Bundle Audit Committee 16 January 2025

1 09:30 - PRELIMINARY MATTERS

1.1 09:30 - AC25/01 Welcome and Apologies - Verbal (Chair)

1.2 09:31 - AC25/02 Declarations of Interest - Verbal (Chair)

1.3 09:33 - AC25/03 Unconfirmed Minutes of Meetings held on 05.11.24 - Attached (Chair)

AC25.03 Minutes from Audit Committee 05.11.24 V0.02 Unconfirmed (Public)

1.4 09:35 - AC25/04 Matters Arising and Action Log - Attached (Chair)

AC25.04 Summary Action Log Audit Committee (Updated 09.01.25) Public

2 09:40 - GOVERNANCE

2.1 09:40 - AC25/05 Update on Outstanding Audit Recommendations - Presentation (Interim Chief Operating Officer)

This item will include an update on the Final Audit Report on Effective Governance - IHC Central

Gareth Evans, Central IHC Director and Naomi Holder, Central IHC Director of Nursing will join for this item

AC25.05 Update on Outstanding Audit Recommendations (COO AC presentation) v2 08.01.25

AC25.05.1 CIHC Concerns Report for Audit Committee - January 2025

2.2 10:10 - AC25/06 Update on Open Audit Recommendations - Presentation / Paper (Attendees confirmed below)

Item to cover:

Audit Wales Community Pharmacy Data Matching Pilot - Adam Mackridge, Strategic Lead for Community Pharmacy will join for this item

Final Audit Report on Llandudno Hospital Orthopaedic Surgical Hub - Chris Stockport and Nicola Etherington will join for this item

Final Internal Audit Report on Consultant Job Planning - Sreeman Andole and Nick Graham will join for this item

AC25.06.1 Coversheet Audit Wales Community Pharmacy Data Matching Pilot - BCUHB Response

AC25.06.2 Annex1 CPhO Letter to Directors of Pharmacy regarding Audit Wales Data Matching Pilot September 2024

AC25.06.3 Audit Committee Executive Presentation - LLGH Orthopaedic Jan 25

AC25.06.4 Final Internal Audit Report Consultant Job Planning BCU-2425-20

2.3 10:40 - AC25/07 Update Report on Internal and External Audit Recommendations - Paper (Director of Corporate Governance / Head of Covid-19 and Thirlwall Inquiry)

AC25.07 Update Report on Internal and External Audit Recommendations (Audit Tracking Report) 16.01.25 v1.00

AC25.07.1 App 1 Closure summary table v1.00

AC25.07.2 App 2 All unsatisfactory open v1.00

AC25.07.3 App 3 All open limited v1.00

2.4 10:50 - AC25/08 Historical External Audit Recommendations - Paper (Director of Corporate Governance / Head of Covid-19 and Thirlwall Inquiry)

AC25.08 Historical External Audit Recommendations 16.01.25 v1.00

AC25.08.1 App 1 - AW Pre-2022 recs v1.00

AC25.08.2 App 2 - 2022-24 AW recs v2.00

AC25.08.3 App 3 - Board Effectiveness v2.00

2.5 11:00 - AC25/09 WRP Penalties - Learning from Events Report (LFER) - Paper (Deputy Director for Legal Services)

AC25.09 WRP Penalties LFERs (Jan 2025)

2.6 11:20 - AC25/10 Update on Health Board Policies and Written Control Documents - Paper (Director of Corporate Governance / Head of Covid-19 and Thirlwall Inquiry)

AC25.10 Update on Health Board Policies and Written Control Documents 16.01.2025 v1.00

AC25.10.1 App 1 All overdue at 02.10.2024 v1.00

AC25.10.2 App 2 Q2 overdue a review 02.10.2024 v1.00

AC25.10.3 App 3 All overdue policies v1.00

AC25.10.4 App 4 All overdue WCDs by risk cat v1.00

2.7 11:30 - AC25/11 Standards of Business Conduct Policy (OBS02 – Minor Changes) - Paper (Director of Corporate Governance)

AC25.11 SOBC Policy Audit Committee

AC25.11.1 OBS02 - Standards of Business Conduct Policy - V2.1 - Updated links

AC25.11.2 SoBC Guidance

2.8 11:35 - AC25/12 Board Assurance Framework - Paper (Director of Corporate Governance / Head of Risk Management)

AC25.12 Board Assurance Framework V6 - Audit Committee

2.9 11:50 - AC25/13 Annual Report 2024/25 Arrangements - Paper (Director of Corporate Governance)

AC25.13 Annual Report 2024-25 Arrangements

3 12:00 - INTERNAL AUDIT

3.1 12:00 - AC25/14 Internal Audit Progress Report - Paper (Head of Internal Audit)

AC25.14 IA Progress Report Cover Sheet Jan 2025

AC25.14.1 BCUHB Audit Committee Progress Report January 2025

4 12:20 - EXTERNAL AUDIT

4.1 12:20 - AC25/15 External Audit Progress Report - Paper (Audit Manager, Audit Wales)

AC25.15.1 EA BCU Audit Committee Update 16012025

AC25.15.2 BCUHB Review of Cost Savings Arrangements

4.2 12:40 - AC25/16 Structured Assessment - Paper (Audit Manager, Audit Wales)

AC25.16 BCUHB Structured Assessment 2024 Report Final

5 12:50 - COUNTER FRAUD

5.1 12:50 - AC25/17 Local Counter Fraud Service Progress Report - Paper (Interim Executive Director of Finance)

AC25.17 Counter Fraud Audit Committee Report Jan 25 - PUBLIC

6 13:05 - FOR INFORMATION

6.1 13:05 - AC25/18 Summary of Business to be Reported from Private - Paper (Head of Corporate Affairs)

AC25.18 Audit Committee (Summary of Business to be Reported from Private)

6.2 13:07 - AC25/19 Forward Workplan - Paper (Head of Corporate Affairs)

AC25.19 Workplan for Audit Committee (Live Version as at 08.01.25)

7 13:09 - CLOSING BUSINESS

7.1 13:09 - AC25/20 Agree Items for Referral to Board / Other Committees - Verbal (Chair)

7.2 13:11 - AC25/21 Review of Meeting Effectiveness - Verbal (Chair)

7.3 13:13 - AC25/22 Date of Next Meeting - 04.03.25

7.4 13:13 - Resolution to Exclude the Press and Public

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

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

Betsi Cadwaladr University Health Board (BCUHB)
UNCONFIRMED Minutes of the Audit Committee
held in Public on 5 November 2024
in the Boardroom, Carlton Court, St Asaph and via Teams

Committee Members Present	
Name	**Title**
Karen Balmer	Independent Member (Chair of Audit Committee)
Urtha Felda	Independent Member (Vice Chair of Audit Committee)
Dyfed Jones	Independent Member
Rhian Watcyn Jones	Independent Member *(via Teams)*
In Attendance	
Russell Caldicott	Interim Executive Director of Finance
Pam Wenger	Director of Corporate Governance
Andrea Hughes	Interim Finance Director - Operational
Glesni Driver	Head of Covid-19 Inquiry and Thirlwall Inquiry
Dave Harries	Head of Internal Audit
Nicola Jones	Deputy Head of Internal Audit
Fflur Jones	Performance Audit Lead, Audit Wales
Michelle Phoenix	Financial Audit Manager, Audit Wales *(via Teams)*
Matthew Joyes	Deputy Director for Legal Services
Eifion Jones	Deputy Head of Internal Audit Specialist Services Unit *(via Teams – part meeting)*
Committee Support	
Philippa Peake Jones	Head of Corporate Affairs
Laura Jones	Project Support Manager (Corporate Governance)

PRELIMINARY MATTERS

AC24/142 Welcome and Apologies

The Chair of the Committee welcomed everyone to the meeting and apologies were received for Andrew Doughton, Performance Audit Manager, Audit Wales.

AC24/143 Declarations of Interest

No declarations of interest were raised at the meeting.

AC24/144 Unconfirmed Minutes of Meetings held 12.09.24

There was discussion around the new style of minutes, it was agreed that the style is easier to understand and it was confirmed that the new format is also being tested with the Planning, Population Health & Partnerships Committee before being rolled out.

In was resolved that the Committee:

- **APPROVED** the new style of minutes for use by the Audit Committee.

Unconfirmed

- **AGREED** that the minutes of the meetings held on 12.09.24 were a true and accurate record subject to Urtha Felda being noted as Vice Chair of the Committee and Rhian Watcyn Jones being spelt without a hyphen.

AC24/145 Matters Arising and Action Log

Annual Timetable 23-24 Draft Final Accounts

- There was discussion around action **AC24.43.6** relating to Welsh Risk Pool payments and noted that this item is included on the agenda. It was highlighted that the Quality, Safety & Experience Committee (QSE) recently received a report based on "learning from events" which links with the Welsh Risk Pool payments and the need for the Committee to be assured that there is a robust process in place. It was confirmed that from 1st October 2024, the Legal Function has been moved into the portfolio of the Corporate Governance Directorate and the Director of Corporate Governance has agreed to become the NHS Representative on the Welsh Risk Pool Committee. Historic practice has resulted in Welsh Risk Pool penalties being received as the evidence of learning has not been provided in a timely manner and work is taking place to improve processes and systems. It was confirmed that the next QSE Committee will receive a position statement regarding claims and historic items and a QSE Sub Committee may be developed to focus on litigation and risk in terms of oversight and governance.

Effective Governance – IHC Central Final Internal Audit Report

- There was discussion relating to action **AC24.94.9** and the appendices shared with the Committee for information. It was confirmed that there was a deep dive into complaints performance at the last QSE Committee and the documentation would be shared with the Committee for information. It was also confirmed that the Central IHC are due to join the next meeting of the Committee to provide assurance on the impact of the action being taken in relation to complaints.

Actions:

- AC24/145.1 In relation to action AC24.94.9 it was agreed that the Head of Corporate Affairs would circulate the Complaints Improvement Deep Dive from the October QSE Committee outside of the meeting.
- AC24/145.2 In relation to action AC24.101.13 it was agreed that the Director of Corporate Governance would share the paper that went to the Performance, Finance & Information Governance Committee (PFIG) regarding the role of the Trusted Assessor outside of the meeting.

The Committee reviewed the action log and agreed to close the following actions: **AC24.45.9, AC24.100.12, AC24.100.16, AC24/118.1, AC24/119.1, AC24/119.2, AC24/120.1, AC24/122.1, AC24/123.1, AC24/123.2, AC24/123.3, AC24/124.1, AC24/124.4, AC24/125.1, AC/126.1, AC24/127.1, AC24/127.3, AC24/128.1 & AC24/129.1**

GOVERNANCE

AC24/146 Update Report on Internal and External Audit Recommendations

Members received the report and noted the progress made. In presenting the report, the Director of Corporate Governance highlighted:

Unconfirmed

- The amount of detail included in the report for transparency noting that the team are currently dealing with historical recommendations and this work is being completed with support from Internal Audit.
- The first part of the report focuses on the position in terms of the 52 recommendations considered for closure.
- The report also includes a full update in relation to 'no' assurance and 'unsatisfactory' assurance recommendations as well as a rolling programme relating to 'limited' assurance by Executive stating that the Committee are asked to note the position in terms of progress.
- The team are starting to see some downward trends and movement in terms of recommendations.
- The second part of the report focuses on proposals relating to historic recommendations, the team have reviewed all recommendations received via Internal Audit, External Audit and Structured Assessment and highlighted a number of proposals for consideration by the Committee.

In discussing the report, the Committee:

- Noted the position in terms of sign off within the Office of the Medical Director stating that this issue has also been raised in other areas and these recommendations are currently being signed off by the Chief Executive. It was also noted that the Chief Executive has retained responsibly for additional recommendations including Health and Safety and the Operating Model.
- Confirmed that additional support is being provided for the Chief Operating Officer (COO) to progress recommendations and suggested the COO attends the next meeting to present an update and provide assurance.
- Highlighted areas where responsibility may need to be reviewed and confirmed that work is ongoing to identify recommendation owners.
- Referred to the number of recommendations considered for closure and returned by Internal Audit due to the lack of evidence provided. It was confirmed that all Executives have a responsibility to provide sufficient evidence and those that are returned remain in the table as pending and won't be closed until they have been through an additional process.
- Noted that the remaining two open 'no' assurance recommendations have now been approved for closure by the Executive Team, and will be submitted to Internal Audit for final review. There are now no open 'no' assurance recommendations.
- Reflected that the information being provided is more transparent and there is an improvement in assurance, the Head of Covid-19 Inquiry and Thirlwall Inquiry was thanked for the worked completed.
- Approved four proposals as highlighted in the paper, these are in line with the approval process and the detail is included in appendix 4:
    - Pre-2022 recommendations marked as closed
    - Pre 2022 recommendations – other
    - 2022/23 Internal Audit recommendations marked as closed/implemented
    - Pre 2022 Internal Audit recommendations – other
- Noted the Audit Wales recommendations stating that an update on external audit recommendations will be presented to the next Committee for final closure approval along with a paper on progress against historic external audit recommendations.

Unconfirmed

Actions:

- AC24/146.1 Invite Imran Devji to attend the next meeting to provide an update on the Internal and External Audit Recommendations for the Chief Operating Officer.
- AC24/146.2 Bring a paper to the next meeting relating to external audit recommendations for closure approval and a paper relating to historic external audit recommendations.

It was resolved that the Committee:

- **NOTED** the current position with regards to open recommendations, those proposed for closure, and 'no', 'unsatisfactory' and 'limited' assurance recommendations.
- **APPROVED** the proposals within the report relating to historical recommendations and information from TeamMate.
- **NOTED** that a paper relating to external audit recommendations for closure approval will be presented to the January Audit Committee.
- **NOTED** that a paper relating to historical external audit recommendations will be presented to the January Audit Committee.

AC24/147 Update on Outstanding Audit Recommendations

Members received the presentation and noted the updated in relation to the outstanding audit recommendations for the Interim Executive Director of Finance. The presentation highlighted:

- The 'no' assurance audit report relating to the delivery of Health Board savings and concerns around consistency of reporting.
- Two out of the four key recommendations have been implemented.
- The team are reviewing opportunities for transformational savings and how these could deliver savings in the short term.
- The team have complied with all approved VERS applications in accordance with the requirements of the Remuneration Committee.
- The value and sustainability approach has been endorsed and a process established to report via the Value and Sustainability Group.
- The 'limited' assurance audit reports relating to water safety, budgetary control and charitable funds were discussed.
- In relation to the water safety audit, work has been completed to put actions in place, this includes a water continuity plan linking to Emergency Preparedness, Resilience and Response (EPRR).
- In relation to the budgetary control audit, a budget managers handbook has been produced and work is taking place to ensure officers sign up to their budgets to provide a level of accountability, the work completed to date has seen a significant improvement in response.
- Budget training has been reinstated and provided to over 400 officers including Executives.
- In relation to the Charitable Funds audit, processes have been put in place to review allocation costs and provide a more controlled environment. A strategic plan has been endorsed and the team are reviewing ways to secure further fundraising such as initiating a staff lottery.

In discussing the report, the Committee:

- Discussed whether budget training is included as a mandatory training module and recorded on ESR, it was confirmed that completion is captured via the Finance team and

Unconfirmed

it was recommended that this is discussed with the Workforce team to determine how the training can be linked to the ESR system.

- Referred to the presentation provided by the Chief Executive on Foundations for the Future Programmes and the need to be aware of accountability arrangements, it was suggested that the presentation is shared with the Committee.
- Commented on the progress made in relation to Charitable Funds and the need to ensure the strategy links to the Health Board's medium and long-term plan.
- Suggested that having a staff lottery as a way of raising money could be seen as the Health Board promoting gambling and that this needs to be discussed further.
- Noted that the presentation has provided an assessment around the progress and steps being taken.

Actions:

- AC24/147.1 Share the Interim Executive Director of Finance update presentation on open audit recommendations.
- AC24/147.2 Work with WOD to understand how budgetary training can link in with ESR.
- AC24/147.3 Share the Budget Managers Handbook with the Committee.
- AC24.147.4 Share the presentation from the CEO on Foundations for the Future Programme with the Committee.
- AC24/147.5 Urtha Felda and Dyfed Jones to discuss the suggestion of a Health Board Lottery.

It was resolved that the Committee:

- **NOTED** the progress as highlighted within the presentation.

AC24/148 Welsh Health Circulars and Ministerial Directions

Members received the report and noted the progress made to date. In presenting the report, the Director of Corporate Governance highlighted:

- The paper provides assurance around the process for Welsh Health Circulars and Ministerial Directions and requests the Committee agree the process and reporting cycle.
- As per the Annual Governance Statement this has previously been reported annually however it was suggested the this is reported on a bi-annual basis to the Committee to monitor progress.
- This is a new report and the Head of Covid-19 Inquiry and Thirlwall Inquiry has been working with the Executives to develop this report.

In discussing the report, the Committee:

- Noted that Welsh Government circulate the Ministerial Directions as part of regulatory guidance and it is the Health Board's responsibility to comply.
- Agreed to receive the report bi-annually and ensure a report is produced towards the end of the year to inform the end of year position.
- Discussed the current system for receiving Ministerial Directions as not very efficient and suggested contact is made to determine whether this correspondence can be sent automatically to a central point.

It was resolved that the Committee:

Unconfirmed

- **APPROVED** the process for receiving Welsh Health Circulars (WHCs) and Ministerial Directions (MDs) in the Health Board, and ensuring these are actioned as necessary
- **APPROVED** the reporting cycle on WHCs and MDs to the Audit Committee twice per year
- **NOTED** the current position regarding WHCs and MHDs received from 1st April 2024 to 31st August 2024.

AC24/149 Declarations of Interests / Gifts & Hospitality

Members received the report and noted the progress made to date. In presenting the report, the Director of Corporate Governance highlighted:

- A limited assurance report has previously been received in relation to declarations of interest and it is important for the Committee to be aware of the processes and governance relating to this.
- Further work is required in relation to declarations of interest and gifts & hospitality as the findings from the audit highlighted the lack of focus on monitoring of standards of business conduct.
- A historic system was purchased and not implemented effectively therefore the team are working to address the recommendations and have the opportunity to review the system going forward.
- A position statement has been provided and work is ongoing to link declarations of interest to PADRs and review the current policy to align with NHS Wales.

In discussing the report, the Committee:

- Discussed the figures included in the report and the need for the PADR form to capture declarations of interest and ensure the information goes live on the system.
- Requested to see the data compared to those actually required to make a declaration % format so as to monitor progress.
- Queried whether all staff are required to provide an annual declarations of interest and how this information can be captured throughout the year as PADR are completed on a annual basis. It was confirmed that the figures are based on Band 8c and above but if other staff have an interest they should declare it, a flow chart has been developed and there will be ownness on individuals to provide live updates as requested.
- Stated that in the lead up to Christmas there is a need to focus on gifts & hospitality, this is a continuing process which links into charitable funds, work is ongoing and this needs to be reviewed on a regular basis.

It was resolved that the Committee:

- **RECEIVED** the report for assurance

AC24/150 Minor Changes to Scheme of Delegation

Members received the report and noted the changes to the scheme of delegation. In presenting the report, the Director of Corporate Governance highlighted:

- There has been a transfer of Legal Services to the Director of Corporate Governance, this will ensure the right delegation is in place.
- A wider review of the Scheme of Delegation will be presented to the Committee in January 2025.

Unconfirmed

- The Committee were requested to agree the changes which will then be ratified by the Health Board.

It was resolved that the Committee:

- **SUPPORTED** the changes to the Scheme of Delegation for onward consideration and approval by the Health Board.

AC24/151 Response to Freedom of Information Request

Members received the report and noted the response to the Freedom of Information Request. In presenting the report, the Director of Corporate Governance highlighted:

- The Committee received a verbal update in private at the last meeting in September 2024.
- Ongoing contact has been made with the individual who submitted the FOI request.
- The elements addressed from a governance and assurance perspective are around the processes in place and concerns regarding the scheme of delegation.
- The Committee need to be satisfied that the scheme of delegation process is appropriate and that further work will go via the Performance, Finance & Information Governance Committee in relation to funding and the benefits of the historic arrangement.
- Detailed investigation has taken place, there are currently no areas of concern and a further review will be completed once the Head of Counter Fraud starts in post.

In discussing the report, the Committee:

- Queried whether a full evaluation will be shared within the public domain, it was confirmed that the item is being discussed in public to provide transparency and governance and an evaluation including next steps will take place.
- Enquired at what point does the Health Board reach a conclusion with the request, it was stated that there are some further elements to work through to ensure the Audit Committee and the Board are satisfied that all areas have been addressed and the Health Board will then be able to confirm a position.
- Queried whether the Information Commissioner had been involved, it was confirmed that this would be completed.
- Confirmed that members of the Committee were assured that in depth investigations have been taking place and transparency had been provided.

Actions:

- AC24/151.1 A full evaluation report to be presented at the next Audit Committee.
- AC24/151.2 Gain the opinion of the Information Commissioner on the FOI.

It was resolved that the Committee:

- **CONSIDERED** and **REVIEWED** the governance of the response to an FOI request related to the Health Board's partial funding of the Centre for Mental Health and Society (CfMHaS).

Matthew Joyes and Eifion Jones joined the meeting

FINANCIAL FOCUS

AC24/152 Conformance Report: Q2 2024/25

Unconfirmed

Members received the report and noted the progress made in relation to the Conformance Report. In presenting the report, the Interim Finance Director, Operational highlighted:

- The report is a comprehensive document which includes clear metrics highlighting the sustainability of a level of improvement and the realisation of benefits such as single tender waivers.
- In relation to purchase orders, significant improvements have been made in relation to the number and value of breaches.
- The All Wales letter relating to requisitions has been shared with all budget managers to reiterate the expectation to raise requisitions in advance.
- IProcurement refresher training sessions have been offered to all staff with an Oracle log on and over 400 staff have completed the training to date.
- The year to date achievement in relation to the Public Sector Payment Policy for non-NHS invoices is around 96%.
- In relation to the contract procurement review, out of the 24 actions provided by Internal Audit, 22 actions have now been closed with 2 remaining open.
- One open action relates to financial procedures where significant progress has been made, a desktop review of procedures has been completed and the team have engaged with Internal Audit and Charitable Funds.
- In relation to the open action regarding the contract register, the team have met with all Divisions to discuss the required minimum data set and evidence has been received from the majority of teams.
- The table illustrating the losses and special payments for approval was provided to the Committee.

In discussing the report, the Committee:

- Considered the narrative included in the Executive Summary referring to staff overpayments and it was agreed that this needs to be consistent and further work is required with Workforce colleagues to manage this issue. It was also suggested that a more in depth review could been completed in a future private session.
- Noted the number of PO breaches regarding non pay and confirmed that these relate to areas such as out of area placements and insourcing of radiography.
- Discussed how debts can be recovered from overseas visitors and confirmed that the relevant information has been provided to the Home Office to allow charges to be placed against individuals' passports.
- Suggested that further information is included in the table in section 3 to highlight movement in the number of claims outstanding and progress made.

Actions:

- AC24/152.1 Provide an update on payroll procedures and the public sector payment policy at a Private meeting if the issues are not resolved.
- AC24/152.2 In section 3 of the report include a movement column in the table to highlight new, current and resolved cases.

It was resolved that the Committee:

- **NOTED** and **DISCUSSED** discuss the elements of performance highlighted in the report.
- **APPROVED** the Losses and Special Payments (July to September 2024).

Unconfirmed

AC24/153 Penalties from the Welsh Risk Pool

Members received the report and noted the information provided. In presenting the report, the Deputy Director for Legal Services highlighted:

- His change in role to Deputy Director of Legal Services which will allow greater focus on managing the Legal function across the organisation.
- The requirement of the team to submit a Learning from Events Report form along with supporting evidence to the Welsh Risk Pool within four months of settling a claim as a process to try and reduce incidents from reoccurring.
- Penalties of between £2.5k and £25k are arranged for any late submissions, last year the Health Board incurred four penalties and this year to date have incurred three penalties.
- The cause of the penalties this year have been incurred due to delays in providing the required information for the Learning from Events Report and the detail was included in the report.
- The transfer of Legal into the Corporate Governance team will allow the team to review plans in place and make amendments to the current policies and processes.
- A new integrated concerns policy was implemented in September 24 to manage concerns more effectively and this should help the teams to provide evidence of learning.

In discussing the report, the Committee:

- Noted that at any one time there are approximately 900 open claims across the organisation and around 200 claims are concluded per year.
- Suggested that learning is not being sufficiently embedded if similar issues are coming through the system therefore there is a need to test whether the learning has been embedded. It was agreed that the link to learning is key and ensuing the evidence of learning is provided at the point of incident rather than at the end of the claims process.
- Queried the timescale of the review and whether a deep dive would be useful, it was confirmed that the process is being improved and there is a need to review this at divisional level.
- Highlighted this as a potential financial risk due to the value of the penalties, queried how this is monitored to ascertain the specific charges and suggested further information is presented to the next meeting.
- Emphasised the intention to be transparent in terms of the current position and financial exposure of the risk and suggested this could form part of the Conformance Report.

Actions:

- AC24/153.1 As part of the process and review of Legal Services look at quality and a potential Deep Dive.
- AC24/153.2 Review the penalties incurred via the Welsh Risk Pool in terms of risk and financial implication and bring this back to the Committee in January 25. Assess whether this information could form part of the quarterly Conformance Report going forward.

It was resolved that the Committee:

- **NOTED** the content of the report

INTERNAL AUDIT

AC24/154 Internal Audit Progress Report

Unconfirmed

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

- New Global Internal Audit Standards are being introduced by the Institute of Internal Audit from 1st January 2025 and these will be applicable to the Public Sector from 1st April 2025.
- A new reporting template has been introduced and rolled out across the organisation for use from 1st October 2024.
- The team are engaging with managers to discuss management responses which is starting to provide a quicker turnaround time.
- In relation to audit reports, four have been finalised since the last meeting with two in draft and seven due to be finalised by the end of November.
- Evidence has been provided for forty nine recommendations, twenty have been closed, twelve require further evidence and seventeen are outstanding.
- The management response rate has dropped and the team are engaging with managers to discuss responses as part of the new process with the aim to provide a quicker turnaround time. It was requested that Independent Members are updated where managers fail to respond.
- An update on the audit of the Llandudno Orthopaedic Surgical Hub was provided by the Deputy Head of Internal Audit Specialist Services Unit stating that there has been focus on progress and that this is part of a wider programme of work for the organisation.
- Limited assurance has been attained for some objectives and the reasons for this include minutes not being available, decision making not captured resulting in a lack of assurance, with regular updates not being provided to the Board or Committee on an ongoing basis.
- Concerns were raised in relation to the tender evaluation and approval process as details of value of money were not available along with concerns that documented formal approvals were not obtained for the main works contract.
- An update on the Value Based Healthcare audit was provided stating that this has received a reasonable assurance rating and included a good level of tracking in terms of areas and schemes where money has been utilised although there is limited assurance on oversight via the Health Board to monitor the progress.
- An update on the Recruitment of substantive and interim executive and senior posts audit was provided stating that the Board did not formally appoint all Executive and other Board level Director posts.

In discussing the report, the Committee:

- Referred to the performance indicators and how the team plan to managed the timescales and reporting mechanisms going forward. It was noted that the management response time had dipped to 67% but that steps were in place to improve this.
- Highlighted that the Health Board do not currently have a process for managing Value Based Healthcare, it was confirmed that this work is in progress but not currently widespread across the organisation.
- Noted the concerns raised in relation to the tender evaluation and contract for the Llandudno Orthopaedic Hub and welcomed a review and further discussion outside of the meeting.
- Stated that the Llandudno Orthopaedic Hub report has been returned on a number of occasions due to the lack of required information within the management response and

Unconfirmed

noted that the project was developed under significant time pressures and that improved governance arrangements are now in place.

- Agreed that due to the lack of assurance in relation to the Llandudno Orthopaedic Hub that this should be noted by the Performance, Finance and Information Governance Committee and to invite Chris Stockport to join the January 25 meeting to provide an update.
- Noted that the Remuneration Committee have discussed the Recruitment of substantive and interim executive and senior posts audit in depth and the progress required in terms of the recommendations.
- Discussed the Corporate Legislative Compliance Fire Safety and agreed that Fire Safety training should be included as a Mandatory Training module rather than at staff discretion to ensure this is completed by the relevant members of staff, a review of the policy should also be completed.

Actions:

- AC24/154.1 Ensure Independent Members are updated with regard to failure for management to respond to Internal Audit Recommendations.
- AC24/154.2 Russell Caldicott and Dave Harries to meet outside of the meeting to discuss the findings of the Final Audit report on the Llandudno Hospital Orthopaedic Surgical Hub.
- AC24/154.3 Circulate relevant minute from the Health Board meeting in relation to the effective award of contract and delegation of approval of the Llandudno Hospital Orthopaedic Surgical Hub.
- AC24/154.4 Due to the lack of regular oversight of the Llandudno Hospital Orthopaedic Surgical Hub, note this via PFIG Committee and provide an update back to the Committee and invite Chris Stockport to join the January 25 meeting.
- AC24/154.5 Review the option to include Fire Safety Training within Mandatory Training rather than it being at staff discretion and also review the policy.

It was resolved that the Committee:

- **RECEIVED** the progress report.
- **NOTED** the introduction of the Global Internal Audit Standards from January 2025 with implementation in the Public Sector from 1 April 2025.
- **NOTED** the change in the internal audit report template.

Eifion Jones left the meeting

AC24/155 Internal Audit Plan (Oct 24 to March 25)

Members received the report and noted the Internal Audit Plan. In presenting the report, the Head of Internal Audit highlighted:

- The plan has been circulated to members outside of the meeting for consideration and feedback and had also been presented to the Executive Team where no changes were highlighted.
- Following consultation, the draft plan has not been amended and the Committee were requested to formally approve the plan.

It was resolved that the Committee:

- **APPROVED** the Internal Audit Plan 2024/25 – October 2024 to March 2025.

Unconfirmed

EXTERNAL AUDIT

AC24/156 External Audit Progress Report

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

- The final accounts audit for 2023/24 has been completed, recommendations have been shared for consideration, a management response for all recommendations has been accepted and a report will come to the next meeting.
- Post project discussions have taken place with the Finance Team and the Director of Corporate Governance to capture the learning.
- Planning for the Charitable Funds audit has commenced and will be discussed at the Charitable Funds Committee on 12th November 2024.
- The performance audit update was shared and it was confirmed that work in underway in the following areas: Structured Assessment, Planned Care and Urgent and Emergency Care and an update will be provide at the next meeting.
- Over the next few weeks the team will focus on a deep dive into investment into digital systems and quality governance arrangements.

In discussing the report, the Committee:

- Referred to cost savings and budgets and it was confirmed that there is a need to reflect on how budgets are set and the work required to review overspends.
- Noted that the budgets have been set in a more coherent manner for this financial year.

It was resolved that the Committee:

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

COUNTER FRAUD

AC24/157 Local Counter Fraud Service Progress Report (Q2)

Members received the report and noted the Local Counter Fraud Service Progress Report. In presenting the report, the Interim Finance Director, Operational highlighted:

- This is the first time the Counter Fraud report has been presented in public.
- Danielle Timmins has been appointed as the Head of Local Counter Fraud Services and will commence the role on 1st December 2024.
- It was noted that the Counter Fraud policy was due to be updated in September and that this has been delayed.
- The Committee were made aware of the current key activities being completed by the Team which include a review policies and procedures and communication via media reports in relation to fraud deterrence.
- The need to ensure qualifications are valid when appointing staff members.
- The position at the end of Quarter 1 which highlights that five cases have been closed and there are currently thirty two open cases.

It was resolved that the Committee:

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

FOR INFORMATION

Unconfirmed

AC24/158 Summary of Business to be Reported from Private

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

AC24/159 Committee Forward Workplan

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

CLOSING BUSINESS

AC24/160 Agree Items for Referral to Board / Other Committees

It was resolved that this would be discussed outside of the meeting.

AC24/161 Review of Meeting Effectiveness

In discussing the item, the Committee:

- Noted the high quality of discussion and that challenge around relevant topics was conducted in a constructive way.
- Highlighted a good balance of agenda items.
- Noted the progress made by the Committee in a short space of time.
- Suggested the Committee would benefit from the attendance of Executive Directors going forward and that Executive Directors would not send a deputy and instead attend to support their team members.
- Agreed that the Interim Chief Operating Officer would attend the next meeting.

AC24/162 Date of Next Meeting

Audit Committee Development Session: Thursday 5th December 2024, 11.00-12.30
Audit Committee: Thursday 16th January 2024, 9.30-13.30

Resolution to Exclude the Press and Public

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

Unconfirmed

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

Audit Committee Action Log (Public)

Updated 09.01.25

Open Actions						
Action No.	**Minute Ref.**	**Date**	**Agreed Action**	**Lead**	**Timescale**	**Status**
REMAIN OPEN						
1	**AC24/147.2**	05.11.24	**Update on Outstanding Audit Recommendations** Work with WOD to understand how budgetary training can link in with ESR.	Russell Caldicott Andrea Hughes	~~Jan 2025~~ Revised timescale March 25	**Remain Open** **09.01.25** Update from RC to follow.
2	**AC24/151.1**	05.11.24	**Centre for Mental Health and Society (CfMHaS)** (Title changed from Response to Freedom of Information Request) A full evaluation report to be presented at the next Audit Committee.	Russell Caldicott	March 25	**Remain Open** **08.01.25** An evaluation of the CaMHS Agreement will be commissioned and the final report will be brought to the Committee once received. The terms of reference for the review is currently being finalised in order that procurement for the review can be commissioned.
3	**AC24/151.2**	05.11.24	**Centre for Mental Health and Society (CfMHaS)** (Title changed from Response to Freedom of Information Request) Gain the opinion of the Information Commissioner on the FOI.	Pam Wenger Phil Meakin	~~Jan 2025~~ Revised timescale March 25	**Remain Open** **08.01.25** Associate Director of Governance has followed this up. Communication with the Information Commissioners Office (ICO) commenced in September 24 and the Health Board is awaiting a response. (ICO communication normally takes

						2-3 months).
4	**AC24/152.1**	05.11.24	**Conformance Report: Q2 2024/25** Provide an update on payroll procedures and the public sector payment policy at a Private meeting if the issues aren't resolved.	Russell Caldicott Andrea Hughes	~~Jan 2025~~ Revised timescale March 25	**Remain Open** **09.01.25** Update from RC to follow.
5	**AC24/152.2**	05.11.24	**Conformance Report: Q2 2024/25** In section 3 of the report include a movement column in the table to highlight new, current and resolved cases.	Russell Caldicott Andrea Hughes	~~Jan 2025~~ Revised timescale March 25	**Remain Open** **09.01.25** Update from RC to follow.
6	**AC24/154.2**	05.11.24	**Internal Audit Progress Report** Russell Caldicott and Dave Harries to meet outside of the meeting to discuss the findings of the Final Audit report on the Llandudno Hospital Orthopaedic Surgical Hub.	Russell Caldicott Dave Harries	~~Jan 2025~~ Revised timescale March 25	**Remain Open** **09.01.25** Update from RC to follow. **06.12.24** A draft brief was shared with Russell Caldicott and Chris Stockport has now approved the final brief.
7	**AC24/154.5**	05.11.24	**Internal Audit Progress Report** Review the option to include Fire Safety Training within Mandatory Training rather than it being at staff discretion and also review the policy.	Russell Caldicott Andrea Hughes	~~Jan 2025~~ Revised timescale March 25	**Remain Open** **09.01.25** Update from RC to follow.
8	**AC24.60.1.8**	07.05.24	**Internal Audit Progress Report** Quality, safety and commissioned services. The Committee agreed to a 6-month deferral requesting that the review take place before the end of the current financial year - it was agreed to inform the QSE of this decision and for the QSE committee to drive progress on	Philippa Peake Jones to inform the Quality, Safety and Experience Committee (QSE)	~~May 2024~~ ~~Nov 2024~~ ~~Jan 2025~~ Revised timescale March 2025	**Remain Open** **08.01.25** An update on the progress against the Quality, Safety and Commissioned Services Report has been included on the forward plan for the QSE Committee. **24.10.24** Action to remain open and to be taken forward with the new Director of Planning &

			recommendations from the May 23 report.			Commissioning. **02.09.24** PPJ confirmed that this has been referred to QSE Committee however the issue has not yet been resolved therefore the action remains open.
9	**AC24.60.1.10**	07.05.24	**Internal Audit Progress Report** Limited Assurances relating to the Lessons Learnt Report dated July 2023 and the follow up progress to date. Chair / Director of Corporate Governance to raise in the Chairs Advisory Group as an emerging topic.	Karen Balmer Pam Wenger Philippa Peake-Jones	~~July 2024~~ ~~Nov 2024~~ ~~Jan 2025~~ Revised timescale March 2025	**Remain Open** **08.01.25** PPJ to add this item to the agenda for the next Chairs Advisory Group for discussion which is due to take place on 26.02.25. **08.10.24** The recommendations included in the Lessons Learnt Audit Report have been shared with the Chair, this will be discussed at the Chairs Advisory Group in October and the Chair will provide a verbal update at the Audit Committee in November. **12.09.24** This will be discussed at the next Committee Chair's Meeting. **02.09.24** Update to be provided during the meeting. **18.07.24** To be raised at the next meeting in August 2024 as part of feedback from the Audit Committee Chair.
10	**AC24.62.1.4**	07.05.24	**Local Counter Fraud** F03 BCUHB Counter Fraud Policy is due for review – to be approved by August 2024. (Audit Committee	Russell Caldicott Andrea Hughes Sjef Molmans	~~Sept 2024~~ ~~Nov 2024~~ ~~Jan 2025~~	**Remain Open** **09.01.25** Update from RC to follow. **25.10.24** With the recent appointment of the Head of Counter Fraud and the

