and services.
- There are no formal processes in place to review the effectiveness of implemented learning.
- Make it Safe (Plus) requirements are not formally documented.
- There is significant variation in the quality and detail of Make it Safe (Plus) and lessons learnt information recorded in Datix.

Further matters arising concerning the areas for refinement and further development have also been noted (see Appendix A).

We recognise that a number of issues raised in this review will be considered by the work being undertaken on learning as part of Special Measures.

Report Opinion

		Trend
Limited 	More significant matters require management attention. **Moderate impact** on residual risk exposure until resolved.	n/a

Assurance summary[1]

Objectives		Assurance
1	Integrated Health Communities and pan-North Wales services have established robust process to capture, manage, and share lessons learnt from sources including claims, concerns, and incidents. Operational processes comply with relevant policies and Make it Safe principles.	Limited
2	There is evidence to demonstrate opportunities for learning are implemented, and outcomes are reviewed to ensure effectiveness to limit future occurrence.	Limited
3	Lessons learnt are subject to robust governance arrangements with clear lines of accountability, reporting, escalation, and evidence of outcome sharing within Integrated Health Communities and pan-North Wales services. Information management and reporting structures support the identification of common themes and to promote learning across services.	Limited

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

Key Matters Arising		Objective	Control Design or Operation	Recommendation Priority
1	The Health Board does not have a formal policy, SOP, guidance notes or other formal written control document in place to support the management of learning. Established working practice varies by IHCs and pan North Wales services, and there are no formal processes in place to review the effectiveness of implemented learning. We also found variation in the quality of information recorded in Datix.	1,2,3	Design	High
2	Each IHC and service reviewed have established processes to manage Make it Safe (Plus) reviews. However, we cannot confirm compliance as the principles and requirements of Make it Safe (Plus) have not been formally documented. As with lessons learnt, we found significant variation in the quality and consistency of information recorded in Datix and were unable to extract robust performance data from the system.	1	Design	High

1. Introduction

1.1 Learning from events is a critical tool used by organisations to ensure continuous improvements in the quality and safety of services provided.

Whilst the Health Board will always seek to limit the occurrence of adverse events and incidents, it is important that when they do occur that the organisation learns from these and implements controls, operational, or procedural changes that prevent or limit the impact of future occurrence.

Opportunities for learning can arise from a diverse range of sources including (but not limited to) regulatory reports, claims, concerns, and incidents.

During our initial planning meeting, management advised that the Health Board's overarching approach to the management and sharing of lessons learnt was included within the remit of pending high-level external reviews. To avoid duplication management requested we focus our review on the operational management of lessons learnt and Make it Safe (Plus) reviews within a sample of Integrated Health Communities and pan-North Wales services.

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

- No formal controls or processes in place to manage lessons learnt, or to follow-up the effectiveness of learning.
- Make it Safe (Plus) principals / requirements not met.
- Lessons learnt are not identified, shared or subject to scrutiny in the form or review / evaluation.
- Risk to patient safety and reputational damage due to recurring incidents.

1.3 This review focuses solely on the management of lessons learnt and Make it Safe (Plus) reviews within a sample of Integrated Health Communities (IHC) and pan-North Wales services. We have not reviewed the work, role, or remit of the corporate Patient Safety team.

1.4 This report is based upon the information provided by the Directors of Nursing, Governance Leads, and/or delegated officers of the Area IHCs and pan-North Wales Services reviewed, and information available in the public domain. We would like to express our gratitude to colleagues in for their input during the undertaking of the review.

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

2. Detailed Audit Findings

To undertake this audit, we chose a sample of Integrated Health Communities (IHC) and pan-North Wales Services to review. Our sample comprised the following:

- East Integrated Health Community (IHC).
- Central Integrated Health Community (IHC)
- West Integrated Health Community (IHC)
- Mental Health and Learning Disabilities.
- Womens.

We met with the Nursing Directors and Governance Leads (or delegated officers) for each area / service - the review findings are based on the responses provided, supporting documentation received, and information available in the public domain. Note that we were unable to complete our review fieldwork for IHC West due to staff availability.

Objective 1: Integrated Health Communities and pan-North Wales services have established robust process to capture, manage, and share lessons learnt from sources including claims, concerns, and incidents. Operational processes comply with relevant policies and Make it Safe principles.

2.1 To establish the robustness of processes in place to manage and share learning and ensure compliance with Make it Safe (Plus) requirements, we sought to compare working practice against relevant Health Board policies, guidance notes and / or Standard Operation SOPs. However, we found the following limitations:

- The Health Board does not have an overarching policy, guidance notes, or Standard Operating Procedure in place to support and guide the management of lessons learnt arising from Incidents. We were advised that an Incident Management Procedure document is currently in draft stage however has not been formally approved, widely shared, or published. A copy was provided for review.
- For Concerns and Complaints - learning features prominently in the Health Board Claims Handling Procedure document however the mechanisms for sharing learning are not defined. We noted that evidence of learning must be included in claim submissions to the Welsh Risk Pool.
- We reviewed a sample of relevant policies and guidance notes published on the Health Board intranet site and found that many of the key documents were overdue for review. Despite this we reviewed the content and found that whilst the importance of identifying and sharing learning is noted in several of the documents, there is no practical guidance for management and services to follow.
- Make it Safe (Plus) requirements are not documented – published information is limited to Datix user guides. We confirmed that the draft

Incident Management Procedure document includes a comprehensive section outlining the requirements of Make it Safe (Plus) however there is currently no approved guidance to inform process.

- We searched the Health Board intranet site (BetsiNet) for other relevant documents / information using search terms such as "Lesson", "Learning", "Make it Safe" and found that results were limited to Datix user guides.

2.2 Despite the absence of formal documented Health Board instruction, we reviewed the processes and practices established by the area Integrated Health Communities (IHCs) and pan-North Wales services in our review sample and found the following:

- Each IHC and pan-North Wales service reviewed have established processes to manage and share learning as part of their incident and claims management procedures.
- All incidents are reviewed daily to determine the level of investigation and are subject to robust oversight and scrutiny at various forums. Examples of established forums include daily huddle / clinical meetings, daily Patient Safety Team meetings, weekly Putting Things Right meetings, weekly HARMs meetings, Patient and Carer Experience Groups, Mortality Group meetings, area / service specific Group meetings, Incident Learning Panels, and area / service monthly Patient Safety and Quality Group meetings.
- We were advised that in addition to ensuring that incidents are managed appropriately, the meetings above are used as forums to share and discuss lessons learnt. Other examples of mechanisms used to share learning included bulletins, seven-minute briefings, learning posters, newsletters, presentations, Theme of the Month, and debrief sessions.
- The IHCs and pan North Wales services have developed their processes independently therefore, whilst there are some areas of common practices, lessons learnt are not managed consistently across Health Board IHCs and services. Examples where processes and working practice vary include:
- Tracking, monitoring, and reporting of lessons learnt, Make it Safe (Plus), and incidents.
- Governance arrangements, including the role and remit of established meetings / Groups.
- Mechanisms for sharing learning.
- Datix administration, including the role of area / service governance teams.
- Whilst outside the scope of this review we were advised that the Patient Safety team also share learning via email notices and maintain an online Learning Library.

2.3 All NHS Wales Health Boards use Datix as the primary system to record and manage incidents and concerns. Datix is also used to record the outcome of Make it Safe (Plus) reviews. Make it Safe (Plus) are rapid reviews (to be completed within 72 hours of the incident occurring) of all moderate or above graded incidents to understand what happened and implement immediate actions to prevent future occurrences.

2.4 All areas advised that relevant incidents are identified and allocated responsible officers tasked with undertaking the Make it Safe (Plus) review as part of the daily review of incidents. Whilst this is standard practice across the IHCs and pan North Wales services reviewed, we did note some areas where practice varied, specifically around the oversight, scrutiny and sign-off of completed reviews.

2.5 We received a report from Datix detailing all incidents graded as moderate harm or above for the period 1st May 2023 to 31st July 2023. During this period 2,116 incidents (graded as moderate or above) were reported for the IHCs and services in our sample. We reviewed the data and noted the following:

- The form, content, and detail of completed Make it Safe (Plus) reviews vary significantly across areas and incidents.
- Make it Safe (Plus) reviews are recorded in Datix within a free-text box that is shared with the Management Review field. It is not always clear from the narrative whether a Make it Safe (Plus) review has been undertaken.
- Make it Safe (Plus) reviews are not consistently undertaken where incidents have been regraded from moderate or above severity to low or no harm.
- We were unable to determine whether the Make it Safe (Plus) reviews were completed within the required 72-hour timeframe as there is no provision in Datix to record review start and completion dates. The "Date that Management Review Started" is recorded in Datix however this may not be the date that the Make it Safe (Plus) review was undertaken.
- The following table provides a summary of the number of days between the recorded Incident Date and the recorded Date that Management Review Started – note that the data has not been verified and does not include seventy-nine incidents where the service / Division was not specified, nor has it been adjusted for any duplicate entries / multiple incident entries for the same patient:

Table 1: Summary by Area/Service of Number of days between recorded Incident Date and the recorded Date that Management Review Started - 1st May 2023 to 31st July 2023

	Number of days between recorded Incident Date and the recorded Date that Management Review Started				Number of Incidents as % of Total by Area / Service		
Area/ Service	**Management Review Start date not stated**	**0 – 3 days (72 hours)**	**4 days and over**	**Total Number Incidents (Mod>)**	**Management Review Start date not stated**	**0 – 3 days (72 hours)**	**4 days and over**
IHC East	131	149	262	**542**	24%	27%	48%
IHC Central	103	153	410	**666**	15%	23%	62%
IHC West	112	164	244	**520**	22%	32%	47%
Mental Health	20	67	205	**292**	7%	23%	70%
Womens	18	27	51	**96**	19%	28%	52%
Total	**384**	**560**	**1172**	**2116**			

Source: Datix report / extract provided for review.