			Agenda in September)		Revised timescale March 25	continued difficulties within the team owing to absence, the policy review has been deferred to the next Audit Committee for ratification with advice taken from national leads as to whether this offers a risk in relation to the recent changes in legislation. **12.09.24** RC to review the policy and check whether the legislation is due in September 24. **05.09.24** The Counter Fraud Policy required further work and has been included on the forward workplan for the November meeting. **26.06.24** Counter Fraud Policy F03, is in the process of being reviewed by the team and will be placed out for wider consultation in July. **20.05.24** Item now on CoB for September 2024.
11	**AC24/121.1**	12.09.24	**Speak Up Safely** – Share benchmarking information from other Health Boards in relation to the number of concerns being raised.	Jason Brannan Gareth Evans	~~Nov 2024~~ ~~Jan 2025~~ Revised timescale March 2025	**Remain Open** **28.10.24** The Freedom to Speak Up Lead Guardian has begun liaising with colleagues from across the other Health Boards and will explore numbers of concerns as part of a benchmarking exercise, whilst also factoring in other considerations such as size of Health Board in relation to numbers of concerns received, and current impact factors that may also

						influence referral rates, e.g. impact of Special Measures and/or similar levels of external intervention into Health Boards.
12	**AC24/121.2**	12.09.24	**Speak Up Safely** – Future update to consider the compliance against the policy/protocol and particularly in the context of raising concerns and Whistleblowing arrangements.	Internal Audit Jason Brannan Gareth Evans	~~Nov 2024~~ ~~Jan 2025~~ Revised timescale March 2025	**Remain Open** **28.10.24** Speaking Up Safely as a mechanism and route to raising concerns was included in the Raising Concerns policy and process when first launched in July 2021, and again reviewed when the Raising Concerns policy and process was updated. The SUS team will engage in further work to explore any specific additions or adaptions to current practice that may be needed in relation to Public Disclosure (Whistleblowing) **16.09.24** Internal Audit will consider Speak Up Safely as a key risk area for the 2025/26 internal audit planning cycle following presentation of the report by Officers and observations made by Committee Members.
13	**AC24/124.3**	12.09.24	**Update on Health Board Policies and Written control Documents** It was agreed that further work is required to put mechanisms in place and establish a process on the review of policies and procedures and an update will be provided in the future.	Pam Wenger Glesni Driver	~~Nov 2024~~ ~~Jan 2025~~ Revised timescale June 2025	**Remain Open** **10.12.24** A paper has been included on the agenda for the January meeting. Further work is required on policies once progress has been made against the current policies. **24.10.24** The immediate focus is reviewing the work in terms of the

						governance and overdue policies. There is opportunity to review the current processes going forward but given the focus on dealing with overdue policies this will be the immediate priority. This has been included on the forward workplan in terms of the long term review of the processes.
ACTIONS PROPOSED FOR CLOSURE						
1	**AC24.43.6**	15.03.24	**Annual Timetable 23-24 Draft Final Accounts** To feedback to Committee in relation to the levels of exposure costs in terms of Welsh Risk Pool payments.	Russell Caldicott	~~May 2024~~ ~~Nov 2024~~ Revised timescale Jan 2025	**Action proposed for closure** **28.11.24** A paper on the penalties from the Welsh Risk Pool has been included on the agenda for the January 25 meeting. **05.11.24** Committee lack of learning from events report. Risk pool penalties are going up Legal function has just transferred over to Pam. The challenge is that we haven't been able to evidence the learning. There will be a legal update at the next QSE meeting, looking at setting up a sub committee on legal and risk, acknowledge the position, further work to be completed. **29.10.24** A paper on penalties from the Welsh Risk Pool has been include on the agenda for the November meeting. **03.05.24** Update to be provided at the

						meeting.
2	**AC24.57.7.5**	07.05.24	**Audit Tracker** The need for a clearer process for monitoring timeliness, performance, and principles on a case-by-case basis was raised. It was agreed that the process for external audits needed to be different to the proposal in 2.1 of the report.	Pam Wenger Russell Caldicott	~~July 2024~~ ~~Nov 2024~~ Revised timescale Jan 2025	**Action proposed for closure** **08.01.25** The paper on the agenda includes a proposal in terms of closure of external audit recommendations. **10.12.24** Director of Corporate Governance to meet with Fflur Jones, External Audit, 11.12.24 to discuss. **02.09.24** Director of Corporate Governance to discuss with External Audit to agree closure process. **03.07.24** Process to be developed and agreed with External Audit following the end of year accounts process being concluded.
3	**AC24.94.9**	18.07.24	**Effective Governance – IHC Central Final Internal Audit Report** The Chair of the Committee referred to the number of open complaints since April, and questioned the position at the end of June. The Director agreed to forward the detail to the Chair following the meeting, it was noted that overdue complaints had significantly reduced. It was also agreed to provide a future update on the impact of the actions being taken, with regards to the reduction of outstanding complaints responses at a future meeting.	~~IHC Director Central (Libby Ryan Davies)~~ Gareth Evans	~~Sept 2024~~ ~~Nov 2024~~ Revised timescale Jan 2025	**Action proposed for closure** **28.11.24** Gareth Evans & Naomi Holder are due to join the January meeting to provide an update. **08.10.24** The Central IHC have provided a positional update of formal complaints and this has been included as an attachment to the action log (items AC24/145.2 & AC24/145.3). The IHC will be invited to attend the meeting in Jan 25 to provide an update on the impact of the actions being taken. **03.09.24** Since the July meeting there has been a change in the IHC

						Director Central role. The team are aware of the action and will provide a response ahead of the November meeting.
4	**AC24.99.8**	18.07.24	**Annual report from NHS Shared Services Partnership on Post Payment Verification 2023/2024** The Committee Chair requested details on the availability of comparative trend analysis, including geographical data (in relation to East, Central and West IHC areas). The All Wales Post Payment Verification (PPV) Manager (NWSSP) agreed to provide this information.	Amanda Legge	~~Sept 2024~~ ~~Nov 2024~~ Revised timescale Jan 2025	**Action proposed for closure** **09.12.24** Trend data and supporting narrative circulated by email. **05.11.24** Update provided during meeting that the Committee are happy for information to be shared outside of the meeting. **24.10.24** The prototype is still in development, the relevant data can be extracted and presented as an internal report, Committee to confirm whether they want this report to be presented at the next meeting in Jan 25 or for information to be shared outside of the meeting. **02.09.24** Amanda Legge confirmed that this information can be provide by locality area (e.g. Flintshire, Wrexham, Denbighshire, Conwy, Gwynedd & Anglesey). A prototype is being developed to include trend data and will be shared once available.
5	**AC24.99.9**	18.07.24	**Annual report from NHS Shared Services Partnership on Post Payment Verification 2023/2024** The Director of Corporate Governance questioned if any	Amanda Legge	~~Sept 2024~~ ~~Nov 2024~~ Revised timescale	**Action proposed for closure** **09.12.24** Trend data and supporting narrative circulated by email. **05.11.24** As per update for action above.

			particular themes had been raised upon the visits in terms of learning, and of the resolutions or progress and (where applicable) to counter fraud. The NWSSP Lead provided an overview of the current actions taken and it was agreed to include any anonymised common themes within future reports to the Committee.		Jan 2025	**24.10.24** As per update for action above. **02.09.24** As per action above AC24.99.8 the information being collated will include any issues and common themes.
6	**AC24/124.2**	12.09.24	**Update on Health Board Policies and Written control Documents** A summary to be provided at the next meeting as to which policies carry the biggest risks (financial, legal compliance, safety etc) and progress being made against them.	Pam Wenger Glesni Driver	Jan 2025	**Action proposed for closure** **03.12.24** This will be covered in the Policy Update Report at the January 25 meeting. **24.10.24** Work is in progress; this is being progressed via the Policy Oversight Group and the Executive Team. This will come to the Committee in January 25.
7	**AC24/127.2**	12.09.24	**Internal Audit Progress Report** EPRR/Civil contingencies will go to the PPHP Committee in October and feedback on the discussion will be provided back to the Audit Committee.	Pam Wenger	~~Nov 2024~~ Revised timescale Jan 2025	**Action proposed for closure** **25.11.24** An item focussing on the EPRR Risks will be considered by the PPHP Committee at the meeting on 18.02.25. **03.10.24** A report on EPRR was considered at the PPHP Committee on 22.10.24 and it was agreed for the next meeting to receive an update in terms of the risks. The issue of the deferred audit was discussed and recognised that the Internal Audit Team had no option but to defer the

						audit.
8	**AC24/127.4**	12.09.24	**Internal Audit Progress Report** Consider options for raising awareness and understanding of internal audit.	Pam Wenger Dave Harries	~~Nov 2024~~ Revised timescale Jan 2025	**Action proposed for closure** **28.11.24** A video is being developed to share with staff about the role of Internal Audit and Internal Audit have been included in the development. There will be an opportunity to consider the profile as part of the Annual Audit Plan. **03.10.24** PW to discuss options including developing video resource, an update will be provided in Jan 25.
9	**AC24/145.1**	05.11.24	**Matters Arising & Action Log** Share paper that Imran Devji took to PFIG regarding the role of the Trusted Assessor.	Pam Wenger	Jan 2025	**Action proposed for closure** **26.11.24** The document has been shared with the Committee via email
10	**AC24/145.2**	05.11.24	**Matters Arising & Action Log** Circulate the Complaints Improvement Deep Dive from the October QSE Committee.	Philippa Peake-Jones	Jan 2025	**Action proposed for closure** **05.11.24** PPJ circulated the document to the Committee via email
11	**AC24/146.1**	05.11.24	**Update Report on Internal and External Audit Recommendations** Invite Imran Devji to attend the next meeting to provide an update on the Internal and External Audit Recommendations for the Chief Operating Officer.	Philippa Peake-Jones	Jan 2025	**Action proposed for closure** **25.11.24** Imran Devji will attend the January 25 meeting to give a presentation on outstanding Audit recommendations.
12	**AC24/146.2**	05.11.24	**Update Report on Internal and External Audit Recommendations** Bring a paper to the next meeting relating to external audit	Pam Wenger Glesni Driver	Jan 2025	**Action proposed for closure** **28.11.24** A paper on Historical External Audit Recommendations has been included on the agenda for the

			recommendations for closure approval and a paper relating to historic external audit recommendations.			January 25 meeting.
13	**AC24/147.1**	05.11.24	**Update on Outstanding Audit Recommendations** Share the Interim Executive Director of Finance update presentation on open audit recommendations.	Philippa Peake-Jones	Jan 2025	**Action proposed for closure** **05.11.24** PPJ circulated the document to the Committee via email
14	**AC24/147.3**	05.11.24	**Update on Outstanding Audit Recommendations** Share the Budget Manager Handbook with the Committee.	Russell Caldicott Andrea Hughes	Jan 2025	**Action proposed for closure** **26.11.24** The Budget Manager Handbook has been shared with the Committee via email
15	**AC24/147.4**	05.11.24	**Update on Outstanding Audit Recommendations** Share the presentation from the CEO on Foundations for the Future Programme with the Committee.	Pam Wenger	Jan 2025	**Action proposed for closure** **25.11.24** The CEO Foundations for the Future Programme presentation was uploaded to iBabs for all Board members following the Board Development session held on 31.10.24
16	**AC24/147.5**	05.11.24	**Update on Outstanding Audit Recommendations** Urtha Felda and Dyfed Jones to discuss the suggestion of a Health Board Lottery.	Urtha Felda Dyfed Jones	Jan 2025	**Action proposed for closure** **27.11.24** Urtha & Dyfed have discussed the implications of the Board promoting an activity which causes addiction and harm to individuals and their families. It has been agreed that going forward Dyfed will request input from Urtha if any related item are included on the agenda for the Charitable Funds Committee.

17	**AC24/153.1**	05.11.24	**Penalties from the Welsh Risk Pool** As part of the process and review of Legal Services look at quality and a potential Deep Dive.	Pam Wenger	Jan 2025	**Action proposed for closure** **28.11.24** A paper has been included on the agenda for the January 25 meeting to address this action.
18	**AC24/153.2**	05.11.24	**Penalties from the Welsh Risk Pool** Review the penalties incurred via the Welsh Risk Pool in terms of risk and financial implication and bring this back to the Committee in January 25. Assess whether this information could form part of the quarterly Conformance Report going forward.	Russell Caldicott Andrea Hughes	Jan 2025	**Action proposed for closure** **28.11.24** A paper has been included on the agenda for the January 25 meeting to address this action.
19	**AC24/154.1**	05.11.24	**Internal Audit Progress Report** Ensure Independent Members are updated with regards to failure for management to respond to Internal Audit Recommendations.	Dave Harries	Jan 2025	**Action proposed for closure** **06.12.24** Internal Audit will include details in progress reports where they encounter untimely responses to reports. In addition, where management do not accept a recommendation, Internal Audit will raise this at Committee where they believe the risk is such that the Audit Committee need to be aware.
20	**AC24/154.3**	05.11.24	**Internal Audit Progress Report** Circulate relevant minute from the Health Board meeting in relation to the effective award of contract and delegation of approval of the Llandudno Hospital Orthopaedic Surgical Hub.	Philippa Peake-Jones	Jan 2025	**Action proposed for closure** **26.11.24** The extract from the Health Board minutes held in September 2023 has been circulated to members for information (noting this is not for wider circulation)
21	**AC24/154.4**	05.11.24	**Internal Audit Progress Report** Due to the lack of regular oversight of	Pam Wenger Philippa Peake-	Jan 2025	**Action proposed for closure** **28.11.24** Chris Stockport and Nicola

			the Llandudno Hospital Orthopaedic Surgical Hub, note this via PFIG Committee and provide an update back to the Committee and invite Chris Stockport to join the January 25 meeting.	Jones		Etherington will join the January 25 meeting to discuss the Llandudno Hospital Audit to address this action.
22	**AC24.101.13**	18.07.24	**Internal Audit Progress Report** An IM requested clarification on the role of the Trusted Assessor and the strengthening of this role within the overall process. The Director of Corporate Governance noted the request and agreed to arrange for the clarification to be provided to all Independent Members.	Pam Wenger	~~Sept 2024~~ ~~Nov 2024~~ Revised timescale Jan 2025	**Action proposed for closure** **26.11.24** A paper on the Trusted Assessor Role Guidance has been shared with the Committee via email. **03.10.24** A paper on Urgent and Emergency Care was presented to the Board in September which covered the role of the Trusted Assessor. Committee to confirm whether further action is required. **12.09.24** This will be covered in a paper going to the Board in September on Urgent and Emergency Care and is part of the work taking place with Local Government. **04.09.24** Briefing on the role of the Trusted Assessor to be commissioned.
Closed Actions (as agreed at meeting on 05.11.24)						
Action	**Minute Ref.**	**Date**	**Agreed Action**	**Lead**	**Timescale**	**Status**
1	**AC24.45.9**	15.03.24	**Internal Audit Reports** Regarding the Limited Assurance IA water safety report and	Russell Caldicott	~~May 2024~~ Revised	**25.10.24** Action to be closed, it is the responsibility of the Nursing teams to ensure the low flow areas (toilets with

			responsibilities of areas, the Interim Executive Director of Finance agreed to gain further insight into the area responsibilities and risk sharing between Facilities staff.		timescale Nov 2024	low use) are flushed and a record maintained. **03.05.24** The Estates provision of maintenance for areas was clarified as complete by Internal Audit, Nursing teams completion of water safety checks (flushing in low use areas) clear within action plan for rectification of key concerns.
2	**AC24.100.12**	18.07.24	**SFI Conformance Report** The Chair of the Committee requested clarification on the "phases" of breaches in the SFI Conformance Report on page 6 of 21, in relation to purchase order breaches. It was agreed for the Interim Director to follow up on the detail and report back to the Chair.	Andrea Hughes	~~Sept 2024~~ Revised timescale Nov 2024	**24.10.24** Additional detail has been added into the report in Q2. **02.09.24** Clarity to be provided at the September meeting on the information required for the Conformance Report to be presented to the Committee in November 24.
3	**AC24.100.16**	18.07.24	**SFI Conformance Report** The Chair requested that a "movements" column be inserted into the SFI Conformance Report data in future reports to indicate progress or otherwise.	Andrea Hughes	~~Sept 2024~~ Revised timescale Nov 2024	**24.10.24** Additional detail has been added into the report in Q2. **12.09.24** It was agreed that this action would remain open until the next meeting in November 24. **02.09.24** This will be incorporate into the Q2 report due to be received by the Committee in Nov 24.
4	**AC24/118.1**	12.09.24	**Minutes** – Pam W to meet with Rhian W with regards to her experience with minute writing.	Pam Wenger Philippa Peake-Jones	Nov 2024	**03.10.24** PW and RWJ meeting 24.10.24 to discuss.
5	**AC24/119.1**	12.09.24	**Matters Arising and Action Log** – In relation to point AC24.101.15 in the	Pam Wenger Philippa Peake-	Nov 2024	**Update provided in meeting** **12.09.24** The People & Culture

			minutes from the Audit Committee held 18.07.24, clarity was requested in relation to the Operating Model and the engagement process with Board Members in quarter 2.	Jones		Committee are leading on this piece of work, the programme has now been established, the end of the discovery phase is being finalised and following this, engagement with Board Members will take place.
6	**AC24/119.2**	12.09.24	Actions **AC24.43.6** and **AC24.45.9** to be added to the action log from a previous version.	Laura Jones	Nov 2024	**30.09.24** These actions have now been included on the action log.
7	**AC24/120.1**	12.09.24	**BAF/Risk** – Share the point scoring matrix with the Committee and possibly some examples of completed audits and improvement plans via email.	Pam Wenger Nesta Collingridge	Nov 2024	**15.10.24** Risk Register Audit Template and Risk Register Review Cancer Services circulated via email 15.10.24
8	**AC24/122.1**	12.09.24	**Internal and External Audit Tracker Report** Share the Audit tracking presentation from the Chairs of the Audit Committee across Wales with members.	Pam Wenger	Nov 2024	**07.10.24** The presentation was shared with members outside of the meeting.
9	**AC24/123.1**	12.09.24	**Update on Open "Limited" Audit Recommendations** Add additional column in the chart highlighting the recommendation number to be able to cross reference the information in the presentation with the report and also to provide additional narrative in relation to the barriers to implementation section as necessary.	Pam Wenger Glesni Driver	Nov 2024	**16.09.24** The presentation template has been updated to include: An additional column for the Internal Audit / Audit Wales recommendation reference number and information around the context required in the narrative.
10	**AC24/123.2**	12.09.24	**Update on Open "Limited" Audit**	Russell Caldicott	Nov 2024	**01.10.24** This has been agreed and

			Recommendations Russell Caldicott to be the Executive Director presenting at the next meeting.			included on the agenda for the November meeting.
11	**AC24/123.3**	12.09.24	**Update on Open "Limited" Audit Recommendations** Check on where 1274 has moved to from the tracker.	Pam Wenger Glesni Driver	Nov 2024	**16.09.24** On checking the tracker in relation to recommendation 1274 it was noted there was an error as this was not included on the list of outstanding open recommendations, this has now been rectified.
12	**AC24/124.1**	12.09.24	**Update on Health Board Policies and Written control Documents** Clarify the most up to date position on Summary of overdue WCDs outside of the meeting.	Pam Wenger Glesni Driver	Nov 2024	**01.10.24** The position as at 15.07.24 & 16.09.24 and supporting spreadsheets were shared with members outside of the meeting. The information showed a slight improvement from 361 to 340 overdue policies / written control documents.
13	**AC24/124.4**	12.09.24	**Update on Health Board Policies and Written control Documents** Head of Internal Audit and Deputy Head of Internal Audit to join the Policy Oversight Group to provide some guidance.	Pam Wenger Dave Harries Nicola Jones	Nov 2024	**07.10.24** Dave Harries and Nicola Jones have been invited to attend the next meeting of the Group taking place on 17.10.24.
14	**AC24/125.1**	12.09.24	**Structured Assessment** Add a deadline date and a target date for completion against historic structured assessment recommendations and to include updates in the audit tracking report in future.	Pam Wenger Glesni Driver	Nov 2024	**03.10.24** This will be added to the recommendation tracker in line with the Audit Wales standard template and will be noted as the "completion date".

15	**AC24/126.1**	12.09.24	**Audit Committee Development Plan** Schedule the development sessions and review the content of the programme interlinking this with the cycle of business.	Pam Wenger Philippa Peake-Jones	Nov 2024	**03.10.24** The sessions have been agreed to take place on 05.12.24 and 20.02.24. The first session will focus on Counter Fraud.
16	**AC24/127.1**	12.09.24	**Internal Audit Progress Report** Dave Harries to share with Chief Executive and Director of Corporate Governance the draft internal audit report in relation to the Orthopedic Surgical Hub – Llandudno.	Dave Harries	Nov 2024	**08.10.24** A copy of the Final Audit Report was shared with Committee members on 08.10.24 **13.09.24** Report shared with Chief Executive and Director of Corporate Governance
17	**AC24/127.3**	12.09.24	**Internal Audit Progress Report** The second six-month Audit Plan to be circulated to members before coming back to the Committee in November 24 for formal presentation.	Dave Harries	Nov 2024	**09.10.24** Dave Harries circulated the Draft Internal Audit Plan Oct 24 to March 25 to members for comment and this is being presented at the November meeting.
18	**AC24/128.1**	12.09.24	**External Audit Progress Report** Share the Audit Wales Consultation on the Fee Scales 2025-26 with the Committee.	Andrew Doughton	Nov 2024	**07.10.24** The Audit Wales Consultation on the Fee Scales 2025-26 was shared with members outside of the meeting.
19	**AC24/129.1**	12.09.24	**Audit Wales Community Pharmacy Data Matching Pilot** Add to the forward work plan for the January 2025 meeting.	Pam Wenger Philippa Peake-Jones	Nov 2024	**30.09.24** This has been included on the forward workplan for the meeting in January 2025.

Audit Committee

Interim Chief Operating Officer update presentation on “open” ‘limited assurance’ audit recommendations

16th January 2025

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

Internal Audit Recommendations – Chief Operating Officer Limited Audit Reports presented: highlighted below

Report Title	Year	Assurance Level	Number of report recs	Number of recs pending approval	Total number of report recs open
Discharge Arrangements	**2024**	**Limited**	**22**	**7**	**15**
Effective Governance – Integrated Health Community (IHC) Central	**2024**	**Limited**	**6**	**0**	**6**
Planned Care Recovery & Transformation Group	2023	Limited	2	2	0
Unscheduled Care: Urgent Primary Care Centres – Business Case outcomes achieved	2023	Limited	4	0	0
Effective Governance – Ysbyty Gwynedd (YG)	**2022**	**Limited**	**15**	**3**	**12**
Effective Governance - Ysbyty Wrexham Maelor Hospital	2022	Limited	5	5	0
Waiting List Management: Review of the WG initiated Patient Validation Exercise, Risk Stratification and patient removal from lists	2022	Limited	9	9	0

Chief Operating Officer Limited Assurance - Summary

- This presentation focusses on the three COO limited assurance Internal Audits with **"open recommendations"**
- This presentation is supported by a presentation by the IHC Central Team on Complaints, Concerns & Incidents
- The Corporate Governance Directorate has been working with the three senior teams to review the outstanding "open" report recommendations (with oversight and ownership from the COO)
- Good progress has been made. Now a focus on providing evidence of implementation so that it can be reported to the Executive Team, Internal Audit and thereafter the Audit Committee.
- Following review by Internal Audit all open recs for Effective Governance (Ysbyty Gwynedd) reviewed and approved for closure

Chief Operating Officer Limited Assurance - Summary

Report	Discharge Arrangements		Effective Governance - Central IHC		Effective Governance – Ysbyty Gwynedd (YG)	
	Number of open report recs at 30 Nov 24	Number of proposed open report recs at 5 Jan 24	Number of open report recs at 30 Nov 24	Number of proposed open report recs at 5 Jan 24	Number of open report recs at 30 Nov 24	Number of proposed open report recs at 5 Jan 4
No	**15**	**8**	**6**	**2**	**12**	**0**
Comments		High confidence that 7 recs have been implemented, and evidence to support completion of these 7. The remaining 8 will be submitted for consideration of closure end of February 2025.		High confidence that 4 recs have been implemented and evidence provided High confidence that evidence to support completion of remaining 2 will be submitted by end of January 2025		Following IA review of historical recommendations the 12 open recs have been reviewed and approved for closure.

Discharge Arrangements- Summary

PROGRESS TO DATE - SUMMARY	BARRIERS TO IMPLEMENTATION/ DELIVERY	MITIGATION IN PLACE TO ENSURE IMPLEMENTATION/ DELIVERY	PLAN AND TIMELINE FOR DELIVERY
✓ **15 remaining recommendations open without update as at 30 November 2024.** ✓ **7 (of the 15) recommendations have been implemented, and currently sourcing evidence to put forward for closure by end of Jan 25.** ✓ **8 (of the 15) remain open with high confidence of clear completion dates by February 2025 (outlined in next slides)** • Associate Director of Governance worked with COO and new Programme Director for Urgent and Emergency Care to drive improvement against audit tracker. • Regular slot at Operational Leadership Team with Associate Director of Governance embedded into meeting to highlight requirements when needed	• Capacity in UEC Programme Team • Delay in All Wales guidance to all Health Boards that impacts on these recs • 3 (of the 15) medium recommendations have been missed due to the timelines of the action required so deferred timescales have been put in place (461, 462, 463)	• Strengthened UEC Programme Leadership arrangements • Development of new UEC Programme Structure supports the recommendations • WG Guidance now received and reviewed • Monthly meetings with Associate Director of Governance • Oversight by COO	• All outstanding audit actions will be submitted for closure by end of February 2025 • Evidence provided to Corporate Governance Directorate for review by 20 January 2024 • Evidence provided to Executive Team for consideration to close before review by Internal Audit

Effective Governance – Integrated Health Community (IHC) Central- Summary

PROGRESS SUMMARY	BARRIERS TO IMPLEMENTATION/DELIVERY –	MITIGATION IN PLACE TO ENSURE IMPLEMENTATION/ DELIVERY	PLAN AND TIMELINE FOR DELIVERY
✓ **6 remaining recommendations open without update as at 30 November 2024.** ✓ **4 (of the 6) recommendations have been implemented, and currently sourcing evidence to put forward for closure by end of Jan 25. (1285, 1286, 1287, 1288)** ✓ **2 (of the 6) remain open with high confidence of implementation by February 2025 (outlined in next slides)** • IHC Director Team has been successful with senior appointments after a short period of change and this has enabled a focus on "Effective Governance" • Presentation to be made at Audit Committee on Concerns, Complaints and Incidents • Associate Director of Governance worked with IHC Director IHC to support collation and review of evidence.	There have been successful appointment to senior level roles to the IHC Central Team There are now no barriers to the implementation or delivery of these actions	The development and appointment of key IHC Central Director roles has enabled a focus on implementing these recommendations	• All outstanding audit actions will be implemented by end of February 2025 • Evidence provided to Corporate Governance Directorate for review by 20 January 2025 (for those recommendations implemented by end of January) • Evidence provided to Corporate Governance Directorate for review by 20 February 2024 (for those recommendations implemented by end of February) • Evidence to be provided to Executive Team for consideration to close

Effective Governance – Ysbyty Gwynedd (YG) – Summary

PROGRESS TO DATE - SUMMARY	BARRIERS TO IMPLEMENTATION/DELIVERY –	MITIGATION IN PLACE TO ENSURE IMPLEMENTATION/ DELIVERY	PLAN AND TIMELINE FOR DELIVERY
✓ **Following IA review of historical recommendations the 12 open recs have been reviewed and approved for closure** • YG Team able to demonstrate significant progress made. Corporate Governance Team and Associate Director of Governance worked with IHC Director, Dir of Nursing and team to provide focus on providing evidence of recommendations for closure.	N/A	N/A	N/A

Discharge Arrangements – Actions not proposed for closure

PROGRESS TO DATE ON ACTIONS THAT HAVE NOT BEEN PROPOSED FOR CLOSURE	BARRIERS TO IMPLEMENTATION/DELIVERY –	MITIGATION IN PLACE TO ENSURE IMPLEMENTATION/ DELIVERY	PLAN AND TIMELINE FOR DELIVERY
458 Matter Arising 1: Policy, guidance, and training (Design) (Establish an overarching Policy)	All Health Boards in Wales have been awaiting this reissued Hospital Discharge guidance on the advice of the national 6 Goals Programme.	The final draft of the BCU policy will be considered at the UEC Improvement Programme Board, which has membership from partner organisations initially for review before review at the Executive Policy Oversight Group then to Board for approval	• Policy for review in January 2025 Programme Board (16th January). • Receive at Executive Policy Oversight Group in February 2025. • Evidence provided to Corporate Governance Directorate for review by 20 January 2024
459 - Matter Arising 1: Policy, guidance, and training (Design) (Training Needs Analysis across each Acute Hospital Site)	Resource for Training Needs Analysis and implementation	National 6 goals programme has provided funding for 2WTE x Optimal Flow Trainers, from slippage monies, to work across acute and community sites for a period of 12 months	• Evidence provided to Executive Team for consideration to close

Discharge Arrangements- Actions not proposed for closure

PROGRESS TO DATE ON ACTIONS THAT HAVE NOT BEEN PROPOSED FOR CLOSURE	BARRIERS TO IMPLEMENTATION/ DELIVERY	MITIGATION IN PLACE TO ENSURE IMPLEMENTATION/ DELIVERY	PLAN AND TIMELINE FOR DELIVERY
460 - Matter Arising 1: Policy, guidance, and training (Design) **Establish training plan, informed by TNA (to include staff across acute, community hospitals and from disciplines, doctors, nursing, AHP as well as students and including agency / bank staff).**	Resource for Training Needs Analysis and implementation	see action 459 above. As part of the preparatory work for the above trainers a full review of the Loss, data integrity, D2RA compliance will be undertaken to ensure that the roll of the training is targeted to those areas that can benefit the most. support for the training is being provided by the National 6 Goals Lead to 'train the trainers' alongside providing a national training package for roll out (currently in progress)	• Estimated completion of recommendation and available evidence for consideration by Executive Team by 27 February 2025.
464 Matter Arising 1: Policy, guidance, and training (Design) **Develop Comms and engagement plan, informed by TNA to refocus and raise awareness to increase focus & awareness on D2RA pathways, STREAM, etc. (Qtr. 4 – Action numbers 461,462 and 463 were for 2024/25 – Q1 ,Q2 and Q3 which have now passed so the actions can be considered for closure once Rec 464 has been completed.**	Training Needs Analysis and implementation needed before comms and engagement plan	TNA needed before comms and engagement plan can be formalised Comms and engagement plan will be developed concurrently with TNA	• Estimated completion of recommendation and available evidence for consideration by Executive Team by 27 February 2025.

Discharge Arrangements- Actions not proposed for closure

PROGRESS TO DATE ON ACTIONS THAT HAVE NOT BEEN PROPOSED FOR CLOSURE	BARRIERS TO IMPLEMENTATION/DELIVERY	MITIGATION IN PLACE TO ENSURE IMPLEMENTATION/ DELIVERY	PLAN AND TIMELINE FOR DELIVERY
468 – Pathways of Care Design Management: **• Establish formal escalation framework to address and support resolution of Pathways of Care Delays.** **• Ensure working practice complies with Welsh Government requirements.**	The delay in delivery of the training needs analysis and training has delayed the implementation of this recommendation.	As part of the delivery of the training outlined in action 459 above a baseline audit across each site (commencing with Acute Sites will be undertaken using the learning from other Health Boards. This baseline audit, coupled with the evidence base from our performance data related to Loss, Pod delays D2RA compliance etc will form the basis of our targeted roll out plan. We are working with the national 6 goals lead to develop a consistent training plan and to support the rollout a ward blueprint document, with associated supporting guidance, will be developed to further assist in the consistent messaging.	• Baseline audits have been undertaken in each IHC. • As part of the baseline assessment a further audit of those targeted wards will be undertaken and can be submitted. • These wards will be re-audited once the training programme has been delivered to measure the impact. • A resource pack is being developed to support the training programme and can be used as evidence. • Estimated completion of recommendation and evidence for consideration to close by 27 February 2025.

Discharge Arrangements- Actions not proposed for closure

PROGRESS TO DATE ON ACTIONS THAT HAVE NOT BEEN PROPOSED FOR CLOSURE	BARRIERS TO IMPLEMENTATION/DELIVERY	MITIGATION IN PLACE TO ENSURE IMPLEMENTATION/ DELIVERY	PLAN AND TIMELINE FOR DELIVERY
476 Pathway of Care Delays (Management: **• Establish formal escalation framework to address and support resolution of Pathways of Care Delays.** **• Ensure working practice complies with Welsh Government requirements.**	Final confirmation and evidence that that working practice complies with Welsh Government requirements. Clear Urgent and Emergency Care (UEC) Programme arrangements to review and implement responses to recommendations.	As part of the national reporting arrangements each regional partnership board is required to submit a quarterly regional action plan. Refreshing the UEC Improvement Programme. Appointment of Programme Director. The UEC Improvement Programme, incorporating the 6 goals programme, has been refreshed and reset in November 2024 following appointment of the Programme Director.	• The governance structure has been considered by the Programme Board in December 2024. • As part of the monthly programme board, performance against the ministerial priorities will be discussed with partners from the UEC system. • All outstanding audit actions will be implemented by end of February 2025 • Evidence provided to Corporate Governance Directorate for review by 20 January 2024 • Evidence provided to Executive Team for consideration to close by end of February 2025

Effective Governance – Integrated Health Community (IHC) Central

PROGRESS TO DATE ON ACTIONS THAT HAVE NOT BEEN PROPOSED FOR CLOSURE	BARRIERS TO IMPLEMENTATION/DELIVERY	MITIGATION IN PLACE TO ENSURE IMPLEMENTATION/ DELIVERY	PLAN AND TIMELINE FOR DELIVERY
1283 Matter Arising 1: Governance arrangements (Operation) **1.1: Working with the Corporate Governance Directorate, review the governance arrangements within the IHC, ensuring all Terms of Reference are reviewed and updated and consider the dates of meetings to always enable quorum**	Chairs of various meetings within the CIHC have been asked to review the Tor's, Cycle of Business	Chairs of meeting area appointed and these reviews have taken place.	• All outstanding audit actions will be implemented by end of January 2025 • Evidence provided to Corporate Governance Directorate for review by 20 January 2024 (where available)
1284 Matter Arising 2: Financial control assurance (Operation) **2.1: The IHC Director ensures the Financial Control Group complies with its Terms of Reference and actively supports the IHC in delivering its expenditure reduction to meet its allocated resource.**	Consolidation of the financial paper and the project plans, including PIDS for the next PFIG in September.	Terms of Ref for Performance and Information Group with 2 Sets of agenda and minutes from Jan meeting to evidence progress	• Evidence to be submitted to Executive Team for consideration to close ahead of Internal Audit review

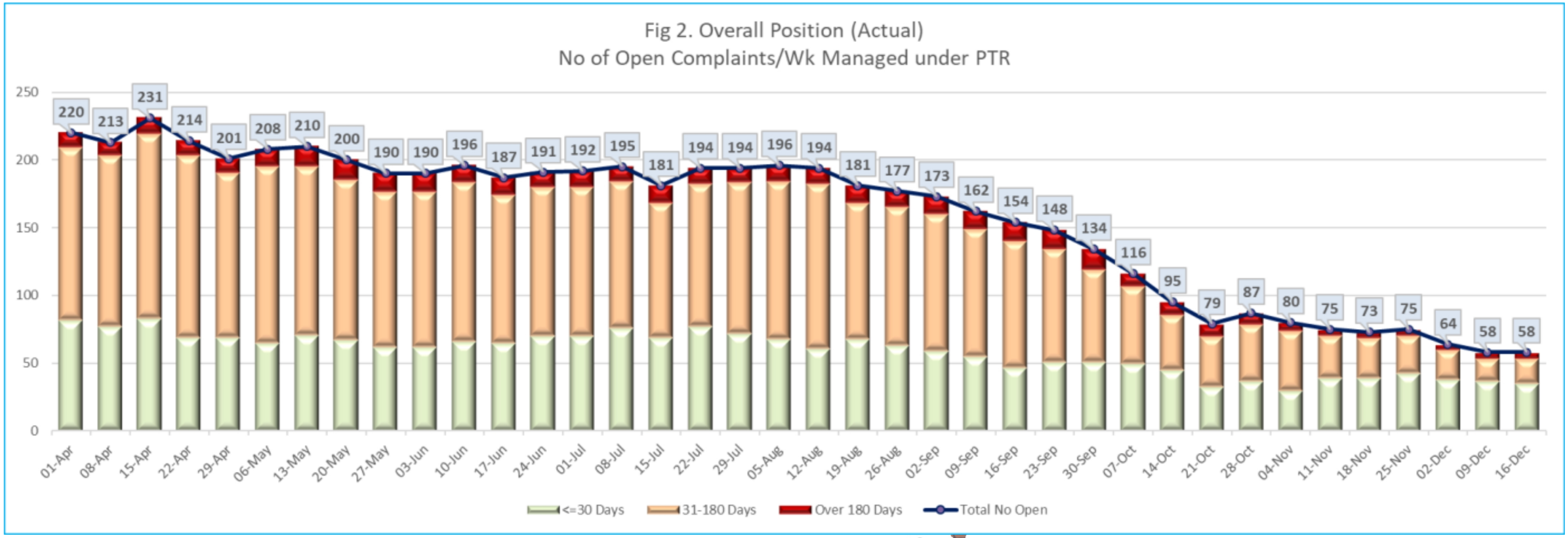
Audit Committee

IHC Central – Patient Concerns, Complaints and Incidents

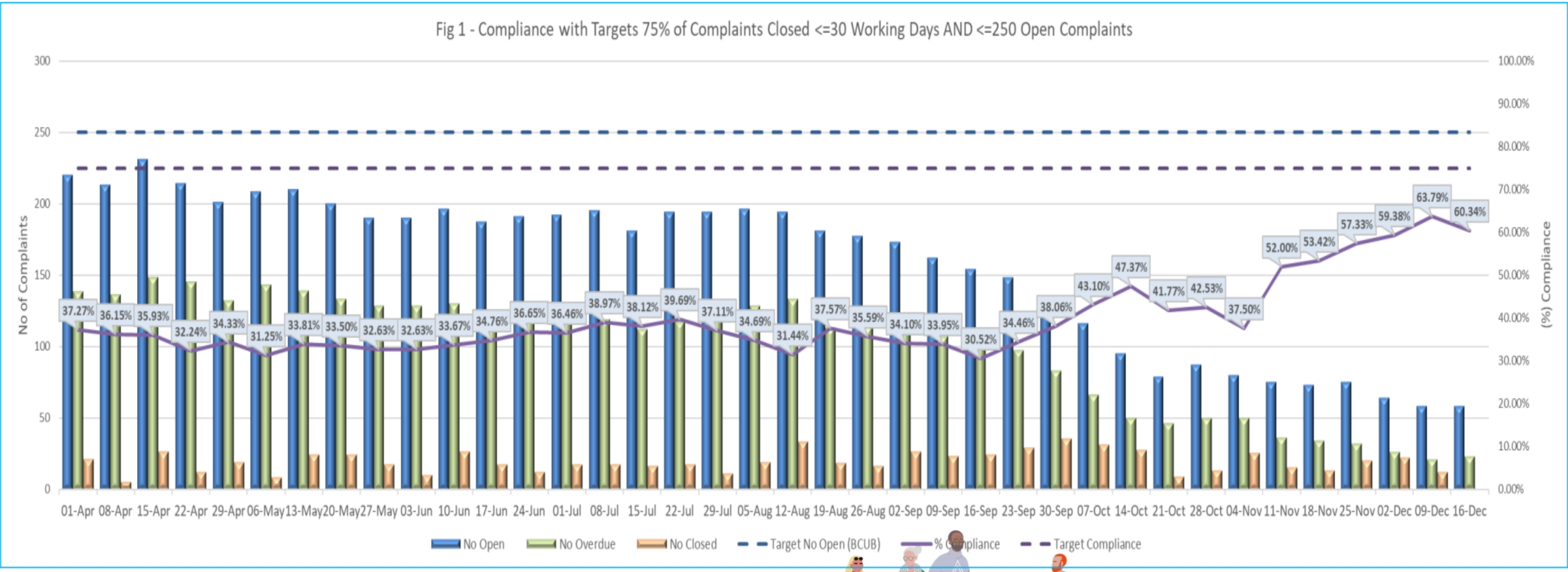
GIG CYMRU NHS WALES
Bwrdd Iechyd Prifysgol
Betsi Cadwaladr
University Health Board

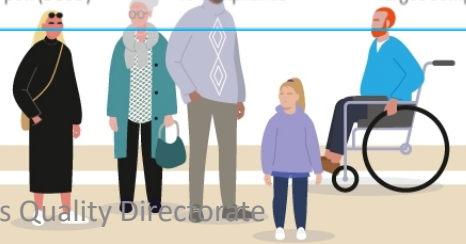
16th January 2025

IHC CENTRAL- COMPLAINTS



IHC CENTRAL- COMPLAINTS





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

Teitl adroddiad: ***Report title:***	Central IHC, formal complaints positional update
Adrodd i: ***Report to:***	Audit Committee
Dyddiad y Cyfarfod: ***Date of Meeting:***	Thursday, 16 January 2025
Crynodeb Gweithredol: ***Executive Summary:***	This paper is to provide the Audit Commitee an update in terms of the Central Integrated Health Community Performance against the 'Putting Things Right' Standards for the Management of formal Concerns. The members of the committee are asked to note improvements made, however there is still work to do to achieve and sustain compliance.
Argymhellion: ***Recommendations:***	The members of the committee are asked to note the report.
Arweinydd Gweithredol: ***Executive Lead:***	Angela Wood, Executive Director of Nursing and Midwifery
Awdur yr Adroddiad: ***Report Author:***	Naomi Holder, Interim Director of Nursing, Central IHC

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

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

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

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

Cyswllt ag Amcan/Amcanion Strategol: ***Link to Strategic Objective(s):***	4. Improving quality, outcomes and experience
Goblygiadau rheoleiddio a lleol: ***Regulatory and legal implications:***	Compliance with NHS executive/Welsh Government standards

Yn unol â WP7, a oedd EqIA yn angenrheidiol ac a gafodd ei gynnal? ***In accordance with WP7 has an EqIA been identified as necessary and undertaken?***	No EqIA not required as no proposed changes have occurred.
Yn unol â WP68, a oedd SEIA yn angenrheidiol ac a gafodd ei gynnal? ***In accordance with WP68, has an SEIA identified as necessary been undertaken?***	No
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)***	No new risks have been identified.
Goblygiadau ariannol o ganlyniad i roi'r *argymhellion ar waith* ***Financial implications as a result of implementing the recommendations***	No new financial implications identified
Goblygiadau gweithlu o ganlyniad i roi'r argymhellion ar waith ***Workforce implications as a result of implementing the recommendations***	No new workforce implications identified
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)*	
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: To continue with the supportive implementation of the process to manage and respond to formal concerns in line with specified timeframes, enabling the IHC to achieve compliance.	
List of Appendices: Appendix 1 Complaints Compliance and Trajectory data.	