Conclusion:

2.6 The Health Board does not have any formal overarching policies, guidance documents, or Standard Operating Procedures in place to support the management of lessons learnt or outlining the requirements and principles of Make it Safe (Plus). Therefore, we cannot confirm that established practices comply with relevant Health Board policies or Make it Safe (Plus) principles.

2.7 Despite the absence of formal written control documents, we confirmed that each Integrated Health Communities and pan-North Wales services in our review sample have established processes to capture, manage, and share lessons learnt as part of their incident and claims management procedures.

IHCs and pan North Wales services have also established processes to manage the undertaking of Make it Safe (Plus) reviews. However, we were unable to confirm the robustness of controls in place – a review of Datix showed significant variance in terms of the quality and consistency of completed Make it Safe (Plus) reviews and highlighted the limitations of Datix for reporting and tracking.

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

Objective 2: There is evidence to demonstrate opportunities for learning are implemented, and outcomes are reviewed to ensure effectiveness to limit future occurrence.

2.8 All IHCs and pan North Wales services reviewed have established processes to share learning and track and monitor incident progress / action implementation. Evidence of senior oversight and scrutiny, action trackers, action logs, action cards, tracking via incident reports, Datix action tracking, requirements for evidence submission, was provided for review.

2.9 However, there is no formal process in place to review the effectiveness of implemented learning or confirm its impact on reducing future occurrence - one service advised that they audit the effectiveness of learning however we were unable to verify this from the evidence submitted.

2.10 Several of the area Governance Leads stated that whilst it is possible to demonstrate that learning is shared, and evidence that actions have been implemented, it is much more difficult to obtain assurance that learning outcomes have been effective and have impacted working practices. We queried whether learning would result in a reduction of incidents, and whilst this may happen, incidents would not necessarily reduce as the number would depend on the type of patients and nature of incidents.

2.11 Lessons learnt and action implementation are captured and recorded in Datix. However, several of the key fields, including lessons learnt and management review / Make it Safe (Plus) are not mandatory fields. This can result in incidents being closed whilst incomplete or without sufficient relevant evidence – we observed two examples whereby closed incidents were re-opened after a manual review identified that the records had not been completed appropriately. We reviewed the lessons learned field for closed incidents for the period 1st May 2023 to 31st July 2023 and noted the following:

- The quality of recorded learning is inconsistent – in addition to learning, we noted examples where the field has been used to record actions taken, incident review conclusions, summary of incidents, in addition to 'nil', 'N/A', and 'as above' responses.
- The Lessons Learnt field is not always completed, though the number is not significant – we found 24 omissions from a total of 1,618 closed incidents.

Conclusion:

2.12 The Health Board requirements regarding the review of implemented learning is not documented. Whilst there is evidence to demonstrate that opportunities for learning are identified, tracked, and shared, there is no formal process in place to review effectiveness and confirm that implemented learning has been embedded into working practice – i.e. closing the loop.

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

Objective 3: Lessons learnt are subject to robust governance arrangements with clear lines of accountability, reporting, escalation, and evidence of outcome sharing within Integrated Health Communities and pan-North Wales services. Information management and reporting structures support the identification of common themes and to promote learning across services.

2.13 There are no formal Health Board wide policies, SOPs, guidance notes, or other written control documents in place to support the management of lessons learnt or outline the required governance arrangements.

2.14 Lessons learnt are not managed in isolation but rather are incorporated into the IHC and services' incident and claims management procedures. We reviewed the governance arrangements in place and found the following:

- Each IHC and pan-North Wales service reviewed stated that they have established forums and escalation arrangements to ensure incidents and learning are subject to oversight and scrutiny. However, we were unable to confirm the robustness of established governance arrangements for all areas reviewed due to variation in submitted evidence.
- Examples of Terms of Reference, Chairs assurance reports, divisional reports, Director briefings, meeting minutes and agendas showing provision for learning to be discussed and shared were provided for review. However, the evidence submitted was not exhaustive – we did not receive Terms of Reference for all stated meetings and forums, nor did we receive relevant minutes for all meetings.
- Each IHC and pan North Wales service reviewed referenced internal governance frameworks and provided examples of incident tracking, action logs, reports, analysis of trends, and the sharing of outcomes and learning to demonstrate established operational processes.

2.15 In terms of identifying common themes, all IHCs and pan North Wales services reviewed stated that they actively review and monitor trends and emerging themes – evidence of incident trend / trajectory reports were provided for review. Four of the sample areas stated that they undertake deep dive reviews and / or targeted training sessions to address and better understand common / emerging themes, though we were unable to verify this as no evidence was provided for review. One service stated that adverse incidents are often the result of either a local policy not being followed, or the policy failing to capture the risk of occurrence. Consequently, they review the robustness of local policies and either update the policy or instigate training focussed on policy requirements.

Conclusion:

2.16 The IHCs and pan North Wales services reviewed have all incorporated learning within their respective internal governance arrangements. Whilst we observed examples of robust practices, the established governance arrangements for learning vary by IHC and service.

The Health Board does not have an overarching policy, guidance document, or Standard Operating Procedure outlining the governance requirements or expected controls to support the management of learning, therefore lines of accountability, reporting, escalation, and sharing mechanisms have not been defined. Consequently, we cannot determine whether established governance arrangements are sufficiently robust or meet Health Board requirements.

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

Appendix A: Management Action Plan

Matter Arising 1: Lessons Learnt (Design)			**Impact**
The Health Board does not have any formal policies, guidance documents, or Standard Operating Procedures in place to support the operational management of lessons learnt across the organisation. IHCs and services reviewed have established operational processes and governance arrangements to manage, monitor, and share learning however we noted the following: • Lessons learnt are not managed consistently across IHCs and services. • There are no formal processes in place to review the effectiveness of implemented learning. • The lessons learnt field within Datix is not always completed appropriately. • We cannot determine whether established practices are sufficiently robust and meet Health Board requirements.			Potential risk of: • Lack of clarity, consistency, and transparency. • Lack of organisational direction resulting in a fragmented approach to the management and sharing of learning. • Lack of robust governance arrangements. • Learning not impacting working practice. • Recurring incidents.
Recommendations			**Priority**
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.		**High**
1.2	Management to ensure all relevant fields within Datix are completed appropriately prior to closing the incident.		
1.3	Management to review implemented learning to ensure effectiveness.		
Agreed Management Action		**Target Date**	**Responsible Officer**
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.	29/02/2024	Deputy Director for Quality Governance

1.2	Lessons have been learned from the initial implementation of the Once for Wales Datix System whereby handlers of incidents were able to close incidents without completing all mandatory fields – this is being changed forcing completion of the mandatory fields.	30/11/2023	Lead Manager Quality Informatics and Learning
	The ability for incident managers to by-pass steps in the incidents process within the system has also been identified. This issue will be fed back into the national team for development and where this is identified, then education and training will be offered to services/individuals.	Commencing 30/11/2023	Head of Patient Safety
	A regular audit has started and is ongoing providing services with information on where managers are not completing the process.	Commencing 30/11/2023	Head of Patient Safety
1.3	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.	31/03/2024	Lead Manager Quality Informatics and Learning
	The Organisational Learning Forum was launched earlier this year whose purpose is to identify themes and mechanisms to enable learning to be embedded across the organisation.	Completed	Deputy Executive Director of Nursing
	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.*	31/03/2024	Lead Manager Quality Informatics and Learning

Matter Arising 2: Make it Safe (Plus) (Design)	**Impact**
Each IHC and pan North Wales services reviewed have established processes to manage Make it Safe (Plus) reviews. However, we cannot confirm compliance as the principles and requirements of Make it Safe (Plus) have not been formally documented. We reviewed the Datix entries for incidents reported between 1 May 2023 and 31 July 2023 and noted the following limitations: • The form, content, and quality of completed Make it Safe (Plus) reviews vary significantly. • It is not always clear whether a Make it Safe (Plus) review has been completed. • There is no specific provision in Datix to record Make it Safe (Plus) start and completion dates. • It is difficult to track and measure performance using Datix.	Potential risk of: • Lack of clarity, consistency, and transparency. • Lack of robust governance and reporting.

Recommendations		**Priority**
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.	**High**
2.2	Management to ensure all Make it Safe (Plus) reviews are documented and recorded appropriately i.e. though regular audit / review.	

Agreed Management Action		**Target Date**	**Responsible Officer**
2.1	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.	31/03/2024	Head of Patient Safety

2.2	The Patient Safety Team (PST) review and report on completion of MIS Plus and timescales. This information is shared with services. The PST will undertake a weekly audit/review to provide assurance that reviews are documented and recorded appropriately.	Commencing 30/11/2023	Head of Patient Safety

Appendix B: Assurance opinion and action plan risk rating

Audit Assurance Ratings

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

	**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 assurance**	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.

Prioritisation of Recommendations

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

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

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

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Decarbonisation
Final Internal Audit Report
December 2023

Betsi Cadwaladr University Health Board

GIG CYMRU NHS WALES
Partneriaeth Cydwasanaethau
Gwasanaethau Archwilio a Sicrwydd
Shared Services Partnership
Audit and Assurance Services

GIG CYMRU NHS WALES
Bwrdd Iechyd Prifysgol Betsi Cadwaladr University Health Board

Contents

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Executive sign-off:	Russell Caldicott, Interim Executive Director of Finance
Distribution:	Denise Roberts, Head of Value Based Healthcare and Clinical Pathways Marie Lewis, Transformation / Programme Manager, Paolo Tardivel, Director of Transformation & Improvement Richard Daniels, Interim Director of Capital & Estates Arwel Hughes, Head of Operational Estates Phil Meakin, Associate Director of Governance Nesta Collingridge, Head of Risk Management Andrea Hughes, Interim Director of Finance Joanna Garrigan, Finance Director - Commissioning & Strategy Bathen Wassel, Statutory Compliance, Governance and Policy Manager
Committee:	Audit Committee

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

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

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

Executive Summary

Purpose

We sought to determine the adequacy of management arrangements to ensure compliance with the requirements of the Welsh Government's decarbonisation strategic delivery plan and ensure that the UHB has appropriate controls and management arrangements in place to achieve the same.

Overview

We have issued limited assurance on this area. The significant matters which require management attention include:

- Decarbonisation is not reported into existing organisation accountability and reporting frameworks for 2023.

  An appropriate decarbonisation reporting structure which monitors the progress of the action plan within the Health Board is not currently in place.
- Due to the existing status of actions the Decarbonisation Action plan risks falling further behind schedule and failing to achieve the key deliverable decarbonisation activities.

Further matters arising concerning the areas for refinement and further development have also been noted (see Appendix A).

Other advisory points are within the detail of the report.

Report Opinion

		Trend
Limited 	More significant matters require management attention. **Moderate impact** on residual risk exposure until resolved.	 Add year of issue i.e. 2023/24

Assurance summary[1]

	Objectives	Assurance
1	Governance – To obtain assurance that appropriate governance arrangements have been established.	Limited
2	Localised Strategies – To ensure that a tailored decarbonisation strategy and action plan has been developed in accordance with available legislation and guidance.	Reasonable
3	Funding Strategy – There is an appropriate funding strategy targeting discretionary, EFAB and All-Wales funding.	Reasonable
4	Monitoring & Reporting – To ensure appropriate monitoring and reporting arrangements are in place.	Limited
5	Project Delivery: To obtain assurance that projects included within the 2023/24 funding commitments have been successfully delivered, and that appropriate arrangements are in place to secure available funding during 2024/25.	Limited

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

Key Matters Arising		Objective	Control Design or Operation	Recommendation Priority
1	There is no reporting of decarbonisation into existing organisation accountability and reporting frameworks. Currently no decarbonisation reporting structure which monitors the progress taking place	1,4	Design	High
2	Risk of the Decarbonisation Action plan falling behind schedule and failing to achieve the key deliverable decarbonisation activities.	5	Operation	High

1. Introduction

1.1 The Welsh Government is party to international agreements to reduce carbon emissions and control climate change, most notably as arising from the 2016 Paris Accord. Accordingly, they have sought to create a framework of controls, guidance and support to achieve these aims.

Targets include waste reduction, and reductions in supply chain carbon as part of the overall carbon footprint.

To support these aims, the Welsh Government published a number of strategic documents entitled *Prosperity for All – Economic Action Plan, Prosperity for All – A Low Carbon Wales* and *Prosperity for All – A Climate Conscious Wales*

In March 2021 the Welsh Government approved a net zero target for the public sector of 2030. Net zero means balancing the greenhouse gas emissions with the amount of gases being removed from the atmosphere. For NHS Wales, an accompanying "*Strategic Delivery Plan*" was published, setting interim targets (from a 2018/19 base) of:

	Carbon budget reduction
2025	16%
2030	34%

Category targets were also set for:

- Buildings;
- Procurement;
- Fleet and business travel; and
- Staff, patient, and visitor travel.

All Wales activity support streams have been created, including Estates planning, and approaches to Healthcare.

The Welsh Government has made funding available of circa £19.9m for decarbonisation initiatives via the Estates Funding Advisory Board in both 2023/24 and 2024/25 (based on each organisation matching 30% of the WG contribution from their own discretionary programme).

This audit seeks to build upon the advisory review undertaken in 2022/23 which identified common themes nationally to be considered by the Health Board.

1.2 Associated Risks

- Regulatory/legislative risk through not achieving mandated reductions in carbon emissions.
- Reputational risk by failing to meet emission targets.
- Failing key stakeholders by not reducing carbon emissions which have a detrimental effect on health. In so doing not meeting the requirements of the Well Being of Future Generations Act (2016).

2. Detailed Audit Findings

Objective 1: Governance – To obtain assurance that appropriate governance arrangements have been established in relation to decarbonisation that integrate with existing organisational accountability and reporting structures.

2.1 We reviewed governance arrangements in place for the reporting of decarbonisation within the Health Board. Whilst we were able to see reporting during 2022, we were unable to see any reporting through appropriate governance structures for 2023.

Development of the strategic governance plan and the action plan was reported to the Partnerships, People and Population Health Committee (PPPH), Executive Team meetings and Health Board (assurance paper) throughout 2022.

Health Board meeting 24 November 2022 - minutes from 29th September 2022 state:

22.209.8 It was agreed that a further update should come to the Board in early 2023.

The last information provided to the Health Board meeting relating to decarbonisation was on 29th of September 2022. The PPPH has not convened since 17th January 2023.

We were informed a proposed Decarbonisation Programme Board Structure is to be presented at the next Decarbonisation Programme Board meeting in October 2023.

2.2 Roles for Senior Responsible Officer – Executive Director of Finance, Head of Value - Head Of Value Based Health Care & Clinical Pathways and Programme Manager Decarbonisation - Transformation/programme Manager have been in established within the Health Board.

2.3 With regards to training there is a module on Electronic Staff Record (ESR) module on the Health Boards system called "building a net zero NHS". This is available to all staff. The Programme Manager for Decarbonisation is currently in the process of establishing whether the training can become mandatory for staff.

2.4 We received the latest Corporate Risk Register dated 3 October 2023 to determine if decarbonisation had been identified as a risk to the Health Board; there was no risk relating to decarbonisation noted. The Risk Management Team, checked all Risk Registers within the specialties and divisions to see if decarbonisation had been identified as a risk; no risks relating to decarbonisation were recorded.

Conclusion:

2.5 Despite being able to observe reporting arrangements for 2022, we have been unable to establish reporting of decarbonisation via existing organisational accountability and reporting structures for 2023.

Changes in Board membership and placement into Special Measures in 2023 has impacted the governance and committee arrangements within the Health Board.

We note that PPPH has not taken place since the 17 January 2023 which would have disrupted the reporting process.

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

Objective 2: Localised Strategies – To ensure that a tailored decarbonisation strategy and action plan has been developed in accordance with available legislation and guidance.

2.6 In response to the NHS Wales Decarbonisation Strategic Delivery Plan, the Health Board has created a Decarbonisation Action Plan with the assistance of the Carbon Trust.

It has been based on an analysis of data supplied by the Health Board, observations made during site visits, and data gathered during targeted engagement with key functions across the Health Board (Estates, Finance, Procurement, Transport, and Clinical leads).

It outlines the primary deliverable decarbonisation activities that will be put in place over the following two years, starting in 2022/23 and 2023/2024, as well as establishing the strategic direction of travel for the next five years.

On 13 September 2022, the action plan was submitted to PPPH, who endorsed it for submission to the Health Board for approval. It was approved by the Health Board on 24 November 2022.

2.7 We reviewed the Integrated Medium Term Plan (IMTP) 2022/25, Estates Strategy and Annual Plan 2023/24, to establish whether the strategy and action plan have been adequately reflected within organisational documentation.

Integrated Medium Term Plan 2022/25

We reviewed appendix 1,3,5 and 6 (appendix 2,4 had not been published) of the IMTP documents and the IMTP plan. Only the IMTP plan under discretionary and national programmes and appendix 6 under digitisation of Welsh nursing care records had references to decarbonisation.

We note that the Health Board does not currently have an approved three-year IMTP, and instead have an annual plan (see below).

Estates strategy

The strategy has effectively considered decarbonisation, including areas such as estates risks and challenges, vision for future estates, and strategy alignment.

Annual Plan 2023/24

We were able to verify that decarbonisation had been incorporated in the annual plan, with the legislative and ministerial requirements, estates strategy and capital programmes, and climate change and decarbonisation sections.

Conclusion:

A Decarbonisation Action Plan that sets the strategic direction of travel for the Health Board over the next five years and identifies deliverable actions for the two years from March 2022 has been developed and agreed by the Health Board.

The strategy and plan are adequately reflected within the Estates Strategy and Annual Plan. References to decarbonisation with the IMTP are limited, however it is noted this is not an approved IMTP.

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

Objective 3: Funding Strategy – There is an appropriate funding strategy targeting discretionary, EFAB and All-Wales funding.

2.8 The Estates Funding Advisory Board (EFAB) was established in 2021- 2022 allowing Health Boards to bid for monies to support the following categories:

- Infrastructure (inc. Emergency Department facilities improvements for patients, general building and engineering upgrades, Mental Health safety enhancements; and rationalisation).
- Fire Safety Compliance works. and
- Decarbonisation Schemes.

The Estates Funding Advisory Board (EFAB) announced on the 7 September 2022 that they had approved the reinstatement of the EFAB for 2023-24 and 2024-25. The total funding package for all Health Boards/Trusts each year is £20m, the funding for each year will be split across the following headings:-

- £12m for Infrastructure.
- £5m for Fire Safety Compliance works. and
- £3m for Decarbonisation schemes.

Health Boards/Trusts were informed that they will be required to provide 30% contribution to all schemes supported by through EFAB from the discretionary allocations.

2.9 We were provided with the funding approval letter for discretionary capital which states that funding of £12,696,000 has been awarded to the Health Board. The funding relates to the period 1 April 2023 to 31 March 2024.

2.10 We reviewed the 2023/24 Capital Resource Limit (CRL) to determine if the appropriate 30% discretionary allocation had been implemented. The CRL highlights a total of £11,399,000 discretionary capital funding, this is a difference of £1.297m from the Welsh Government allocation. This amounts to the 30% contribution towards the EFAB schemes deducted from discretionary capital funding.

2.11 We were able to establish that £720,000 (£360,000 for each year) had been allocated towards EFAB decarbonisation for the years 2023–2024 and 2024–2025.

We received an EFAB tracker from Estates and Facilities which highlights the three areas of funding including Decarbonisation. The tracker emphasises that the Decarbonisation funding for 2023- 2025 is allocated towards a project Building Management Systems Upgrade (Pan BCU- 2-year programme).