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

Teitl adroddiad: ***Report title:***	Audit Wales: Community Pharmacy Data Matching Pilot: Betsi Cadwaladr University Health Board (BCUHB) assurance response
Adrodd i: ***Report to:***	Audit Committee
Dyddiad y Cyfarfod: ***Date of Meeting:***	Thursday, 16 January 2025
Crynodeb Gweithredol: ***Executive Summary:***	The Audit Committee received a paper at its September 2024 meeting outlining that Audit Wales and the NHS Wales Counter Fraud Service conducted a pilot in Swansea Bay and Cwm Taf Morgannwg Local Health Boards to analyse community pharmacy dispensing data to identify areas of high-cost and potential fraud. Although the analysis did not identify any examples of fraud, the Chief Pharmaceutical Officer at Welsh Government has since communicated with all Local Health Boards (LHBs) and sought assurance regarding the processes in place to minimise avoidable expenditure and the risk of fraud and error from prescribing and dispensing expensive items. Areas with high expenditure and/or risk of fraud have been identified as: • Expensive items, particularly where small numbers of contractors make significant claims. • Controls around the cost of Special items without price restrictions in place. This paper details the response provided from the Chief Pharmacist's Office and Counter Fraud team and provides: 1. A summary of the health board ongoing control activities and facilitators; 2. Proposed actions that the Welsh Government could facilitate for improved health board controls; and 3. Future enhancements to controls for consideration/progression.
Argymhellion: ***Recommendations:***	The Committee is asked to note the response provided from the health board's Chief Pharmacist's Office and Local Counter Fraud Specialist.
Arweinydd Gweithredol: ***Executive Lead:***	Lois Lloyd, Chief Pharmacist
Awdur yr Adroddiad: ***Report Author:***	Adam Mackridge, Strategic Lead for Community Pharmacy Sjef Molmans, Local Counter Fraud Specialist

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

Lefel sicrwydd: ***Assurance level:***	Arwyddocaol *Significant* ☐	Derbyniol *Acceptable* ☒	Rhannol *Partial* ☐	Dim Sicrwydd *No Assurance* ☐

	Lefel uchel o hyder/tystiolaeth o ran darparu'r mecanweithiau / amcanion presennol *High level of confidence/evidence in delivery of existing mechanisms/objectives*	Lefel gyffredinol o hyder/tystiolaeth o ran darparu'r mecanweithiau / amcanion presennol *General confidence / evidence in delivery of existing mechanisms / objectives*	Rhywfaint o hyder/tystiolaeth o ran darparu'r mecanweithiau / amcanion presennol *Some confidence / evidence in delivery of existing mechanisms / objectives*	Dim hyder/tystiolaeth o ran y ddarpariaeth *No confidence / evidence in delivery*
Cyfiawnhad dros y gyfradd sicrwydd uchod. Lle bo sicrwydd 'Rhannol' neu 'Dim Sicrwydd' wedi'i nodi uchod, nodwch gamau i gyflawni sicrwydd 'Derbyniol' uchod, a'r terfyn amser ar gyfer cyflawni hyn: ***Justification for the above assurance rating. Where 'Partial' or 'No' assurance has been indicated above, please indicate steps to achieve 'Acceptable' assurance or above, and the timeframe for achieving this:***				
Cyswllt ag Amcan/Amcanion Strategol: ***Link to Strategic Objective(s):***	Access to medicines			
Goblygiadau rheoleiddio a lleol: ***Regulatory and legal implications:***				
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)***	CRR24-05 Financial Sustainability			
Goblygiadau ariannol o ganlyniad i roi'r *argymhellion ar waith* ***Financial implications as a result of implementing the recommendations***	Early identification and fraud reduction			
Goblygiadau gweithlu o ganlyniad i roi'r argymhellion ar waith ***Workforce implications as a result of implementing the recommendations***	NIL			
Adborth, ymateb a chrynodeb dilynol ar ôl ymgynghori ***Feedback, response, and follow up summary following consultation***	NIL			
Cysylltiadau â risgiau BAF: (neu gysylltiadau â'r Gofrestr Risg Gorfforaethol)				

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

Camau Nesaf:
Gweithredu argymhellion

Next Steps:
Implementation of recommendations

The health board's Chief Pharmacist's Office and Counter Fraud Team have confirmed their arrangements to minimise risks of fraud with the Chief Pharmaceutical Officer at the Welsh Government.

Rhestr o Atodiadau:

List of Appendices:

1. Audit Wales Community Pharmacy Data Matching Pilot - Welsh Government Response

Audit Wales: Community Pharmacy Data Matching Pilot

Title:	Audit Wales: Community Pharmacy Data Matching Pilot
Author/s:	Adam Mackridge, Strategic Lead for Community Pharmacy Sjef Molmans, Local Counter Fraud Specialist
Responsible Director:	Lois Lloyd, Chief Pharmacist
Report date:	Tuesday, 08 October 2024
Report version:	V 2.0

1. Situation

Audit Wales and the NHS Counter Fraud Service Wales conducted a pilot in Swansea Bay and Cwm Taf Morgannwg Local Health Boards to analyse community pharmacy dispensing data to identify areas of high-cost and potential fraud. Although the analysis did not identify any examples of fraud, the Chief Pharmaceutical Officer has communicated with all Local Health Boards (LHBs) and sought assurance regarding the processes in place to minimise avoidable expenditure and the risk of fraud and error from prescribing and dispensing expensive items.

Areas with high expenditure and/or risk of fraud have been identified as:

- Expensive items, particularly where small numbers of contractors make significant claims.
- Controls around the cost of Special items without price restrictions in place.

2. Background & Assessment

Controls in place in Betsi Cadwaladr University Health Board (BCUHB)

Expensive items (over £100 in value)

When the reimbursement value for a single item on a prescription exceeds £100, a 2% fee is payable to cover additional costs incurred by the pharmacy due to the 3-month reimbursement delay. The net ingredient cost payable is determined by the Tariff price and the prescribed quantity, both of which are beyond the dispensing pharmacist's control. Therefore, fraudulent claims for this fee on items listed in the Drug Tariff are not possible where an expensive item has been prescribed that amounts to >£100 in value. However, if a contractor frequently claims for expensive items and is an outlier, the Welsh Analytical Prescribing Support Unit (WAPSU) expensive items dashboard will be used to review their activity, with prescriptions being viewed via the Catalogue. Outliers may result from proximity to a hospital issuing high-cost items or from patients requiring particularly expensive medications. Also, as treatment periods extend, the number of expensive item prescriptions may increase, leading to higher fees based on total item costs.

Unlisted and special items

Unlisted items available on the open market and reimbursed based on the wholesaler's listed price for the endorsed product, provide a potential opportunity for pharmacies to supply higher-cost preparations (on which they may have better margins) even though cheaper products may be available. Where these practices are identified, these are tackled and pharmacies encouraged to make supplies of the cheaper product, or prescriptions amended to achieve this.
Products that are imported, or manufactured to order, (specials) and are not listed in parts VIIIB or VIIID of the Drug Tariff, are frequently supplied at significantly increased cost and where these are identified by expensive item monitoring, efforts are made to switch unlisted products to an equivalent that is listed in parts VIIIB or VIIID, where a clinically appropriate alternative exists. Also, in some cases, dispensing may be brought in-house to a hospital pharmacy dispensary where it is possible for the medicines procurement team to obtain the special product at a significantly lower price.
It is important to note that pharmacies are not currently required to prove the purchase of special items, creating a potential opportunity for fraudulent claims. Requiring pharmacies to retain invoices

for non-Part VIII items in an easily retrievable manner could aid investigations into inappropriate claims. This would require changes to the requirements set out for contractors as part of national systems and is currently beyond the control of LHBs.

Currently, whilst pharmacies are required to retain the invoice for such items, there is no requirement for them to retain them in a separate/retrievable format and this can hinder any investigation. Introducing a requirement to retain these invoices in a separate folder, such that they can be easily linked to the original prescription would significantly improve the ability of counter fraud teams to investigation claims and confirm whether the remuneration endorsed is accurate.

Medicines management teams routinely review prescribing of high-cost items to identify potential opportunities to reduce the use of these products. Where it is possible to make changes, this work helps to deliver savings on the cost of the product as well as the expensive item fee that they would have attracted.

Where significant examples of fraud or potential for fraud is identified within BCUHB, this is shared through the networks of Community Pharmacy Leads, Heads of Pharmacy for Primary care, and Counter Fraud Specialists, to aid colleagues in identifying potential issues in their own areas.

As data become richer with the introduction of Electronic Prescription Service (EPS), and Artificial Intelligence (AI) technologies develop, there is likely to be an opportunity to utilise AI approaches to identifying abnormal patterns in claims data to enable more targeted investigations to be carried out. These approaches could be used to develop national dashboards that quickly identify targets for local investigation.

Summary of ongoing control activities and facilitators

- Routine investigation, using the WAPSU Expensive Items Dashboard and the Prescription Catalogue, of pharmacies where the value of Expensive Items claimed is exceptionally high, to confirm that these have not arisen from mis-coding or any fraudulent activity.
- Focused review to reduce prescribing of specials to the minimum and, where they are required, maximising the use of items listed in Part VIIIB and VIIID wherever possible.
- Where appropriate, explore repatriation of very high-cost Specials to hospital supply routes where this is the most cost-effective option for that item/patient.

3. Conclusion

Future enhancements to controls for consideration/progression

- The widespread rollout of the Electronic Prescription Service, anticipated in 2024/25, will provide new opportunities to monitor and investigate potentially fraudulent activity, with Catalogue being searchable by the dispensing pharmacy, as well as by prescribing clinician.
- Opportunities to make use of Artificial Intelligence technologies to examine dispensing and claims data should be explored further by the Post-Payment Verification and Counter Fraud Teams across Wales.

Prif Swyddog Fferyllol
Chief Pharmaceutical Officer

Llywodraeth Cymru
Welsh Government

By email to:

Directors of Pharmacy, Local Health Boards

Cc:

Directors of Finance, Local Health Boards, Directors of Primary Care

10 September 2024

Dear Colleague,

Audit Wales Community Pharmacy Data Matching Pilot

Earlier this year, Audit Wales published the findings of the Community Pharmacy Data Matching Pilot it undertook with the NHS Wales Counter Fraud Service. The pilot which included 200 community pharmacies in the Swansea Bay and Cwm Taf Morgannwg University Health Boards, involved analyses of every prescription dispensed at these pharmacies over a three year period to identify points of concern relating to anomalies, potential fraud, and areas of high cost. The report of the pilot can be accessed on Audit Wales' website.

The extensive pilot covering around 30% of pharmacies in Wales found no evidence of systemic fraud or error. However, Audit Wales identified three areas of potential concern relating to pricing errors, dispensing expensive items, and specials, and queried whether health boards had adequate arrangements in place to identify and prevent fraud or error in these areas.

The Welsh Government has responded to Audit Wales' findings and a copy of the response is enclosed with this letter.

Of the issues of concern raised by Audit Wales, it is not proposed to take any further action in respect of pricing errors for the reasons set out in the Welsh Government's response. However, in response to Audit Wales' findings this letter asks health boards to provide assurance that appropriate systems are in place to prevent losses arising in respect of

Rydym yn croesawu derbyn gohebiaeth yn Gymraeg. Byddwn yn ateb gohebiaeth a dderbynnir yn Gymraeg yn Gymraeg ac ni fydd gohebu yn Gymraeg yn arwain at oedi.

We welcome receiving correspondence in Welsh. Any correspondence received in Welsh will be answered in Welsh and corresponding in Welsh will not lead to a delay in responding.

BUDDSODDWYR MEWN POBL | INVESTORS IN PEOPLE

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unnecessary or inappropriate prescribing and dispensing of expensive medicines including specials.

Based on Audit Wales' findings we consider additional checks are likely to support reducing avoidable expenditure as well as loss from error or fraud on expensive medicines including liquid preparations and specials. Whilst I am aware health boards may undertake some checks on expensive prescriptions already, this letter seeks your assurance that robust arrangements are in place for such checks to be undertaken as a matter of routine within your health board.

To support health boards in undertaking these checks the Wales Analytical Prescribing Support Unit (WAPSU) has developed an interactive expensive items dashboard which can be used to identify expensive prescriptions prescribed and dispensed in the health boards area. The dashboard provides information on prescribing of expensive items by general practitioners and hospital outpatient departments and dispensing of these items by community pharmacies in the health board's area. Dispensing information includes prescriptions originating from a general practice or hospital in another health board or equivalent NHS body outside Wales.

The expensive items dashboard can be accessed here. Directors of Pharmacy have been granted access to the dashboard and health boards can request additional users are given access by emailing AWTTC@wales.nhs.uk.

I would be grateful if you could confirm what arrangements are or will be put in place to ensure your health board minimises avoidable expenditure and the risk of fraud and error from prescribing and dispensing expensive items. Responses should be submitted by email to Pharmacyand.PrescribingBranch@gov.wales by no later than 29 November 2024. If you have any queries in relation to this letter please feel free to contact me using the same email address.

Yours sincerely

Andrew Evans FRPharmS
Prif Swyddog Fferyllol/Chief Pharmaceutical Officer
Llywodraeth Cymru/Welsh Government

Audit Committee

Executive Director update presentation on open audit recommendations

GIG CYMRU NHS WALES

Bwrdd Iechyd Prifysgol
Betsi Cadwaladr
University Health Board

Limited/No assurance Audit Reports presented:

Internal Audit/ Audit Wales	IA/AW ref	Report Title	Year	Assurance Level	Number of report recommendations	Number of recommendations implemented/ complete /pending approval	Total number of report recommendations open
Internal	BCU_SSU_2324_02	Orthopaedic Surgical Hub Llandudno Hospital Internal Audit Report	2024	Limited	19	13	6

Orthopaedic Surgical Hub Llandudno Hospital Internal Audit Report

PROGRESS TO DATE	BARRIERS TO IMPLEMENTATION/ DELIVERY – *include as much context as possible*	MITIGATION IN PLACE TO ENSURE IMPLEMENTATION/ DELIVERY	PLAN AND TIMELINE FOR DELIVERY
Time: • Current operational date is October 2025 with a potential further delay under discussion. • Enabling works commenced on site in Feb 24. • Main works commenced on site in Nov 24 • The Aberconwy Ward refurb milestone is on track to be met in March 2025 **Cost:** Need capital to input here including outturn cost and impact. Actions to mitigate incl ordering of equipment etc.	**Time:** Contractor related issues in providing a project plan that is deliverable. BCUHB has engaged with an external planner from GLEEDS to support. **Cost:** The project is currently forecasting an underspend overall from the amount released to the Health Board, excluding contingency held by Welsh Government. We would expect to see an increase in costs based on an elongated programme, however, would not expect this to exceed the agreed amount.	**Time:** Strengthened Governance on Capital side to be implemented in January, including instructions to Contractor for analysis on delays. Support from Shared Services and addition planning support to remain in place **Cost:** Cashflow has been revised for 24/25 and communicated with Welsh Government. Discussions with Contractor will continue in January regarding new timeline for completion and associated costs	**Time:** Revised schedule to be approved by February confirming handover date **Cost:** Monthly cost reviews continue

Orthopaedic Surgical Hub Llandudno Hospital Internal Audit Report

PROGRESS TO DATE	BARRIERS TO IMPLEMENTATION/ DELIVERY – *include as much context as possible*	MITIGATION IN PLACE TO ENSURE IMPLEMENTATIO N/ DELIVERY	PLAN AND TIMELINE FOR DELIVERY
3.1: The PEP should be reviewed and updated to reflect this project.	Completed	Completed	• Completed Dec 2024
4.3: Retrospective approval should be obtained to appoint the preferred contractor for the main works project.	No retrospective approval	Contract was approved at Board level as per agreement at the time.	• No further action

Orthopaedic Surgical Hub Llandudno Hospital Internal Audit Report

PROGRESS TO DATE	BARRIERS TO IMPLEMENTATION/ DELIVERY – *include as much context as possible*	MITIGATION IN PLACE TO ENSURE IMPLEMENTATIO N/ DELIVERY	PLAN AND TIMELINE FOR DELIVERY
4.4: The UHB should ensure that changes of works packages post tender are appropriately reported and approved.	4.4: Agreed - Changes to works packages are approved in line with the health board's capital procedures manual and the change control process noted within the PEP. Going forward full cost report will be issued to the project board for information / approval. Cost report No 6 included in September Project Board Meeting. Any significant variations are highlighted within PM highlight report.	Actioned - Current variations that were highlighted at the September 2024 Project Board were approved as per the Capital Manual process.	• Minutes of Project Board include evidence

Orthopaedic Surgical Hub Llandudno Hospital Internal Audit Report

PROGRESS TO DATE	BARRIERS TO IMPLEMENTATION/ DELIVERY – *include as much context as possible*	MITIGATION IN PLACE TO ENSURE IMPLEMENTATIO N/ DELIVERY	PLAN AND TIMELINE FOR DELIVERY
5.1: Formal Welsh Government approval is required to avoid using the Project Bank Account at both the enabling and main works contracts.		5.1: Agreed - The contractor is willing to set up a project bank account, we are currently exploring the process and timescale. Contractor have been instructed to progress.	Awaiting confirmation from contractor that it has been opened

Orthopaedic Surgical Hub Llandudno Hospital Internal Audit Report

PROGRESS TO DATE	BARRIERS TO IMPLEMENTATION/ DELIVERY – *include as much context as possible*	MITIGATION IN PLACE TO ENSURE IMPLEMENTATIO N/ DELIVERY	PLAN AND TIMELINE FOR DELIVERY
8.1: Noting that meetings to discuss design are now held virtually, consideration should be given to how formal sign off can be captured in the future.	8.1: Agreed - Meetings to confirm sign off have been recorded in teams and some responses have also been confirmed by email as evidence. We will review alternative approaches that support virtual sign off going forward.	A review of the Capital Manual procedures is to commence and will reflect the changes in how formal sign off's are recorded following the shift from in person to Teams meetings.	Its targeted this is completed during 25/26.

Orthopaedic Surgical Hub Llandudno Hospital Internal Audit Report

PROGRESS TO DATE	BARRIERS TO IMPLEMENTATION/ DELIVERY – *include as much context as possible*	MITIGATION IN PLACE TO ENSURE IMPLEMENTATIO N/ DELIVERY	PLAN AND TIMELINE FOR DELIVERY
9.1: The condition tracker maintained by the UHBs design team should be shared and discussed at Project Board Meetings.	9.1: Agreed - condition tracker to be requested from Architect and submitted as appendices to highlight report.	Tracker has been shared and all conditions closed	• Closed

Consultant Job Planning

Internal Audit Report

2024/25

Betsi Cadwaladr University Health Board

Unsatisfactory Assurance

Contents

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Findings & Agreed Action Plan 4

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Review Reference	BCU-2425-20
Fieldwork	October 2024 - November 2024
Executive Sign Off	2 January 2024
Audit Committee	January 2025
Executive Lead	Interim Medical Director & Deputy Director of People
Audit Team	Dave Harries, Head of Internal Audit
	Nicola Jones, Deputy Head of Internal Audit

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

Executive Summary

Purpose

To review arrangements across the health board for management of the systems and controls in place for consultant job planning.

Overview

A job plan is a professional and contractual obligation for consultants and employers and sets out the duties, responsibilities and outcomes and the support and resources provided by the employer for the coming year. Job plans record the work that a consultant will undertake for the Betsi Cadwaladr University Health Board (the health board), split by Direct Clinical Care (DCC) and Supporting Professional Activities (SPA).

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

- The is no agreed Health Board policy in place for job planning. The Health Board must agree and publish its draft policy *Job Planning for Consultants, Speciality and Specialist Doctors: Betsi Cadwaladr University Health Board* as a matter of urgency to ensure standardisation and equity across all its services.
- Overall, the Health Board is not compliant with the requirements set out in the *Amendment to the National Consultant Contract in Wales* where annual job plans are required. Compliance is generally poor, at the time of this report thirty-four percent (34%) of job plans had expired.
- There were limited personal and service/team objectives evident throughout our sample and it is unclear why operational management are approving job plans without a key element of the national contract included. The recording of the Health Board's strategic goals was evident throughout our sample; however, these are outdated and do not reflect the strategic objectives detailed in the 2024-2027 Three-Year Plan.
- The Health Board pays Consultants for whole sessions and do not include part sessions (where agreed in the job plan). This may adversely impact the delivery of clinical sessions and impact the timely delivery of services to patients.
- It is unclear how the delivery and outcomes of sessions agreed in job plans are measured to ensure that clinical capacity is utilised effectively. For example, the number of patients to be seen in clinics/session time and theatre time and whether this is being achieved.
- Generally, there is inadequate reporting of job plan performance and scrutiny at operational management level, with limited use advised of the job plan dashboard. The Medical Workforce Group has not been meeting in accordance with its Terms of Reference, however its assurance reporting to the executive has not happened due to the People & Culture Executive Delivery Group also not meeting. There is little focus on medical and dental workforce matters reported to the People & Culture Committee.

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

Scope & Assurance Summary

	Objectives	Related Findings	Assurance
1	There is relevant and up to date procedures in place that are available to staff and align to the All-Wales guidance.	1, 2, 3 & 4	**Unsatisfactory**
2	Job plans accurately reflect both the individual and organisation activity requirements and are completed in a timely manner.	5, 6	**Limited**
3	Job plans include outcomes that are linked to the health board's organisational objectives, and the level of achievement is subject to appropriate assessment.	7	**Unsatisfactory**
4	Completed job plans reconcile to system records and session payments are correct.	8, 9	**Limited**

5	The completion rates of job plans are monitored and reported to an appropriate forum, with further escalation if there is low compliance.	10, 11	**Unsatisfactory**

Management Actions

8	3
High Priority	Medium Priority

Themes

- Communication & Engagement
- Contractual
- Finance Management & Control
- Governance
- Information, Data Quality & Data Accuracy
- Performance Monitoring
- Policies & Procedures
- Reporting
- Resourcing

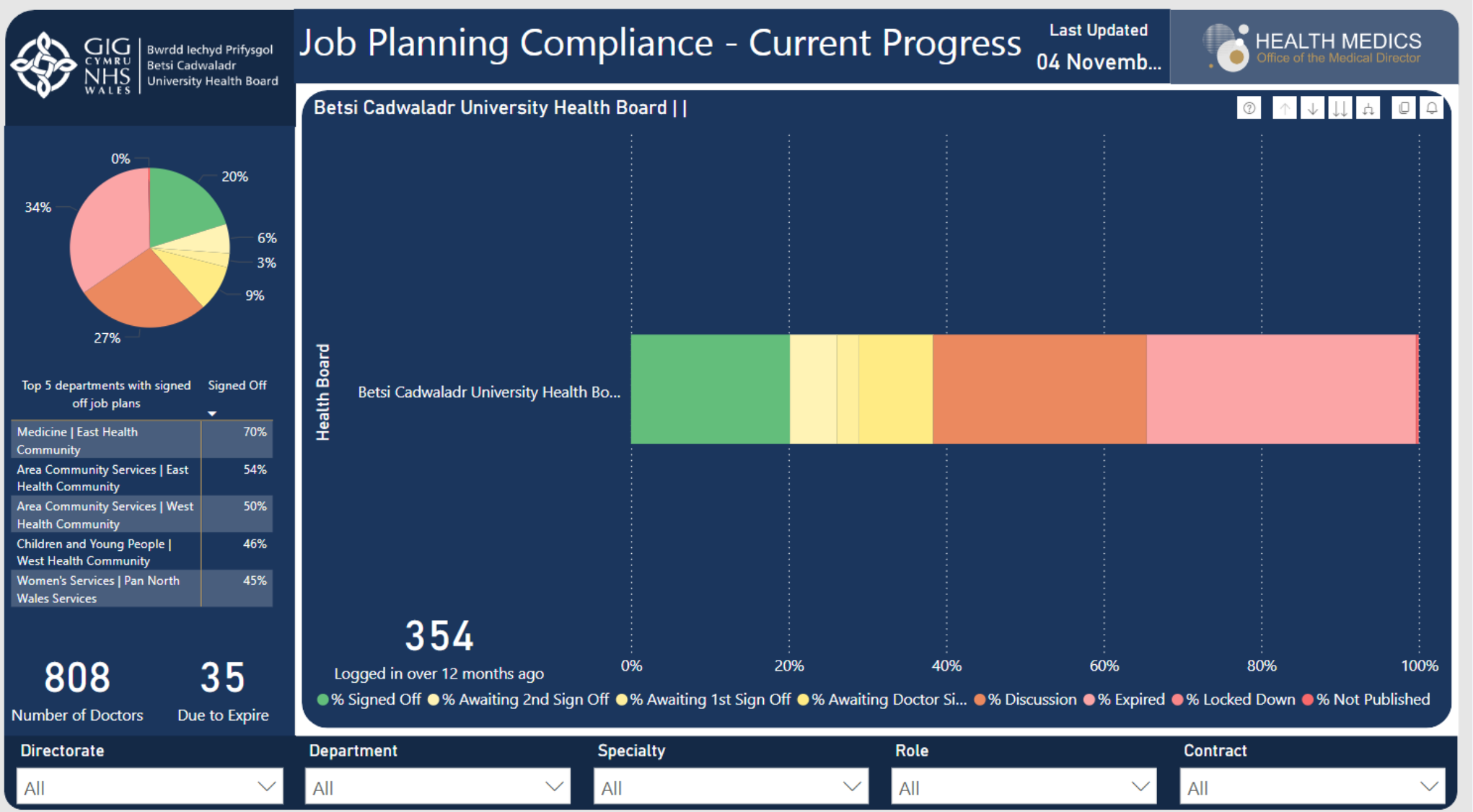
Risk Types

Quality or Safety Issues

Legal & Regulatory Non-Compliance

Financial Loss

At a Glance - Job Planning Compliance Dashboard as of 4 November 2024



Source: Screen shot taken 6 November 2024, Job Planning Compliance - Current Progress - Power BI via the Health Board Job Planning intranet site for Consultant and Specialty and Associate Specialists (SAS) Doctor.
The data does not identify job plans which are with respective Medical Directors for resolution due to non-agreement with local management.

Findings & Agreed Action Plan

Objective 1: There is relevant and up to date procedures in place that are available to staff and align to the All-Wales guidance. **Unsatisfactory**

Overview / Summary of Observations

There is no Health Board Policy or Standard Operating Procedure currently published to support both Operational Managers and the Consultant to fulfil the requirements of the *Amendment to the National Consultant Contract in Wales*. This issue was raised by Wales Audit Office (Audit Wales) in its NHS Consultant Contract review in 2011 and follow-up of recommendation progress in 2016.

We recognise steps were taken by the Office of the Medical Director in developing a draft policy in June 2023 which was issued for comment, however several issues have been raised with the policy that have not been resolved, and industrial action has curtailed progress.

To fulfil the requirements of job planning, the Health Board uses an EJob Plan system which is hosted by the supplier on the cloud. The system has replaced paper and enables the accurate calculation of sessions as well as reducing the administration time of clinicians and managers. There is an intranet page for job planning which includes a YouTube 'Job Planning and the Job Plan Review' video from the British Medical Association (BMA) and signposting to EJob Plan user guide documentation. Through discussions, we were advised that the system has some functionality limitations, but we have not undertaken a system specific review to corroborate the issues raised.

Medical and Dental contracts are more complex than other staff group contracts and require expertise to support clinical services. We found there is no dedicated Medical Staffing function to support clinical services with both contractual matters and wider people performance issues.

There is one officer dedicated to Job Planning, based in the Office of the Medical Director, to support all services with Consultant and SAS Doctors with job plans.

	Key Findings	Risk & Impact	Agreed Management Action
1	**Health Board Policy** The Health Board has no Policy or Procedure detailing the expectations of both management and Consultant in discussing and agreeing the Job Plan in line with the nationally agreed Consultant Contract. Based on our review, it has not had a comprehensive Policy in place for thirteen years, per the original review undertaken by the former Wales Audit Office in 2011. Limited training is provided to all individuals involved in the job plan process.	Inability to demonstrate compliance with the Amendment to the National Consultant Contract in Wales.	**Agreed Action:** • Review and update Job Planning policy to be aligned with All Wales guidance and nationally agreed Consultant Contract, which is readily accessible to staff. • Continue with regular updates of compliance to IHC/Division, to reflect organisational job planning status. • Complete a training needs analysis across BCUHB to establish training for medical and management teams by March 2025. • Develop and deliver targeted training sessions for managers and consultants by April 2025.

			Expected Evidence of Implementation: Updated policy *Job Planning for Consultants, Speciality and Specialist Doctors: Betsi Cadwaladr University Health Board* , which has been ratified and issued. Evidence of training and support provided to Consultant and management to ensure the process is effective and supports both parties.
	Theme: Policies & Procedures	**High Priority** Control Design	**Officer:** Interim Medical Director **Date:** 31 May 2025
2	**Medical Resourcing** Through discussion with all clinical directorates/divisions, each advised on the limited support available to them in relation to Medical and Dental Contract matters, following the removal of a dedicated medical staffing resource. We have confirmed this was absorbed in 2019. The Office of the Medical Director is responsible for some people related functions, with limited contingency arrangements in the event of annual leave/prolonged absence. There is possibility of duplication within the Health Board through the operation of standalone people systems and development of silo expertise.	Lack of dedicated support for operational leaders to ensure compliance with the medical and dental contract.	**Agreed Action:** • Provide comprehensive training for consultants and managers on job planning processes, focusing on linking individual objectives with organisational goals. • Establish clear communication channels for escalating job planning concerns or discrepancies.
			Expected Evidence of Implementation: Details and records of training provided to consultants and managers on the job planning process. Documented details of key contacts and escalation route for job planning issues.
	Theme: Resourcing	**Medium Priority** Control Operation	**Officer:** Interim Medical Director **Date:** 30 September 2025
3	**EJob Plan First and second sign-off** Through a review of first and second sign off details in the Ejob plan system, and verification with the seven clinical directorates / divisions, there were several issues noted with the accuracy of the information on the system . This includes gaps in second approvers, officers no longer in post, and	Job Plans are not approved by officers delegated to do so, and do not clearly reflect the requirements of	**Agreed Action:** • Develop a standardised and systematic approach to monitor job plan completion rates, reporting results to the appropriate forums. • Create escalation protocols for addressing non-compliance promptly and on regular basis and appropriate form.

	inconsistency with operational management included as either first or second sign off. There was also test data included in the live system.	the service, which could result in services not being delivered effectively.	**Expected Evidence of Implementation:** The first and second sign-off details are shared regularly with the respective Director and Medical Director to confirm the accuracy of both approvers in line with expectations of the Policy. All test data is removed from the live system and reserved for the Training module of the system.
	Theme: Governance	**High Priority** Control Design	**Officer:** Interim Medical Director **Date:** 30 April 2024
4	**Business Continuity** The EJob Plan system is a hosted platform on the cloud and is wholly reliant on an internet connection. We have not reviewed the contractual arrangement regarding disaster recovery arrangements with the supplier. We have confirmed there is no documented business continuity plan in place centrally but are unsighted whether there are arrangements in place locally.	Potential loss of the Ejob plan system will impact the ability of the Health Board to comply with the National Consultant Contract in Wales.	**Agreed Action:** • The system is web based so accessible anywhere and backup by Allocate. • Testing and approval of Medical Dental and Elements report from ESR (sessional payments) which will all periodically audits to verify that job plans reconcile with system records and ensure session payments are accurate. • Automate data entry processes wherever possible to reduce human error in transferring information to ESR.
			Expected Evidence of Implementation: Confirmation of a co-ordinated business continuity plan for the EJob Plan system in the event of unplanned system downtime.
	Theme: Information & Data Management	**Medium Priority** Control Design	**Officer:** Deputy Director of People **Date:** 30 September 2024

Objective 2: Job plans accurately reflect both the individual and organisation activity requirements and are completed in a timely manner.	**Limited**

Overview / Summary of Observations

There are eight hundred and eight (808) Consultant and Specialty and Specialist (SAS) Doctor job plans recorded in the EJob Plan system; five hundred and sixty-five (565) are Consultant – We have not corroborated that this is the complete list o consultants and SAS doctors.

The national contract requires:

- *1.22 The job plan will be agreed between the employer and the individual Consultant on appointment to the post and reviewed annually at the job plan review.*
- *1.27 Job plan reviews for all Consultants will take place within one month of the Consultant's incremental date, unless jointly agreed otherwise.*
- *1.28 It is the employer's responsibility to arrange the job plan review within the relevant timescale…*

Health Board achievement against the annual review requirement is poor, with only 20% signed off at the time of this report (4 November 2024); 34% are reported as expired with a further 27% at discussion stage.

All job plans in our sample had clear timetables and summary of activities assigned with some minor omissions regarding place of work and clarity concerning what the additional Supporting Professional Activity (SPA) session was to be used for. However, the Service Outcome section of the job plan was lacking SMART objectives.

We were advised that one division includes a draft job plan at advert stage which has been subject to Royal College review at time of agreeing the advert – we consider this good practice as applicants know in advance the draft sessions and location where the sessions will be fulfilled.

Key Findings		Risk & Impact	Agreed Management Action
5	**Job Plan annual review** Through our review meetings, we were advised that undertaking the job plan within one month of the incremental date is not something that is actively followed as the system does not capture the data. The Health Board is not compliant with its responsibility for ensuring annual job plan reviews are undertaken every twelve months and ensuring adequate narrative is completed around additional SPA sessions and place of work.	Non-compliance with the Amendment to the National Consultant Contract in Wales.	**Agreed Action:** • The Medical Dental and Elements pay report from ESR once approved will identify employment start date, which would be their incremental date. • Use the power BI compliance report as an evaluation framework to assess the level of achievement of these outcomes regularly. • To ensure detailed information around SPA sessions is captured within job plans by IHC/Division. **Expected Evidence of Implementation:** Overall increase in signed off job plans as captured by the Job Planning dashboard and corresponding job plans have all required information completed.
	Theme: Contractual	**High Priority** Control Operation	**Officer:** Interim Medical Director and Deputy Director of People **Date:** 30 April 2025

6	**Directorate/Specialty objectives are explicit** There is a generic statement within the Service Outcomes section of job plans *"To ensure service and jobplan aligned to deliver CPG and wider BCU Strategic direction", (sic).* The Service Outcomes section overall was either incomplete or noted *"During job plan discussions need to review this"*. From our review, we are unclear how management are approving job plans without expected service objectives. We note different approaches taken in agreeing team objectives where colleagues collectively agree on the service requirements and then meet individually as part of the job plan approach to agree individual objectives. These should be SMART and recorded in the system.	Inconsistent and non-achievement of service/team objectives to deliver high quality and safe clinical services.	**Agreed Action:** • Establish with the team a cross-departmental assessment to address identified areas not complete, for example service outcomes not recorded. • Schedule regular reviews of job planning practices to ensure continuous improvement and compliance with audit standards. **Expected Evidence of Implementation:** Evidence of quality review of job plans. All job plans include SMART objectives within the Service Outcomes section.
		High Priority	**Officer:** Interim Medical Director
	Theme: Performance Monitoring	Control Operation	**Date:** 30 April 2025

Objective 3: Job plans include outcomes that are linked to the Health Board's organisational objectives, and the level of achievement is subject to appropriate assessment.	**Unsatisfactory**

Overview / Summary of Observations

We found that all job plans included the Health Board's seven Strategic Goals and recognise these are set in the system.

However, the seven goals recorded in each job plan do not mirror the five strategic objectives set out in the Health Board Three-Year Plan for 2024-27. In addition, we could find no measurable outcome specified and agreed between management and the Consultant that would support measuring achievement against Health Board objectives.

It is also unclear how the delivery and outcomes of sessions agreed in job plans are measured, to ensure that clinical capacity is utilised appropriately, for example, the number of patients to be seen in clinics / session time and theatre time and whether this is being achieved. We are advised there are nationally available measures available for clinics, and through discussion with areas, we were advised that there is little use of measurable data to confirm the expectations of what can be delivered in clinical sessions.

Key Findings		Risk & Impact	Agreed Management Action
7	**Evidencing achievement of the Board objectives**	Job plans are not framed to deliver the Board's	**Agreed Action:** To revisit with Office of the Medical Director the current outcomes section of the job plan and align more fully with the PADR process for other staff groups to ensure objectives can

	Whilst there were strategic goals detailed in the Board Outcomes section of the job plan, they did not reflect the current strategic objectives, and there were no measurable outcomes agreed from which it could be evidenced as being worked to/achieved.	Strategic Objectives, thus undermining the ability of the Consultant & SAS Doctor to support in achieving them.	be aligned to allow Consultant & SAS Doctors to support in achieving them. **Expected Evidence of Implementation:** Updated Strategic Objectives included for all Job Plans with local agreement at each job plan meeting where outcomes can be noted as specific and measurable.
		High Priority	**Officer:** Interim Medical Director
	Theme: Communication & Engagement	Control Operation	**Date:** 30 April 2025

Objective 4: Completed job plans reconcile to system records and session payments are correct. — **Limited**

Overview / Summary of Observations

Through our comparison of twenty-two job plans to pay data, we found the Health Board pays in whole sessions; however, our sample noted several plans agreed that were over a whole session (i.e. 10.6 sessions) but the individual was not paid this. This could lead to a reduction in clinical activity where the Consultant reduces their time to reflect the sessions paid.