A Welsh Government approved spend total of £504,000 for 2023 -2025 is stated with a 30% Health Board contribution of £216,000 totalling £720,000 for the two

years, the spend to date shows zero.

2.12 We note that the Health Board has one approved bid towards the whole of the allocated spend of £720,000 over the two years. Whereas other Health Boards/Trusts have various projects relating to the EFAB Funding.

The Specialist Estates Services Notification Memorandum dated 21 September 2022 states under Funding allocations – Key points (4), that all underspends will be re-allocated by Welsh Government.

Of concern is if the project is not completed with the timeframe, the funding which could have been utilised for other projects will have to be returned to Welsh Government.

Although approved the Specialist Estates Services Notification Memorandum also states that:

The Estates Funding Advisory Board will not be involved with capital projects that fall within the remit of the normal business case process with scrutiny provided through the Welsh Government's NHS Infrastructure Investment Board.

We consider It could be challenged that with the project being an upgrade this could fall under the remit of normal business.

2.13 Welsh Government is supporting public sector bodies in Wales to make their buildings and assets more energy efficient. Re:Fit Cymru is a framework for Energy Conservation Retrofits within Public Sector buildings in Wales. It allows public bodies to include multiple buildings and saving measures within a single procured Energy Performance Contracting framework providing energy reduction and alternative energy schemes.

The Performance Finance & Information Governance Committee (PFIG), 30th June 2023, approved recommendations for the implementation of a Re-Fit programme which supports the Health Board's Decarbonisation Action Plan. This was to progress with Phase 1 of a Carbon Reduction Programme with an initially scoped value of £7 million investment over 2 years.

The Re-fit programme has gone through a Soft Market Testing procedure, which resulted in six national Energy Performance Contractors expressing interest in assisting the Health Board in meeting its carbon reduction objective.

A Re:Fit and Alternative funding update paper was presented to the Executive Team on the 8th November 2023 with a recommendation for the Health Board to " *approve Phase 1 of the Re:fit programme and progress with a Mini-competition to choose a Service Partner which offers the best overall value for money to the health Board".*

Conclusion:

2.14 The Health Board has a funding strategy in place which targets the discretionary funding for the EFAB projects, £720,00 of funding has been allocated over the two years towards decarbonisation.

There is potential that the Health Board may have to return any underspend should

the Building Management Systems Upgrade (Pan BCU- 2-year programme) not be achieved within its time frame.

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

Objective 4: Monitoring & Reporting – To ensure appropriate monitoring and reporting arrangements are in place

2.15 The NHS Wales Decarbonisation Strategic Delivery Plan states: *A 'Decarbonisation Board' will be put in place to oversee implementation of the Delivery Plan; this will be a sub-group of the Welsh Government NHS Wales Climate Change Group.*

The Decarbonisation Programme Board (DPB) is set up to lead the implementation of the Health Boards designated initiatives through the Decarbonisation Action Plan. The programme board meets on a quarterly basis, is led by the Executive Director of Finance and is set up to ensure that actions and commitments contained within the action plan are taken forward and implemented.

The first meeting of the DPB took place on the 31 January 2023, followed by meetings on the 20 April 2023 and August 2023 (Agenda details provided does not record the date). These meetings were led by the Senior Responsible Officer (SRO) – Interim Executive Director of Finance.

2.16 The Decarbonisation Programme Board Draft Terms of Reference states:

The DPB will provide timely and robust position updates to the Executive Director of Finance and People, Partnership and Public Health Committee to support reporting requirements into the Health Board Governance and into Welsh Government.

Evidence was provided demonstrating that action plan reporting for the period of quarter one 2023/24 was submitted on the 15 September 2023. This was the Health Board first submission with evidence having been provided to us granting the Health Board an extension on the submission date. The submission was approved by the Interim Executive Director of Finance.

2.17 The action plan is discussed within the DPB, but we have not been able to determine whether the actions are being contested. We were informed that pivot tables are being created for all of the Red/Amber/Green ratings in the action plan. This will enable the DPB to question actions that are not moving forward in a timely manner.

Sub-groups to the DPB are in the process of being developed, and are to be consistent with Welsh Governments structured six main activity streams:

- Carbon Management
- Buildings
- Transport
- Procurement
- Estate Planning and Land Use
- Approach to Healthcare

We have not been able to establish any reporting of position updates into PPPH or the Health Board from the DPB.

We note that the PPPH has not met since January 17 2023, which has hampered the reporting procedure.

Conclusion:

2.18 A Decarbonisation Programme Board has been established as per NHS Wales Decarbonisation Strategic Delivery Plan, and progress on the action plan is now being reported to the Welsh Government.

Sub-groups need to be implemented to further support the progress and reporting of the action plan.

A decarbonisation reporting structure needs to be re-established to provide ongoing Health Board assurance on the implementation of the strategy and action plan.

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

Objective 5: Project Delivery: To obtain assurance that projects included within the 2023/24 funding commitments have been successfully delivered, and that appropriate arrangements are in place to secure available funding during 2024/25.

2.19 As evidence to establish if projects have been or are being successfully delivered on time, we were provided with the Decarbonisation Action plan that had been submitted to the Welsh Government on the 15 September 2023.

In order to understand the findings, the methodology of delivery confidence is detailed below.

Confidence of Delivery	
Highly Likely	Successful delivery of the action/initiative to cost and quality appears highly likely and there are no major outstanding issues that at this stage appear to threaten delivery.
Probable	Successful delivery appears probable. However, constant attention will be needed to ensure risks do not materialise into major issues threatening delivery.
Feasible	Successful delivery appears feasible but significant risks and issues already exist requiring management attention. These appear resolvable at this stage and, if addressed promptly.
In Doubt	Successful delivery of the action/initiative is in doubt with major risks or issues apparent in a number of key areas. Urgent action is needed to ensure these are addressed, and establish whether resolution is feasible.
Unfeasible	Successful delivery of the action/initiative appears to be unachievable. There are major issues which at this stage do not appear to be manageable or resolvable. The action/initiative may need rebaselining and/or overall viability reassessed.
Complete	Successful delivery of initiative/action. There is no further input required.
Default	The confidence of delivery has not been set by the organisation / default RAG.
Exempt	The organisation is exempt from this action / initiative.

The spreadsheet contains the six main activity streams with 46 initiatives underpinned by 135 actions. Our findings from the action plan are set out below.

- Sixty actions were exempt from the Health Board, per Welsh Government guidance, leaving 75 actions relevant to the Health Board.

- Of these, 27 actions (36%) were showing as Green according to the RAG rating with delivery confidence of the 27 actions stated below: -
  - 9 actions complete
  - 3 Feasible
  - 8 Highly unlikely
  - 4 Probable
  - 3 Default
- thirty actions (40%) were showing as Amber with delivery confidence of the 30 actions stated below: -
  - 5 in doubt
  - 4 probable
  - 17 feasible
  - 4 default
- sixteen actions(21%) showing as Red with delivery confidence of the 16 actions stated below: -
  - 10 Feasible
  - 4 In Doubt
  - 2 Default
- two actions (3%) do not have a RAG rating stating:-
  - 1 in doubt
  - Default
- Twenty-two actions had implementation dates that had passed.
- For the Action Owned, Responsible, and Accountable sections, one action (44.2) was left blank.

Other observations we noted are detailed below: -

- The comments sections of the action plan tend to state what has been done rather than what progress is being made to complete the action.
- Given the current financial situation within the Health Boards, there is limited reference to funding in the action points' comments.
- In certain actions, the Action Owner section identifies a specific post, however in others, it is not specific, which may cause confusion when implementing actions.
- Percentage completion of the actions are discussed with the lead but could be deemed subjective and not scientific.

Conclusion:

2.20 A review of the plan shows that twenty two of the actions (29% of the total plan) are past their implementation date, with a further ten actions (13%) in doubt and 30 actions (40%) at the feasible stage (delivery appears possible, but significant risks and issues already exist requiring management action).

Without further emphasis on the plan's efforts, the plan risks falling further behind schedule and failing to achieve the key deliverable decarbonisation activities that have been put in place throughout the two years of 2022/23 and 2023/2024.

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

Appendix A: Management Action Plan

Matter Arising 1: Governance Structure (Design), **Monitoring & Reporting** (Operation)	**Impact**
Despite being able to observe reporting arrangements for 2022, we have been unable to establish that decarbonisation is reporting into existing organisation accountability and reporting frameworks for 2023. An appropriate decarbonisation reporting structure which monitors the progress of the action plan within the Health Board is not currently in place.	Potential risk of: • Ineffective oversight of Decarbonisation strategy and action plan. • Health Board not receiving up to date information on the progress of the action plan.

Recommendations		**Priority**
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.	**High**
1.2a	Ensure that the Health Board has suitable reporting systems in place to provide continuing assurance on the progress of the decarbonisation action plan.	**High**

Agreed Management Action		**Target Date**	**Responsible Officer**
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	31 May 2024	Executive Director of Finance and Programme Leads

	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		
1.2a	As per the above response		

Matter Arising 2: Project Delivery (Design / Operation)			**Impact**
Twenty two actions are out of date with a further 40 actions either in doubt or significant risks and issues already exist requiring management action. The plan risks falling further behind schedule and failing to achieve the key deliverable decarbonisation activities.			Potential risk of: • Not completing the actions within the action plan as agreed by the Health Board and in response to the NHS Wales Decarbonisation Strategic Delivery Plan.
Recommendations			**Priority**
2.1a	To complete the actions within the specified timeframe, greater focus and scrutiny is required on the action plan.		**High**
Agreed Management Action		**Target Date**	**Responsible Officer**

2.1a	The Health Board is currently part of the discussions as all actions, timeframes and targets are being reviewed Welsh Government. The Decarbonisation Programme Board do monitor those actions at risk however in the current financial climate all actions will be reviewed and prioritised accordingly to understand what can be implemented and actioned with a realistic timeframe.	31 May 2024	Executive Director of Finance and Programme Leads

Appendix B: Assurance opinion and action plan risk rating

Audit Assurance Ratings

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

	**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 assurance**	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.

Prioritisation of Recommendations

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

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

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

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Waiting List Management: Review of the Welsh Government initiated Patient Validation Exercise, Risk Stratification and patient removal from lists
Final Internal Audit Report

March 2022

Betsi Cadwaladr University Health Board

GIG CYMRU NHS WALES
Partneriaeth Cydwasanaethau
Gwasanaethau Archwilio a Sicrwydd
Shared Services Partnership
Audit and Assurance Services

GIG CYMRU NHS WALES
Bwrdd Iechyd Prifysgol Betsi Cadwaladr University Health Board

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Acknowledgement

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

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Executive Summary

Purpose

The objective of the audit was to assess the Welsh Government initiated tranche 'patient' validation exercise and more broadly, the prioritisation of waiting lists for planned care and removal of patients from the waiting lists.

Overview

We have issued limited assurance on this area.

The significant matters which require management attention include:

- The outpatient's governance spreadsheet needed tighter controls to ensure the integrity of the data relating to access and who is populating the spreadsheet with information.
- Evidence from the risk stratification waiting list (2.16) shows that patients within Orthopaedics and Urology as being overdue within the "Risk Strat/Reprioritised Status" section.
- 56 reasons for the removal of patients from waiting list. Information extracted from respective PAS systems for East, Central and West slightly differ in the wording of the reasons, making it difficult when merging reports as well as potential confusion for inputting.

Report Classification

		Trend
Limited 	More significant matters require management attention. **Moderate impact** on residual risk exposure until resolved.	N/A

Assurance summary[1]

	Assurance objectives	Assurance
1	Oversight and review of the status and progress of waiting lists within the Health Board	Reasonable
2	The Welsh Government (WG) initiated, locally delivered tranche 'patient' validation exercise	Limited
3	Assessment of clinical risks relating to delays, with these recorded and actioned where appropriate.	Limited
4	Patients removed from waiting lists.	Limited

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

	Key Matters Arising	Assurance objective	Control Design or Operation	Recommendation Priority
1	Future arrangements for large scale tranche validation exercises		Operation	High
2	Assessment of clinical risks relating to delays		Operation	High
3	Patients removed from waiting lists		Operation	Medium

1. Introduction

1.1 The review of Planned Care – Waiting List Management has been completed in line with the 2021/22 Internal Audit Plan. The review has sought to provide the Health Board with assurance that waiting lists are accurate and being managed appropriately, with risks to patients assessed and monitored.

Following the impact of the COVID-19 pandemic, the health board is intending to recover delayed planned care activity in a timely, risk-based manner. As of July 2021, there were more than 40,000 patients affected. Clinical and Operational teams are taking actions to address the backlog, with specialties managing waiting lists through validation of patient data and assessment of clinical risks.

1.2 The following risks are identified at the outset of the review:

- waiting lists are not effectively managed, resulting in inaccurate lists and delays to patients (this risk was considered only in the context of the tranche validation exercise);
- patients have been removed from lists without appropriate communication; and
- there is a lack of assurance that clinical risks have been assessed.

1.3 The internal audit has assessed the adequacy and effectiveness of the internal controls in operation. Weaknesses have been brought to the attention of management and advice issued on how particular problems may be resolved and control improved to minimise future occurrence.

1.4 This audit has reviewed the implementation of the one-off Welsh Government initiated tranche patient validation (not the standard patient validation carried out within each site as part of their core functions) – it is not expected that this will be repeated in this way again. This report will support the lessons learnt currently being carried out on that one-off initiative which will inform how the Health Board moves towards automation/digitisation/business as usual.

1.5 The objective of the audit was to assess the arrangements in place for review and prioritisation of waiting lists for planned care. The review has considered the following areas:

- oversight and review of the status and progress of waiting lists within the Health Board;
- the WG initiated, locally delivered tranche 'patient' validation exercise;
- assessment of clinical risks relating to delays, with these recorded and actioned where appropriate; and
- patients removed from waiting lists, to ensure they have received the appropriate communication.

The audit has sampled Urology, Orthopaedics and Dermatology.

2. Detailed Audit Findings

Objective 1: Oversight and review of the status and progress of waiting lists

2.1 There is a Planned Care Transformation Group (PCTG) in place which meets fortnightly and has oversight of the waiting lists within the Health Board. The Terms of Reference (ToR) includes the following objective:

Treatment of patients

Monitoring of cohort 1 and 2 and the allocation of funding to differing services to reduce backlogs and scrutinise business cases from a planned care perspective.

2.2 We were provided with the minutes of four of the meetings and confirm that all were quorate, with appropriate attendance. Cohort 1 and 2 are an agenda item on three of the sets of minutes however discussion taking place on both cohorts is visible within all the minutes provided. The Group reports to the Executive team meeting and we were provided with evidence to demonstrate this reporting for the meetings in June and August 2021.

2.3 Previously, a Planned Care Performance Review Group met monthly, however these have since been superseded, moving to weekly with overarching access meetings alternating between Surgical and Women's and Area, Medical, Diagnostics and Therapies. This meeting reports into the Planned Care Transformation Group, the meetings are not minuted but an action log is in place.

2.4 Local access meetings take place weekly, chaired by the Directorate General Managers (Surgery) and the Interim Assistant Director of Community Services (Dermatology). Waiting lists are reviewed at a patient level to determine actions that need to be taken to ensure patients are treated as soon as possible. The information from these meetings is report into the overarching access meeting.

Conclusion

2.5 There are oversight and reporting arrangements in place within the Health Board that oversee the total waiting lists, and local meetings that review the lists at a patient level. The Executive Team are provided with an update from the Planned Care Transformation Group.

Objective 2: Welsh Government initiated, locally delivered tranche 'patient' validation exercise

2.6 'Stage of Pathway' is used to identify the point at which a patient is waiting in respect of their overall diagnosis and treatment. The definition of each stage is shown in the table below.

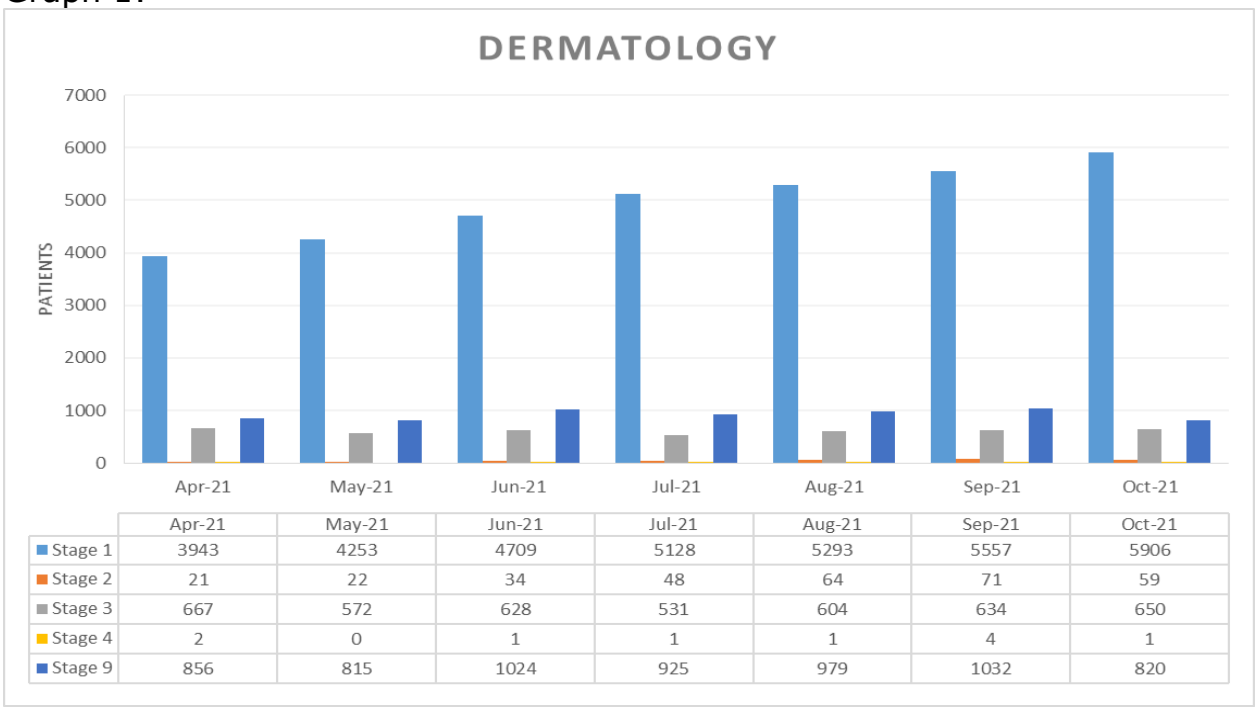
Table 1: NHS Wales Data Dictionary Stages of pathway

Stages of the Pathway	Stage of the Pathway
1	*Waiting for a new outpatient appointment. A new Outpatient Appointment may come from any referral source. A patient will be at Stage 1 only once.*
2	*Waiting for a diagnostic or Allied Health Professional (AHP) test, intervention or result. For relevant diagnostic and AHP services.*
3	*Waiting for a follow-up outpatient appointment or waiting for a decision following:* *1) An outpatient appointment.* *2) A diagnostic or AHP intervention result.* *3) Or where the patient is waiting, and the stage is uncertain/unknown.*
4	*Waiting for an admitted diagnostic or therapeutic intervention (i.e., treatment) only.*
9	*Not applicable – e.g., closed pathway*

2.7 We obtained data from Informatics for April 2021 – October 2021 displaying referral to treatment (RTT) summary details sent to the Digital Health and Care Wales (DHCW) monthly. The tables below depict what movement through the stages has taken place during the time period stated within the sampled areas of Dermatology, Urology and Orthopaedics.