We were advised that one division have regular meetings to verify pay to sessions across specialties but have not corroborated any outcome from these meetings.

Our review of the job plans also found individuals with other assignments for different roles that were outside those of the clinical service we reviewed, but these were not evident as being raised in discussion with the substantive role.

	Key Findings	Risk & Impact	Agreed Management Action
8	**Regular review of payments to agreed job plan commitments** We identified six (27%) of the twenty-two job plans with a variance between the sessions paid and that recorded on the job plan. We also found a variance in Intensity Band payments and are unclear whether these payments are subject to annual review or simply roll-over. The payment of only whole sessions could adversely impact the Health Board to deliver against its waiting lists as this does not always reflect the agreed job plan.	Clinical activity is reduced to reflect the sessions paid as opposed to the sessions agreed.	**Agreed Action:** • Medical Dental and Elements report from ESR (under development) will be able to flag up issues with sessional pay, intensity bandings. **Expected Evidence of Implementation:** Directorates/Divisions undertake regular reviews of sessions and allowances paid to ensure the Consultant is being paid in accordance with the agreed job plan.
		High Priority	**Officer:** Deputy Director of People

	Theme: Financial Management & Control	Control Design	**Date:** 30 April 2025
9	**Additional sessions undertaken outside of the substantive post** We found instances where some Consultants are undertaking additional sessional work for the Health Board, but these are not fully reflected/declared within their substantive job plan – This could lead to a Working Time Directive breach.	Working Time Directive is breached as management are not sighted on additional sessions contracted directly with the Consultant.	**Agreed Action:** • IHC/Divisions need to have detailed meetings with Consultants to breakdown the job plan, to identify what sessions are additional and justification of still being required to be completed. **Expected Evidence of Implementation:** Through the annual job plan meeting, operational management document whether the Consultant is undertaking additional work outside the main job plan and note the professional view of the Clinical Lead/Director and/or Medical Director.
		Medium Priority	**Officer:** Interim Medical Director
	Theme: Resourcing	Control Operation	**Date:** 30 September 2025

Objective 5: The completion rates of job plans are monitored and reported to an appropriate forum, with further escalation if there is low compliance.	**Unsatisfactory**

Overview / Summary of Observations

There is no reporting of Consultant & SAS Doctor Job Plan performance to the Health Board or People & Culture Committee. The People Operations Report is presented at each People & Culture Committee and includes high-level metrics on vacancies, turnover, sickness, mandatory training and workforce profile for medical and dental colleagues.

Through our discussions with the seven clinical divisions, the approach to job plan reporting varies with some having a standing agenda item on their monthly consultant meeting, and others not reporting anything on job plan completion.

A Medical Workforce Group (MWG) has been established but has not been meeting monthly as set out in its Terms of Reference (ToR), with meetings regularly cancelled. The MWG reports to the People & Culture Executive Delivery Group, however this has also not been meeting.

Job Plan performance data is available via Betsinet, with a dashboard reporting overall performance which is customisable to specific services, however through discussions its use appears limited.

At the time of our review 34% of job plans have expired but this has not been openly reported to the People & Culture Committee.

Key Findings	Risk & Impact	Agreed Management Action

10	**Medical and Dental Job Plan reporting** There is inadequate reporting of medical and dental job plan performance, across the Health Board from operational management to the Executive and associated scrutiny meetings up to Committee for assurance.	Medical and Dental staff reporting is not subject to scrutiny.	**Agreed Action:** • Compliance report sent out each week to IHCs/Division which breaks down job plan compliance and can be filtered to obtain more detail as required.
			Expected Evidence of Implementation: Regular reporting on Medical and Dental job plan performance with actions being taken to ensure annual compliance reported through both operational and executive through to People & Culture Committee via the People Operations Report.
		High Priority	**Officer:** Deputy Director of People
	Theme: Reporting	Control Operation	**Date:** 30 April 2025
11	**Medical Workforce Group & People & Culture Executive Delivery Group (EDG)** The Medical Workforce Group (MWG) has responsibility in its Terms of Reference that it *"….will receive regular reports (on job plans) as per its Cycle of Business"* but we have been unable to verify they have actually received any reports for assurance recently. Of the ten MWG meetings scheduled to take place this calendar year, only three have taken place (April, June and September 2024). The MWG provides assurance to the People & Culture EDG although we have been advised this meeting has similarly not been taking place, exposing an operational gap in control and assurance across the Health Board.	Medical and Dental staff reporting is not subject to scrutiny.	**Agreed Action:** • To establish the People and Culture EDG which the Medical Workforce Group will report into. The TORs for Medical Workforce are to be reviewed. • Dashboards will be provided to Medical Workforce Group • Reports are sent out on weekly basis to IHC/Divisions with link to access Power BI to review all relevant data.
			Expected Evidence of Implementation: Both Medical Workforce Group and the People & Culture EDG meetings re-commence with regular reporting on medical and dental job plan achievement happening and holding operational management to account on performance.
		High Priority	**Officer:** Deputy Director of People
	Theme: Governance	Control Operation	**Date:** 30 April 2025

Appendix A

Assurance Opinion

Substantial

Few matters require attention and are compliance or advisory in nature.

Low impact on residual risk exposure.

Reasonable

Some matters require management attention in control design or compliance.

Low to moderate impact on residual risk exposure until resolved.

Limited

More significant matters require management attention.

Moderate impact on residual risk exposure until resolved.

Unsatisfactory

Action is required to address the whole control framework in this area.

High impact on residual risk exposure until resolved.

Advisory

Given to reviews and support provided to management which form part of the internal audit plan, to which the assurance definitions are not appropriate.

These reviews are still relevant to the evidence base upon which the overall opinion is formed.

Prioritisation of Findings

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

Disclaimer

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

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

The report is based on the review work undertaken and is not necessarily a complete statement of all weaknesses that exist or potential improvements. Whilst every care has been taken to ensure that the information provided in this report is as accurate as possible, no complete guarantee or warranty can be given with regard to the advice and information contained.

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

Public Sector Internal Audit Standards

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

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

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

Teitl adroddiad: ***Report title:***	Update Report on Internal and External Audit Recommendations
Adrodd i: ***Report to:***	Audit Committee
Dyddiad y Cyfarfod: ***Date of Meeting:***	Thursday, 16 January 2025
Crynodeb Gweithredol: ***Executive Summary:***	The purpose of this report is to provide the Audit Committee with: • an update of the current position with regards to open recommendations, and those proposed for closure • details of all 'unsatisfactory' or 'limited' assurance recommendations.
Argymhellion: ***Recommendations:***	The Audit Committee is asked to: • **NOTE** the current position with regards to open recommendations, those proposed for closure, and 'unsatisfactory' and 'limited' assurance recommendations.
Arweinydd Gweithredol: ***Executive Lead:***	Pam Wenger, Director of Corporate Governance
Awdur yr Adroddiad: ***Report Author:***	Glesni Driver, Head of Covid-19 Inquiry and Thirlwall Inquiry

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

Lefel sicrwydd: ***Assurance level:***	Arwyddocaol *Significant*	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:***	
Even though a considerable amount of work has been undertaken by action owners and Executive Directors since the last update to the Executive Team to ensure progress on all open recommendations, a number of overdue recommendations remain open, with many of these being from 'limited' or 'no' assurance reports, and of 'high' priority. As usual, guidance and support is provided to all recommendation action owners and Executive Leads by the Corporate Governance Directorate.	
Cyswllt ag Amcan/Amcanion Strategol: ***Link to Strategic Objective(s):***	Not applicable, other than those relating to individual audit reviews/recommendations.
Goblygiadau rheoleiddio a lleol: ***Regulatory and legal implications:***	Compliance with Internal and External Audit requirements.
Yn unol â WP7, a oedd EqIA yn angenrheidiol ac a gafodd ei gynnal? ***In accordance with WP7 has an EqIA been identified as necessary and undertaken?***	The Equality duty is not applicable. This report is purely administrative in nature and submitted for information only. The associated public sector duties are not engaged, and there are no associated impacts on any of the protected groups
Yn unol â WP68, a oedd SEIA yn angenrheidiol ac a gafodd ei gynnal? ***In accordance with WP68, has a SEIA identified as necessary been undertaken?***	The Socio-Economic duty is not applicable. This report is purely administrative in nature and submitted for information only. The associated public sector duties are not engaged, and the report does not relate to a decision, strategic or otherwise.
Manylion am risgiau sy'n gysylltiedig â phwnc a chwmpas y papur hwn, gan gynnwys risgiau newydd (croesgyfeirio at y BAF a'r CRR) ***Details of risks associated with the subject and scope of this paper, including new risks (cross reference to the BAF and CRR)***	Not applicable, other than those relating to individual audit reviews/recommendations.
Goblygiadau ariannol o ganlyniad i roi'r *argymhellion ar waith* ***Financial implications as a result of implementing the recommendations***	Not applicable, other than those relating to individual audit reviews/recommendations.
Goblygiadau gweithlu o ganlyniad i roi'r argymhellion ar waith ***Workforce implications as a result of implementing the recommendations***	Not applicable, other than those relating to individual audit reviews/recommendations.
Adborth, ymateb a chrynodeb dilynol ar ôl ymgynghori ***Feedback, response, and follow up summary following consultation***	The report has been prepared following feedback from previous Executive Team and Audit Committee meetings, and ongoing discussions with Internal Audit and Audit Wales.

Cysylltiadau â risgiau BAF: (neu gysylltiadau â'r Gofrestr Risg Gorfforaethol) ***Links to BAF risks:*** *(or links to the Corporate Risk Register)*	Not applicable, other than those relating to individual audit reviews/recommendations.
Rheswm dros gyflwyno adroddiad i fwrdd cyfrinachol (lle bo'n berthnasol) ***Reason for submission of report to confidential board (where relevant)***	Not applicable

Camau Nesaf:
Gweithredu argymhellion

Next Steps:
Implementation of recommendations

The Corporate Governance Directorate will continue to support recommendation owners and Executive leads with the work around the implementation of audit recommendations.

Rhestr o Atodiadau:

List of Appendices:

- Appendix 1 - Summary of the rationale for closure
- Appendix 2 - Tracker with all Open 'Unsatisfactory' Assurance Recommendations
- Appendix 3 - Tracker with all Open 'Limited' Assurance Recommendations
-

INTERNAL AND EXTERNAL AUDIT RECOMMENDATIONS

1. INTRODUCTION AND BACKGROUND

This report provides an update on the progress around both internal and external audit recommendations, and focusses on the those with 'limited' or 'unsatisfactory' assurance.

2 NEWLY PUBLISHED AUDIT REPORTS

Since the last update to the Audit Committee, the recommendations from three newly published Internal Audit report have been added to the tracker, and one External Audit Report.

3 CURRENT POSITION

The information below reflects the period up to 14th November 2024.

3.1 Recommendations for closure approval

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

Executive Lead	Approved for closure	Awaiting approval by Executive
Executive Director Therapies and Health Science	0	0
Executive Director of Public Health	0	0
Chief Digital and Information Officer	0	1
Chief Executive	13	3
Chief Operating Officer	32	9
Executive Director of Nursing	6	0
Executive Director of Transformation and Strategic Planning	2	0
Executive Director of Allied Health Professions & Health Science	0	0
Deputy Director of People	3	2
Executive Medical Director*	1	3
Director of Corporate Governance	6	0
Interim Executive Director of Finance	0	0
Total	**63**	**18**

** The recommendations assigned to the Executive Medical Director have been closed by the Chief of Staff on behalf of the Chief Executive, in liaison with the recommendation owners.*

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

3.1.1 Recommendations awaiting Executive closure approval

A total of 18 recommendations were submitted to the responsible Executive for approval to close, but to date these have not been approved for closure.

The Corporate Governance Directorate has provided additional support to the Interim Chief Operating Officer to assist with seeking assurances from the owners that the work has been completed. This support is ongoing, and will continue for the foreseeable future.

Both the Chief Executive and the Interim Executive Medical Director are currently reviewing recommendations put forward for closure under their portfolios, with those approvals reported at a future meeting.

3.2 Open recommendations

3.2.1 'Unsatisfactory' assurance recommendations

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

Executive Lead	'Unsatisfactory' Assurance recs - started	'Unsatisfactory' Assurance recs - pending	Total open 'Unsatisfactory' Assurance recs overdue original implementation date	Total 'Unsatisfactory' Assurance recs put forward for closure
Chief Executive	2	0	2	2
Total	**2**	**0**	**2**	**2**

The recommendations above relate to the Operating Model, which is being led by the Chief Executive. A review of the current operating model has taken place and the discovery phase report has been published. The Health Board has established the Foundations for Future Programme that will oversee the new operating model design phase over the coming winter and spring, which will include the whole organisation. The workshops are currently in progress. Progress against the Programme will be overseen by the People and Culture Committee.

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

3.2.2 'Limited' assurance recommendations

Table 3 below shows a summary, by Executive, of all 'limited' assurance recommendations, and their status, including historical (pre-2022) recommendations:

Executive Lead	'Limited' Assurance recs - started	'Limited' Assurance recs - pending*	Total open 'Limited' Assurance recs overdue original implementation date	Total 'Limited' Assurance recs put forward for closure
Interim Executive Director of Finance	1	10	3	-
Chief Executive	4	-	4	5
Executive Director of Transformation and Strategic Planning	-	4	3	2
Director of Corporate Governance	5	-	5	2
Deputy Director of People	1	-	1	-
Chief Operating Officer	33	-	26	22
Executive Director of Nursing	11	-	7	6
Executive Medical Director	-	-	-	1
Executive Director of Public Health	17	-	17	-
Director of Performance and Commissioning	13	-	13	-
Total	**85**	**14**	**79**	**38**

** A number marked 'pending' have retrospectively been added to the tracker, and therefore no request for updates made due to this.*

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

4 SUMMARY OF ALL RECOMMENDATIONS

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

	As at 30/06/2024	As at 31/08/2024	As at 19/11/2024
Newly added Internal Audit recommendations	19	1*	56
Newly added Audit Wales recommendations*	0	0	24**
Open - historical and ongoing recommendations	337	193	-
Open - historical recommendations pending closure approval, as per report proposals	-	427	-
Pending - for Executive approval	16	0	18
Pending - for Executive Team approval	81	0	63
Pending Internal Audit closure approval, or ongoing work to respond to IA queries	46	77	32
Pending Audit Wales closure approval	34	8	0
Pending Audit Committee approval	53	77	38

** as at 25/09/2024*

*** 3 of these recommendations assigned to other outside the Health Board, therefore recorded as closed*

5 AUDIT COMMITTEE PRESENTATIONS

As per the action from the last Audit Committee, the Interim Chief Operating Officer will provide an update to the January Audit Committee of all his outstanding recommendations, and plans to progress the closure of these recommendations.

6 CONCLUSION AND RECOMMENDATIONS

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

7 BUDGETARY/FINANCIAL IMPLICATIONS

There are no budgetary implications associated with this paper.

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

Work is ongoing to identify an electronic audit tracking system, which will have a budgetary and resource implication. However, at this stage, no further information is available in this respect, and will be presented at a future meeting, when more details are available.

8 RISK MANAGEMENT

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

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

9 EQUALITY AND DIVERSITY IMPLICATIONS

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

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

APPENDIX 1 - SUMMARY OF THE RATIONALE FOR CLOSURE

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

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

SUMMARY OF AUDIT RECOMMENDATIONS PROPOSED FOR CLOSURE
FOR EXECUTIVE TEAM APPROVAL ON 04/12/2024

Summary of recommendation with rationale for closure			
EXECUTIVE DIRECTOR OF NURSING			
1	327	Lessons Learnt	Integrated Concerns Framework now live and implemented, and all information on the ICF page on BetsiNet.
2	350	Deprivation of Liberty Safeguards (DoLS) - 2024	Review of training figures has been completed with compliance shared at respective Safeguarding Forums across the Health Board. However, non-compliance will be escalated at the Safeguarding Performance and Governance Group in November and then into the Quality Delivery Group. This will be a recurring action. There is work planned with temporary staffing units to cleanse the data of those currently active on a bank basis. This will improve compliance figures and will be monitored by services.
3	351		All MCA compliance data is now shared at respective Safeguarding Forums. This action is complete but is a recurring action that will remain open as part of the Safeguarding Forum agenda as compliance / non-compliance will be escalated as per action 350.
4	353		
5	362		No further action can be undertaken at this time. The timescales are clearly recorded in process and legislation. A National review of the DoLS process is to be explored by UK Government. Welsh Government are fully aware of the challenges and continue to provided limited additional funding.
6	363		Data is shared at monthly Safeguarding Forums and directly with Managing Authorities. However, the DoLS/MCA Data Dashboard will provide additional assurance and governance.
DIRECTOR OF CORPORATE GOVERNANCE			
1	379	Structured Assessment 2022	This is an old recommendation, and the CRR has since been reviewed and consolidated in October 2023. The CRR reviewed at ET on 18th September 2024.
2	386		The update paper on Audit Tracking presented to the Audit Committee on 12th September 2024 was commended, and therefore this format will be followed for such updates in future. This update includes copies of the live audit tracker, providing detailed updates from owners on 'limited', 'no' or 'unsatisfactory'.
3	420	Follow Up Review of Follow Up Outpatient Services	There has been increased focus within the Health Board on both external and internal audit recommendations over the last few months. All external and internal recommendations have been incorporated onto the Health Board audit tracker, and regular updates on progress requested and reported, firstly to the Executive Team and thereafter Audit Committee. Any recommendations that are proposed for closure follow a rigorous closure approval process, which includes Executive Director approval, Executive Team approval, and thereafter Audit Wales approval.
4	1253	Risk Management - June 2022	The newly launched Integrated Concerns Policy and Framework will cover this now, and is live on BetsiNet and explains the process of reporting and learning and what level of review Is required. The Learning review for 'Never events' follows the appropriate pathway, depending on the level of harm. Most 'never events' are low harm. NHS Executive are currently undertaking a review of what is classified as a 'never event' and will provide an update to the Health board once finalised .
5	1269	Risk Management - June 2024	Dashboard built to now monitor track KPIs and action
6	1271		First round completed. To be reviewed again at the risk scrutiny panel. The CRR reviewed at ET on 18th September.
EXECUTIVE DIRECTOR OF TRANSFORMATION AND STRATEGIC PLANNING			
1	1328	Orthopaedic Surgical Hub Llandudno Hospital	Current variations that were highlighted at the September 2024 Project Board were approved as per the Capital Manual process.
2	1338		We continue to hold and update a planning tracker for the conditions relating to the project.
EXECUTIVE MEDICAL DIRECTOR (approved by the Chief of Staff on behalf of the Chief Executive)			
1	564	Clinical Audit	AMaT has now been implemented in the Health Board, and is being utilised to capture actions from clinical audits, and provides greater facility to document actions. Suggest this is put forward for closure as this is a historical recommendation.

CHIEF EXECUTIVE			
1	377	Review of Quality Governance Arrangements	This recommendation from 2022 is superseded by the review of most recent Committee TOR and COB and also the EDGs being put in place.
2	421	Review of Board Effectiveness	The Chief Executive has undertaken a review of the Executive Portfolios to improve governance and accountability in April 2024. Implementation of the conclusions of this review was then implemented. Portfolios have been amended to reflect the review and JD's for vacancies amended and submitted to WG for consideration of remuneration. A number of these post have been through the recruitment process. By the end of March 2024 the The Board now has a full complement of Independent Members - by end of March 2024. The action taken formed part of Special Measures cycles 1-3 and have been well documented through this process. Deliverables contained within the BCUHB Three Year Plan have been aligned to the portfolio of each Executive Director and are evaluated in a Directorate Performance Review (commenced in June 2024)
3	422		There are matters of confidentiality that relate to individuals that cannot be reported in detail in this update but are being overseen by the Chief Executive. The Chair and Chief Executive updated the Senedd Public Administration Committee on what they could during 2023/24, whilst carefully considering confidentiality. The CEO has moved this matter forwards significantly towards a conclusion. This recommendation is proposed for closure.
4	423		Close working with the Counter Fraud service and North Wales Police took place throughout 2022/23 and 2023/24 and have been the subject of a briefing to the Senedd Public Administration Committee during 2023/24 and their involvement has now come to an end. There are matters of confidentiality that relate to individuals that cannot be reported in detail in this update but are being overseen by the Chief Executive.
5	425		This work was undertaken as part of the interim review work under special measures. Since March 24 there have been no senior agency interims in the organisation.
6	426		This work has been actioned over the last 12 months as part of the special measures work with a series of appointments to the Finance team and a restructure of roles at a senior level, with the appointment of a Interim Executive Director of Finance and a secondment of a Director of Finance from Welsh Government. Audit Wales and Welsh Government have confirmed that there is much more resilience in the finance team. This action can now be closed.
7	427		The Chief Executive undertook a review of the Executive Portfolios to improve governance and accountability in April 2024. Deliverables contained within the BCUHB Three Year Plan have been aligned to the portfolio of each Executive Director and are evaluated in a Directorate Performance Review (commenced in June 2024) This matters is proposed for closure. In addition to this Executive Team Development support has taken place with a recognised organisation in this field. Although evidence of change may take some time to address the actions required to address them have been agreed and formalised.
8	433		The Chief Executive has undertaken a review of the Executive Portfolios to improve governance and accountability in April 2024. Implementation of the conclusions of this review was then implemented. Portfolios have been amended to reflect the review and JD's for vacancies amended and submitted to WG for consideration of remuneration. A number of these post have been through the recruitment process. By the end of March 2024 the The Board now has a full complement of Independent Members - by end of March 2024. The action taken formed part of Special Measures cycles 1-3 and have been well documented through this process. Deliverables contained within the BCUHB Three Year Plan have been aligned to the portfolio of each Executive Director and are evaluated in a Directorate Performance Review (commenced in June 2024)
9	487	Health and Safety - 2024	Health and Safety Policy approved by the Board in September
10	489		This is included in the terms of reference for the People and Culture Committee
11	490		Included in Terms of Reference for the People and Culture Committee and the also the Health and Safety Policy
12	495		This is an IHC Directors responsibility to ensure that all managers in the service conduct safety assessments, to be included in revised TOR when agreed with Chair of SOHSG/ Environment and Estates Director.
13	496		H&S Advisors in East, West and Central are all participating in INCC Safety meetings and reinforcing the need for the IHC managers to take ownership, above the regular reviews carried out by

DEPUTY DIRECTOR OF PEOPLE			
1	453	Taking Care of the Carers?	People Services have seconded a head of staff engagement role who is leading on a range of initiatives that had fed into the operating model review, approved Integrated Leadership Development Framework, the Values and Behaviour framework and OD plan. The results of the 2023/23 staff survey has been developed into a thematic analysis of staff satisfaction and shared with IHCs. All these staff engagement initiatives are now overseen by the new People & OD Steering Group and the Culture Steering Group.
2	646	Roster management	Following review of historical recommendations by Internal Audit, there was a request that these recommendations be reviewed by Executive to confirm closure. Closure approved by Executive.
3	647		

INTERIM CHIEF OPERATING OFFICER			
1	172	Effective Governance - Ysbyty Wrexham Maelor Hospital	COO reviewed evidence and is content to close.
2	173		
3	175		The current controls that have been recently put in place will prevent recurrence. Exec Team and Board have been endorsed these measures. COO reviewed evidence and is happy to close.
4	178	Effective Governance - Ysbyty Gwynedd (YG)	COO reviewed evidence and is content to close.
5	234	Review of Eye Care Services	COO reviewed evidence and is content to close.
6	235		
7	236		
8	240		
9	308	Waiting List Management: Review of the WG initiated Patient Validation Exercise, Risk Stratification and patient removal from lists	This has been supereceded now with further work on waiting list management in relation to validation. Chatbot added for validation. This has been supereceded now with further work on waiting list management in relation to validation. Chatbot added for validation . COO reviewed evidence and is content to close.
10	309		This has been supereceded now with further work on waiting list management in relation to validation. Chatbot added for validation.
11	311		Treat in turn in place and part of the weekly assurance process. COO reviewed evidence and is content to close.
12	312		
13	313		
14	314		
15	315		There is consistency now and further work being done on WPAS upgrade. In West and East. COO reviewed evidence and is content to close.
16	316		
17	416	Follow Up Review of Follow Up Outpatient	This is an ongoing process of quality and safety management - is BAU and can therefore be put forward for closure.
18	417		
19	465	Discharge Arrangements	COO content to proposed closure.
20	466		Urgent and Emergency Care Major transformation in place. This is addressed as part of workstream 4 (discharge into community) and reported at Board in September 2024. COO content to proposed closure.
21	467		In addition to 466. The ten best practice interventions been adapted across the Health Board as part of the UEC Major Transformation Programme. To be reported in November 2024. COO content to proposed for closure.
22	469		PFIG Committee received a report in October 2024 setting out the Trusted Assessor guidance as part of the ten high impact actions. COO content to proposed for closure.
23	470		
24	474		
25	475		
26	501	Effective Governance – Women's Directorate	The first North Wales Postnatal Forum meeting took place on 23rd September 2024. The Terms of Reference were approved at the meeting. There is a section on the agenda for service user feedback. Civica data was reviewed in the September meeting. The forum will be responsible for advising and communicating on any governance risks or resource implications that impact on the provision of high quality postnatal care. COO content to proposed for closure.
27	502		This is monitored closely through surveillance on a weekly basis. The escalation process is active. COO content to proposed for closure.
28	581	Effective Governance - Ysbyty Gwynedd (YG)	The Operational Delivery Groups, to mirror what was understood to be the Health Board approach have been set up and report through the SLT structure. The IHC governance is currently being reviewed, but is in place. Copies of minutes from the West Leadership Team, Population Health LDG and Quality LDG where the Terms of Reference were approved attached as supporting evidence. COO content to proposed for closure.
29	582		The Operational Delivery Groups, to mirror what was understood to be the Health Board approach have been set up and report through the SLT structure. The IHC governance is currently being reviewed, but is in place. Copies of minutes from the West Leadership Team, Population Health LDG and Quality LDG where the Terms of Reference were approved attached as supporting evidence. COO content to proposed for closure.
30	595		Previous submissions in 2022 and 2023 confirmed that the TORs and minutes were accepted and these two actions should have been closed down by the Deputy CEO Gill Harris and interim COO after the Exec changes. COO content to proposed for closure. Wrexham Maelor have up and running, as required full meetings that report to the relevant IHC meetings as listed in the attached document.
31	626	Orthopaedic Services in Wales – Tackling the Waiting List Backlog	Progress made and works continues with leading clinicians to work with COO for areas of low utilisation. COO content to proposed for closure.

32	1290	Discharge Planning Progress Update - June 2024	This action is still to be progressed whilst confirmation of changes are awaited with regards to Executive Lead for U&EC due to structure changes within executive posts and also Central IHC Director role. This will affect a number of the actions where Central IHC Director is identified as action owner As previously mentioned discussions have taken place with senior nursing group, led by Executive Director of Nursing and specific actions will be picked up within the learning events with IHCs. Going forward once confirmation of action owner and exec lead are known, reports will be provided as per this action. Revise implementation date to 30/9/24. COO content to proposed for closure

ALL OPEN 'UNSATISFACTORY ASSURANCE' RECOMMENDATIONS

ID	Internal Audit/ Audit Wales	Report Title	Year	Assurance Level	Priority	Recommendation Title	Recommendation	Management Response	Action Owner	Final Approver	Original implementation date	Revised implementation date	Number of Revisions	Latest update
455	Internal Audit	Operating Model	2024	Unsatisfactory	High	Matter Arising 1: Operating Model (Design and Operation)	1.1 The Health Board, through the Chief Executive should undertake a full review of the operating model including: ● A review of the Operating Model, as implemented, to ensure it is fit for purpose in delivering the Corporate/Strategic Objectives, long-term strategy/medium term plan of the Health Board. ● A review of all twenty-six services identified as 'Outstanding Design – Clinical' with urgency, noting some represent current risk to the Health Board. ● Review of the role, remit and accountability of corporate posts where the services they oversee are delivered through Operational Services, for which they have no delegated responsibility or accountability. ● A review of funding, to ensure any Operating Model/Structure is affordable and transparency in funding is ensured.	Arana (external consultancy) was commissioned in November to undertake an initial review of the operating model. The Chief Executive, supported by the Senior Associate Director of People in May 2024, will commence an engagement process with the Board and other colleagues to consider changes to the organisational structure. This will take account of the gaps in assurance that have been identified as part of this internal audit.	Jason Brannan, Deputy Director of People	Carol Shillabeer, Chief Executive	30/06/2024	31/03/2025	1	A review of the current operating model has taken place and that information is currently being collated. The discovery phase report is due for publication in early November 2024. It is anticipated that the organisation will start a new operating model design phase over the coming winter and spring which will include the whole organisation. The design phase will include a series of workshops to help formulate a number of operating model options.
457	Internal Audit	Operating Model	2024	Unsatisfactory	High	Matter Arising 2: Operational Governance and Accountability Framework (Design and Operation)	The Health Board reviews its Governance and Accountability Framework to ensure it provides the necessary scrutiny and assurance from Ward to Board and vice versa.	As part of the organisational structure review, all accountability frameworks will be reviewed	Pam Wenger, Director of Corporate Governance	Carol Shillabeer, Chief Executive	30/06/2024	31/12/2024	1	Shortlisting for the Director of Environment post has taken place, with interviewing on 26th October 2024.

ALL OPEN 'LIMITED' ASSURANCE RECOMMENDATIONS

ID	Internal Audit/ Audit Wales	Report Title	Year	Assurance Level	Priority	Recommendation Title	Recommendation	Management Response	Action Owner	Final Approver	Original implementation date	Revised implementation date	Number of Revisions	Latest update
150	Internal Audit	Nursing Roster Management: Introduction of e-timesheets for Agency staff	2022	Limited	Medium pre 01/10/2024	Matter Arising 1: Policies and Procedures (Operation)	1.1: Policy WP28a requires a review, needs to include a reference to the E-timesheets also include the SOP within the documents to be read alongside the policy section on the first page. 1.2 Draft SOP needs to be approved and activated.	1.1: Policy WP28a has been reviewed and is with Workforce Policy Group for consideration. Policy to be approved and deployed with a clear compliance audit schedule in place and commenced. 1.2 Draft SOP to be reviewed to amend reference to unpaid break to acknowledge the risks associated on safe staffing in conjunction with Corporate Nursing Team. 1.3 Interim SOP (with exception of paid break element) to be approved for a 3 months period to ensure clarity of process and accountability in intervening period.	Clair Tipton, Head of Digital Systems	Jason Brannan, Deputy Director of People	31/07/2022	31/01/2025	4	Action is still ongoing a revised implementation of 31/01/2025 is requested
158	Internal Audit	On-Call arrangements	2022	Limited	High	Matter Arising 1 – Review of on-call arrangements (Design)	The on-call review should be re-instated as a priority, to ensure arrangements match service requirements, and are reviewed considering changing needs as a result of changes due to VERS and the new Operating Model. Management should consider the feedback from our questionnaire when reviewing on-call arrangements, and how these can be addressed. Following completion of the review and update of guidance (see Matters Arising 2,3 and 4 below), this should be communicated to staff to ensure they understand their obligations and responsibilities for participating in the on-call rotas.	1.1a: The on-call review will be restarted and will be led by the Interim Regional Director of Delivery (IRDD), supported by the Strategic Emergency Preparedness Response and Resilience (EPRR) lead.	Sharon Scott, EPRR Lead	Jane Moore, Acting Executive Director of Public Health	23/09/2022	01/06/2024	3	The Acting Executive Director of Public Health will lead the work around On-call, but as part of a working group with others such as Workforce and Corporate Governance Directorate. The recommendation owner will be Sharon Scott, Head of EPRR.
159	Internal Audit	On-Call arrangements	2022	Limited	High	Matter Arising 2 – Rota guidance / sustainability (Design)	The following should be documented for on-call rotas: Minimum staff numbers; Seniority/experience mix; Timelines for preparation and issuing of rotas; Frequency and type of each employees commitment is equitable; Process for staff being added to the rota when commencing an applicable senior role; Process for staff being removed from the rota, ensuring the impact this will have on other staff is considered, with reasons approved at an Executive level. Any staff removed from the rota should be reviewed regularly to determine if they can be put back on it.	2.1: On-call document, covering the recommendations above will be issued to all staff.	Sharon Scott, EPRR Lead	Jane Moore, Acting Executive Director of Public Health	01/07/2022	01/06/2024	1	The Acting Executive Director of Public Health will lead the work around On-call, but as part of a working group with others such as Workforce and Corporate Governance Directorate. The recommendation owner will be Sharon Scott, Head of EPRR.
160	Internal Audit	On-Call arrangements	2022	Limited	High	Matter Arising 3 – Compensatory rest and payment (Operation)	Workforce policies to be reviewed and updated as necessary, including clear guidance on the requirement for taking compensatory rest. Guidance on compensatory rest and payment entitlement to be included on the staff intranet site and circulated to all staff included on on-call rotas. This should be done on a periodic basis to ensure new staff who are added to rotas are aware of their entitlements. Staff included in on-call rotas to be encouraged to take compensatory rest.	3.1a: All on-call staff to be written to by the Interim Director of Regional Delivery, having agreed content of the letter with the Director of Workforce & OD, and Deputy CEO. *Audit notes: - The Rostering Policy has been reviewed and is with the Workforce Policy Group for consideration (action captured through the review of Nursing Roster Management) - re guidance on compensatory rest / payments - see action 4 below - manual with key information for staff to include this information.*	Sharon Scott, EPRR Lead	Jane Moore, Acting Executive Director of Public Health	11/07/2022	01/06/2024	1	The Acting Executive Director of Public Health will lead the work around On-call, but as part of a working group with others such as Workforce and Corporate Governance Directorate. The recommendation owner will be Sharon Scott, Head of EPRR.
161	Internal Audit	On-Call arrangements	2022	Limited	High	Matter Arising 4 – Training (Design)	The requirements of staff included in on-call rotas should be documented and staff provided with relevant information to ensure they are able to deal with expected issues whilst on-call i.e. key information about sites and services, as staff may not be familiar with the site they are responsible for during the on-call shift. Training should be provided to staff who are on the rotas to ensure they are aware of their responsibilities and possible scenarios of what they may have to deal with.	4.1a: Programme of training to be reviewed. The programme will take into account the areas identified within the audit survey.	Sharon Scott, EPRR Lead	Jane Moore, Acting Executive Director of Public Health	28/09/2022	01/06/2024	1	The Acting Executive Director of Public Health will lead the work around On-call, but as part of a working group with others such as Workforce and Corporate Governance Directorate. The recommendation owner will be Sharon Scott, Head of EPRR.
261	Internal Audit	Contracted Patient Services: Quality and Safety Arrangements	2023	Limited	High	Matter Arising 1: Process management (Design)	1.1.1: Management establish robust overarching Commissioning Assurance Framework, Policy, or relevant Standard Operating Procedure (SOP) to support the healthcare commissioning/contracting process. This should ensure that lines of escalation, roles, responsibilities, and requirements regarding the management and oversight of the quality aspect of services provided are clearly defined.	1.1.1: The Health Board will develop a Commissioning Assurance Framework (CAF) for the management of external healthcare contracts. This will set out the roles, responsibilities and processes and will cover not only the quality assurance of commissioned services but also the commissioning, performance management, business intelligence / analysis and other professional services that input to contract management both where the health board is commissioner and provider. *Update from Executive Team meeting on 19/06/2024 is that, in the absence of the Director of Commissioning and Performance, there will be an oversight of a number of Executive Directors. Work on progressing the commission arrangements for contracts is underway and an update will be provided to the PFIG in August.*	Stephen Powell, Director of Performance and Commissioning	Stephen Powell, Director of Performance and Commissioning	31/07/2023	30/09/2024	2	This work will now be led by the Director of Performance and Commissioning, now that he is in post.