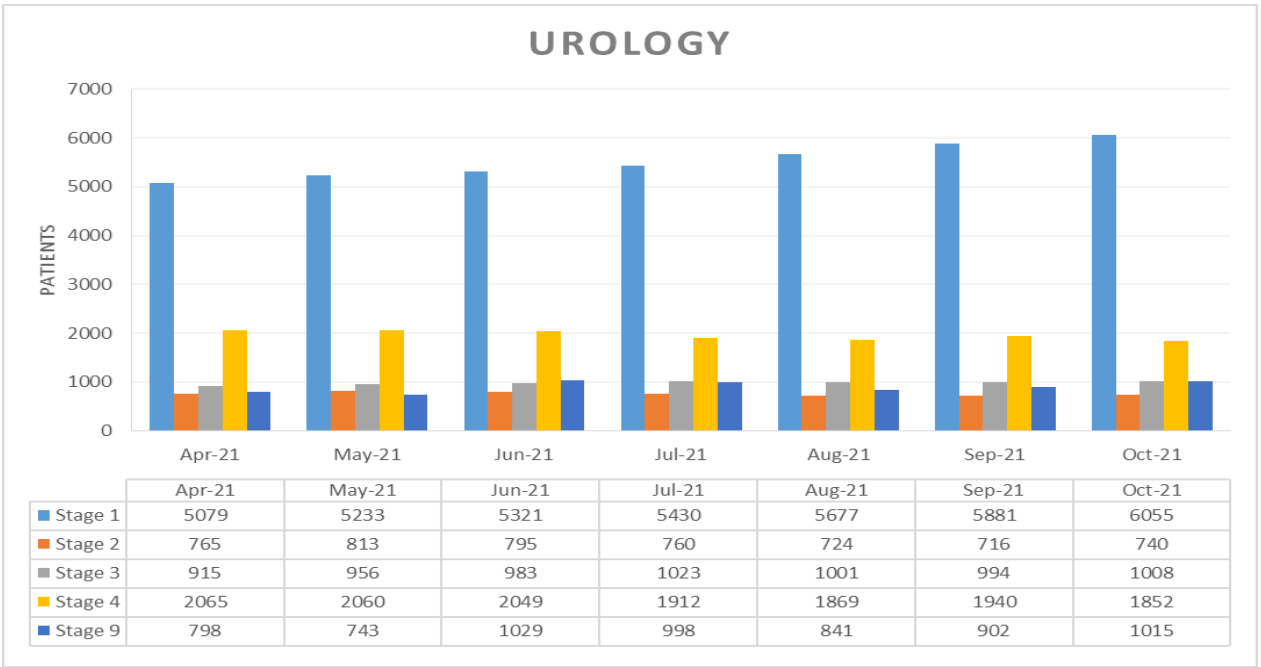
2.8 The data within the graphs shows little movement within the stages over the period stated.

Graph 1:



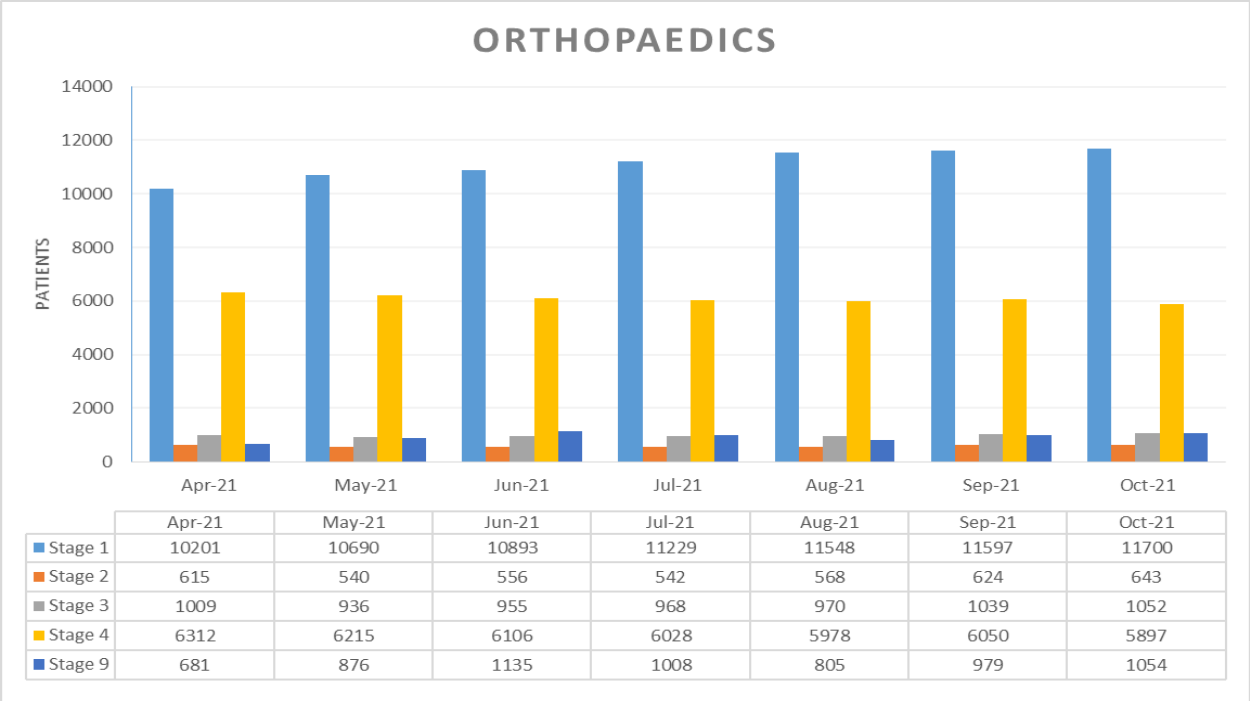
	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21
Stage 1	3943	4253	4709	5128	5293	5557	5906
Stage 2	21	22	34	48	64	71	59
Stage 3	667	572	628	531	604	634	650
Stage 4	2	0	1	1	1	4	1
Stage 9	856	815	1024	925	979	1032	820

Graph 2:



	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21
Stage 1	5079	5233	5321	5430	5677	5881	6055
Stage 2	765	813	795	760	724	716	740
Stage 3	915	956	983	1023	1001	994	1008
Stage 4	2065	2060	2049	1912	1869	1940	1852
Stage 9	798	743	1029	998	841	902	1015

Graph 3:



	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21
Stage 1	10201	10690	10893	11229	11548	11597	11700
Stage 2	615	540	556	542	568	624	643
Stage 3	1009	936	955	968	970	1039	1052
Stage 4	6312	6215	6106	6028	5978	6050	5897
Stage 9	681	876	1135	1008	805	979	1054

2.9 Following the unprecedented circumstances due to the pandemic and inevitable impact on waiting lists within all Health Boards across Wales, the Welsh Government initiated local Health Boards to undertake a large-scale tranche patient validation exercise at Stage 1 and Stage 4.

The Health Board sent out letters to all outpatients on the Stage 1 and Stage 4 a waiting lists (Waiting 48 weeks and over as of 30th June 2021). This was to determine if the patient's circumstances or needs had changed. Patients were asked to complete and return the questionnaire online.

We were advised during the review that in early meetings that took place to formulate the plan to undertake the WG initiated trance validation exercise, the managers on the sites have shared that they expressed concerns with the approach for the reasons of both clinical and administrative capacity and ability to maintain the activity using the methods provided

2.10 A presentation to the Planned Care Transformation Group on the 12th November 2021 provided an update on the stage 1 validation position.

Table 2: Initial Letters sent during period 05/07/21 – 13/08/21

Position as 11th November 2021

Total Records Validated	***20,112***	
Total Responded Remain	*12,544*	*62%*
Total Responded Remove	*2,143*	*11%*
Total Responded Non-responders	*5,280*	*26%*
Total Other (check required, deceased)	*145*	*1%*
Still Requiring Clinical Review/Review Outcome	*7,031*	*5%*
Of which, 'deteriorating statement'	*6,305*	*31%*

Total Records Validated	***20,112***	
Could be removed from waiting lists now	*1,926*	*10%*

2.11 The questionnaire included a 'deteriorating statement', asking if the patient believes they have deteriorated. 6,305 completed the deteriorating statement [for all sites]. The total number of patient responses who said yes for the specialties in our review as of the 11th November 2021 are:

- Urology – 630
- Dermatology - 323
- Trauma & Orthopedics – 1,755

We note that the lack of clinical capacity to review these patients to see if they should be expedited, against the competing priority of the re-purposing of any spare capacity to support the vaccination booster drive, has been logged as a tier 1 corporate risk at a score of 16 (ref.4260) on the 11th January 2022 and is awaiting Executive approval prior to the escalation process.

2.12 Figures detailed above were captured on governance spreadsheets for East, Central and West.

Details on the spreadsheet included, NHS number, patients name, patient contact details, Area, Case Reference Number (CRN), Unique Patient Identification (UPI), Consultant and specialty.

A temporary call centre consisting of shielding nurses and administrators was set up to receive the responses and populate the Governance spreadsheets. We are unclear how many individuals have access to populating the governance spreadsheets, so there is a risk that the data may be corrupted or deleted in error.

2.13 We combined all three governance spreadsheets and corroborated the data back to the total of 20,112 records validated. Using data interrogation software on the three spreadsheets we identified the following:

- Duplications – 1 duplication of the same patient within the same specialty (Trauma & Orthopaedics).
- 3 patients had the same unique patient identification (UPI) and NHS number (including 1 from Trauma and Orthopaedics).
- 51 records did not have a 10-digit NHS ID Number (Some were duplicates of Case Reference Number). This included 11 from our sample areas:
  - 3 urology
  - 6 Orthopaedics
  - 2 Dermatology
- One had a UPI No as a '6' (Urology)

- One with a duplicate NHS number, same name but different dates of births. (Not within our sample)
- Duplicate UPI number but two different names. (Trauma & Orthopaedics and Urology)

2.14 For those patients classed at stage 4, we were advised that all patients on the waiting list (patients who require routine surgery work) have required a refreshed waiting list, where each patient confirms they wish to actively remain on the waiting list.