262	Internal Audit	Contracted Patient Services: Quality and Safety Arrangements	2023	Limited	High	Matter Arising 2: Contractual obligations (Design)	2.1.1: Management establish controls to ensure that all commissioned providers adhere to agreed contractual agreements and assess current contract review meeting arrangements to ensure appropriate levels of oversight and engagement.	2.1.1: The Health Board will, as part of the Commissioning Assurance Framework (CAF) mentioned above, establish roles, responsibilities and escalations for the review of contract performance, including contract meetings. *Update from Executive Team meeting on 19/06/2024 is that, in the absence of the Director of Commissioning and Performance, there will be an oversight of a number of Executive Directors. Work on progressing the commission arrangements for contracts is underway and an update will be provided to the PFIG in August.*	Stephen Powell, Director of Performance and Commissioning	Stephen Powell, Director of Performance and Commissioning	31/08/2023	30/09/2024	2	This work will now be led by the Director of Performance and Commissioning, now that he is in post.
263	Internal Audit	Contracted Patient Services: Quality and Safety Arrangements	2023	Limited	High	Matter Arising 3: Quality measures (Operation)	3.1: Management to review contractual quality measures to ensure they are robust, effective, and appropriate.	3.1.1: For the 2023/2024 period, quality schedules will be included in contracts that reflect national requirements. *Update from Executive Team meeting on 19/06/2024 is that, in the absence of the Director of Commissioning and Performance, there will be an oversight of a number of Executive Directors. Work on progressing the commission arrangements for contracts is underway and an update will be provided to the PFIG in August.*	Stephen Powell, Director of Performance and Commissioning	Stephen Powell, Director of Performance and Commissioning	31/08/2023	30/09/2024	2	This work will now be led by the Director of Performance and Commissioning, now that he is in post.
264	Internal Audit	Contracted Patient Services: Quality and Safety Arrangements	2023	Limited	High	Matter Arising 3: Quality measures (Operation)	3.2.1: Management to ensure procedures have provision for addressing and escalating quality issues that fall outside the agreed measures.	3.2.1: The Health Board will, as part of the Commissioning Assurance Framework mentioned in ID 263, establish roles, responsibilities and escalations for the review of contract performance, including the dissemination of reports, the interpretation and identification of issues, the escalation process, management of remedial actions and ongoing monitoring via ad hoc meetings, contract meetings or any other forum required. *Update from Executive Team meeting on 19/06/2024 is that, in the absence of the Director of Commissioning and Performance, there will be an oversight of a number of Executive Directors. Work on progressing the commission arrangements for contracts is underway and an update will be provided to the PFIG in August.*	Stephen Powell, Director of Performance and Commissioning	Stephen Powell, Director of Performance and Commissioning	31/10/2023	30/09/2024	2	This work will now be led by the Director of Performance and Commissioning, now that he is in post.
265	Internal Audit	Contracted Patient Services: Quality and Safety Arrangements	2023	Limited	High	Matter Arising 4: Board assurance (Design)	4.1: Management to review governance and reporting arrangements to ensure English NHS provider quality and performance data is subject to Health Board review and scrutiny.	4.1 1: The Health Board will establish a six monthly report to the Quality, Safety and Experience Committee setting out a quality assurance position for commissioned services. The ownership and authorship of this report will be clarified in the CAF. *Update from Executive Team meeting on 19/06/2024 is that, in the absence of the Director of Commissioning and Performance, there will be an oversight of a number of Executive Directors. Work on progressing the commission arrangements for contracts is underway and an update will be provided to the PFIG in August.*	Stephen Powell, Director of Performance and Commissioning	Stephen Powell, Director of Performance and Commissioning	31/10/2023	30/09/2024	2	This work will now be led by the Director of Performance and Commissioning, now that he is in post.
298	Internal Audit	Falls Management	2023	Limited	High	Matter Arising 3: Training (Operation and Design)	3.1a: To review training compliance for all areas relating to Patient Handling training and ensure staff who require training undertake this as soon as possible.	3.1a: Manual Handling (MH) is a Tier One risk on the BCUHB risk register scoring 16 requiring regular review of actions being completed. MH training compliance data cascaded monthly to respective IHC's/Division Director of Operations to include compliance, did not attend rates and available capacity for upcoming 2 months. Capacity within the MH training team to be optimised with focused recruitment drive for Band 6 posts (x3) supported by workforce.	Lynne Bushell - Head of Health, Safety and Security	Angela Wood, Executive Director of Nursing and Midwifery	01/01/2024	30/12/2024	3	Action plan instigated to ensure compliance, Bookings taken in house, recruitment to posts and all sessions now ensuring maximum uptake
304	Internal Audit	Falls Management	2023	Limited	High	Matter Arising 4: Governance (Operation)	4.1b: Lessons learned information included in Datix should be reviewed regularly to ensure learning is communicated/reported as appropriate, and to deter staff entering a full stop or a dash in the section.	4.1b: Action 1 - Each Integrated Health Community (IHC) Health Board has established weekly harms review meeting that includes Inpatient Falls, to improve the sharing of lessons learned the Health Board will develop a SOP to ensure standardised practice across the IHCs.	Chris Lynes, Deputy Executive Director of Nursing	Angela Wood, Executive Director of Nursing and Midwifery	30/12/2023	30/09/2024	4	SOP approved at BCUHB Inpatient Falls Group 11/09/2024 and Patient Safety Group 24/09/2024. Lessons learned information reviewed by Patient Safety Team as a sample audit using all incidents reported to NHS Wales Executive. Details of what needs to be inputted in to Datix covered in BCUHB incident awareness and incident management training
326	Internal Audit	Lessons Learnt	2023	Limited	High	Matter Arising 1: Lessons Learnt (Design)	1.3c: Management to review implemented learning to ensure effectiveness.	1.3c: A new, digital repository of learning and cascade system will be developed. *NB: 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.*	Kath Clarke, Head of Quality	Angela Wood, Executive Director of Nursing and Midwifery	31/03/2024	31/01/2025	4	Work continues to develop the new Quality Learning Portal. Due to other work pressures, development on the Solution has slowed and little progress has been made since the previous update. These additional work pressures are being addressed, and the development continues on the admin app that will allow administrators to review learning prior to being published to the organisation. The first of three apps, which will allow users to enter learning into the system, is currently being tested. The second app is due to be completed by the end of December, with the final part of the Solution due to be complete early in the New Year. Whilst this is later than hoped in the original ambitious plan, this work is an entirely new project being developed and the first of its kind in Wales, so an agile development approach is being taken to ensure the solution is reliable, sustainable and delivers a real benefit to BCUHB
352	Internal Audit	Deprivation of Liberty Safeguards (DoLS) - 2024	2024	Limited	Medium pre 01/10/2024	Matter Arising 1: MCA training levels 1 and 2 (Operation)	1.1a (iii): Review training data to identify those staff that have not undertaken training. Once identified, confirm with staff the requirement to complete the training. Where this is not undertaken, escalate as appropriate.	1.1a (iii): Review current BCUHB training policies and procedures with service leads for Bank, Locum and Honorary staff to ascertain current agreements in place in relation to the completion of MCA training prior to and during employment.	Chris Walker, Head of Safeguarding Adults	Angela Wood, Executive Director of Nursing and Midwifery	30/09/2024	31/12/2024	1	This action is now delayed as we are advised that the system to record training for Bank, Locum, and Honorary Staff requires a 'system cleanse'. This will be escalated at the Safeguarding Performance and Governance Group for advice/support/action.
356	Internal Audit	Deprivation of Liberty Safeguards (DoLS) - 2024	2024	Limited	High	Matter Arising 2: DoLS authorisations (Design)	2.1a (i): Supervisory to continue addressing quality issues with relevant areas and continue to review capacity of BIAs and Mental Health Assessor (a s12(2) Approved Doctor).	2.1a (i): Demand and capacity modelling for Best Interest Assessments to be developed by the Safeguarding Business Team to support data driven decisions.	Chris Walker, Head of Safeguarding Adults	Angela Wood, Executive Director of Nursing and Midwifery	31/07/2024	03/12/2024	1	Work ongoing, progress being made with regard to data analysis
357	Internal Audit	Deprivation of Liberty Safeguards (DoLS) - 2024	2024	Limited	High	Matter Arising 2: DoLS authorisations (Design)	2.1a (ii): Supervisory to continue addressing quality issues with relevant areas and continue to review capacity of BIAs and Mental Health Assessor (a s12(2) Approved Doctor).	2.1a (ii): Increase the Supervisory Body's capacity to complete best interest assessments within agreed timescales and legislative compliance by training 5 additional BIA's from Q2 onwards.	Chris Walker, Head of Safeguarding Adults	Angela Wood, Executive Director of Nursing and Midwifery	31/03/2025			Five staff will complete the BIA Course in November/December 2024. A ToR and support plan are being completed to support staff.
358	Internal Audit	Deprivation of Liberty Safeguards (DoLS) - 2024	2024	Limited	High	Matter Arising 2: DoLS authorisations (Design)	2.1a (iii): Supervisory to continue addressing quality issues with relevant areas and continue to review capacity of BIAs and Mental Health Assessor (a s12(2) Approved Doctor).	2.1a (iii): Work Based Quality Improvement programme to be developed and implemented within the 3 high referring areas with high QA rejection rates for applications.	Chris Walker, Head of Safeguarding Adults	Angela Wood, Executive Director of Nursing and Midwifery	30/09/2024	31/03/2024	1	This work is taking longer than first anticipated due to the high numbers of DoLS applications and the change in high referral areas. Work is ongoing with the Data Analyst to progress the DoLS Dashboard.
359	Internal Audit	Deprivation of Liberty Safeguards (DoLS) - 2024	2024	Limited	High	Matter Arising 2: DoLS authorisations (Design)	2.1a (iv): Supervisory to continue addressing quality issues with relevant areas and continue to review capacity of BIAs and Mental Health Assessor (a s12(2) Approved Doctor).	2.1a (iv): Standard Operating Procedure for MCA and BIA service to be reviewed to strengthen visibility of the team within high risk areas. To include structured weekly visits/daily calls by the MCA Team to high referral areas i.e. DGH and Community Hospitals to increase profile of the MCA Team, provide support for staff, feedback regarding application QA rejection themes (date, signatures) etc.	Chris Walker, Head of Safeguarding Adults	Angela Wood, Executive Director of Nursing and Midwifery	30/09/2024	31/12/2024	1	Review of MCA and DoLS paperwork is complete. Some minor amendments to training programmes to be approved at the Safeguarding and Public Protection Senior Leads Meeting and then at the Safeguarding Performance and Governance Group. Daily calls and visits are completed to high referral areas supported by WG monies. Action delayed due to ensuring governance process is followed.
361	Internal Audit	Deprivation of Liberty Safeguards (DoLS) - 2024	2024	Limited	High	Matter Arising 2: DoLS authorisations (Design)	2.1a (vi): Supervisory to continue addressing quality issues with relevant areas and continue to review capacity of BIAs and Mental Health Assessor (a s12(2) Approved Doctor).	2.1 (vi): Digitalise MCA and DoLS documentation to ensure that mandatory fields are completed prior to submission and audit standards.	Chris Walker, Head of Safeguarding Adults	Angela Wood, Executive Director of Nursing and Midwifery	31/03/2025			The National Group for DoLS/MCA are meeting in November 2024. A further update will be provided.

364	Internal Audit	Deprivation of Liberty Safeguards (DoLS) - 2024	2024	Limited	High	Matter Arising 3: DoLS Documentation (Operational)	3.1a (iii): Managing Authorities to ensure that the applications are completed appropriately and returned in a timely manner. Where issues are identified with quality or timeliness, the Supervisory Body should communicate issues with relevant staff, provide support and ensure staff have undertaken appropriate training. Where issues remain this should be escalated as appropriate.	3.1a (iii): Provide the Managing Authority with opportunities to reflect on the quality of documentation through quarterly learning sessions to commence in Q2. As per action 2.1a: Develop a Work Based Quality Improvement Plan based on themes and trends of the data analysis initially focussing on high referral areas to support reduced rejection rates at QA. Within the improvement plan identify measure for reduction in rejection rates and provide bi-monthly updates on progress and areas that require action with agreed escalation in place to managing authority.	Chris Walker, Head of Safeguarding Adults	Angela Wood, Executive Director of Nursing and Midwifery	31/03/2025			Work continues to progress. The 'pilot' MCA/DoLS Supervision sessions are ongoing. The MCA/DoLS trainer will submit a paper for consideration in Q3.
365	Internal Audit	Deprivation of Liberty Safeguards (DoLS) - 2024	2024	Limited	High	Matter Arising 3: DoLS Documentation (Operational)	3.1a (iv): Managing Authorities to ensure that the applications are completed appropriately and returned in a timely manner. Where issues are identified with quality or timeliness, the Supervisory Body should communicate issues with relevant staff, provide support and ensure staff have undertaken appropriate training. Where issues remain this should be escalated as appropriate.	3.1a (iv): The Standing Operating Procedure for the completion of DoLS documentation to include criteria for triggering an escalation process for areas of concern i.e. high % of rejection at QA, low % compliance with agreed time frames.	Chris Walker, Head of Safeguarding Adults	Angela Wood, Executive Director of Nursing and Midwifery	31/12/2024			Work ongoing and due to be completed within the target date.
458	Internal Audit	Discharge Arrangements	2024	Limited	High	Matter Arising 1: Policy, guidance, and training (Design)	1.1a: Management: • Establish an overarching policy or Standard Operating Procedure(s) to support the management of patient discharges and implementation of D2RA. Governance, reporting, and escalation requirements to be clearly defined. • Ensure all staff (substantive, temporary, bank, and agency) involved with patient discharges / flow have a sound understanding of D2RA requirements and expectations.	1.1a: Draft revised BCUHB Hospital Discharge policy has been developed to replace the Covid discharge requirements and the former NU01 BCUHB Hospital Discharge Policy which is out of date. The revised draft policy will be presented through the Health Board's governance process for approval, this will include a consultation period on the BCUHB website and sign off by relevant Health Board committee. Other supporting documentation including Choice & Reluctant Discharge Guidance and Criteria Led discharge is also being reviewed as part of this review of discharge documentation.	Jane Trowman, Acting Assistant Director Care Homes Support and CHC Commissioning; Claire Brennan, Programme Manager (Operations)	Imran Devji, Interim Chief Operating Officer	30/09/2024			The Policy is now in final draft following amendments made with Social Care colleagues and the National Team. Discharge Action Cards / flow charts to support the operational delivery of the Policy have been drafted and will be agreed by Workstream 4 of the USC reset workstream
459	Internal Audit	Discharge Arrangements	2024	Limited	High	Matter Arising 1: Policy, guidance, and training (Design)	1.1b: Management: • Establish an overarching policy or Standard Operating Procedure(s) to support the management of patient discharges and implementation of D2RA. Governance, reporting, and escalation requirements to be clearly defined. • Ensure all staff (substantive, temporary, bank, and agency) involved with patient discharges / flow have a sound understanding of D2RA requirements and expectations.	1.1b: Training Needs Analysis will be undertaken across each acute and community hospital.	Libby Ryan-Davies, IHC Director - Central	Imran Devji, Interim Chief Operating Officer	30/09/2024			Supporting documentation (Action Cards and flow chart and leaflets) are being developed. These materials will be used by operational teams to ensure a consistent approach to Discharge.
460	Internal Audit	Discharge Arrangements	2024	Limited	High	Matter Arising 1: Policy, guidance, and training (Design)	1.1c: Management: • Establish an overarching policy or Standard Operating Procedure(s) to support the management of patient discharges and implementation of D2RA. Governance, reporting, and escalation requirements to be clearly defined. • Ensure all staff (substantive, temporary, bank, and agency) involved with patient discharges / flow have a sound understanding of D2RA requirements and expectations.	1.1c: Establish training plan, informed by TNA (to include staff across acute, community hospitals and from disciplines, doctors, nursing, AHP as well as students and including agency / bank staff).	Libby Ryan-Davies, IHC Director - Central	Imran Devji, Interim Chief Operating Officer	31/12/2024			Work is progressing as part of workstream 4 of the USC reset (priority areas Flow and Discharge)
461	Internal Audit	Discharge Arrangements	2024	Limited	High	Matter Arising 2: D2RA performance Measures (Design)	2.1a: Management: • Establish formal escalation arrangements to address and support areas of low / non-compliance. • Ensure that all patients without an allocated D2RA pathway are identified and highlighted to the relevant ward managers. Persistent failure to meet mandated requirements to be escalated.	2.1a: Develop Comms and engagement plan, informed by TNA to refocus and raise awareness to increase focus & awareness on D2RA pathways, STREAM, etc.	Libby Ryan-Davies, IHC Director - Central; Jane Trowman, Acting Assistant Director Care Homes Support and CHC Commissioning; Claire Brennan, Programme Manager (Operations)	Imran Devji, Interim Chief Operating Officer	30/06/2024	31/03/2025	1	Work is progressing with the national team on introducing new measures. Compliance with reporting is improved and data cleansing completed. All measures on track for implementation by 2025
462	Internal Audit	Discharge Arrangements	2024	Limited	Medium pre 01/10/2024	Matter Arising 2: D2RA performance Measures (Design)	2.2a (i): Management: • Remind staff to utilise STREAM to support their ward board rounds and to ensure that patient records are kept up to date. • Consider incorporating D2RA pathway field onto STREAM summary pages to provide users with an at a glance overview of ward D2RA pathway status.	2.2a (i): Implement comms and engagement plan - Q2	Libby Ryan-Davies, IHC Director - Central	Imran Devji, Interim Chief Operating Officer	30/09/2024	31/03/2025	1	Work is progressing with the national team on introducing new measures. Compliance with reporting is improved and data cleansing completed. All measures on track for implementation by 2025
463	Internal Audit	Discharge Arrangements	2024	Limited	Medium pre 01/10/2024	Matter Arising 2: D2RA performance Measures (Design)	2.2a (ii): Management: • Remind staff to utilise STREAM to support their ward board rounds and to ensure that patient records are kept up to date. • Consider incorporating D2RA pathway field onto STREAM summary pages to provide users with an at a glance overview of ward D2RA pathway status.	2.2a (ii): Implement comms and engagement plan - Q3	Libby Ryan-Davies, IHC Director - Central	Imran Devji, Interim Chief Operating Officer	31/12/2024			Q3 - Not due
464	Internal Audit	Discharge Arrangements	2024	Limited	Medium pre 01/10/2024	Matter Arising 2: D2RA performance Measures (Design)	2.2a (iii): Management: • Remind staff to utilise STREAM to support their ward board rounds and to ensure that patient records are kept up to date. • Consider incorporating D2RA pathway field onto STREAM summary pages to provide users with an at a glance overview of ward D2RA pathway status.	2.2a (iii): Implement comms and engagement plan - Q4	Libby Ryan-Davies, IHC Director - Central	Imran Devji, Interim Chief Operating Officer	31/03/2025			Q4 Not Due
468	Internal Audit	Discharge Arrangements	2024	Limited	High	Matter Arising 3: Pathways of Care Delays (Design)	3.1a: Management: • Establish formal escalation framework to address and support resolution of Pathways of Care Delays. • Ensure working practice complies with Welsh Government requirements	3.1a: Stock take of which areas are doing Board rounds twice daily with the aim of developing an improvement plan to support improved compliance.	Libby Ryan-Davies, IHC Director - Central	Imran Devji, Interim Chief Operating Officer	30/06/2024	31/12/2024	1	As part of the UEC Reset. Review of board rounds - identifying what does good look line. Training and awareness / supporting documentation reviewed and is in the process of being revised.

471	Internal Audit	Discharge Arrangements	2024	Limited	High	Matter Arising 3: Pathways of Care Delays (Design)	3.1c (ii): Management: • Establish formal escalation framework to address and support resolution of Pathways of Care Delays. • Ensure working practice complies with Welsh Government requirements.	3.1c (ii): Regional action plan refreshed in April 2024 discussed with each IHC and respective LAs to ensure actions align with top delays / areas of challenge and submitted to NHS Exec (quarterly). QUARTER 2	Libby Ryan-Davies, IHC Director - Central; Jane Trowman, Acting Assistant Director Care Homes Support and CHC Commissioning; Claire Brennan, Programme Manager (Operations)	Imran Devji, Interim Chief Operating Officer	30/09/2024			Completed - Close
472	Internal Audit	Discharge Arrangements	2024	Limited	High	Matter Arising 3: Pathways of Care Delays (Design)	3.1c (iii): Management: • Establish formal escalation framework to address and support resolution of Pathways of Care Delays. • Ensure working practice complies with Welsh Government requirements.	3.1c (iii): Regional action plan refreshed in April 2024 discussed with each IHC and respective LAs to ensure actions align with top delays / areas of challenge and submitted to NHS Exec (quarterly). QUARTER 3	Libby Ryan-Davies, IHC Director - Central; Jane Trowman, Acting Assistant Director Care Homes Support and CHC Commissioning; Claire Brennan, Programme Manager (Operations)	Imran Devji, Interim Chief Operating Officer	31/12/2024			Not due until Q3
473	Internal Audit	Discharge Arrangements	2024	Limited	High	Matter Arising 3: Pathways of Care Delays (Design)	3.1c (iv): Management: • Establish formal escalation framework to address and support resolution of Pathways of Care Delays. • Ensure working practice complies with Welsh Government requirements.	3.1c (iv): Regional action plan refreshed in April 2024 discussed with each IHC and respective LAs to ensure actions align with top delays / areas of challenge and submitted to NHS Exec (quarterly). QUARTER 4	Libby Ryan-Davies, IHC Director - Central; Jane Trowman, Acting Assistant Director Care Homes Support and CHC Commissioning; Claire Brennan, Programme Manager (Operations)	Imran Devji, Interim Chief Operating Officer	31/03/2025			Not due until Q3
476	Internal Audit	Discharge Arrangements	2024	Limited	High	Matter Arising 3: Pathways of Care Delays (Design)	3.1 (iii): Management: • Establish formal escalation framework to address and support resolution of Pathways of Care Delays. • Ensure working practice complies with Welsh Government requirements.	3.1d (iii): Health & Social Care Trusted Assessor joint action plan submitted monthly to NHS Exec to monitor progress of additional roles and functions to support assessment delays. **QUARTER 3**	Libby Ryan-Davies, IHC Director - Central; Jane Trowman, Acting Assistant Director Care Homes Support and CHC Commissioning; Claire Brennan, Programme Manager (Operations)	Imran Devji, Interim Chief Operating Officer	31/12/2024			Q3 Not due but actions as above
477	Internal Audit	Discharge Arrangements	2024	Limited	High	Matter Arising 3: Pathways of Care Delays (Design)	3.1 (iv): Management: • Establish formal escalation framework to address and support resolution of Pathways of Care Delays. • Ensure working practice complies with Welsh Government requirements.	3.1d (iv): Health & Social Care Trusted Assessor joint action plan submitted monthly to NHS Exec to monitor progress of additional roles and functions to support assessment delays. **QUARTER 4**	Libby Ryan-Davies, IHC Director - Central; Jane Trowman, Acting Assistant Director Care Homes Support and CHC Commissioning; Claire Brennan, Programme Manager (Operations)	Imran Devji, Interim Chief Operating Officer	31/03/2025			Q4 Not due but actions as above
478	Internal Audit	Discharge Arrangements	2024	Limited	High	Matter Arising 4: Adverse discharges / Incidents (Design)	4.1: Management establish formal overarching policy or Standard Operating Procedure to support the operational management of incidents, including providing for adverse discharges. Governance, reporting, and escalation requirements must be clearly defined.	4.1: Each IHC to establish an Adverse Discharge Group with clear ToRs.	Libby Ryan-Davies, IHC Director - Central	Imran Devji, Interim Chief Operating Officer	30/09/2024			This is progressing as part of the USC work. PDSA developed for East and Centre. West well established. Work is supported by Care Home awareness training sessions, again well established in the west but PDSA cycle to roll out in other 2 IHC areas
479	Internal Audit	Discharge Arrangements	2024	Limited	Medium pre 01/10/2024	Matter Arising 4: Adverse discharges / Incidents (Design)	4.2: Management ensure adverse discharges are reviewed in accordance with stipulated timelines, with action taken (where necessary) and outcomes fed back to partner organisations in a timely manner.	4.2: Hold Discharge webinars with Care Homes across each IHC to improve communication and build trust between Health and Providers.	Libby Ryan-Davies, IHC Director - Central; Jane Trowman, Acting Assistant Director Care Homes Support and CHC Commissioning; Claire Brennan, Programme Manager (Operations)	Imran Devji, Interim Chief Operating Officer	30/09/2024	31/12/2024	1	This is progressing as part of the USC work. PDSA developed for East and Centre. West well established. Work is supported by Care Home awareness training sessions, again well established in the west but PDSA cycle to roll out in other 2 IHC areas
488	Internal Audit	Health and Safety - 2024	2024	Limited	High	Matter Arising 1: Policies & Procedures (Operation)	1.1b: Executive level responsibility for Occupational Health and Safety should be considered, to ensure Health and Safety is a key focus within the Health Board	1.1b: The Chief Executive is the responsible Executive Lead until there is a substantive appointment to the Director of Environment post.	Carol Shillabeer, Chief Executive	Carol Shillabeer, Chief Executive	Immediately			Shortlisting for the Director of Environment post has taken place, with interviewing on 26th October 2024.
491	Internal Audit	Health and Safety - 2024	2024	Limited	Medium pre 01/10/2024	Matter Arising 3: Health & Safety Training (Operation)	3.1a : The Health Board Executive Lead for Health and Safety ensures Policy reference 5.1.3 Training for Health Board Executive Directors and Independent Members is adhered to: "the Health Board will provide suitable and sufficient training and instruction to Members of the Board in respect of H&S Management. This will also include responsibilities under section 37 of the Health and Safety at Work etc. Act 1974 and the Corporate Manslaughter and Corporate Homicide Act 2007".	3.1a: Further training for Executive Team to be arranged, Executive responsibility to ensure attendance	David Maslen-Jones, Acting Assistant Director of Occupational Health, Safety and Security	Carol Shillabeer, Chief Executive	01/09/2024			Unchanged awaiting appointment of Executive team members to approve training programme with CEO

493	Internal Audit	Health and Safety - 2024	2024	Limited	High	Matter Arising 5: Gap analysis (Operation)	5.1: The gap analysis is reviewed and management identify what further work needs undertaking to ensure areas of risk / focus remain relevant. This should be considered alongside the strategy to inform Health and Safety activity across the Health Board	5.1: The Review of the Gap Analysis has commenced, completion is due in April 2024	David Maslen-Jones, Acting Assistant Director of Occupational Health, Safety and Security	Carol Shillabeer, Chief Executive	30/04/2024			Policy approved 28/09/2024, Gap analysis presented, Chief Executive now reviewing action plan with Head of Health & Safety
494	Internal Audit	Health and Safety - 2024	2024	Limited	Medium pre 01/10/2024	Matter Arising 6: Action Plans (Operation)	6.1: Estates to standardise action plans resulting from Health and Safety reviews and ensure regular review and update of actions to monitor progress	6.1: Estates are ensuring regular internal reviews of H&S for their areas and working on an action plan to ensure that any actions raised are addressed	Arwel Hughes, Head of Operational Estates	Carol Shillabeer, Chief Executive	01/04/2024	06/12/2024	1	Request that the implementation date is extended to demonstrate the effectiveness of the action plan over a period. Health and Safety meetings are held bi-monthly. Revised implementation date - 6th December 2024
513	Internal Audit	Contracted Patient Services: Quality and Safety Arrangements	2023	Limited	High	Matter Arising 1: Process management (Design)	1.1.2: Management establish robust overarching Commissioning Assurance Framework, Policy, or relevant Standard Operating Procedure (SOP) to support the healthcare commissioning/contracting process. This should ensure that lines of escalation, roles, responsibilities, and requirements regarding the management and oversight of the quality aspect of services provided are clearly defined.	1.1.2: The Health Board will develop a training package for staff engaged in the contract management process to support the delivery of the CAF. Note: the development of the CAF is likely to identify significant gaps in resource across functions in respect of meeting the organisational need identified in this audit, which would therefore be subject to a business case to achieve the required improvement in contract management practices including quality oversight. *Update from Executive Team meeting on 19/06/2024 is that, in the absence of the Director of Commissioning and Performance, there will be an oversight of a number of Executive Directors. Work on progressing the commission arrangements for contracts is underway and an update will be provided to the PFIG in August.*	Stephen Powell, Director of Performance and Commissioning	Stephen Powell, Director of Performance and Commissioning	31/08/2023	30/09/2024	2	This work will now be led by the Director of Performance and Commissioning, now that he is in post.
514	Internal Audit	Contracted Patient Services: Quality and Safety Arrangements	2023	Limited	High	Matter Arising 2: Contractual obligations (Design)	2.1.2: Management establish controls to ensure that all commissioned providers adhere to agreed contractual agreements and assess current contract review meeting arrangements to ensure appropriate levels of oversight and engagement.	2.1.2: The Health Board will ensure all agreements with Providers are backed up by a signed contract. *Update from Executive Team meeting on 19/06/2024 is that, in the absence of the Director of Commissioning and Performance, there will be an oversight of a number of Executive Directors. Work on progressing the commission arrangements for contracts is underway and an update will be provided to the PFIG in August.*	Stephen Powell, Director of Performance and Commissioning	Stephen Powell, Director of Performance and Commissioning	31/08/2023	30/09/2024	2	This work will now be led by the Director of Performance and Commissioning, now that he is in post.
515	Internal Audit	Contracted Patient Services: Quality and Safety Arrangements	2023	Limited	High	Matter Arising 2: Contractual obligations (Design)	2.1.3: Management establish controls to ensure that all commissioned providers adhere to agreed contractual agreements and assess current contract review meeting arrangements to ensure appropriate levels of oversight and engagement.	2.1.3: The Health Board will review current contracts and ensure all Contracts include updated reporting requirements, schedules, timetables, and meeting requirements. *Update from Executive Team meeting on 19/06/2024 is that, in the absence of the Director of Commissioning and Performance, there will be an oversight of a number of Executive Directors. Work on progressing the commission arrangements for contracts is underway and an update will be provided to the PFIG in August.*	Stephen Powell, Director of Performance and Commissioning	Stephen Powell, Director of Performance and Commissioning	31/08/2023	30/09/2024	2	This work will now be led by the Director of Performance and Commissioning, now that he is in post.
516	Internal Audit	Contracted Patient Services: Quality and Safety Arrangements	2023	Limited	High	Matter Arising 2: Contractual obligations (Design)	2.1.4: Management establish controls to ensure that all commissioned providers adhere to agreed contractual agreements and assess current contract review meeting arrangements to ensure appropriate levels of oversight and engagement.	2.1.4: The Health Board will review re-establish the internal monitoring of Provider reporting returns to include the escalation process should information not be provided. *Update from Executive Team meeting on 19/06/2024 is that, in the absence of the Director of Commissioning and Performance, there will be an oversight of a number of Executive Directors. Work on progressing the commission arrangements for contracts is underway and an update will be provided to the PFIG in August.*	Stephen Powell, Director of Performance and Commissioning	Stephen Powell, Director of Performance and Commissioning	31/08/2023	30/09/2024	2	This work will now be led by the Director of Performance and Commissioning, now that he is in post.
517	Internal Audit	Contracted Patient Services: Quality and Safety Arrangements	2023	Limited	High	Matter Arising 2: Contractual obligations (Design)	2.1.5: Management establish controls to ensure that all commissioned providers adhere to agreed contractual agreements and assess current contract review meeting arrangements to ensure appropriate levels of oversight and engagement.	2.1.5: The Health Board will re-establish its internal Contract Assurance Group, reviewing the Terms of Reference to ensure the remit and representation are adequate to make the meeting effective. *Update from Executive Team meeting on 19/06/2024 is that, in the absence of the Director of Commissioning and Performance, there will be an oversight of a number of Executive Directors. Work on progressing the commission arrangements for contracts is underway and an update will be provided to the PFIG in August.*	Stephen Powell, Director of Performance and Commissioning	Stephen Powell, Director of Performance and Commissioning	31/08/2023	30/09/2024	2	This work will now be led by the Director of Performance and Commissioning, now that he is in post.
518	Internal Audit	Contracted Patient Services: Quality and Safety Arrangements	2023	Limited	High	Matter Arising 3: Quality measures (Operation)	3.1.2: Management to review contractual quality measures to ensure they are robust, effective, and appropriate.	3.1.2: The Health Board will review its quality measures and develop a standard suite of measures, retaining the flexibility to include contract specific measures including the capture of patient feedback and will seek to negotiate these into contract documents with Providers. This will take effect from the next contract period – 2024/2025. *Update from Executive Team meeting on 19/06/2024 is that, in the absence of the Director of Commissioning and Performance, there will be an oversight of a number of Executive Directors. Work on progressing the commission arrangements for contracts is underway and an update will be provided to the PFIG in August.*	Stephen Powell, Director of Performance and Commissioning	Stephen Powell, Director of Performance and Commissioning	31/03/2024	30/09/2024	2	This work will now be led by the Director of Performance and Commissioning, now that he is in post.
519	Internal Audit	Contracted Patient Services: Quality and Safety Arrangements	2023	Limited	High	Matter Arising 3: Quality measures (Operation)	3.1.3: Management to review contractual quality measures to ensure they are robust, effective, and appropriate.	3.1.3: The Health Board will, as part of the Commissioning Assurance Framework, review information already produced by Providers, Regulators etc and as part of that review assess what assurance can be taken from these sources and how that can be captured and utilised by the Health Board e.g. Lead Commissioner/CQC. *Update from Executive Team meeting on 19/06/2024 is that, in the absence of the Director of Commissioning and Performance, there will be an oversight of a number of Executive Directors. Work on progressing the commission arrangements for contracts is underway and an update will be provided to the PFIG in August.*	Stephen Powell, Director of Performance and Commissioning	Stephen Powell, Director of Performance and Commissioning	31/07/2023	30/09/2024	2	This work will now be led by the Director of Performance and Commissioning, now that he is in post.
520	Internal Audit	Contracted Patient Services: Quality and Safety Arrangements	2023	Limited	High	Matter Arising 4: Board assurance (Design)	4.1: Management to review governance and reporting arrangements to ensure English NHS provider quality and performance data is subject to Health Board review and scrutiny.	4.1 2: The CAF will establish the reporting requirements and governance process for Contract Management including the reestablishment of the Healthcare Contracts Assurance Group and the onward flow of reports regarding Finance, Performance and Quality including escalation route. *Update from Executive Team meeting on 19/06/2024 is that, in the absence of the Director of Commissioning and Performance, there will be an oversight of a number of Executive Directors. Work on progressing the commission arrangements for contracts is underway and an update will be provided to the PFIG in August.*	Stephen Powell, Director of Performance and Commissioning	Stephen Powell, Director of Performance and Commissioning	31/08/2023	30/09/2024	2	This work will now be led by the Director of Performance and Commissioning, now that he is in post.
553	Internal Audit	Business Continuity Plans	2022	Limited	Medium pre 01/10/2024	Matter Arising 1: Business Continuity Working Group (Operation)	1.1a: The Working Group should meet on a quarterly bases in order to capture any concerns promptly and to ensure any issues or concerns are reported to the Civil Contingencies Assurance Group	1.1a: The working group is now scheduled to meet on a quarterly basis. The agenda will include a report updating the position on BC plans and will highlight areas of concern. These will be reported to the Civil Contingencies Assurance Group in line with the Terms of Reference.	Sharon Scott, EPRR Lead	Jane Moore, Acting Executive Director of Public Health	30/06/2022	31/01/2025	1	The Business Continuity Working Group will be re-established.
554	Internal Audit	Business Continuity Plans	2022	Limited	Medium pre 01/10/2024	Matter Arising 1: Business Continuity Working Group (Operation)	1.1b: The Terms of Reference should ensure it is transparent in its Membership by clearly listing roles of individuals who should be in attendance.	1.1b: The Terms of Reference for the Business Continuity Working Group will be updated to also include a list of individual (job titles) who are required to attend the group.	Sharon Scott, EPRR Lead	Jane Moore, Acting Executive Director of Public Health	30/06/2022	31/01/2025	1	TOR will be reviewed and updated. Membership will include IHC and Corporate/Pan HB BC Leads
555	Internal Audit	Business Continuity Plans	2022	Limited	Medium pre 01/10/2024	Matter Arising 1: Business Continuity Working Group (Operation)	1.1c: The quorum must be clearer as only one meeting in the last two years was quorate.	1.1c: The Terms of reference will be updated to include the revised number of members required for the meetings to be quorate	Sharon Scott, EPRR Lead	Jane Moore, Acting Executive Director of Public Health	30/06/2022	31/01/2025	1	TOR will be reviewed and updated. Membership will include IHC and Corporate/Pan HB BC Leads
556	Internal Audit	Business Continuity Plans	2022	Limited	Medium pre 01/10/2024	Matter Arising 1: Business Continuity Working Group (Operation)	1.1d: The BC Team should ensure they review any outstanding training for the BC Leads and to arrange further sessions as soon as is practicable to do so	1.1d: The training provision for the BC leads will be reviewed and scheduled to take place from the end of June	Sharon Scott, EPRR Lead	Jane Moore, Acting Executive Director of Public Health	13/06/2022	28/02/2025	1	A BC training programme will be developed for service leads to support the development of BC plans
557	Internal Audit	Business Continuity Plans	2022	Limited	High	Matter Arising 2: Incomplete Business Continuity Plans (Operation)	2.1a: The Health Board's Civil Contingencies Assurance Group should ensure that action is taken to ensure the seventy-five BCPs are drafted and implemented as soon as practicable. A process should be put in place to ensure plans are regularly reviewed and amended whenever any changes are made to local processes.	2.1a: The Health Board's Business Continuity Management Policy and Guidance Document will reviewed and incorporated into one policy document. This policy will also include the process for reviewing, training, testing and the amendment of plans. Plans will need to be reviewed every 6 months, staff need to be briefed on the plan and the procedures to follow, new staff also need to be trained in the plan and the plan should be tested every 12 months against a range of scenarios	Sharon Scott, EPRR Lead	Jane Moore, Acting Executive Director of Public Health	30/06/2022			BC SOP was developed in September 2022. This document is available on the BetsiNet EPRR page and is due for review in September 2025. We will review it again from where we are now against a more comprehensive set of criteria. Recommendation to remain open.
558	Internal Audit	Business Continuity Plans	2022	Limited	High	Matter Arising 2: Incomplete Business Continuity Plans (Operation)	2.1b: Localities should be reporting all tested BC plans to the EPRR Team to ensure assurance can be provided to the CCAG that plans work operationally in the event of an incident.	2.1b: Localities need to be advised to report all tested BC plans to the EPRR Team to include lessons identified and action plans	Sharon Scott, EPRR Lead	Jane Moore, Acting Executive Director of Public Health	30/06/2022	31/01/2025	1	A BC progress tracker will be developed to Track status of BC plans (draft, final, tested, review date) with a progress report taken to the CCAG
559	Internal Audit	Business Continuity Plans	2022	Limited	High	Matter Arising 2: Incomplete Business Continuity Plans (Operation)	2.1c: The Business Continuity Update and Monitoring Report to the CCAG should include whether or not plans have been tested as a Key Performance Indicator (KPI).	2.1c: The Business Continuity Update and Monitoring Reports will include the testing of plans included within the KPIs	Sharon Scott, EPRR Lead	Jane Moore, Acting Executive Director of Public Health	30/06/2022	31/01/2025	1	A BC progress tracker will be developed to Track status of BC plans (draft, final, tested, review date) with a progress report taken to the CCAG