2.15 With the Health Bard undertaking the stage 1 validation exercise manually, a business case has been developed for an automated validation tool within the Wales Patient Access System (WPAS).

The Head of Ambulatory Care along with technical colleagues are exploring plans to digitise and automate the patient validation process, to move away from tranche validation into BAU.

Following a meeting with WG leads 13th January 2022, there is an opportunity to seek national funding and deliver locally as a proof of concept to potentially be scaled up nationally.

2.16 Whilst this report does not explore the process undertaken in each site to undertake their specific functions for patient validation of waiting lists. We noted that validation activity in both Urology and Orthopaedics is managed by the respective site leads in Surgery, whilst Dermatology is managed by the Interim Assistant Director of Community Services.

2.17 We were provided with a document that sets out the rules for managing referral to treatment waiting times. The document provides a complete reference source of the waiting times management rules relating to the 26-week referral. This is followed by all three areas for the monitoring of waiting lists.

All three specialities take a comparable approach to the validation process. Weekly access meetings are held where they discuss:

- Follow up backlog,
- Long waiters list, and
- Risk stratification waiting lists.

These meetings feed into the overarching access meeting mentioned above.

Conclusion:

2.18 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 – other options should be reviewed to move away from a spreadsheet to a more stable application.

Evidence within the graphs shows little movement within the stages over the period stated.

Objective 3: Assessment of clinical risks relating to delays

2.19 The Royal College of Surgeons issued a reprioritisation code list and associated documentation where the onset of the pandemic meant many elective surgeries were cancelled. Following recommencement of elective surgery, a large proportion of these patients waiting were either approaching or had exceeded their 26-week target.

Patient risk stratification focuses on patient management of harm and alternative treatment regardless of which area the patient was receiving the treatment.

The table below details the groups and how patients requiring surgery have been classified.

Table 3:

Priority Level	Description
1a	Emergency - operation needed within 24 hours
1b	Urgent - operation needed with 72 hours
2	Surgery that can be deferred for up to 4 weeks
3	Surgery that can be delayed for up to 3 months
4	Surgery that can be delayed for more than 3 months

2.20 Clinicians risk stratify patients when they are listed for surgery and is record within the patient administration system for reporting. At present, the Welsh Patient Administration System (WPAS) is used within East and Central, with the West using Profile Information Management System (PIMS).

2.21 As of 31 January 2022, there were 25,086 admission pathways recorded across the Health Board. Twenty one percent (5,367) of these had not been risk stratified.

2.22 All three areas for Urology and Orthopaedics provided evidence that the patients on the waiting lists had been risk stratified. We received a spreadsheet for East and Central patients titled risk stratification waiting list reconciliation dated 25th October 2021. This document is presented to the local access meetings on a weekly basis. Whilst we can confirm that all patients had been risk stratified, we also noted that out of the 950 patients identified within the "Risk Strat/Reprioritised Status" 938 were classified as being overdue.

We have included the total number of admissions for Urology and Orthopaedics as at the 31st January 2022

- Urology 670, (6603 total admissions)
- Orthopaedics 105, (1501 total admissions)
- Other specialities on spreadsheet 163

2.23 The document highlighted all the elective priority levels that had been left blank for both specialties in East and Central. As well as differing risk

stratification priority scores within the sections of referral comments, elective priority score and risk stratification score.

2.24 We were informed by Dermatology that no risk stratification has taken place as they do not have any stage 4 patients.

Conclusion:

2.25 Evidence from the risk stratification waiting list reconciliation spreadsheet shows that patients within Orthopaedics and Urology have been risk stratified. **However, patients were highlighted as being overdue within the "Risk Strat/Reprioritised Status" section**, which could result in patient harm if they are not seen within the original timescale noted when first risk stratified.

There are conflicting risk stratification priority scores within the sections of referral comments, elective priority score and **risk stratification** score potentially leading to confusion, it is noted that the areas are aware of this and have highlighted it as an issue.

Consideration needs to be given to the potential for harm to the patient on both points above.

Objective 4: Patients removed from waiting lists

2.26 We were provided with evidence from the Informatics Department detailing all the patients removed from the waiting lists of the three specialties between April 2021 and October 2021.

2.27 The data was taken from WPAS and PIMS systems and included in-patients and out-patients. A further breakdown of the data including the reasons for removing patients from the list can be found in Appendix B

2.28 The table below, by specialty, details patients removed from the waiting lists in the period:

Table 4:

	Speciality		
Patient type	Urology	Trauma & Orthopaedics	Dermatology
In-Patient	1,405	2,104	1
Out-patient	1,565	2,349	47
Total	2,970	4,453	48

The review of data identified:

- There were 56 reasons in total for removing the patients.
- Reasoning for removal of patients between West compared to East and Central differ (we note that WPAS does not support the West removal codes).
- 378 patients had been entered in error.
- 788 patients had no reason recorded for being removed from the lists.

Conclusion:

2.29 Data is being recorded in all areas across the three sites, however we have identified issues of concern regarding the patients included in error and those with no reasons recorded – management should undertake a follow-up review to confirm the accuracy of this data.

Standardisation of the reasons to remove patients should be developed to ensure consistency across the Health Board.

Appendix A: Management Action Plan

Matter Arising 1 - WG initiated, locally delivered tranche 'patient' validation exercise - (Operation)	Impact
There is a *governance* spreadsheet in place which contains the details of all patients who are awaiting an Outpatient appointment and have been validated. At the time of the review over 20,000 patients were recorded on this spreadsheet. We were unable to ascertain who has access to and who is populating the governance spreadsheet. We also found the following • Duplications – 1 duplication of the same patient within the same specialty (Trauma & Orthopaedics). • 3 patients had the same unique patient identification (UPI) and NHS number (including 1 from Trauma and Orthopaedics), • 51 records did not have a 10-digit NHS ID Number (Some were duplicates of CRN No's), this included 11 from our sampled areas: • 3 urology • 6 Orthopaedics • 2 Dermatology • One had a UPI No as a '6', • One duplicate NHS number had the same name but different date of births, and • One had the same UPI number but two different names.	The integrity of the data on the governance spreadsheet cannot be determined, which could result in patients not being contacted or details being incorrect.
Recommendation	**Priority**

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	High	
Agreed Management Action	**Target date**	**Responsible Officer**
This report audits information on **ONLY** the one-off WG initiated tranche patient validation (not the standard patient validation carried out within each site as part of their core functions) – it is not expected that this will be repeated in this way again; this report will support the lessons learnt that was carried out on that one-off initiative that has informed the improvements in patient validation. On the 10th December 2021, the patient activity was safely closed down, the spreadsheets locked to 'read only' on the SharePoint site and downloaded by the Head of Ambulatory Care. To manage the remaining activity based on the patient responses, the spreadsheets were split into manageable cohorts of data and handed over to named individuals in the PABC to disseminate the remaining work. Much of the work has completed now with the remaining outstanding areas of work pertain to (i) adding validation markers and (ii) clinical validation of the patients that requested to remain & provided a 'deterioration statement'; both of which have been picked up in the latest validation cleanse activity (Step 1 and Step 2 below) **Action 1** – Cleanse the Waiting Lists	**Action 1 –** 31/07/2022	Head of Ambulatory Care

Steps	
Step 1	Tidy up validation markers in PAS post S1 Tranche Validation Exercise

	Step 2 – Complete the post S1 Tranche Validation Exercise work to clinically validation patients that requested to remain & provided a 'deterioration statement' Step 3 – Undertake cleanse of 'duplicates' on the waiting lists Step 4 – External Validation: Task 1 –run our PTL data through their validation software to report on findings Task 2 – phone contact - validation of all patients >36wks and un-validated S1 and S4 Task 3 – pathways validation to be defined based on the output from Task 1.		
Action 2 - Project to Automate & Digitise the Patient Validation Exercise - 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 who have engaged on the initiative with a view to scaling up pan-BCU		**Action 2** – 30/09/2022 (funding dependant)	Head of Ambulatory Care
Action 3 - Review and redesign the Service Validation Models pan-BCU		**Action 2** – 31/03/2023 (funding dependant)	Head of Ambulatory Care

Matter Arising 2 - Assessment of clinical risks relating to delays (Operation)	Impact	
Evidence from the risk stratification waiting list reconciliation spreadsheet shows that patients within Orthopaedics and Urology have been risk stratified. However, the patients were highlighted as being overdue within the "Risk Strat/Reprioritised Status" section. • Urology 670 (6603 total admissions) • Orthopaedics 105 (1501 total admissions) • Other Specialities on spreadsheet 163 There are conflicting risk stratification priority scores within the sections of referral comments, elective priority score and risk stratification score potentially leading to confusion, it is noted that the areas are aware of this and have highlighted it as an issue.	Patients are not risk stratified when due, which could lead to deterioration and potential harm to patients.	
Recommendation	**Priority**	
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	High	
Agreed Management Action	**Target date**	**Responsible Officer**
This pertains to the risk stratification of patients on the stage 4 waiting lists. Patients are referred into our waiting lists from GPs as either urgent or routine. The patient is then triaged and confirmed as urgent or routine prior to 1st appointment. At 1st appointment the patient is considered for surgery and risk stratified in line with the Royal College of Surgeons guidance as P1-P4, when the patient joins the Stage 4 waiting list.		Site Directorate General Managers