560	Internal Audit	Business Continuity Plans	2022	Limited	High	Matter Arising 3: Escalation of non-completion of BCPs (Operation)	3.1a: The new Civil Contingencies Assurance Group (CCAG) is formally established and Terms of Reference reflect direct reporting groups.	3.1a: The Terms of Reference new CCAG will reflect the direct reporting groups such as the Business Continuity Working Group and the Civil Contingencies Group	Sharon Scott, EPRR Lead	Jane Moore, Acting Executive Director of Public Health	30/06/2022	30/11/2024	1	TOR will be reviewed and updated to include the direct reporting groups
561	Internal Audit	Business Continuity Plans	2022	Limited	High	Matter Arising 3: Escalation of non-completion of BCPs (Operation)	3.1b: Following a review of outstanding BCPs (see recommendation 2 above), relevant Executives should be provided with the detail of any areas within their responsibility that do not have completed plans.	3.1b: The arrangements required to provide an escalation process is currently being determined to ensure that the Executives are regularly appraised concerning the localities and departments that do not have completed plans in place	Sharon Scott, EPRR Lead	Jane Moore, Acting Executive Director of Public Health	30/06/2022	28/02/2024	1	The BC progress tracker will be shared with Executive Leads
583	Internal Audit	Effective Governance - Ysbyty Gwynedd (YG)	2022	Limited	High	Matter Arising 2: Finance (Operation)	2.1a: Management to identify and progress savings schemes as a matter of urgency.	2.1a(i): Savings Forum to be established across the newly formed West IHC to include a cross section of operational and clinical teams to establish further proposals for savings schemes to be worked up	Paul Andrew, IHC Operations Director, West; Chief Finance Officer	Imran Devji, Interim Chief Operating Officer	30/11/2022			Monthly CIP meetings continue to happen and feed into FPP. The meeting is IHC wide, and includes, Area, YG and facilities. The meeting has representation from clinical, Nursing and Ops.
584	Internal Audit	Effective Governance - Ysbyty Gwynedd (YG)	2022	Limited	High	Matter Arising 2: Finance (Operation)	2.1a: Management to identify and progress savings schemes as a matter of urgency.	2.1a(ii): West IHC Senior Team to focus on shorter term rectification / mitigations to manage the financial gap as a result of the incomplete delivery of savings, and identify any further potential transformational schemes and savings through the synergies of coming together as an integrated service.	Paul Andrew, IHC Operations Director, West; Chief Finance Officer	Imran Devji, Interim Chief Operating Officer	30/11/2022			As at month 6 the IHC savings plans are £1,917K short of its target. Forecast delivery is expected to be £1423K short of delivering. The IHC have escalated to value and sustainability and executives savings support required across BCU to facilitate.
585	Internal Audit	Effective Governance - Ysbyty Gwynedd (YG)	2022	Limited	High	Matter Arising 2: Finance (Operation)	2.1b: Management ensure the financial scrutiny is in line with the requirements laid out in the Operating Model.	2.1b(i): Pre-existing Finance & Performance meetings (Area and Ysbyty Gwynedd) to be re-established to maintain overview and scrutiny of the position for Q3 22/23.	Paul Andrew, IHC Operations Director, West	Imran Devji, Interim Chief Operating Officer	31/10/2022			The IHC monthly FPP meeting continues to take place and feed into the governance structure of the IHC.
586	Internal Audit	Effective Governance - Ysbyty Gwynedd (YG)	2022	Limited	High	Matter Arising 2: Finance (Operation)	2.1b: Management ensure the financial scrutiny is in line with the requirements laid out in the Operating Model.	2.1b(ii): In Line with new Operating Model, IHC F&P Operational Delivery Group to be established when corporate position on desired structure is clarified.	Paul Andrew, IHC Operations Director, West	Imran Devji, Interim Chief Operating Officer	31/01/2023			The IHC monthly FPP meeting continues to take place and feed into the governance structure of the IHC.
587	Internal Audit	Effective Governance - Ysbyty Gwynedd (YG)	2022	Limited	High	Matter Arising 4: Complaints and incidents (Operation)	4.1a: Management to review and action overdue incidents and complaints as a priority.	4.1a(i): The new IHC leadership team is concerned about the volume of overdue complaints and the length of time that some complainants are awaiting a response, and considerable effort has already gone in to reducing the backlog, which is much improved as at early October 2022.	Victoria Peach, IHC Nurse Director, West	Imran Devji, Interim Chief Operating Officer	30/11/2022			WICOG ToR is attached evidencing process for the management of all concerns (complaints, inquests, incidents); this has been embedded over the last 6 months. The ToR have been updated in alignment with the revised Integrated Concerns policy. The meetings are well attended and have been ran every week, chaired by DoN or Medical Director. The impact is a reduction of overdue complaints – from 174 April 2024 complaints to 69 on 30th September 2024.
588	Internal Audit	Effective Governance - Ysbyty Gwynedd (YG)	2022	Limited	High	Matter Arising 4: Complaints and incidents (Operation)	4.1a: Management to review and action overdue incidents and complaints as a priority.	4.1a(ii): System of allocating an Investigating Officer for complaints and incidents to be reviewed, to ensure that staff have appropriate training and support, and allocated time to discharge these responsibilities	Victoria Peach, IHC Nurse Director, West	Imran Devji, Interim Chief Operating Officer	30/11/2022			Incidents are managed effectively with a reduction in the number of outstanding NRI's, positive feedback from the Coroner, improved coordination of concerns across complaints, inquests and incidents. There is improved confident and competence of staff evidenced in the quality of the reports and clear alignment of learning to improvement steering groups. There remains challenges to allocate time to discharge the duties of all staff to effectively manage the concerns, this competing priority is an on-going challenge. It is noted that the West IHC does not have similar allocations of staff to support the improvement elements consistent with East and Central who do.
589	Internal Audit	Effective Governance - Ysbyty Gwynedd (YG)	2022	Limited	High	Matter Arising 4: Complaints and incidents (Operation)	4.1a: Management to review and action overdue incidents and complaints as a priority.	4.1a(iii): Oversight of complaints and incidents performance to be formalised via Directorate Accountability meetings on the Ysbyty Gwynedd site	Paul Andrew, IHC Operations Director, West	Imran Devji, Interim Chief Operating Officer	31/10/2022			The IHC hold 9 accountability meets, one-two each week. Oversight of complaints and incidents performance are discussed and monitored.
590	Internal Audit	Effective Governance - Ysbyty Gwynedd (YG)	2022	Limited	High	Matter Arising 4: Complaints and incidents (Operation)	4.1a: Management to review and action overdue incidents and complaints as a priority.	4.1a(iv): Level of manpower that is provided by the Governance team to support the Directorates on the Ysbyty Gwynedd site to be reviewed and benchmarked against the other sites, together with investigation of the analytical tools available to identify recurring themes / common cause in incidents and complaints	Paul Andrew, IHC Operations Director, West	Imran Devji, Interim Chief Operating Officer	31/01/2023			• As of 11th October 2024 we have 2 overdue complaints ID 23461 and ID 24437, both are waiting for medical responses; the latter has been returned for additional information from one consultant in relation to their individual correspondence, the other has been escalated to the Deputy Medical Director for support. This is a significant improvement from the 109 overdue complaints in April 2024. Sustainability of the position is expected as confidence and assurance in the functions in place since April 2024 continues to grow. •Whilst a review of the structure of the clinical governance team has not been completed we have reviewed our functions and reprioritised our oversight developing the local oversight meeting resulting in improvements in the management of the incidents. • There will be a plateau expected, as there will always be a residual number of open incidents being managed at any one time. • Triangulation of the concerns is overseen at the WICOG meeting, previously PTR, and appropriate transfer to specific steering groups is recommended for improvements to be made in practice.
591	Internal Audit	Effective Governance - Ysbyty Gwynedd (YG)	2022	Limited	High	Matter Arising 5: Risk Management (Operation)	5.1a The Risk Register requires review to ensure that risks are accurate and appropriate actions / dates are included	5.1a: A full review of the Risk Register will be undertaken across the West IHC to resolve the issues identified at Ysbyty Gwynedd, to include appropriate controls and mitigating actions. There has already been progress as reported at the Risk Management Group on 4th October, with 93% of risks "in date"	Paul Andrew, IHC Operations Director, West; Victoria Peach, IHC Nurse Director, West	Imran Devji, Interim Chief Operating Officer	30/11/2022			As per changes with the approach to risk for BCU; risks are managed within each of the relevant LDG's and reported to the relevant corporate governance group for oversight and scrutiny
592	Internal Audit	Effective Governance - Ysbyty Gwynedd (YG)	2022	Limited	High	Matter Arising 5: Risk Management (Operation)	5.1b Management to review consistency of reporting in accordance with the revised governance structure.	5.1b: A Risk Operational Delivery Group will be established as part of the revised governance structure with appropriate senior oversight and service representation to ensure that there is consistency of reporting across the West IHC, that risks are appropriately scrutinised and scored and visible on the live register, and appropriate escalation to Tier 1 is followed.	Paul Andrew, IHC Operations Director, West; Victoria Peach, IHC Nurse Director, West	Imran Devji, Interim Chief Operating Officer	31/01/2023			As per changes with the approach to risk for BCU; risks are managed within each of the relevant LDG's and reported to the relevant corporate governance group for oversight and scrutiny

593	Internal Audit	Effective Governance - Ysbyty Gwynedd (YG)	2022	Limited	High	Matter Arising 6 : Assurance to Quality, Safety and Clinical Effectiveness Group (Design)	6.1a(i) Audit data and results of audits (themes / trends / actions taken / improvements) are documented and provided to the relevant assurance meeting within the revised structure on a regular basis for assurance and scrutiny.	6.1a(i): A cycle of business will be established to ensure that the West IHC maintains oversight that audits are being undertaken across all areas and that the results are being reviewed in the appropriate forum and that any follow up action required is tracked. The Quality Operational Delivery Group, in the revised governance structure, will ensure wider visibility and learning from audit activities across the IHC.	Karen Mottart, IHC Medical Director	Imran Devji, Interim Chief Operating Officer	31/01/2023			All this is an internal report governance in Bangor (YG) - it is not the BCUHB one for internal audit of Clinical Effectiveness that was done in 2022 and further one in 2023. With the recent changes in YG Local Clinical Governance meetings and COB being reviewed and the structure of Strategic Clinical Effectiveness, and our processes of the way Clinical Effectiveness team link in.
594	Internal Audit	Effective Governance - Ysbyty Gwynedd (YG)	2022	Limited	High	Matter Arising 6 : Assurance to Quality, Safety and Clinical Effectiveness Group (Design)	6.1a(ii) Audit data and results of audits (themes / trends / actions taken / improvements) are documented and provided to the relevant assurance meeting within the revised structure on a regular basis for assurance and scrutiny.	6.1a(ii): Directorate Accountability meetings at Ysbyty Gwynedd will be relaunched as part of the revised governance structure, and will provide the ability to scrutinise audit activities and follow through of actions.	Paul Andrew, IHC Operations Director, West	Imran Devji, Interim Chief Operating Officer	31/10/2022			Accountability meetings in the IHC are well established and take place each week on a 9 week rolling schedule. There are representation from all IHC directors, as well as ops and clinical leads.
602	Internal Audit	On-Call arrangements	2022	Limited	High	Matter Arising 1 – Review of on-call arrangements (Design)	The on-call review should be re-instated as a priority, to ensure arrangements match service requirements, and are reviewed considering changing needs as a result of changes due to VERS and the new Operating Model. Management should consider the feedback from our questionnaire when reviewing on-call arrangements, and how these can be addressed. Following completion of the review and update of guidance (see Matters Arising 2,3 and 4 below), this should be communicated to staff to ensure they understand their obligations and responsibilities for participating in the on-call rotas.	1.1b: Proposals will be presented to the Executive Team, for approval.	Sharon Scott, EPRR Lead	Jane Moore, Acting Executive Director of Public Health	12/10/2022			The Acting Executive Director of Public Health will lead the work around On-call, but as part of a working group with others such as Workforce and Corporate Governance Directorate. The recommendation owner will be Sharon Scott, Head of EPRR.
603	Internal Audit	On-Call arrangements	2022	Limited	High	Matter Arising 4 – Training (Design)	The requirements of staff included in on-call rotas should be documented and staff provided with relevant information to ensure they are able to deal with expected issues whilst on-call i.e. key information about sites and services, as staff may not be familiar with the site they are responsible for during the on-call shift. Training should be provided to staff who are on the rotas to ensure they are aware of their responsibilities and possible scenarios of what they may have to deal with.	4.1b: Manual to be developed with key information, and details for those on call.	Sharon Scott, EPRR Lead	Jane Moore, Acting Executive Director of Public Health	24/10/2022			The Acting Executive Director of Public Health will lead the work around On-call, but as part of a working group with others such as Workforce and Corporate Governance Directorate. The recommendation owner will be Sharon Scott, Head of EPRR.
604	Internal Audit	On-Call arrangements	2022	Limited	High	Matter Arising 4 – Training (Design)	The requirements of staff included in on-call rotas should be documented and staff provided with relevant information to ensure they are able to deal with expected issues whilst on-call i.e. key information about sites and services, as staff may not be familiar with the site they are responsible for during the on-call shift. Training should be provided to staff who are on the rotas to ensure they are aware of their responsibilities and possible scenarios of what they may have to deal with.	4.1c: All staff to receive training with a programme and timescale set for refresher training every two years.	Sharon Scott, EPRR Lead	Jane Moore, Acting Executive Director of Public Health	12/12/2022			The Acting Executive Director of Public Health will lead the work around On-call, but as part of a working group with others such as Workforce and Corporate Governance Directorate. The recommendation owner will be Sharon Scott, Head of EPRR.
605	Internal Audit	On-Call arrangements	2022	Limited	High	Matter Arising 4 – Training (Design)	The requirements of staff included in on-call rotas should be documented and staff provided with relevant information to ensure they are able to deal with expected issues whilst on-call i.e. key information about sites and services, as staff may not be familiar with the site they are responsible for during the on-call shift. Training should be provided to staff who are on the rotas to ensure they are aware of their responsibilities and possible scenarios of what they may have to deal with.	4.1d: Real time log to be introduced for all levels of on-call to aid action learning with a rolling process of review by the IRDD and Strategic EPRR lead.	Sharon Scott, EPRR Lead	Jane Moore, Acting Executive Director of Public Health	10/09/2022			The Acting Executive Director of Public Health will lead the work around On-call, but as part of a working group with others such as Workforce and Corporate Governance Directorate. The recommendation owner will be Sharon Scott, Head of EPRR.
1272	Internal Audit	Risk Management - June 2024	2024	Limited	High	Matter Arising 3: Risk Management Group (Operation)	3.1: Consideration should be given to the role of the Risk Management Group and whether alternative arrangements may provide effective and regular scrutiny of operational risk registers, and corporate risks for escalation/de-escalation	3.1: The role and remit of the Risk Management Group will be reviewed, and a paper has been drafted for discussion of 'the role and future of RMG' with proposed options at the June meeting. The proposals also notes the need to increase this meeting to monthly. Options will be further considered by the Executive Team for alternative arrangements to provide more effective, regular scrutiny of operational risks and corporate risks. The new arrangement will be approved by Executive Team and Audit Committee. A new arrangement will be established following approval in Q2. Any agreed changes will be reflected in a revised Risk Management Framework and supporting procedures. A terms of reference will be drafted for this meeting following establishment and review Q3 2024. New meeting to be established in September 2024	Nesta Collingridge, Head of Risk Management	Pam Wenger, Director of Corporate Governance	30/09/2024			
1273	Internal Audit	Standards of Business Conduct - Declarations of Interest, Gifts and Hospitality - June 2024	2024	Limited	High	Matter Arising 1: Policy (Design)	1.1: Management: • Update policy to reflect current working practice and systems. • Ensure that the requirements regarding mandatory annual declarations of interest for staff that fall outside the documented pay band thresholds are clearly stated.	1.1: (a) Review and update Policy to ensure that it is in line with the rest of Wales (b) Review Policy to ensure that the pay bands are consistent with the rest of Wales (c) Discuss and agree with the Workforce Directorate ways in which the annual declarations of interest can be embedded into existing mechanisms.	Philippa Peake-Jones, Head of Corporate Affairs	Pam Wenger, Director of Corporate Governance	31/07/2024	31/10/2024	2	(a) Policy now amended and going through the internal approval. It now reflects declarations for 8c and above as per the rest of Wales – the policy will be reviewed again as part of a piece of work that is ongoing on an all-Wales basis. (b) Policy now amended and going through the internal approval. It now reflects the 8c and above as per the rest of Wales – the policy will be reviewed again as part of a piece of work that is ongoing on an all-Wales basis. (c) COMPLETED - see previous update
1274	Internal Audit	Standards of Business Conduct - Declarations of Interest, Gifts and Hospitality - June 2024	2024	Limited	Medium pre 01/10/2024	Matter Arising 1: Policy (Design)	1.2: Management: • Communicate operational requirements and ensure that relevant staff groups are aware of their responsibilities (e.g. role of line managers and Governance Leads in reviewing, approving, and escalating issues of concern).	1.2: • Communication briefing to all managers on responsibilities in relation to Declarations of Interest	Philippa Peake-Jones, Head of Corporate Affairs	Pam Wenger, Director of Corporate Governance	30/09/2024			Automated Communications go out via the Declare system.

1281	Internal Audit	Standards of Business Conduct - Declarations of Interest, Gifts and Hospitality - June 2024	2024	Limited	High	Matter Arising 5: BCU staff declarations of interest (Operation)	5.1: Management: • Ensure line managers are aware of their responsibilities regarding approving declarations of interest (and gifts and hospitality). • Ensure staff understand when, and how often, a declaration should be made. • Establish controls and /or oversight arrangements to manage and escalate non-responses (from Decision Makers) and failure to approve (by line managers). • Ensure data extracted from Declare is reviewed and adjusted appropriately prior to reporting (e.g. to Audit Committee).	5.1: (a) Draft a new communication plan and SOP for Declarations to include flow charts so that Managers are clear about their responsibilities. (b) Work with the Workforce Directorate on options around including Declarations on PADR templates(c) (c) Regularly review Declarations and identify and escalate non-responses (from Decision Makers) and failure to approve (by line managers)	Philippa Peake-Jones, Head of Corporate Affairs	Pam Wenger, Director of Corporate Governance	30/09/2024	31/10/2024	1	(a) COMPLETE - flow charts now in place, and provided as evidence to support closure. (b) ONGOING - This is ongoing and will be included in the PADR refresh. This has been agreed by the Deputy Director of People that they can be amended. (c) COMPLETE - These are reviewed on a weekly basis and are followed up – up to date ESR data is received at the beginning of every month and decision makers will change when the policy comes into place.
1282	Internal Audit	Standards of Business Conduct - Declarations of Interest, Gifts and Hospitality - June 2024	2024	Limited	High	Matter Arising 6: Gifts, Hospitality, and Sponsored Events (Operation)	6.1: Management: • Ensure all offers of hospitality and sponsored events are declared, reviewed, and approved prior to attending per policy requirements. All retrospective declarations to be escalated. • All hospitality and sponsored events to be approved by a Director / Assistant Director. • Ensure all declarations pending approval are reviewed and approved / declined. • Ensure provider details are recorded to enable effective monitoring per policy requirements.	6.1: (a) Reviewed gift, hospitality, and sponsored event declarations and produce a SOP and flow chart to ensure clarity. (b) Produce a communications plan to raise awareness and compliance	Philippa Peake-Jones, Head of Corporate Affairs	Pam Wenger, Director of Corporate Governance	31/10/2024			COMPLETE - flow charts now in place, and provided as evidence to support closure.
1283	Internal Audit	Effective Governance – Integrated Health Community (IHC) Central	2024	Limited	High	Matter Arising 1: Governance arrangements (Operation)	1.1: Working with the Corporate Governance Directorate, review the governance arrangements within the IHC, ensuring all Terms of Reference are reviewed and updated and consider the dates of meetings to always enable quorum	1.1: Central IHC will complete the review of the governance arrangements including frequency of meetings, Terms of Reference (ToR) and Cycle of Business. Suitable Chairs and Vice-Chair will be reviewed within this process.	Gareth Evans, IHC Director - Central	Imran Devji, Interim Chief Operating Officer	31/07/2024	31/12/2024	1	Chairs of various meetings within the CIHC have been asked to review the ToRs, Cycle of Business and this is taking place, this continues to be part of the ongoing process Revised implementation date 31 Dec 2024
1284	Internal Audit	Effective Governance – Integrated Health Community (IHC) Central	2024	Limited	High	Matter Arising 2: Financial control assurance (Operation)	2.1: The IHC Director ensures the Financial Control Group complies with its Terms of Reference and actively supports the IHC in delivering its expenditure reduction to meet its allocated resource.	2.1: Financial Recovery Plan meetings have been re-established and the ToR will be developed to reflect the reporting arrangements to Performance, Finance and Information Governance (PFIG). The purpose of these groups will be to oversee the planning and delivery of financial targets whilst understanding the impacts of the necessary change to deliver a reduction in financial spend. The implementation of the Financial Recovery framework for the IHC including regular meetings supported by the ToR, will be in place by end of July 2024.	Gareth Evans, IHC Director - Central	Imran Devji, Interim Chief Operating Officer	31/07/2024	31/12/2024	1	Regular cycle of meetings has been in place for some time, finance are reporting through pig (this last month) the update on the plan and we will be consolidating both the financial paper and the project plans, including PIDS for the next PFIG in September.
1285	Internal Audit	Effective Governance – Integrated Health Community (IHC) Central	2024	Limited	High	Matter Arising 3: Clinical Audit (Operation)	3.1: IHC to ensure that all audits at Tier 1, 2 and 3 are undertaken, and all outstanding responses are received. Findings and lessons learnt must be shared across the IHC and Health Board.	3.1: The Central IHC Clinical Effectiveness Group (CEG) will be the responsible forum for ensuring that required clinical audit is completed and assurance will be overseen by QODG.	Tania Bugelli, Consultant Psychiatrist in Liaison and Chair of CEG	Imran Devji, Interim Chief Operating Officer	31/07/2024	31/03/2025	1	The purpose of the Clinical Effectiveness Group (CEG) is to identify clinical risk via oversight and review of the following programs: •National and Local Clinical Audits •NICE Guidance Providing assurance in relation to improving clinical effectiveness and the safety of patients within the Health Board's services, as well as those provided by other organisations on behalf of the Health Board or as part of a partnership arrangement. CEG will discuss and confirm the level of clinical risk being held, triangulate against risk register and escalate any significant risk to QODG. CEG central will triangulate across directorates to oversee and support the development of IHC wide action/improvement plans to mitigate any clinical risks identified. CEG also ensures clinical and operational teams are aware of all clinical risks, and share improvement / action plans that have been developed across other services and be a point to oversee development of New Ways of Working and act as a point of approval and dissemination for new Policies-Standard Operating Procedures (SOP) process (see flow chart via link BCUHB Clinical Effectiveness Group (sharepoint.com)

1286	Internal Audit	Effective Governance – Integrated Health Community (IHC) Central	2024	Limited	High	Matter Arising 3: Clinical Audit (Operation)	3.2: IHC Clinical Effectiveness Group (CEG) and Quality Operational Delivery Group (QODG) meetings are aligned appropriately so that CEG meets prior to the QODG to enable the reporting of assurance/matters for escalation in a timely manner.	3.2: The TOR will be reviewed to ensure that this is reflected.	Tania Bugelli, Consultant Psychiatrist in Liaison and Chair of CEG	Imran Devji, Interim Chief Operating Officer	31/07/2024			The purpose of the Clinical Effectiveness Group (CEG) is to identify clinical risk via oversight and review of the following programs: •National and Local Clinical Audits •NICE Guidance Providing assurance in relation to improving clinical effectiveness and the safety of patients within the Health Board's services, as well as those provided by other organisations on behalf of the Health Board or as part of a partnership arrangement. CEG will discuss and confirm the level of clinical risk being held, triangulate against risk register and escalate any significant risk to QODG. CEG central will triangulate across directorates to oversee and support the development of IHC wide action/improvement plans to mitigate any clinical risks identified. CEG also ensures clinical and operational teams are aware of all clinical risks, and share improvement / action plans that have been developed across other services and be a point to oversee development of New Ways of Working and act as a point of approval and dissemination for new Policies-Standard Operating Procedures (SOP) process (see flow chart via link BCUHB Clinical Effectiveness Group (sharepoint.com)
1287	Internal Audit	Effective Governance – Integrated Health Community (IHC) Central	2024	Limited	High	Matter Arising 4: Concerns, Complaints, Incidents (Operation)	4.1: The IHC Director: • Ensures the IHC responds to all complaints according to expected reporting timelines and all learning is shared across the IHC. • Ensures operational management review all open incidents	4.1: The IHC have since developed trajectories to address the backlog of Open and overdue complaints, which will support completion of complaints against the reporting timelines. The QODG will receive assurance through the Patient, Safety Group (PSG). All Services will review their respective open incidents and performance will be monitored at PSG and assurance provided to QODG	Rachel Bowen, Associate Director of Nursing	Imran Devji, Interim Chief Operating Officer	31/07/2024			This action is ongoing, with trajectories being measured weekly. There is still work to do. These trajectories are also discussed weekly at HMT, with information being escalated via QDG
1288	Internal Audit	Effective Governance – Integrated Health Community (IHC) Central	2024	Limited	High	Matter Arising 5: Risk Management (Operation)	5.1: The IHC Director: • Ensures regular member attendance at the Health & Safety and Risk Management Group in order that they and the Senior Management Team receive assurance concerning the review and progression of all risks. • Ensures that all services regularly review their risks in accordance with RM02 Risk Management Procedures - 6.1 registers.	5.1: All services will regularly review their service risks in accordance with RMO2 Risk Management Procedures – 6.1 registers. Assurance will be received at the CIHC Health & Safety Risk Management Group. A review of the terms of reference will be undertaken in July 2024 to support regular member attendance.	Gareth Evans, IHC Director - Central	Imran Devji, Interim Chief Operating Officer	31/07/2024			TORs were reviewed at 25 July 2024 meeting and members were asked to give feedback for next meeting - ongoing process
1306	Internal Audit	Budgetary Control	2024	Limited	Medium pre 01/10/2024	Matter Arising 5: Virement Procedure (Operation)	5.1a The Virement procedure is reviewed and updated as necessary ensuring the requirements stipulated in the Standing Financial Instructions are embedded throughout. The procedure should then be published on the Finance Policy/Procedure intranet site for all Budget Holders/Managers to comply with.	5.1a The Finance teams currently operate a budget virement, management agreeing to an action to review the existing local finance procedure and will look to incorporate the existing procedure (with any amendments following review) within the Budget Manager Handbook.	Michelle Jones, Head of Financial Reporting	Russell Caldicott, Interim Executive Director of Finance	30/09/2024			The current SOP, which is very much an internal Finance department document, has been updated in a number of areas, and has been strengthened in relation to SFI requirements. The updates are under review, and we hope to report this as complete in time for the 24/10/24 update. The budget holders handbook makes reference to the SFI in terms of the budget responsibilities of the Budget Holders and this is published on the BCU webpage.
1324	Internal Audit	Orthopaedic Surgical Hub Llandudno Hospital	2024	Limited	Medium pre 01/10/2024	Matter Arising 3: Project Execution Plan (Operation)	3.1: The PEP should be reviewed and updated to reflect this project.	3.1: Agreed - the PEP is to be updated to reflect current project status and the governance refresh agreed following Gateway review.	Daniel Eyre, Head of Capital Development	Chris Stockport, Executive Director of Transformation and Strategic Planning	31/08/2024			Following the revision of the project governance in response to the gateway review in July 2024, it is now in place and the PEP is currently being updated to reflect this change.
1327	Internal Audit	Orthopaedic Surgical Hub Llandudno Hospital	2024	Limited	High	Matter Arising 4: Works Procurement (Operation)	4.3: Retrospective approval should be obtained to appoint the preferred contractor for the main works project.	4.3: Agreed – Discussions to take place with DoF/Deputy DoF to discuss most appropriate approval route.	Daniel Eyre, Head of Capital Development	Chris Stockport, Executive Director of Transformation and Strategic Planning	31/08/2024			Process and options for route are being reviewed, targeted to be concluded during November 2024
1331	Internal Audit	Orthopaedic Surgical Hub Llandudno Hospital	2024	Limited	High	Matter Arising 5: Project Bank Account (Operation)	5.1: Formal Welsh Government approval is required to avoid using the Project Bank Account at both the enabling and main works contracts.	5.1: Agreed - The contractor is willing to set up a project bank account, we are currently exploring the process and timescale. Contractor have been instructed to progress.	Daniel Eyre, Head of Capital Development	Chris Stockport, Executive Director of Transformation and Strategic Planning	31/12/2024			We have requested that the contractor establishes the project bank account, however confirmation is currently outstanding. This will be escalated at the next bi-weekly director meeting.
1337	Internal Audit	Orthopaedic Surgical Hub Llandudno Hospital	2024	Limited	Low	Matter Arising 8: Design sign off (Operation)	8.1: Noting that meetings to discuss design are now held virtually, consideration should be given to how formal sign off can be captured in the future.	8.1: Agreed - Meetings to confirm sign off have been recorded in teams and some responses have also been confirmed by email as evidence. We will review alternative approaches that support virtual sign off going forward.	Ruth Stiles, Senior Project Manager	Chris Stockport, Executive Director of Transformation and Strategic Planning	31/08/2024			A review of the Capital Manual procedures is to commence and will reflect the changes in how formal sign off's are recorded following the shift from in person to Teams meetings. It is targeted that this is completed during 2025/26.
1339	Internal Audit	Corporate Legislative Compliance - Fire Safety	2024	Limited	High	Matter Arising 1: Governance (Design)	1.1a Reporting and committee structure should be reviewed and agreed to ensure there are appropriate governance arrangements in place to receive assurance on fire safety.	1.1a Reporting structure to be reviewed and align with escalation processes set out within the Health Board	Pam Wenger, Director of Corporate Governance	Russell Caldicott, Interim Executive Director of Finance	10/04/2025			*New to tracker*
1340	Internal Audit	Corporate Legislative Compliance - Fire Safety	2024	Limited	High	Matter Arising 1: Governance (Design)	1.1b Fire safety reporting groups and committees should meet at regular intervals as per their agreed terms of refence. Any issues with attendance should be escalated to the relevant director	1.1b Meeting to take place in accordance with the Terms of Reference of the Strategic Occupational Health and Safety Group	Carol Shillabeer, Chief Executive (in absence of Director of Environment and Estates)	Russell Caldicott, Interim Executive Director of Finance	29/10/2024			*New to tracker*
1341	Internal Audit	Corporate Legislative Compliance - Fire Safety	2024	Limited	Medium	Matter Arising 2: Policy for the Management of Fire Safety (Design)	2.1a The Health Board review and update its policy for the Management of Fire Safety to ensure compliance with the Welsh Health Technical Memorandum (WHTM) 05-01 'Firecode – Managing healthcare fire safety', and Welsh Assembly Government NHS Wales Fire Safety Policy	2.1a Fire Safety Policy to be reviewed and updated to reflect the current management structure and contents in accordance with current legislation and WHTM 05-01 Firecode - Managing healthcare fire safety.	Arwel Hughes, Head of Operational Estates	Russell Caldicott, Interim Executive Director of Finance	20/03/2025			*New to tracker*

1342	Internal Audit	Corporate Legislative Compliance - Fire Safety	2024	Limited	Medium	Matter Arising 3: Fire Risk Assessments (Operation)	3.1a All officers accountable for Fire Risk Assessments ensure documents are reviewed and updated at regular intervals to ensure potential and new risks have been identified and evaluated. This should be monitored and escalated via the Fire Safety Management Group.	3.1a Fire Safety Advisors to ensure Fire Risk Assessments are undertaken within the recognised timeframes contained within HTM05-03: Operational provisions Part K - Guidance on fire risk assessments in complex healthcare premises. Reports will be generated and presented to the Fire Safety Management Group. Results will be escalated as appropriate.	Arwel Hughes, Head of Operational Estates	Russell Caldicott, Interim Executive Director of Finance	26/03/2025			*New to tracker*
1343	Internal Audit	Corporate Legislative Compliance - Fire Safety	2024	Limited	High	Matter Arising 4: Fire Training (Operation)	4.1a The Health Board ensure compliance with its Fire Safety Policy and ensure full participation of its employees through a tailored training programme applicable to their individual needs. This should be constantly monitored through the Fire Safety Management Group to ensure staff compliance.	4.1a Fire Safety training to be carried out in accordance with the Fire Safety Training Delivery Plan contained within Fire Safety Policy ES04. Staff compliance levels will be reported through the Fire Safety Management Group. Data will be collected from ESR and reported accordingly. Training needs analysis will be reviewed against the new HTM o5-03 Part A.	Arwel Hughes, Head of Operational Estates	Russell Caldicott, Interim Executive Director of Finance	20/03/2025			*New to tracker*
1344	Internal Audit	Corporate Legislative Compliance - Fire Safety	2024	Limited	High	Matter Arising 5: Annual Management Fire Audit (Operation)	5.1a Management ensure compliance with the requirement of Welsh Health Technical Memorandum (WHTM) 05-01 'Firecode – Managing healthcare fire safety, and annual management fire audit be submitted within the mandatory timeframes	5.1a Fire Safety Audit to be conducted as detailed in WHTM05/01 Managing Healthcare Fire Safety utilising the Fire Safety Audit System. The outcomes communicated to the Board via the escalation process through the SOHSG	Arwel Hughes, Head of Operational Estates	Russell Caldicott, Interim Executive Director of Finance	06/08/2024			*New to tracker*
1345	Internal Audit	Corporate Legislative Compliance - Fire Safety	2024	Limited	High	Matter Arising 6: Site Specific Issues / Documentation (Operation)	6.1a (i) Management ensure issues identified in Appendix C of this report should be progressed through local arrangements and assurance provided to the Fire Safety Management Group on progress / completion.	6.1a (i) Action plan has been generated to address the issues raised in Appendix C of this report and progress on resolving the findings will be reported to the Fire Safety Management Group.	Arwel Hughes, Head of Operational Estates	Russell Caldicott, Interim Executive Director of Finance	20/03/2025			*New to tracker*
1346	Internal Audit	Corporate Legislative Compliance - Fire Safety	2024	Limited	High	Matter Arising 6: Site Specific Issues / Documentation (Operation)	6.1a (ii) Management ensure issues identified in Appendix C of this report should be progressed through local arrangements and assurance provided to the Fire Safety Management Group on progress / completion.	6.1a (ii)Review the current arrangements for the undertaking of pre-planned maintenance and present the findings and recommendations to the Fire Safety Management Group.	Arwel Hughes, Head of Operational Estates	Russell Caldicott, Interim Executive Director of Finance	20/03/2025			*New to tracker*
1347	Internal Audit	Corporate Legislative Compliance - Fire Safety	2024	Limited	High	Matter Arising 6: Site Specific Issues / Documentation (Operation)	6.1a (iii) Management ensure issues identified in Appendix C of this report should be progressed through local arrangements and assurance provided to the Fire Safety Management Group on progress / completion.	6.1a (iii) Report the number and results of Fire Drills to the Fire Safety Management Group.	Arwel Hughes, Head of Operational Estates	Russell Caldicott, Interim Executive Director of Finance	27/11/2024			*New to tracker*
1348	Internal Audit	Corporate Legislative Compliance - Fire Safety	2024	Limited	High	Matter Arising 6: Site Specific Issues / Documentation (Operation)	6.1a (iv) Management ensure issues identified in Appendix C of this report should be progressed through local arrangements and assurance provided to the Fire Safety Management Group on progress / completion.	6.1a (iv) Review the current arrangements for the undertaking of Fire drills across BCUHB and present the findings and recommendations to the Fire Safety Management Group.	Arwel Hughes, Head of Operational Estates	Russell Caldicott, Interim Executive Director of Finance	27/11/2024			*New to tracker*

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

Teitl adroddiad: ***Report title:***	Historical External Audit Recommendations
Adrodd i: ***Report to:***	Audit Committee
Dyddiad y Cyfarfod: ***Date of Meeting:***	Thursday, 16 January 2025
Crynodeb Gweithredol: ***Executive Summary:***	The purpose of this report is to provide the Audit Committee with: • an update on the historical External Audit recommendations • proposals around historical External Audit recommendations.
Argymhellion: ***Recommendations:***	The Audit Committee is asked to: • **NOTE** the current position with regards to historical External Audit recommendations; • **APPROVE** the proposals within the report relating to historical External Audit recommendations; • **NOTE** the position in relation to the Board Effectiveness Review and Follow-up and **APPROVE** the closure of recommendations if the Audit Committee is satisfied with the assurances provided
Arweinydd Gweithredol: ***Executive Lead:***	Pam Wenger, Director of Corporate Governance
Awdur yr Adroddiad: ***Report Author:***	Glesni Driver, Head of Covid-19 Inquiry and Thirlwall Inquiry

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

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

Cyfiawnhad dros y gyfradd sicrwydd uchod. Lle bo sicrwydd 'Rhannol' neu 'Dim Sicrwydd' wedi'i nodi uchod, nodwch gamau i gyflawni sicrwydd 'Derbyniol' uchod, a'r terfyn amser ar gyfer cyflawni hyn: ***Justification for the above assurance rating. Where 'Partial' or 'No' assurance has been indicated above, please indicate steps to achieve 'Acceptable' assurance or above, and the timeframe for achieving this:***	
A number of historical (pre-2022) External Audit recommendations are included on the live tracker following the work to retrospectively update the live tracker with recommendations previously omitted following the transfer from the previous audit tracking system, TeamMate to the current live tracker. These are now historical in nature, and have been presented to the Executive Team for review on 18th December 2024, and now for Audit Committee review meeting at its January 2025 meeting.	
Cyswllt ag Amcan/Amcanion Strategol: ***Link to Strategic Objective(s):***	Not applicable, other than those relating to individual audit reviews/recommendations.
Goblygiadau rheoleiddio a lleol: ***Regulatory and legal implications:***	Compliance with Internal and External Audit requirements.
Yn unol â WP7, a oedd EqIA yn angenrheidiol ac a gafodd ei gynnal? ***In accordance with WP7 has an EqIA been identified as necessary and undertaken?***	The Equality duty is not applicable. This report is purely administrative in nature and submitted for information only. The associated public sector duties are not engaged, and there are no associated impacts on any of the protected groups
Yn unol â WP68, a oedd SEIA yn angenrheidiol ac a gafodd ei gynnal? ***In accordance with WP68, has a SEIA identified as necessary been undertaken?***	The Socio-Economic duty is not applicable. This report is purely administrative in nature and submitted for information only. The associated public sector duties are not engaged, and the report does not relate to a decision, strategic or otherwise.
Manylion am risgiau sy'n gysylltiedig â phwnc a chwmpas y papur hwn, gan gynnwys risgiau newydd (croesgyfeirio at y BAF a'r CRR) ***Details of risks associated with the subject and scope of this paper, including new risks (cross reference to the BAF and CRR)***	Not applicable, other than those relating to individual audit reviews/recommendations.
Goblygiadau ariannol o ganlyniad i roi'r *argymhellion ar waith* ***Financial implications as a result of implementing the recommendations***	Not applicable, other than those relating to individual audit reviews/recommendations.
Goblygiadau gweithlu o ganlyniad i roi'r argymhellion ar waith ***Workforce implications as a result of implementing the recommendations***	Not applicable, other than those relating to individual audit reviews/recommendations.
Adborth, ymateb a chrynodeb dilynol ar ôl ymgynghori ***Feedback, response, and follow up summary following consultation***	The report has been prepared following feedback from previous Executive Team and Audit Committee meetings, and ongoing discussions with Internal Audit and Audit Wales.

Cysylltiadau â risgiau BAF: (neu gysylltiadau â'r Gofrestr Risg Gorfforaethol) ***Links to BAF risks:*** *(or links to the Corporate Risk Register)*	Not applicable, other than those relating to individual audit reviews/recommendations.
Rheswm dros gyflwyno adroddiad i fwrdd cyfrinachol (lle bo'n berthnasol) ***Reason for submission of report to confidential board (where relevant)***	Not applicable
Camau Nesaf: **Gweithredu argymhellion** ***Next Steps:*** ***Implementation of recommendations***	
Rhestr o Atodiadau: ***List of Appendices:*** • Appendix 1 – All pre-2022 Audit Wales Audit recommendations • Appendix 2 – All 2022-24 Audit Wales recommendations • Appendix 3 – Board Effectiveness Review and Follow-up Recommendations	

HISTORICAL EXTERNAL AUDIT RECOMMENDATIONS

1. INTRODUCTION AND BACKGROUND

The report provides an update on historical External Audit recommendations from reports published prior to 2022, and proposals on how to progress these in line with updates included on the TeamMate system. This follows the presentation of historical internal audit recommendations to the Audit Committee in November 2024.

2. HISTORICAL RECOMMENDATIONS – PRE-2022

As has previously been reported, the Health Board was able to obtain a copy of the information included within the TeamMate system - the audit tracking system in use by the Health Board at that time to capture recommendations, prior to ceasing its use in late 2023. Within that TeamMate update, each Internal Audit and Audit Wales recommendation was categorised at different approval stages, and Internal Audit have confirmed that the below were the different approval categories used at that time:

Approval stage	Internal Audit description of recommendation stage
Closed - Not Verified	No verification as closed by the Audit Committee but not verified by IA as outside IA scope
Closed - Verified	Closed by IA following verification
Implemented - Audit Approved	Closed by the Audit Committee but not verified by IA. Any limited/No assurance reports require review by IA but this has not happened yet. IA would review them and then would assign 'Closed - verified' or 'Closed - not verified' if it was outside the scope of IA follow-up
Implemented - Final Client Approved	Exec has approved after the Owner has confirmed complete
Implemented - Partial Client Approved	Owner has confirmed implemented and an email has been sent to the Executive asking them to approve and move it to Final Client Approved stage - Awaiting Executive Director approval
Started	This is where the work to progress the recommendation has started

All recommendations and associated information contained within the TeamMate update has now been transferred into the live tracker, some pre-dating 2022.

2.1 Pre-2022 recommendations

In line with the approval process in place at that time, many of the recommendations were deemed as ‘closed’, and the recommendation completed on the TeamMate system. Also, due to the historical nature of many of these recommendations, it is likely that they are outdated or superseded.

The work required to source updates on progress, and evidence to support closure for recommendations that have already been implemented under the historical process would be inefficient and ineffective, and divert the focus away from implementing more current and appropriate recommendations. Also, many of the Executive leads and recommendation owners have since left the Health Board, which would mean identifying new owners for these recommendations. However, some of these are still be valid, and work may still be required to implement changes.

Appendix 1 shows all the pre-2022 Audit Wales recommendations, and all the narrative around the progress of each recommendation at that time has been transposed from the TeamMate information onto the live tracker.

Proposal 1: The Director of Corporate Governance has discussed with Audit Wales, who were supportive of the proposal to close all recommendations pre-2022. This is consistent with the approach taken by Audit Wales in relation to the Structured Assessment.

Therefore, the Audit Committee is asked to **approve** this proposal.

3 HISTORICAL RECOMMENDATIONS – 2022/2023

Again, due to the historical nature of some of these recommendations, it is likely that they are outdated or superseded. As with those pre-dating 2022, the work required to source updates on progress, and evidence to support closure for recommendations that have already been implemented under the historical process would be inefficient and ineffective, and divert the focus away from implementing more current and appropriate recommendations. However, some of these may still be valid, and work still required to implement changes.

Appendix 2 shows all the 2022/24 Audit Wales recommendations.

Proposal 2: It is proposed that the Audit Wales recommendations included in Appendix 2 are closed as per the approach outlined in Proposal 1 (above). It is furthermore noted that there will be a review of Quality Governance Arrangements undertaken by Audit Wales in 2025/26 as well as planned internal audit reviews.

Therefore, the Audit Committee is asked to **approve** this proposal.

4 BOARD EFFECTIVENESS REVIEW

Audit Wales undertook a Board Effectiveness Review in 2023 and a follow-up review in 2024. The details are included in Appendix 3.

The following recommendations are proposed for closure which have been reviewed by Audit Wales. Whereby the recommendation was outside of the scope of the Structured Assessment, narrative update is provided so that the Audit Committee can consider if there is sufficient assurance to close the recommendation.

Board Effectiveness and Follow-up Review – Recommendations for closure

Ref	Audit Report	Recommendation Title	Recommendation	Status
421	Review of Board Effectiveness	Responding to independent reviews and investigations	1a: Take the necessary action in response to the findings from the investigations into whistleblowing disclosures that relate to Executive Directors and senior management (noting that any actions in respect of concerns about Independent Members would be matters for the Minister).	**Audit Wales Commentary** Outside of the scope of Structured Assessment 2024 **Management Commentary** Superseded with changes in the Board
424	Review of Board Effectiveness	Rebuilding and strengthening senior leadership capacity	2a: Expedite plans to recruit a substantive Chief Executive Officer as a matter of urgency.	**Audit Wales Commentary** Complete.
426	Review of Board Effectiveness	Rebuilding and strengthening senior leadership capacity	2c: Act urgently to bolster senior staff capacity in the Finance Team to mitigate the impact on business continuity.	**Audit Wales Commentary** Outside of the scope of Structured Assessment 2024 **Management Commentary** Interim Director of Finance in post and senior team. Recruitment for Finance Director in progress
428	Review of Board Effectiveness	Building a more cohesive and effective board and Executive Team	3b: Take urgent action to create a more collegiate and unified approach to leadership of the organisation, which involves: • Ensuring the Executive Team understand the concerns held by Independent Members over performance and assurances received, including issues relating to the quality of papers presented to the board and its committees.	**Audit Wales Commentary** This is superseded due to changes to the Board made in February 2023
429	Review of Board Effectiveness	Building a more cohesive and effective board and Executive Team	3c: Take urgent action to create a more collegiate and unified approach to leadership of the organisation, which involves: • Ensuring that Independent Members understand Executive team concerns about the impact of overly robust challenge, with the aim of moving to a 'high support and high challenge' leadership approach.	**Audit Wales Commentary** This is superseded due to changes to the Board made in February 2023

430	Review of Board Effectiveness	Building a more cohesive and effective board and Executive Team	3d: Take urgent action to create a more collegiate and unified approach to leadership of the organisation, which involves: • Establishing an agreed level of risk appetite and tolerance between Executives and Independent Members.	**Audit Wales Commentary** Whilst we are aware that the Board set its risk appetite at a board development session in 2024 we have not reviewed this work in detail **Management Commentary** Significant work in relation to risk management has been processed and this is evidenced through Board and Committee papers as well as Internal Audit reports
431	Review of Board Effectiveness	Building a more cohesive and effective board and Executive Team	3e: Take urgent action to create a more collegiate and unified approach to leadership of the organisation, which involves: • Establishing a working environment and culture at board and its committees that promotes transparency and maintains the correct balance between scrutiny, challenge and support, reflecting the organisation's expected values and behaviours.	**Audit Wales Commentary** Transparency of board business covered in paragraphs 26 - 30 of the 2024 Structured Assessment. Positive view on the commitment to transparency. Paragraphs 38 - 39 also comment on how the committees are maturing and there was evidence of constructive challenge during our fieldwork. (AW view that has been achieved but will clearly need to be maintained)
432	Review of Board Effectiveness	Building a more cohesive and effective board and Executive Team	3f: Take urgent action to create a more collegiate and unified approach to leadership of the organisation, which involves: • Using appropriate external facilitators and mediators to work through the above issues as part of a wider board development programme which is informed by the King's Fund's reflections on the previous board development programme.	**Audit Wales Commentary** Positive feedback on the SilverMaple work and specifically how it encourages a collegiate approach which was expressed during the fieldwork for this year's SA, but we cannot comment on the extent to which they have delved into detail on historical challenges. **Management Commentary** Development Plan agreed by the Board and ongoing development for the Board to be agreed with the Chair
433	Review of Board Effectiveness	Building a more cohesive and effective board and Executive Team	3g: Take urgent action to create a more collegiate and unified approach to leadership of the organisation, which involves: • Aligning Independent Member portfolios to Executive Director portfolios to support information and knowledge sharing.	**Audit Wales Commentary** Outside of the scope of Structured Assessment 2024 **Management Commentary** Board Member roles have been clarified with alignment to Board Committees and Board Champions appointed.

434	Follow Up Review of Board Effectiveness		There is an immediate need to continue, and to conclude the work aimed at stabilising the board and the wider senior leadership of the organisation. That includes getting to a position where the board has a full complement of substantive Independent Members	**Audit Wales Commentary** Complete.
435	Follow Up Review of Board Effectiveness		There is an immediate need to continue, and to conclude the work aimed at stabilising the board and the wider senior leadership of the organisation. That includes getting to a position with a substantive Chair in place	**Audit Wales Commentary** Complete.
436	Follow Up Review of Board Effectiveness		urgent need to re-establish a committee structure below the board that provides the necessary oversight, scrutiny, and support across all aspects of the organisation's business	**Audit Wales Commentary** Covered in paragraphs 37 – 41 Structured Assessment
437	Follow Up Review of Board Effectiveness		The raft of disclosures that were received towards the end of 2022 should be used to inform the programme of board development that the new board will need to put in place. In particular, it should inform the work that is underway on organisational culture and compassionate leadership, and ensure that this starts with the right 'tone from the top'.	**Audit Wales Commentary** Outside of the scope of Structured Assessment 2024
439	Follow Up Review of Board Effectiveness		Must also look to get itself as quickly as possible to a position where it has the necessary internal capacity and capability to sustain improvement and avoid the need to continually look to the outside for support to achieve the improvements which are necessary.	**Audit Wales Commentary** Outside of the scope of Structured Assessment 2024 **Management Commentary** Significant work has been undertaken to recruit to the Executive Team but also recognising there are still some posts. The appointments made in the last 12 months should provide assurances about the internal capacity that was an issue identified in the follow-up review

Board Effectiveness and Follow-up Review – Recommendations update (open)

This table provides an update on the recommendations from the Board Effectiveness Review and Follow-up which are considered to be open. The status provides a position from Audit Wales and where the recommendations have been superseded by the Structured Assessment 2024 these will be cross referenced in future reports.

Ref	Audit Report	Recommendation Title	Recommendation	Status
422	Review of Board Effectiveness	Responding to independent reviews and investigations	1b: Resolve quickly any issues arising from the Ernst Young review.	**Audit Wales Commentary** included in SA 2024 - paragraph 119 (AW view is that the associated rec R8 from 2023 is ongoing) **Management Response** The Health Board is working through the processes and will report progress in 2025
423	Review of Board Effectiveness	Responding to independent reviews and investigations	1c: Fully support any investigations the National Counter Fraud Service need to undertake in response to the Auditor General's audit of the 2021-22 accounts and the subsequent Ernst Young review.	**Audit Wales Commentary** included in SA 2024 - paragraph 119 (AW view is that the associated rec R8 from 2023 is ongoing) **Management Response** The Health Board is working through the processes and will report progress in 2025
425	Review of Board Effectiveness	Rebuilding and strengthening senior leadership capacity	2b: Critically review the use of interim senior appointments and management consultants with a view to reducing reliance on such appointments within the senior leadership structures.	**Audit Wales Commentary** Paragraphs 16-18 highlight need to fill remaining gaps on the Executive team **Management Response** Review the Structured Assessment 2024 to cross check)
427	Review of Board Effectiveness	Building a more cohesive and effective board and Executive Team	3a: Take urgent action to create a more collegiate and unified approach to leadership of the organisation, which involves: • Repairing / addressing the working relationships within the Executive Team.	**Audit Wales Commentary** Paragraphs 16-18 highlight need to fill remaining gaps on the Executive team **Management Response** Review the Structured Assessment 2024 to cross check)
1419	Follow Up Review of Board Effectiveness	Leadership	There is an immediate need to continue, and to conclude the work aimed at stabilising the board and the wider senior leadership of the organisation. That includes getting to a position where the board has a full complement of substantive Executive Directors	**Audit Wales Commentary** Paragraphs 16-18 highlight need to fill remaining gaps on the Executive team **Management Response** Review the Structured Assessment 2024 to cross check)

Ref	Audit Report	Recommendation Title	Recommendation	Status
1424	Follow Up Review of Board Effectiveness	Leadership	A key priority for the new Chief Executive will be to build a stable, cohesive, and appropriately skilled Executive Team that can provide the organisation with the operational leadership it needs. This will include settling on the right mix of Executive Director portfolios, reducing reliance on interim arrangements for senior leadership roles, and building leadership capacity and capability for the Health Board's corporate governance arrangements	**Audit Wales Commentary** Paragraphs 16-18 highlight need to fill remaining gaps on the Executive team **Management Response** Review the Structured Assessment 2024 to cross check.
1425	Follow Up Review of Board Effectiveness		The Executive Team must also be appropriately connected to the leadership structures that sit below it, something which will need to be supported by ensuring the Health Board's operational model is fit for purpose.	**Audit Wales Commentary** Commented in paragraphs 21- 24 of the SA 2024. **Management Response** Review the Structured Assessment 2024 to cross check.

5 CONCLUSION AND RECOMMENDATIONS

The work to close historical recommendations will ensure that the live tracker only includes recommendations from audit reports that are still valid and relevant, and in line with this, that there is an appropriate approval process for the closure of all those historical recommendations.

Once the live tracker has been cleansed, this will ensure that only those valid and relevant recommendations are transferred to a new electronic audit tracking system once identified, and the work to look at options around this system can then continue.

6 BUDGETARY/FINANCIAL IMPLICATIONS

There are no budgetary implications associated with this paper.

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

Work is ongoing to identify an electronic audit tracking system, which will have a budgetary and resource implication. However, at this stage, no further information is available in this respect, and will be presented at a future meeting, when more details are available.

7 RISK MANAGEMENT

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

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

8 EQUALITY AND DIVERSITY IMPLICATIONS

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

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

APPENDIX 1 – ALL PRE-2022 AUDIT WALES AUDIT RECOMMENDATIONS

APPENDIX 2 – ALL 2022-24 AUDIT WALES RECOMMENDATIONS

APPENDIX 3 – BOARD EFFECTIVENESS REVIEW AND FOLLOW-UP RECOMMENDATIONS

APPENDIX 1 - ALL EXTERNAL AUDIT PRE-2022 RECOMMENDATIONS

Excludes Structured Assessments

ID	Report Title	Year	Assurance Level	Priority	Recommendation Title	Recommendation	Management Response	Action Owner	Final Approver	Original implementation date	Revised implementation date	Number of Revisions	TeamMate system update	TeamMate state
226	Continuing Healthcare Arrangements	2020	N/A	High	R3 - The Health Board should increase consistency of its CHC team structures and ensure roles are clearly articulated and understood	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.	Kathryn Titchen, Commissioning Manager CHC; Jane Trowman, Acting Assistant Director Care Homes Support and CHC Commissioning	Chris Stockport, Executive Director of Transformation and Strategic Planning	31/03/2021	30/06/2024	12		*No categorisation in TeamMante*
227	Continuing Healthcare Arrangements	2020	N/A	High	R5 - The Health Board should seek to invest and develop its CHC contracting and commissioning team	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.	Kathryn Titchen, Commissioning Manager CHC; Jane Trowman, Acting Assistant Director Care Homes Support and CHC Commissioning	Chris Stockport, Executive Director of Transformation and Strategic Planning	30/04/2021	31/03/2025	10		Started
231	Review of Eye Care Services	2021	N/A	High	Workforce planning for eye care services	R10: Develop a single medium-term workforce plan for eye care services (acute and NHS funded community services) that: • links to the future intended models of care; • builds further opportunities for working with training providers; • includes succession planning; and • develops a more strategic approach to recruitment.	R10: Workforce planning needs to be strengthened and will include opportunities for new roles across the whole system. As part of the RTC models of care work, which will include all elements, opportunities for retention and recruitment will support succession planning as well as current recruitment issues which need to be tackled through a North Wales approach.	Nick Graham, Associate Director of Workforce Optimisation	Jason Brannan, Deputy Director of People	31/03/2022	31/12/2024	1		*No categorisation in TeamMante*
232	Review of Eye Care Services	2021	N/A	High	Estate	R11: Ensure estate improvements and wider capital needs are included within Eye care business cases and plans. This should include investment to support improved efficiency and use of existing estate as well as any additional estate capacity to support the longer-term sustainability of services.	R11: The longer-term strategy for Eye Care in terms of secondary care estate is to have re-provision within the RTC(s); this needs to progress at pace which is supported by both Welsh Government and the Health Board. The Eye Care Coordination Group has already identified that there is a need to review, post approval in July 2021 of the recently prioritised business case, the services and future needs. The capital plans are owned by the accountable parts of the organisation as it is important to ensure that the whole of site or community plans are understood. However, smaller short-term requirements should be identified and reported through to the formal process for capital requirements to ensure maximum resources / assets are enabled across North Wales.	Russell Caldicott, Interim Executive Director of Finance	Russell Caldicott, Interim Executive Director of Finance	31/03/2022			The longer term strategy for Eye Care is the RTCs and these are now being progressed through a 3 Phase process. The first stage is currently being planned for implementation which will see the development of a conceptual design to RIBA level 2 by Q3 2022/23. The Eye Care teams, along with other specialties will be involved in the design of their services and the requirements from the RTCs in terms of facilities and equipment. In the meantime, we anticipate the recruitment of a Pan BCU Eye Care lead who will take forward the review of the National Eye Care Audit and that commissioned by BCU over the coming months in order to identify further Business Case requirements for the next available planning round. Additionally in the meantime, there has been a refresh of Eye Care equipment (not internal IT)	Implemented - Final Client Approved
234	Review of Eye Care Services	2021	N/A	High	Subregional variation of patient waits	R1: Improve quality of referral to treatment data to ensure that the Health Board can undertake analysis of sub-regional variation in waits.	R1: Data quality key to ensuring business analysis can support decision making.	Rhys Blake, Associate Director of Planned Care	Imran Devji, Interim Chief Operating Officer	31/03/2022				*No categorisation in TeamMante*
235	Review of Eye Care Services	2021	N/A	High	Subregional variation of patient waits	R2: Undertake analysis on sub-regional variation in waits, either by the Health Board's three main locality areas or by county of residence.	R2: 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.	Rhys Blake, Associate Director of Planned Care	Imran Devji, Interim Chief Operating Officer	31/03/2022	31/08/2023	6		*No categorisation in TeamMante*

236	Review of Eye Care Services	2021	N/A	High	Subregional variation of patient waits	R3: For as long as variation exists, include performance data on sub-regional variation in waiting times within existing performance reports to the Executive team and to Performance Finance and Information Governance Committee	R3: The Health Board will consider long-term performance data for as long as there is provision on more than 1 site to ensure not only equity but also optimisation of resources. Performance already provided through Secondary Care Accountability meetings, although very high level due to the required reporting criteria, which the provision of dashboards will simplify.	Rhys Blake, Associate Director of Planned Care	Imran Devji, Interim Chief Operating Officer	31/12/2021	31/05/2022	3	a. Monthly RAG rated report to Eye Care Collaborative Group: with individual sites reception against Amber/RED actions b. Monthly Eye Care report provided to PFIG: including exceptions/solutions and risks c. Access meeting with performance review re-established to provide monitoring & control of waiting times and performance by exception.	Implemented - Final Client Approved
238	Review of Eye Care Services	2021	N/A	High	Efficiencies	R5: 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.	R5: 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.	Rhys Blake, Associate Director of Planned Care	Imran Devji, Interim Chief Operating Officer	31/03/2023	30/04/2024	3		Started
239	Review of Eye Care Services	2021	N/A	High	Financial monitoring	R6: Improve financial reporting to all those accountable for eye care services in the Health Board. This should include variance to budget and support value-based healthcare through a better understanding of cost, outcomes, and expenditure on its improvement plans.	R6: Good financial management is important to both excellent clinical and operational management. Provision of key data within Eye Care sections across the Health Board but also a North Wales view supported by the appropriate responsibility and accountability (R7 - Accountability for eye care service) to enable change.	Russell Caldicott, Interim Executive Director of Finance	Russell Caldicott, Interim Executive Director of Finance	31/03/2022	01/07/2022	2	Complete	Implemented - Final Client Approved
240	Review of Eye Care Services	2021	N/A	High	Accountability for eye care services	R7: 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.	R7: 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.	Rhys Blake, Associate Director of Planned Care	Imran Devji, Interim Chief Operating Officer	31/03/2022	30/11/2023	8		Started
241	Review of Eye Care Services	2021	N/A	High	Eye care clinical leadership	R8: 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.	R8: 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.	Rhys Blake, Associate Director of Planned Care	Imran Devji, Interim Chief Operating Officer	31/03/2022	30/06/2024	7		Started
242	Review of Eye Care Services	2021	N/A	High	Eye care clinical leadership	R9: Appoint to the clinical leadership structure.	R9: Health Board support appointment to the clinical leadership structure.	Rhys Blake, Associate Director of Planned Care	Imran Devji, Interim Chief Operating Officer	31/03/2022	31/10/2022	6	Appointments to Clinical Leadership structure achieved: with Pan BCU Ophthalmology Lead recruitment in Q1 and Optometric Advisor commencing post on 5. 9.22.	Implemented - Final Client Approved
243	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.	Lois Lloyd, Chief Pharmacist	Nick Lyons, Executive Medical Director	30/09/2017	31/01/2024	17		Started
448	Taking Care of the Carers?	2021	N/A	N/A	Retaining a strong focus on staff wellbeing	R1: NHS bodies should continue to maintain a strong focus on staff wellbeing as they begin to emerge from the pandemic and start to focus on recovering their services. This includes maintaining a strong focus on staff at higher risk from COVID-19. Despite the success of the vaccination programme in Wales, the virus (and variations thereof) continues to circulate in the general population. All NHS bodies, therefore, should continue to roll-out the Risk Assessment Tool to ensure all staff have been risk assessed, and appropriate action is taken to safeguard and support staff identified as being at higher risk from COVID-19.	No management response within report	Jason Brannan, Deputy Director of People	Jason Brannan, Deputy Director of People	N/A				*No categorisation in TeamMante*

449	Taking Care of the Carers?	2021	N/A	N/A	Considering workforce issues in recovery plans	R2: NHS bodies should ensure their recovery plans are based on a full and thorough consideration of all relevant workforce implications to ensure there is adequate capacity and capability in place to address the challenges and opportunities associated with recovering services. NHS bodies should also ensure they consider the wider legacy issues around staff wellbeing associated with the pandemic response to ensure they have sufficient capacity and capability to maintain safe, effective, and high-quality healthcare in the medium to long term.	No management response within report	Jason Brannan, Deputy Director of People	Jason Brannan, Deputy Director of People	N/A				*No categorisation in TeamMante*
450	Taking Care of the Carers?	2021	N/A	N/A	Evaluating the effectiveness and impact of the staff wellbeing offer	R3: NHS bodies should seek to reflect on their experiences of supporting staff wellbeing during the pandemic by evaluating fully the effectiveness and impact of their local packages of support in order to: (a) consider what worked well and what did not work so well; (b) understand its impact on staff wellbeing; (c) identify what they would do differently during another crisis; and, (d) establish which services, programmes, initiatives, and approaches introduced during the pandemic should be retained or reshaped to ensure staff continue to be supported throughout the recovery period and beyond. NHS bodies should ensure that staff are fully engaged and involved in the evaluation process	No management response within report	Jason Brannan, Deputy Director of People	Jason Brannan, Deputy Director of People	N/A				*No categorisation in TeamMante*
451	Taking Care of the Carers?	2021	N/A	N/A	Enhancing collaborative approaches to supporting staff wellbeing	R4: NHS bodies should, through the National Health and Wellbeing Network and/or other relevant national groups and fora, continue to collaborate to ensure there is adequate capacity and expertise to support specific staff wellbeing requirements in specialist areas, such as psychotherapy, as well as to maximise opportunities to share learning and resources in respect of more general approaches to staff wellbeing.	No management response within report	Jason Brannan, Deputy Director of People	Jason Brannan, Deputy Director of People	N/A				*No categorisation in TeamMante*
452	Taking Care of the Carers?	2021	N/A	N/A	Providing continued assurance to boards and committees	R5: NHS bodies should continue to provide regular and ongoing assurance to their Boards and relevant committees on all applicable matters relating to staff wellbeing. In doing so, NHS bodies should avoid only providing a general description of the programmes, services, initiatives, and approaches they have in place to support staff wellbeing. They should also provide assurance that these programmes, services, initiatives, and approaches are having the desired effect on staff wellbeing and deliver value for money. Furthermore, all NHS bodies should ensure their Boards maintain effective oversight of key workforce performance indicators – this does not happen in all organisations at present.	No management response within report	Jason Brannan, Deputy Director of People	Jason Brannan, Deputy Director of People	N/A				*No categorisation in TeamMante*
453	Taking Care of the Carers?	2021	N/A	N/A	Building on local and national staff engagement arrangements	R6: NHS bodies should seek to build on existing local and national workforce engagement arrangements to ensure staff have continued opportunities to highlight their needs and share their views, particularly on issues relating to recovering, restarting, and resetting services. NHS bodies should ensure these arrangements support meaningful engagement with underrepresented staff groups, such as ethnic minority staff.	No management response within report	Nick Graham, Associate Director of Workforce Optimisation	Jason Brannan, Deputy Director of People	N/A				*No categorisation in TeamMante*

621	Continuing Healthcare Arrangements	2020	N/A	High	R1 - The Health Board should develop a range of relevant and accessible governance documents for its management of CHC	Building on the new national Framework (when published) and supporting tools, the Health Board should develop a set of key guidance documents to ensure consistent management of CHC across its teams. In addition, the Health Board should develop standard operating procedures that guide team members in the use of certain CHC tools such as the checklist.	A set of key local guidance documents will be finalised by November 2020 and a work programme will be signed off. Key documents will be completed by March 2021 with full completion by June 2021. All the documents will be available on the Health Board Intranet site and where appropriate on the dedicated pages of the Health Boards' website. Documentation will be reviewed and refreshed when the new national CHC Framework is published.	Chris Stockport, Executive Director of Transformation and Strategic Planning	Chris Stockport, Executive Director of Transformation and Strategic Planning	30/06/2021		0	page address location; howis.wales.nhs.uk/site plus/861/page/79868 (Search for " CHC " on the staff intranet page) CHC BCUHB staff intranet resource site now has a programme of local guidance documents to support individual CHC reviewers/ commissioners implement the CHC Framework. The documents are on a rolling programme of review for accuracy and to ensure they are current. This includes compliance with the July 2021 CHC Framework for Wales revision in implementation period until 30th November 2021 go live date. Additional future proof safeguards are in place to ensure as the wider HB intranet is upgraded the resource remains available on the new SharePoint system.. This recommendation is now fully implemented and is closed moving to the wider service cycle of improvements.	Implemented - Audit Approved
622	Continuing Healthcare Arrangements	2020	N/A	High	R2 - The Health Board should introduce a consistent and accessible training programme for CHC team members and those that engage with CHC	Following development of new guidance detailed in R1 the Health Board should develop a consistent and accessible training programme for CHC team members and those that routinely engage with CHC (ie members of the MDT). In developing the programme, the Health Board could usefully engage with key partners such as local authorities and providers.	A tiered training programme will be designed by 31 March 2021. This will provide the foundations for a rolling training programme reflecting competency levels required for different roles associated the CHC process on a 1-4 tier system. The design of the programme will be discussed with partners including those representing providers. Level 1 will be a core on-line training for all CHC active staff. Level 2 will include additional CHC support for key CHC staff such as CHC coordinators. Level 3 will be a focused programme of training for clinical staff in CHC teams including an in-team induction programme and corporate supported training events. Level 4 will be focused on sharing learning between CHC staff from corporate and area teams, including case reflection and themed learning integrated into practice such as learning from appeals and retrospective cases.	Kathryn Titchen, Commissioning Manager CHC	Chris Stockport, Executive Director of Transformation and Strategic Planning	N/A			This has been implemented. A training programme which is consistent (in structure) and accessible has been created and has been rolled out. Arrangements to create further capacity for ongoing sustainable delivery also underway.	Implemented - Audit Approved
623	Continuing Healthcare Arrangements	2020	N/A	High	R4 - The Health Board should introduce a formalised escalation procedure to resolve CHC disputes between its teams	The Health Board should formalise and implement escalation arrangements for CHC disputes at pace. There should be a clear procedure which is widely understood by relevant staff and can be used to quickly resolve internal disputes, for example, which team should take the budgetary responsibility for specific CHC patients	The Health Board will develop an internal disputes process mirroring the three stages in the PPA agreement used with external providers. This will be health board wide covering Area teams and the MHLD division.	Kathryn Titchen, Commissioning Manager CHC	Chris Stockport, Executive Director of Transformation and Strategic Planning	30/04/2021	31/07/2021	2	The internal HB disputes process between teams has now been agreed, piloted and implanted and included into a 2 year review process internally.	Implemented - Audit Approved
624	Continuing Healthcare Arrangements	2020	N/A	High	R6 - The Health Board should formalise and implement escalation arrangements for CHC disputes at pace. There should be a clear procedure which is widely understood by relevant staff and can be used to quickly resolve internal disputes, for example, which team should take the budgetary responsibility for specific CHC patients	The finance team provides a range of different reports for each operational CHC area team and division which produces different insights on performance and expenditure. This makes it difficult to identify areas of good practice or learning opportunities between teams. Quality metrics for CHC are also underdeveloped. With central co-ordination and oversight, Operational CHC teams and divisions should work together to explore and agree on a set of quality, financial and performance metrics to manage CHC effectively and consistently across the Health Board.	CHC quality and performance tools are in development to support CHC delivery. They build on the learning during pandemic and the changes implemented in pathways of care. Quality metrics will be explicit in the revised PPA which providers will be required to sign as a core component of the contractual arrangements (to be completed by March 2021). Finance Metrics – with the full adoption of the BroadCare system, the opportunity is recognised to improve reporting efficiency and agree a standardised set of Financial metrics reports. Work on this through the Health Boards CHC Operational Group has already commenced and any requests for non-standard reports to support the different Operational requirements will be evaluated by that Group to see if they should be adopted and add value to all Divisions (to be completed by February 2021	Kathryn Titchen, Commissioning Manager CHC	Chris Stockport, Executive Director of Transformation and Strategic Planning	31/03/2021	30/04/2022	5	complete please see update 03.03.2022.	Implemented - Audit Approved
625	Continuing Healthcare Arrangements	2020	N/A	High	R7 - The Health Board should ensure its CHC teams use the BroadCare IT system effectively and consistently	The BroadCare IT system for managing CHC patients is not yet operating effectively at the Health Board due to weaknesses in its implementation, lack of training and lack of administrative support. In order to maximise the value of the system in managing CHC, the Health Board should: • address the backlog of incomplete records through additional short-term capacity; • ensure the system is set-up correctly for the Health Board, with system terminology matching that of the CHC process; • ensure CHC teams are sufficiently trained on the use of the system; and • ensure the corporate finance team use the system effectively.	The Health Board accepts this recommendation and is implementing a BroadCare optimisation programme. The optimisation programme will ensure: (a) Consistent case management documentation, a peer support programme and improved data quality in CHC operational teams. (b) Financial reconciliation and transfer to BroadCare software case management for authorisation and payment of care packages.	Kathryn Titchen, Commissioning Manager CHC	Chris Stockport, Executive Director of Transformation and Strategic Planning	28/02/2021	03/12/2021	4	as per status update 22.11.2021	Implemented - Audit Approved

849	Operating Theatres Review (Consolidated)	2020	N/A	High	R1	By April 2021, develop a single Health Board-wide operating theatre plan which takes account of emerging clinical strategy and pathways and the need to recover waiting list performance which deteriorated as a result of Covid. The theatre plan will need to reflect: an increase in capacity requirements, and possible repatriation of externally commissioned services new and proposed clinical pathways theatre estate and workforce requirements opportunity to re-engineer pre-operative assessment processes, and ensure that the service is consistent across North Wales a need to strengthen productivity, whilst also considering covid safety requirements.	The Health Board will develop a single Health Board-wide operating theatre plan which takes account of emerging clinical strategy and pathways and the need to recover waiting list performance which deteriorated as a result of Covid. The theatre plan will reflect: an increase in capacity requirements, and possible repatriation of externally commissioned services new and proposed clinical pathways theatre estate and workforce requirements opportunity to re-engineer pre-operative assessment processes, and ensure that the service is consistent across North Wales a need to strengthen productivity, whilst also considering covid safety requirements.	Keith Dibble, Planned Care Program Lead	Gill Harris, Executive Director Nursing And Midwifery	30/04/2021	29/04/2022	6	The previous comment indicated that this action should be closed.	Implemented - Final Client Approved
850	Arrangements for Interim Senior Staff Appointments	2020	N/A	High	R1	The Health Board should update its guidance on the implementation of Standing Financial Instructions to provide better clarity of requirements when procuring goods. This should include the required processes and controls when procuring through the national framework and switching to non-framework contracts	Finance will devise and implement a new procedure regarding the hiring of temporary agency staff.	Tom Stanford, Finance Director - Operational Finance	Sue Hill, Executive Director of Finance	31/10/2020	30/04/2021	4	The Executive Team has approved the SOP. The document will be made available on the intranet.	Implemented - Audit Approved
851	Arrangements for Interim Senior Staff Appointments	2020	N/A	High	R2	The Health Board must ensure that an audit trail is maintained to evidence the rationale and approval arrangements behind any procurement decisions that do not conform with its policies and procedures	This will be reflected in the procedure as a requirement to document any procurement decisions that do not conform to the policy.	Tom Stanford, Finance Director - Operational Finance	Sue Hill, Executive Director of Finance	31/10/2020	30/04/2021	4	The Executive Team has approved the SOP including the new application process.	Implemented - Audit Approved
852	Arrangements for Interim Senior Staff Appointments	2020	N/A	High	R3	Where benchmarking is undertaken to assist in the appointment of interim senior staff, the benchmarking information should be as up to date, robust and as comparable with the circumstances of the appointment as possible.	This will be stated in the procedure.	Tom Stanford, Finance Director - Operational Finance	Sue Hill, Executive Director of Finance	31/10/2020	30/04/2021	4	The Executive Team has approved the SOP and the new electronic application process.	Implemented - Audit Approved
853	Effectiveness of Counter Fraud Arrangements	2020	N/A	High	R1	Greater uptake of counter-fraud staff training leading to greater awareness of associated issues and responsibilities.	The Health Board will explore if it is viable to include Counter Fraud e-learning as part of its mandatory training.	Karl Woodward, Head Of Local Counter Fraud Services	Sue Hill, Executive Director of Finance	31/12/2020	19/04/2021	2	This Recommendation was implemented on 19th April 2021	Implemented - Audit Approved
854	Effectiveness of Counter Fraud Arrangements	2020	N/A	High	R2	Maximise the potential of the service.	A review of resources employed will be undertaken, taking into account current workload, benchmarking with comparative organisations and the current fraud risk.	Karl Woodward, Head Of Local Counter Fraud Services	Sue Hill, Executive Director of Finance	31/12/2020	31/03/2021	1	The Actions taken, confirm that this recommendation has been implemented.	Implemented - Audit Approved
855	Effectiveness of Counter Fraud Arrangements	2020	N/A	High	R3	Improved management of risk and minimised opportunities for fraud to occur	The Health Board will use fraud risk assessments as a live resource and fraud will be integrated within the general risk management framework, to ensure that these risks are appropriately managed and escalated as necessary. This process has already started. The Welsh NHS counter-fraud community both nationally and at a local level share fraud alerts, (especially in relation to scams and fraud relating to the COVID-19 pandemic) in real time. The fraud alerts are shared with the relevant stakeholders. The Health Board will establish a monitoring programme to measure the speed and effectiveness of the fraud alerts, which are issued at a local level.	Karl Woodward, Head Of Local Counter Fraud Services	Sue Hill, Executive Director of Finance	31/12/2020	24/02/2021	2	This recommendation has been actioned.	Implemented - Audit Approved
856	Effectiveness of Counter Fraud Arrangements	2020	N/A	High	R4	Maximised impact through the use of data analytics.	The Health Board will undertake the appropriate research on how to make greater use of data analytics to both prevent and detect fraud.	Karl Woodward, Head Of Local Counter Fraud Services	Sue Hill, Executive Director of Finance	31/12/2020	24/02/2021	2	This recommendation has been implemented.	Implemented - Audit Approved
857	Effectiveness of Counter Fraud Arrangements	2020	N/A	High	R5	Mutual benefit from increased information sharing leading to a further strengthening of the service.	The Health Board will explore avenues to improve collaboration more widely across sector boundaries on common risks and challenges.	Karl Woodward, Head Of Local Counter Fraud Services	Sue Hill, Executive Director of Finance	31/12/2020	31/03/2021	1	Recommendation Implemented.	Implemented - Audit Approved
868	Continuing Healthcare Arrangements	2020	N/A	High	R8 - The Health Board should formalise leadership within the corporate CHC team	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.	Kathryn Titchen, Commissioning Manager CHC	Chris Stockport, Executive Director of Transformation and Strategic Planning	31/01/2021	30/09/2023	10	Signed off as implemented on local CHC Audit Action Plan 07.03.23.	Implemented - Partial Client Approved

869	WBFG Act	2021	N/A	High	R1	The Health Board is refreshing its living healthier staying well strategy. As part of this refresh, ensure: that there is appropriate consideration of challenges and opportunities in relation to population health and wellbeing including building on healthy lifestyles within the strategy. the approach to address those challenges is aligned to the Health Board's wellbeing objectives and that within integrated medium-term/annual planning the Wellbeing of Future Generations Act Five Ways of Working is used as the basis for responding to these challenges. Explore opportunities to move towards a long-term funding model to help secure the implementation of new service models.	Accepted	Sally Baxter, Assistant Director - Health Strategy	Chris Stockport, Executive Director of Transformation and Strategic Planning	31/12/2021	31/03/2022	1	The review and refresh of Living Healthier, Staying Well has confirmed the well-being objectives and the focus on population health adn well-being was widely supported. The draft IMTP was approved by Board on 30.03.22 and includes the WFG Act within the foundation for the plan and includes Well-being and Resilience as one of the five planning principles, focusing on maximising prevention, self-schemes are now prioritised for ongoing funding. other enabling schemes such as the decarbonisation plan and the foundational economy work also support the further implementation of the sustainable development principle and 5 ways of working enshrined in the Act.	Implemented - Final Client Approved
873	Review of Eye Care Services	2021	N/A	High	R1	Sub-regional variation of patient waits: Improve quality of referral to treatment data to ensure that the Health Board can undertake analysis of sub-regional variation in waits.	R1: Data quality key to ensuring business analysis can support decision making.	Nikki Foulkes, Outsourcing And Insourcing Manager	Gill Harris, Executive Director Nursing And Midwifery	31/03/2022	31/05/2022	3	The quality of referral to treatment data has been reviewed and the following improvements implemented: a/Pan BCU Cataract Pathway agreed (Achieved June 2021) b/ Pan BCU Patient Treatment List (enhanced to include RAG rating) in place, to reflect National and Professional Pandemic prioritisation guidance (Achieved July 2021)	Implemented - Final Client Approved
874	Review of Eye Care Services	2021	N/A	High	R10	Workforce planning for eye care services: Develop a single medium-term workforce plan for eye care services (acute and NHS funded community services) that: • links to the future intended models of care; • builds further opportunities for working with training providers; • includes succession planning; and • develops a more strategic approach to recruitment.	R10: Workforce planning needs to be strengthened and will include opportunities for new roles across the whole system. As part of the RTC models of care work, which will include all elements, opportunities for retention and recruitment will support succession planning as well as current recruitment issues which need to be tackled through a North Wales approach.	Nick Graham, Associate Director of Workforce Optimisation	Sue Green, Executive Director WOD	31/03/2022		0	This action has now been completed with medium term planning actioned and delivered through the planned care recovery programme as past of the IMTP and long term planning actioned and delivered through the RTC programme. These are both monitored and report to the EDG for Transformation and Finance	Implemented - Final Client Approved