As at 10th March 2022 the data across all sites shows by speciality the number of patients where the P value is 'unknown' i.e. not entered into the PAS is as follows: ▪ T&O – 298 ▪ Urology – 150 ▪ General Surgery – 21 ▪ Breast – 24 ▪ Colorectal – 58 ▪ UGI – 18 ▪ Vascular – 108 ▪ ENT – 56 ▪ Max Fax - 28 As the focus of this internal audit report highlighted T&O and Urology; with these two specialities making up 64% of all patients without a P value in the PAS, these will be prioritised, followed by the remaining specialities to achieve the following actions:		
Action 4 – Validation of missing risk stratification data at an *individual patient level* (i.e. patients with unknown P value where the 1st appointment has already been held and where the PAS has not yet been updated) with planned review including informatics team pulling a live report in readiness for 30th April 2022.	**Action 4**- 30/04/2022	
Action 5 - In line with generic admin processes, each site will work to ensure that for those patients that have received their 1st appointment and are awaiting surgery, a P value will be entered into the PAS within 6 weeks of that 1st appointment.	**Action 5** – 31/05/2022	
Action 6 – Progress will be monitored locally on each site through a standing item at the weekly site *Access Meetings* to ensure the progress in action 4 is maintained	**Action 6 -** 31/03/2022	

Action 7 – Pan-BCU progress will be reviewed and monitored monthly at the Planned Care Operational Meetings to ensure the progress in action 4 is maintained	**Action 7 -** 31/03/2022	

Matter Arising 3 - Patients removed from waiting lists (Operation)	Impact	
Information on patients removed from waiting lists was extracted from the respective Patient Administration Systems for East, Central and West. The wording of the reasons is slightly different between the systems, making it difficult when merging reports as well as potentially confusing for those who are inputting the reasons. We identified: • 378 patients had been entered in error • 788 patients had no reasoning provided for being removed from the lists (these were categorised as "Null" and "Unspecified")	Potential for miss-reporting	
Recommendation	**Priority**	
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.	Medium	
Agreed Management Action	**Target date**	**Responsible Officer**

WPAS Central is the nationally hosted instance into which 'West PIMS' and 'East WPAS instance' data will be moved over to (project full end May 2023). Whilst we cannot risk any delays to the West implementation which is due in May 2022, there is opportunity to standardise the codes on East WPAS earlier than their planned migration in 2023. The following actions reflect this:		
Action 8 – West Standardisation: WPAS West implementation is due to go live 16th May 2022 and this will standardise the removal reasons with the Central WPAS instance	**Action 8** May 2022	WPAS Standardisation lead
Action 9 – Ahead of the East migration to the Central WPAS instance, the codes will be standardised in the East WPAS instance tables to align with the Central WPAS removal codes.	**Action 9** July 2022	WPAS Standardisation lead
At this point the removal codes for all patients pan-BCU will be standardised.		

Appendix B: Out-Patients and In-Patients Reasons for removal from Health Board Waiting List

AREA	Out-Patients

Row Labels	Urology	Trauma & Orthopaedics	Dermatology
Appointment Inconvenient		1	
C.N.A & discharge	18	15	
Cancelled by GP	12	1	
Cancelled by GP or Cons	1		
Cancelled by Health Authority	1	10	
Cancelled by Hospital	40	142	2
Cancelled by patient	60	70	
Clerical error	30	23	
Conditioned Resolved	4	2	
Did not attend & Patient Discharged	18	192	1
Died (before appointment)	7	3	
Discharged by Consultant	12	1	
Discharged following consultant decision		1	
Entered in error	46	115	3
Inappropriate Referral	195	368	9
Moved to Treatment waiting list	397		
NHS Patient seen as Private	43	66	
No response to partial booking letters	4	10	
NULL	7	12	
Outpatient Attendance	96	8	
Patient cancelled repeatedly	1	1	
Patient did not attend	9	2	
Patient did not phone	59	135	30
Patient died	72	76	1
Patient failed to opt-in		1	
Patient moved away from area	4	7	
Patient no longer requires treatment	15	12	
Patient no longer traceable	1	1	
Patient no longer wants treatment	29	26	
Patient treated at a Private Hospital	8	26	
Patient treated at another NHS Trust	3	4	
Patient treated at this Trust	15	58	
Referred to GP - LHB ruling		1	
Refusal of reasonable offer	5		
Removed - INNU		30	

Removed - Insufficient referral information	18		
Removed - Lifestyle	1		
Removed after validation - Consultant request		10	
Removed discharged back to care of GP	3		
Removed unavailable ref to other consultant	1		
schedule	2	1	
Seen at other hospital	8	164	
Seen at treatment centre		10	
Seen via emergency admission	9	3	
Seen via other treatment	145	170	
Telephone Contact	2		
Transferred to Inpatient/Daycase waiting list	19	2	
Treatment no longer required	145	569	1
Grand Total	**1565**	**2349**	**47**

AREA	**In-Patients**

Row Labels	**Urology**	**Trauma & Orthopaedics**	**Dermatology**
Appointment Inconvenient	3		
C.N.A & discharge	2	1	
Cancelled by GP		1	
Cancelled by GP or Cons	4	2	
Cancelled by Health Authority	2		
Cancelled by Hospital	189	238	
Cancelled by patient	90	166	
Clerical error	8	5	
Conditioned Resolved	10	4	
Did not attend & Patient Discharged	3	3	
Died (before appointment)	7		
Discharged by Consultant	3	2	
Discharged following consultant decision	1	5	
Domiciliary		1	
Entered in error	43	105	
Inappropriate Referral	1	3	
Moved to Treatment waiting list	13		
NHS Patient seen as Private	15	39	
Not Specified	433	332	
NULL	2	2	
Outpatient Attendance	1	1	
Patient cancelled repeatedly	1	1	
Patient did not attend	14	7	
Patient did not phone	3	20	
Patient died	115	53	1
Patient failed to opt-in	79	46	

Patient moved away from area	2	12	
Patient no longer requires treatment	52	102	
Patient no longer traceable	2	8	
Patient no longer wants treatment	86	133	
Patient treated at a Private Hospital	5	67	
Patient treated at another NHS Trust	8	14	
Procedure not wanted by patient	1		
Refusal of reasonable offer	10	3	
Rejected - lack of capacity		1	
Removed after validation - Consultant request	3	4	
Removed after validation - no response	5	79	
Removed after validation - patient request	2	97	
Removed discharged back to care of GP	1		
Removed unavailable social	2	9	
Removed unavailable unfit	3	20	
Seen at other hospital	23	90	
Seen at treatment centre		68	
Seen via emergency admission	7	18	
Seen via other treatment	28	114	
Transfered to Inpatient/Daycase waiting list	5		
Treatment no longer required	118	228	
Grand Total	**1405**	**2104**	**1**

Appendix C: Assurance opinion and action plan risk rating

Audit Assurance Ratings

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

	**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.
	**No assurance**	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.

Prioritisation of Recommendations

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

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

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

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Audit Committee Update – Betsi Cadwaladr University Health Board

Date issued: December 2023

Document reference: 3733A2023

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

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

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Contents

Audit, Risk and Assurance Committee update

About this document

1 This document provides the Audit Committee with an update on our current and planned accounts and performance audit work at Betsi Cadwaladr University Health Board.

2 We also provide additional information on:

- Other relevant examinations and studies published by the Audit General.
- Relevant corporate documents published by Audit Wales (e.g. fee schemes, annual plans, annual reports), as well as details of any consultations underway.

3 Details of future and past Good Practice Exchange (GPX) events 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 Accounts: planning for 2023-24	Russel Caldicott, Interim Executive Director of Finance	Ongoing dialogue and meetings held to follow up on matters identified in our joint post project learning in preparation of the 2023-24 draft accounts and subsequent audit.	Ongoing	Not applicable
Charitable Funds: • Planning • Audit of the Charitable Fund Financial Statements	Russel Caldicott, Interim Executive Director of Finance	This work involves undertaking risk assessment procedures to identify risks of material misstatement within the Charitable Fund's financial statements. The subsequent design and performance of our audit approach will be responsive to each assessed risk. We will follow the audit approach designed as part of our planning work and undertake appropriate audit testing to enable the Auditor General to provide his opinion on the financial statements of the Charitable Fund.	Audit work has commenced.	Early 2024

Performance audit update

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

Exhibit 2 – Performance audit work

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

Area of work	Executive Lead	Focus of the work	Current status	Planned date for consideration
Follow-on work on board effectiveness	Carol Shillabeer – Chief Executive Officer	This work will consider the progress the Health Board has made in addressing the concerns on board effectiveness identified in the Auditor General's report in the public interest in February 2023.	Draft report issued	Timing of reporting to the Board or Audit Committee to be determined.
Structured Assessment 2023	Carol Shillabeer – Chief Executive Officer	Our core structured assessment work is designed to examine the existence of proper arrangements for the efficient, effective, and economical use of resources. Our 2023 core Structured Assessment work will review: • Corporate systems of assurance; • Corporate planning arrangements; and • Corporate financial planning, management, and performance arrangements. Please note that board effectiveness, which is normally part of our core structured assessment work, will be considered separately in the follow-on work that has been referenced above.	Fieldwork in progress	March 2024
		In addition to the core structured assessment work, we will also undertake "deeper dive" work in a specific area. We had initially identified digital transformation as the deeper dive topic. However, given the financial challenges facing the NHS at present, we are looking to now focus our deep dive work in health boards on **financial savings / cost improvement plans**.	Fieldwork in progress	To be confirmed

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

Other relevant publications

6 Exhibit 3 provides information on other relevant examinations and studies published by the Auditor General in the last six months. The links to the reports on our website are provided. The reports highlighted in **bold** have been published since the last committee update.

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

Title	Publication Date
NHS Wales Workforce data briefing	**September 2023**
Approaches to achieving net Zero across the UK	**September 2023**
NHS Wales Finances Data Tool	**September 2023**

Additional information

7 Audit Wales recently consulted on its fee rates. The closure for response was 10 October 2023. There are no other ongoing consultations.

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