876	Review of Eye Care Services	2021	N/A	High	Reporting and monitoring	R12: Strengthen formal reporting into the corporate programme management structures on eye care business case milestones and impact of investment in eye-care services.	R12: Formal reporting takes place through the secondary care accountability governance structure whilst updates are provided to the Planned Care Transformation group, which is not a formal approval / decision making group. The Health Board governance structure has been reviewed and it is expected that Executive Delivery Groups, once implemented, will have oversight of major projects / programmes such as the work undertaken by the Eye Care Collaborative Group and the Business Cases produced following this audit, further reviews and planning work.	Paolo Tardivel, Director of Transformation and Improvement	Chris Stockport, Executive Director of Transformation and Strategic Planning	31/12/2021	31/08/2022	3	The Transformation and Improvement Office and the Eye Care Network Manager have discussed incorporating reporting for the Eye Care Business Case Programme and it was confirmed the programme already reports directly into PFIG and into the quarterly Annual Plan Monitoring Report, which includes milestone tracking. Because of this and the fact that currently the Eye Care Programme sits alongside the Planned Care Transformation Programme and not within, this does not need to be incorporated into the Executive Delivery Group – Transformation reporting. Therefore we propose that this item is closed.	Implemented - Final Client Approved
877	Review of Eye Care Services	2021	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.	R2: 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.	Rhys Blake, Associate Director of Planned Care	Imran Devji, Interim Chief Operating Officer	31/03/2022	31/08/2023	6		Started
879	Review of Eye Care Services	2021	N/A	High	Efficiencies	R4: Implementation of the all-Wales cataract pathway – ensure that the all-Wales cataract pathway is effectively implemented and then routinely adhered to. As this will take time, the Health Board should set clear milestones and intermediate targets.	R4: All Wales cataract pathway is a shared objective across all three sites. Whilst sign up to RTC is an enabler and being clinically driven, further review to agree the incremental steps over the next 18 months is required due to the many compounding challenges identified in this report.	Rhys Blake, Associate Director of Planned Care	Imran Devji, Interim Chief Operating Officer	31/12/2022		0	Achieved and maintaining the Pre-operative, Operative and Post-operative efficiency key performance indicator for the Pan BCU cataract pathway as reflected in WG advice. BCU has established an integrated referral refinement with Primary Care and an Enhanced RAG rated cataract patient treatment list so support equitable Pan BCU access. All routine cataract patients to be streamed to Onestop clinics. The new Heath Economies and GIRFT review will support provision to deliver pre-covid planned care capacity recovery that will be ongoing.	Implemented - Final Client Approved
915	Governance Review of Betsi Cadwaladr University Health Board: Lessons Learnt	2019	N/A	High	R1	We are unconvinced that sufficient resources are being devoted to turnaround action and although the Board has appointed a Director of Turnaround, we recommend the Board consider bringing in additional specialist external turnaround expertise to assist with this.	In summer 2018, investment was received from Welsh Government to increase capacity and capability in the turnaround team (as well as in operational teams across Secondary Care). This investment was used primarily to support the restructuring as well as interim appointments. Subsequently, the effectiveness of the arrangements in place for improvement, transformation, turnaround and recovery have been subject to further discussion. For the Health Board to achieve its strategic priorities, a significant shift is required. From July 2019, the Health Board will move to an organisation-wide approach which will ensure that activities are aligned, coordinated and appropriately resourced. To oversee and support the delivery of this shift, with the support of Welsh Government, the Health Board has appointed an external expert as Director of Recovery, reporting to the Chief Executive. This is an interim appointment. The former Turnaround team have been split into 3 specialist areas and additional expertise recruited into the roles currently vacant: Turnaround – under the leadership of the Director of Finance; Service & Productivity Improvement; and Delivery Management Office – both under the leadership of Executive Director of Workforce & OD.	Sue Green, Executive Director	Gary Doherty, Chief Executive Officer	01/07/2019		0	Revised structure agreed and steps taken to fill vacancies. Progress paused to align to the Recovery programme	Closed - Not Verified
916	Review of Follow up Outpatient Appointments	2015	N/A	N/A	WA266	Improve the reporting of clinical risk information in relation to delayed follow-up outpatients to ensure that: •incidents of harm resulting from delays are analysed, escalated and reported; and •scrutiny and assurance focus on the high-risk specialties and clinical conditions.	Ensure that any potential or known causes of harm are notified through Datix Follow up backlog and its improvement to be included as a standard item on each Hospital Sites Quality and Safety Committee As at February 2016 - The completion of DATIX is actively encouraged on each site, specifically within ophthalmology. Each sites Quality and Safety Committee have the follow up backlog as a standing agenda item. Update June 2016 : This action will be included in the review described in WA265. Hospital Sites will be required to report Follow up incidents through site QSE, and also to the Follow up Task & Finish Group Update Aug 2016 - action to be included within draft paper Update Nov 2016 - 1) Sept 2016 Secondary Care Medical Director reviewing paper to describe identification and management of risk. 2) Ophthalmology analysis completed and used as topic for Board Development day in Nov 2016Ensure that any potential or known causes of harm are notified through Datix Follow up backlog and its improvement to be included as a standard item on each Hospital Sites Quality and Safety Committee	Kate Clark, Secondary Care Medical Director	Deborah Carter, Associate Director Of Quality Assurance	06/04/2017		0	Status updates reviewed and satisfied this meets the requirements of the recommendation	Closed - Not Verified

917	Review of Follow up Outpatient Appointments	2015	N/A	N/A	WA267	Identify and put in place the change management arrangements and resources needed to accelerate the pace of delivery for long-term outpatient transformation, including: •clinical resources, including medical, nursing and allied health practitioners; •change management capacity and capability; •internal and external engagement with stakeholders; •primary and community care leadership capacity to support outpatient modernisation; •the need to start Health economy care pathway redesign early, and deliver this concurrently with other improvement initiatives; and •applying lessons learnt from other recent related projects.	Through clinical engagement and leadership within the demand and capacity planning processes ensure that the pathway transformation and sustainable service models are described within the Health Boards plan and that the implementation of agreed plans are delivered Ensure that the learning and methodology from the Simpler project in 2015/2016 is sustained and that the transformational techniques used are cascaded through outpatient teams. Establish strong networks between the Areas and Secondary Care teams in prioritising and delivering change management programmes and pathways The Programme Management Office and Improvement Teams to continually review the support to primary and secondary care in delivering the transformation changes required as part of the PMO/Service improvement review. Sustain the cross site Scheduled Care Forum and Planned Care Forums to ensure that best practice is shared and implemented NB: OPD transformation will be included within BCUHB's IMTP As at February 2016 - In progress and forms part of the capacity planning work for 16/17. Update June 2016 : OPD PID refreshed for 2016/17. Vision and plan developed for the FY and event planning underway. OPD will form one of the key strands within the overall Planned Care Transformation programme, and is included within BCU operational plan. The monthly Follow up Task & Finish group will focus on active reduction in backlog, liaison with primary care as well as clarity on clinical risk and mitigation. Options for service re-design will be developed within the wider OPD transformation group, witha national workstream on OPD shortly starting - both primary and secondary care will take active part in this Update Aug 2016 - HD YGC nominated as lead for OPD programme, with link to PMO. Aim to set trajectories for DNA, Hospital initiated cancellations and link to follow up group for reduction of backlog (NB - Q1 saw reduction of 3000 patients from backlog). Update Sept 2016 - Under management of monthly group, trajectories for continued reduction for Q3 and Q4 in place (per site and per specialty). BCU linked closely to WG National OPD development. Pathway redesign, including referral reduction and transfer of follow up included in Primary Care Transformation Programme.	Kate Clark, Secondary Care Medical Director	Deborah Carter, Associate Director Of Quality Assurance	06/04/2017		0	Status updates reviewed and satisfied this meets the requirements of the recommendation	Closed - Not Verified
918	A Comparative Picture of Orthopaedic Services	2015	N/A	N/A	WA279	Clinical musculoskeletal assessment and treatment services: • The level of CMATS staff per 1,000 GP referrals is lower than the majority of teams across Wales. • The average wait from referral to face-to-face assessment by CMATS is outside the Welsh Government target of eight weeks, with a wait of 12 weeks in east and west, and 14 weeks in central.	September 2016 update - Refresh the business case for additional CMAT capacity to meet the 8 week access standard. Deadline: Oct 15. Submit business case for consideration. Deadline: Nov 15. Aim to ensure no one waits longer than 14 weeks with an average wait of 8 weeks from existing resources. Deadline: Dec 15. Ensure maximum wait of 8 weeks Deadline: June 16 dependent on approval of business case. Waiting time information is enclosed with the CMATs performance and outcome information (attached-appendix 1). A number of developments are being picked up with a new group chaired by Jill Newman looking at the future of Orthopaedics. It may be worth highlighting the TORs/scope of this group, as this will be complementary to the audit recommendations. We need to ensure we are joined up and not stay isolated on major pieces of work. This issue remains overdue. Actions have taken place to improve PC direct access to physiotherapy with a view to reducing demand for and waits for CMATS interventions, the team continue to deliver good turnaround times for triage and signposting of referrals to appropriate services. Waits for face to face treatments remain outside national guidelines and are subject of discussion in relation to sustainable models of service provision going forward. Dec 2016 Update - The business case developed last year was not supported. This has now been revised and is being included in the operational planning for 2017/18. Feb 2017 Update - additional resources for CMAT services are included into the orthopaedic bids for 2017/18 operational plan.	Gareth Evans, Acting Executive Director Therapies and Health Science		06/04/2017		0	Recommended for closure	Closed - Verified
919	Diagnostic review of ICT capacity and resources	2015	N/A	N/A	WA295	To ensure that new staff have timely access to the clinical systems, the Health Board needs to understand and address the negative perceptions from ward-based nursing staff in relation to delays for new staff to access the appropriate training.	The audit demonstrated that the Health Board follows good practice in not allowing access without appropriate training. However, a strategy will be developed with clinical and workforce leads to establish robust processes and appropriate capacity to provide training and release staff. The strategy will also identify alternative training methods to maximise use of modern technology and establish links with University training programmes to include system and data quality training as core requirements Whilst progress is being made a conclusion from this audit was that despite being the largest health board BCU Informatics services when benchmarked attract the lowest level of funding in Wales. Progress can be made in some areas overcoming the funding constraints likely to make the most significant difference. November 16 Update: An Informatics User Group and a Clinical Informatics Network will be established following approval of the "Governance and Leadership paper". The Chief Medical Information Officer (yet to be appointed) will lead on developing a strategy to establish robust processes and appropriate capacity to provide training and release for clinical staff. Dec 16 Update - the Chief Medical Officer role has been agreed and is in the process of being advertised. Feb 2017 Update; An Appointment has been made to the posts of Chief Medical Information Officer. They will take up post iat the end of March 2017. Following induction this will be a priority area of work.	Dylan Williams, Assistant Director Of Informatics	Mark Walker, Deputy Medical Director	04/06/2017			addressing the perceptions will not lead to reducing the delay in training. Working closely with Chief Medical Information Officer and Nursing Director to develop a Chief Nursing Information officer to address all nursing informatics concerns.	Closed - Not Verified
920	Diagnostic review of ICT capacity and resources	2015	N/A	N/A	WA293	The Health Board needs strengthen integration between systems, and at the very minimum, ensure that same data items contained on multiple clinical information systems, for example, patient demographics, are consistent.	Much of the lack of integration is due to legacy systems and limited integration which exists within the national system (i.e. Myrddin, RadiS, Canisc, Welsh Clinical Portal etc, Welsh Community Care Information System do not actively communicate with each other. However, the existing Informatics plan maps out the rationalisation of most of the main systems over the next two years. In addition a combination of technology to actively keep system in synch and better data quality and process training will be used to resolve any major data quality issues. June 2016 Update: Software testing to overwrite the date of death if incorrect between a source system of the Master Patient Index to Audiology and Pharmacy has been undertaken. Whilst more testing would be required for any additional data fields the concept has been proved. Work is currently underway to identify data fields within systems that are commonly out of sync due to manual input. The conclusions of this work will inform a plan of automated data input/verification going forward. Whilst progress is being made a conclusion from this audit was that despite being the largest health board BCU Informatics services when benchmarked attract the lowest level of funding in Wales. Progress can be made in some areas overcoming the funding constraints likely to make the most significant difference. November 16 Update: A strategic review of long term resources required by Informatics to underpin the Strategic Outline Plan (SOP) and to deliver a transformative digital agenda is currently underway. This will include the identification of resources required to achieve this objective and the benefits of doing so / the risks of not. Feb 2017 Update: A strategic review of long term resources required by Informatics to underpin the Strategic Outline Plan (SOP) and to deliver a transformative digital agenda has been completed and submitted to Welsh Government for consideration.	Dylan Williams, Assistant Director Of Informatics	Mark Walker, Deputy Medical Director	04/06/2017			Integrations and of systems being delivered via the national agenda - ensuring adherence to data standards and interoperability group. A new national group has been established to deal with this and BCU is represented.	Closed - Not Verified
921	Diagnostic review of ICT capacity and resources	2015	N/A	N/A	WA296	The Health Board needs to understand and address the negative perceptions from medical staff in relation to access, reliability and inability to use the clinical information systems that currently exist within the Health Board to ensure that the systems potential is maximised.	See R1 and development of the Strategic Outline Case. In addition a) Health Records are implementing innovative technology which will allow them to release staff time on more direct engagement and support with clinical staff and help manage the transition to digital record. (Deadline Sept 16) June 2016 UPDATE: RFID Tagging software procured and first project board met in May 2015 for pilot site implementation in Wrexham Maelor. Update: Go live confirmed as October 16/ project progressing well. b) We have been successful with Efficiency through Technology ETTF bid for "floor walker" resources to provide direct support for ward and front line staff to help improve training and the adoption of existing and future systems with particular for WCP, electronic discharge and flow. (Deadline - Complete) c) ETTF bid for Single Sign on approved to pilot in Ward errors and improve access to clinical systems via smart card log in. (Deadline - March 17) August 16 Update: Procurement paper complete, tender documents due to be published by Shared Services in September 16. Whilst progress is being made a conclusion from this audit was that despite being the largest health board BCU Informatics services when benchmarked attract the lowest level of funding in Wales. Progress can be made in some areas overcoming the funding constraints likely to make the most significant difference. November 16 Update: this is now implemented within the East, plans are being developed to implement this technology in other sites (funding dependent) . b) We have been successful with Efficiency through Technology ETTF bid for "floor walker" resources to provide direct support for ward and front line staff to help improve training and the adoption of existing and future systems with particular for WCP, electronic discharge and flow. (Deadline - Complete) c) ETTF bid for Single Sign on approved to pilot in Ward errors and improve access to clinical systems via smart card log in. (Deadline - March 17) August 16 Update: Procurement paper complete, tender documents due to be published by Shared Services in September 16. Whilst progress is being made a conclusion from this audit was that despite being the largest health board BCU Informatics services when benchmarked attract the lowest level of funding in Wales. Progress can be made in some areas overcoming the funding constraints likely to make the most significant difference.	Dylan Williams, Assistant Director Of Informatics	Mark Walker, Deputy Medical Director	04/06/2017		0	Chief Medical Information Officer and area based Medical Information Officers appointed (All at Consultant Level) to establish network address clinical information priorities and prioritise and optimise use of clinical systems. The MIO now engage on all new informatics requests and help prioritise and mandate all work.	Closed - Not Verified

928	All Wales review - Operating Theatres - Summary of local findings	2016	N/A	N/A	WA307 - R8	Health boards should routinely report a rounded picture of theatre efficiency, productivity and safety to an appropriate committee of the board. These reports should consider metrics related to quality and safety, patient experience, patient outcomes, use of theatre time, start and finish times, turnaround times and cancellations.	Whilst the project for theatre improvement was set up during 2015/16, the aim during June 2016 is to set up a pan-secondary care theatres steering group to ensure delivery of the PID outcomes. The theatres meeting will have the exec sponsor present - Director of Finance. This meeting will report to the Planned Care Transformation group, which feeds up to the Exec led transformation group September 2016 update - The monthly BCUHB Theatre Transformation Group has been established. The group is chaired by the East Hospital Director and has the Director of Finance as the executive sponsor. This meeting reports to the Planned Care Transformation group, which feeds up to the Executive led transformation group. October 2016 update: As above - also -Transformation group may need to consider quality and safety issues to meet recommendation - it is currently discussed in other forums (Q and S specific groups)- Open until decision on Q and S issues to be raised at TTG November 2016 update - Q&S discussions yet to be raised at TTG, keep open	Nigel Lee, Director Of Secondary Care		31/07/2016		0	approved for closure by aduit committee 140917	Closed - Verified
929	All Wales review - Operating Theatres - Summary of local findings	2016	N/A	N/A	WA308 - R9	R9 Health boards should ensure up-to-date performance and safety information is continuously visible within operating theatres. This should contribute to better staff engagement with the drive to improve performance and safety.	Weekly data performance and quality safety information is displayed continuously in theatres, this information is used to engage all staff groups on a weekly basis at the theatre planning cell meetings. September 2016 update - Performance data and quality safety information is displayed continuously in theatres. This information is used to engage all staff groups and forms part the weekly theatre planning meetings. October 2016 update - As above - However, Theatre Managers will need to meet to agree the information displayed - once the standardised datasets are approved. Need to ensure that each site has the same information - as a minimum. Keep open. November 2016 update - Theatre Planning Cells operational now on all three sites however content is not standardised at present, keep open	Nigel Lee, Director Of Secondary Care		31/07/2016		0	Performance data and quality & safety information is displayed continuously in operating theatres. This information is used in performance monitoring with all staff working in theatres. In addition, this is used in weekly theatre planning cells, which take place on all 3 sites.	Closed - Verified
930	NHS Consultant Contract: Follow-up of previous audit recommendations	2016	N/A	High	R1	Processes to review job plans annually NHS bodies should ensure that all consultants have a job plan that is reviewed annually to ensure that it reflects the business needs of the NHS organisation and the continuous professional development of the consultant. (Auditor General for Wales National Report, Rec 1a)	Audit Committee discussed at its Dec 16 meeting that members discussed the role of other committees in monitoring the action plan going forward and it was discussed to refer to CBMG. January 2017: Implementation of site based job planning technical support team to support and empower managers and staff to job plan. Implementation of a consistent approach to job planning through development of a LHB Job Planning Policy based on the BCUHB guidance. The draft of this policy is currently being discussed with the LNC. Monthly report of current compliance for in date, signed off job plans on the Allocate eJob Plan system is 27.3%	Michael Rees, Professor	Evan Moore, Executive Medical Director	30/11/2017		0	Regular meetings are held by the job planning team with each site, and areas, to support them in the process and with guidance. Compliance % is sent out each month, with list of forecast for next 3 months of job plans due to expire, so meeting can be arranged in timely manner. Total job plans on the electronic system is 660 Total in date 394 Total in progress and in discussion is 179	Closed - Not Verified
931	NHS Consultant Contract: Follow-up of previous audit recommendations	2016	N/A	High	R10	The Health Board should strengthen its job planning arrangements to ensure all available information is used to inform discussions and, where information is not available, that a range of outcome indicators are developed and introduced. (BCUHB UHB Local Report, 2011, Rec 2)	Audit Committee discussed at its Dec 16 meeting that members discussed the role of other committees in monitoring the action plan going forward and it was discussed to refer to CBMG. January 2017 The Health Board is working towards a robust and supportive annual cycle of job planning incorporating outcome setting will enable a range of outcomes indicators to be developed and introduced. Our job planning system will support robust good quality indicator and outcome information. Scoping exercise will be undertaken by February 2017 to further understand information which can inform discussions eg CHKS data and to understand ongoing work to improve robustness of data used to support clinicians.	Michael Rees, Professor	Evan Moore, Executive Medical Director	31/10/2017		0	As noted on status update	Closed - Not Verified
932	NHS Consultant Contract: Follow-up of previous audit recommendations	2016	N/A	High	R11	NHS bodies should ensure that they have clear and robust processes in place to discuss and agree objectives and outcomes for consultants as part of the job planning process. It will be important to ensure that clinicians and managers involved in setting these objectives and outcomes receive the appropriate training and support to undertake effective job planning with consultants. (Auditor General for Wales National Report, Rec 4)	Audit Committee discussed at its Dec 16 meeting that members discussed the role of other committees in monitoring the cation plan going forward and it was discussed to refer to CBMG January 2017 Strategic objectives have now been embedded onto the eJob Plan system. The seminar held facilitated agreement on this. Job Planning policy is being discussed to ensure robust process. The use of outcomes in job plans needs to provide meaningful consideration of how a doctor will contribute and link to the corporate objectives rather than being an exercise in the cut and paste boiler plate text. It would be possible to specify activity levels in clinic templates or on theatre lists, rather than generic text on activity.	Michael Rees, Professor	Evan Moore, Executive Medical Director	30/11/2017		0	Updated on status	Closed - Not Verified
933	NHS Consultant Contract: Follow-up of previous audit recommendations	2016	N/A	High	R12	NHS bodies should ensure that while job planning and appraisal are separate processes, there is a clear linkage between appraisal outcome and job planning when meeting the development needs of a consultant. NHS organisations will need to ensure the two separate processes are appropriately aligned and integrated to support the requirements for the new General Medical Council revalidation requirements that will be introduced in 2013. (Auditor General for Wales National Report, Rec 1e)	Audit Committee discussed at its Dec 16 meeting that members discussed the role of other committees in monitoring the action plan going forward and it was discussed to refer to CBMG January 2017 The appraisal and job planning systems are not currently compatible. It is our intention to support as fully as possible incorporating agreed PDPs into job planning so that any financial or resource implications can be appropriately discussed. This will be done through engagement with staff and close working with the appraisal team. We will consider how appraisal and job planning can be timetabled to ensure it happens in the right order and at the right time, considering the logistics of effective job planning for service leads.	Michael Rees, Professor	Evan Moore, Executive Medical Director	30/11/2018		0	The job planning system and appraisal system are not compatible. Meeting have been held between the job planning team and revalidation team to work together to prompt doctors to provide appraisal information when attending job plan meetings, so that their personal objectives can be captured. It has also been noted within training sessions the importance of capturing information from appraisals and for specialities asking the doctors to provide and share any evidence from their appraisals within job planning meetings, if they consider it relevant.	Closed - Not Verified

934	NHS Consultant Contract: Follow-up of previous audit recommendations	2016	N/A	High	R13	NHS bodies should ensure that they have monitoring processes in place to check that all consultants have an up-to-date job plan, and that job planning is being undertaken in accordance with guidance that has been issued; monitoring processes should include an update report to the Board, at least annually, that demonstrates the extent to which consultant job planning is embedded across the organisation as a routine management practice. (Auditor General for Wales National Report, Rec 1g)	Audit Committee discussed at its Dec 16 meeting that members discussed the role of other committees in monitoring the action plan going forward and it was discussed to refer to CBMG January 2017 Monthly reporting template has been designed, with consultant level data, and is provided to the medical director team and available for board/committee scrutiny.	Michael Rees, Professor	Evan Moore, Executive Medical Director	30/09/2017		0	Development of this will be on going, however the process is in place to capture the information and report on monthly basis	Closed - Verified
935	NHS Consultant Contract: Follow-up of previous audit recommendations	2016	N/A	High	R14	The Health Board will need to establish effective quality assurance and monitoring arrangements to ensure job plan guidelines are being applied consistently and appropriately. (BCUHB UHB Local Report, 2011, Rec 8)	Audit committee discussed at its Dec 16 meeting that members discussed the role of other committees in monitoring the action plan going forward and it was discussed to refer to CBMG January 2017 Strategic and local reporting e.g though Finance and Performance. We will consider a more balanced scorecard approach to job planning that ensures that focus is given to the quality of job plans.	Michael Rees, Professor	Evan Moore, Executive Medical Director	31/01/2018		0	Please refer to status update	Closed - Not Verified
936	NHS Consultant Contract: Follow-up of previous audit recommendations	2016	N/A	High	R15	NHS bodies should ensure that where changes to NHS services are occurring following public consultation, consultant job plans should be updated and agreed to reflect new service models. This should happen as an integral part of the process to redesign services, rather than a retrospective activity that occurs after the new services are in place. (Auditor General for Wales National Report, Rec 1b)	Audit Committee discussed at its Dec 16 meeting that members discussed the role of other committees in monitoring the action plan going forward and it was discussed to refer to CBMG January 2017 Ensuring proactive updating of consultant job plans as service redesign progresses. This is will be done through developing engaged clinicians and managers supported by the Office of the Medical Director. We are designing a flexible job planning process where any any interim changes can be incorporated and reviewed.	Michael Rees, Professor	Evan Moore, Executive Medical Director	30/04/2018		0	Please review status comments	Closed - Not Verified
937	NHS Consultant Contract: Follow-up of previous audit recommendations	2016	N/A	High	R16	NHS bodies should demonstrate more explicitly, how consultant job planning is being used to support the delivery of service improvement and modernisation, and the achievement of organisational priorities and performance targets. (Auditor General for Wales National Report, Rec 8)	Audit Committee discussed at its Dec 16 meeting that members discussed the role of other committees in monitoring the action plan going forward and it was discussed to refer to CBMG January 2017 Health Board values, aims and strategic objectives have already been incorporated into the eJob Plan system. Within job planning doctors will be encouraged to be involved in service improvement and modernisation. The use of outcomes in job plans needs to provide meaningful consideration of how a doctor will contribute and link to the corporate objectives. This will require meaningful dialogue between service/clinical managers and clinicians. Clear demonstration of job planning to support service delivery through improved use of eJob Plan reporting to inform service improvement and modernisation	Michael Rees, Professor	Evan Moore, Executive Medical Director	30/04/2018		0	Board objectives and outcomes have been uploaded and now need to be developed within the process	Closed - Verified
938	NHS Consultant Contract: Follow-up of previous audit recommendations	2016	N/A	High	R17	The Clinical Programme Groups should use consultant job planning as a vehicle for helping to secure the service modernisations that are identified in their plans to support the Health Board's five-year plan. (BCUHB UHB Local Report, 2011, Rec 2)	Audit Committee discussed at its Dec 16 meeting that members discussed the role of other committees in monitoring the action plan going forward and it was discussed to refer to CBMG January 2017 The Health Board needs to ensure that it is consistently engaging with consultants to understand their role in service modernisation, leadership, education and research. The process needs to be embraced by both sides to ensure the process of job planning is a meaningful one to support and lead service modernisations.	Michael Rees, Professor	Evan Moore, Executive Medical Director	30/04/2018		0	This recommendation has been implemented as far as is possible within the changed organisational structure which has replaced CPGs and within current planning structure. Responsibility for updating planning objectives now lie with the planning department to inform clinical leads of service change, which will in turn be incorporated into job planning.	Closed - Not Verified
939	NHS Consultant Contract: Follow-up of previous audit recommendations	2016	N/A	High	R18	NHS bodies should ensure their job planning process includes a clear and informed discussion on the SPA needs of individual consultants, recognising that these will not be the same at different stages in a consultant's career. The job planning discussion should specify the SPA activities to be included in the job plan, and identify the outputs and outcomes that should be achieved, and the location where these activities will be carried out. (Auditor General for Wales National Report, Rec 5)	Audit Committee discussed at its Dec 16 meeting that members discussed the role of other committees in monitoring the action plan going forward and it was discussed to refer to CBMG. January 2017 The health board aims to use job planning in a positive and supportive manner to produce modernisation of service delivery, develop staff and to encourage excellence in research, education and leadership and to include doctors more completely in the process of service delivery. The development of a job planning policy will consider the inclusion of evidence of SPA business case in criteria on which job plans are reviewed/judged. Clear outcomes are required which can then be reviewed and judged.	Michael Rees, Professor	Evan Moore, Executive Medical Director	30/09/2017		0	Clear guidance and discussions are within the training to ensure the importance to Managers, and Doctors to evidence and capture the detail within the job plan process	Closed - Verified
940	NHS Consultant Contract: Follow-up of previous audit recommendations	2016	N/A	High	R19	The Health Board needs to ensure that its guidance material on job planning clearly defines what constitutes SPA activity, and the importance of agreeing the outcomes from different SPA activities. (BCUHB Local Report, 2011, Rec 6)	Audit Committee discussed at its Dec 16 meeting that members discussed the role of other committees in mentoring the action plan going forward and it was discussed to refer to CBMG. January 2017 . Agreed definition of SPA to be detailed in a Job Planning Policy communicated to all staff involved by February 2017. Feedback report from Job Planning Seminar held on 9th Sept 2016 was shared with doctors. Training on SPA will be included in job planning training once agreed.	Michael Rees, Professor	Evan Moore, Executive Medical Director	30/09/2017		0	Clear guidance is promoted, and the importance of including SPA activities and the details is discussed within the job planning training. Importance of protected time is also discussed.	Closed - Verified
941	NHS Consultant Contract: Follow-up of previous audit recommendations	2016	N/A	High	R2	The Health Board must ensure that job planning becomes effectively embedded within the new Clinical Programme Group structure as a means of harmonising the job plans inherited from predecessor bodies, and ensure that all consultants receive an annual job plan review. (BCUHB Local Report, 2011, Rec 1)	Audit Committee discussed at its Dec 16 meeting that members discussed the role of other committees in monitoring the action plan going forward and it was discussed to refer to CBMG. The process of identifying management and clinical leads within the new structure is presently in place. However, there is currently a consultation on the medical leadership structure in secondary care lead by the Secondary Care Medical Director. Ensuring consistent use of eJob Plan through engagement with leads and assessment of every job plan against the guidance to ensure appropriate and consistent application of BCUHB guidance. Supporting a focus on the quality of job planning it is proposed that a job planning policy for the Health Board will include a 3 stage sign off of Clinical Director, Site Medical Director and Secondary Care Medical Director. This policy has now been drafted and is currently being discussed with the LNC	Michael Rees, Professor	Evan Moore, Executive Medical Director	31/01/2018		0	The recommendation applies to the management structure that does not currently exist, which means it is impossible to complete at this current time	Closed - Not Verified

942	NHS Consultant Contract: Follow-up of previous audit recommendations	2016	N/A	High	R20	NHS bodies should look to adopt a team-based approach to job planning where it can be shown that this would be beneficial. Consultants would need to be persuaded to participate rather than coerced, based on a clear explanation of the benefits associated with a team-based approach, and should still retain the right to agree an individual job plan with their employing organisation. (Auditor General for Wales National Report, Rec 6)	Audit Committee discussed at its Dec 16 meeting that members discussed the role of other committees in monitoring the action plan going forward and it was discussed to refer to CBMG. January 2017 A recent job planning seminar was supportive of adopting team job planning as best practice in the Health Board. How this can be facilitated is currently being discussed. Use of successes within the Health Board to engage and encourage others by showcasing examples of where it works well and considering the formation of a 'super-user' type virtual team among those who now do team based job planning to support and advise those who may want to do it but need more support.	Michael Rees, Professor	Evan Moore, Executive Medical Director	28/02/2018		0	Team job plans are being held now more frequently across BCUHB, and being encouraged as a way forward to review the service and outcomes and objectives to support job planning process	Closed - Not Verified
943	NHS Consultant Contract: Follow-up of previous audit recommendations	2016	N/A	High	R21	The Health Board must develop and implement a plan to reduce consultants' workloads where these are excessive. (BCUHB Local Report, 2011, Rec 9)	Audit Committee discussed at its Dec 16 meeting that members discussed the role of other committees in monitoring the action plan going forward and it was discussed to refer to CBMG. January 2017 It is the aim that it will be a routine part of job planning that an assessment of workload pressures will carried out. Review of job plans in excess of 13 sessions to ensure workload is not excessive for the individual. The Health Board will promote a culture which encourages clinicians to flag excessive workloads, and managers to ensure they are assured timetables DCC and SPA and actually feasible. Identifying consultant's with excessive workloads and addressing this with operational managers and clinical directors responsible to allow any sessions to be redistributed across the team, or possibly consider additional posts. Part time posts should also be discussed.	Michael Rees, Professor	Evan Moore, Executive Medical Director	30/04/2018		0	Discussions are being had to review and discuss excessive workloads, to look at other ways of working and how this can be addressed. It is on going and although being reviewed and addressed and implemented within areas, it will take time to fully implement across BCUHB	Closed - Not Verified
944	NHS Consultant Contract: Follow-up of previous audit recommendations	2016	N/A	High	R3	Guidance and training NHS bodies should ensure that job planning is supported by up-to-date local guidance material and regular training for all staff who participate in the process. (Auditor General for Wales National Report, Rec 1c)	Audit Committee discussed at its Dec 16 meeting that members discussed the role of other committees in monitoring the action plan going forward and it was discussed to refer to CBMG. January 2017: The local guidance is in the process of being reviewed to achieved consistency with national guidance and achieve maximal use of DCC, SPA and additional activities. Job planning to be supported by the local job planning lead to facilitate engagement with the process. Training and support for doctors utilising the Allocate eJob Plan system is now in place on a monthly basis.	Michael Rees, Professor	Evan Moore, Executive Medical Director	30/09/2017		0	Training package for doctors, management to ensure clear guidance is given of the job planning process Monitoring of returned evaluation feedback forms are being reviewed to ensure that any areas that need further clarification or development are maintained On going drop in sessions to support doctors, management and admin staff are being maintained, to support uploading of job plans onto the system from all involved within process	Closed - Verified
945	NHS Consultant Contract: Follow-up of previous audit recommendations	2016	N/A	High	R4	The Health Board must ensure all job plans contain the necessary details about consultants' activities and responsibilities, and the location where the work will be undertaken. Agreed records of discussions held during the job plan review meetings should also be kept. (Betsi Cadwaladr University Health Board Local Report, 2011, Rec 3)	Audit Committee discussed at its Dec 16 meeting that members discussed the role of other committees in monitoring the action plan going forward and it was discussed to refer to CBMG. Clear accountability of clinical and operational managers to deliver 95% job plans. Training and facilitating doctors to use the eJob Plan system to allow control over the information in the job plan. We will aim to achieve an annual cycle of job planning review for all job plans within one year. The development of a job planning policy will allow consideration of incentives to facilitate full coverage across the consultant body.	Michael Rees, Professor	Evan Moore, Executive Medical Director	31/01/2018		0	All doctors who undergo job planning meetings with their manager, have a discussion of current details on the system, review activities and which location these are done, and should ensure all details are correct and up to date	Closed - Verified
946	NHS Consultant Contract: Follow-up of previous audit recommendations	2016	N/A	High	R5	The Health Board should revisit its document setting out the principles of consultant job planning in light of the comments we have made in this report. A revised set of principles and guidance notes should be issued to all staff involved in job planning to promote a shared understanding of the Health Board's approach to job planning, including its approach to developing measurable outcomes from consultant activities. (Betsi Cadwaladr University Health Board Local Report, 2011, Rec 4)	Audit Committee discussed at its Dec 16 meeting that members discussed the role of other committees in monitoring the action plan going forward and it was discussed to refer to CBMG. Engagement with clinical leads and operational managers within specialties, to gain consensus on approach of the language/activities in the job plan, which align to the service plan. Job Planning Seminar undertaken Sept 2016. Review of documentation and guidance. Clear and consistent guidance for specialities in terms of structure and all stakeholder responsibilities and accountabilities, including the reporting support e job plan provides. Review of communication in terms of where job planning guidance is found. The guidance and training programmes are accessible and have been communicated to consultants, SAS doctors, operational managers and admin staff.	Michael Rees, Professor	Evan Moore, Executive Medical Director	30/09/2017		0	All guidance is being reviewed and awaiting LNC confirmation Intranet site being developed to ensure all updated and relevant information is available and to date Evaluation forms have been introduced to support feedback to trainer in order to develop training for now and future support to areas	Closed - Verified

947	NHS Consultant Contract: Follow-up of previous audit recommendations	2016	N/A	High	R6	The issuing of guidance on job planning arrangements should be accompanied by supporting training programmes for the different staff groups involved in job planning. (Betsi Cadwaladr University Health Board Local Report, 2011, Rec 5)	Audit Committee discussed at its Dec 16 meeting that members discussed the role of other committees in monitoring the action plan going forward and it was discussed to refer to CBMG. Different types of training have been made available to doctors, managers and administrative staff involved in the job planning process including one to one, video clips and groups. The identification of champions within specialties to support at a local level and provide advice needs to be identified. Training on job planning includes current guidance on SPA activity and outcomes.	Michael Rees, Professor	Evan Moore, Executive Medical Director	30/09/2018		0	Face to face job planning training including managers, consultants and SAS doctors is being conducted on the 3 sites. A video has been developed and published, containing many of the elements of the training is being implemented on to the intranet website. Also we are contacting all doctors who have not attended training to invite to remaining training sessions up to March 2018 and if they are unable to make these dates then the video is being sent to them.	Closed - Verified
948	NHS Consultant Contract: Follow-up of previous audit recommendations	2016	N/A	High	R7	NHS bodies should ensure that there is involvement in consultant job planning from general managers to ensure that wider organisational objectives, service improvements and financial issues are considered when agreeing consultants' job plans, and to help managers understand what resources and support consultants need to deliver their job plan commitments. (Auditor General for Wales National Report, Rec 1d)	Audit Committee discussed at its Dec 16 meeting that members discussed the role of other committees in monitoring the action plan going forward and it was discussed to refer to CBMG. January 2017 There has been engagement with all clinical and operational/service managers on sites to ensure the responsibilities are clearly defined and understood. The Health Board is fully supportive of engaging managers to incorporate wider organisational objectives effectively into job plans.	Michael Rees, Professor	Evan Moore, Executive Medical Director	30/09/2018			This has been discussed with audit and they have noted on the report that all evidence has been given and consider this has now be implemented.	Closed - Not Verified
949	NHS Consultant Contract: Follow-up of previous audit recommendations	2016	N/A	High	R8	NHS bodies should ensure that they work jointly with universities in agreeing job plans for consultants that have academic contracts, such that the expectations and requirements of both organisations are properly and fairly considered; similar arrangements should be in place for consultants working for two or more NHS organisations. (Auditor General for Wales National Report, Rec 1f)	Audit Committee discussed at its Dec 16 meeting that members discussed the role of other committees in monitoring the action plan going forward. January 2017 The Health Board is having proactive discussions with higher education institutions. It is our aim to promote academic involvement consistent with national guidelines. Discussion to be held at the next BCUHB/Bangor University collaborative board. MD for Workforce and Professionalism has regular meetings with the College of Health and Behavioural Sciences in Bangor University about job planning and will be undertaking similar meetings to support other HCIs locally. Where job plans are jointly hosted, all should be involved in job planning, and this should be demonstrated in the guidance. Consideration of developing a Memorandum of Understanding with partner academic institutions to ensure delivery of agreed support for job planning.	Michael Rees, Professor	Evan Moore, Executive Medical Director	28/02/2018		0	Please see status update	Closed - Not Verified
950	NHS Consultant Contract: Follow-up of previous audit recommendations	2016	N/A	High	R9	NHS bodies develop an information 'framework' to support job planning, on a speciality-by-speciality basis. Clinicians and managers will need to work together to identify the components that need to be included in such a framework for each speciality, but it would be expected to include: • information on activity; • cost; • performance against local and national targets; • quality and safety issues; • workforce measures; and • plans and initiatives for service modernisation and reconfiguration. (Auditor General for Wales National Report, Rec 3)	Audit Committee discussed at its Dec 16 meeting that members discussed the role of other committees in monitoring the cation plan going forward and it was discussed to refer to CBMG. January 2017 Workforce Medical Director and operational MDs to develop a template for supporting job planning by specialty - this is outstanding. A seminar was held in September with a wide variety of clinical and operational managers, consultants and SAS staff to improve effectiveness of job planning and team based job planning and the recommendations of the seminar are currently being considered. Discussion and incorporation of objectives into job plans is a priority. Measures to institute team job planning are being considered following engagement with staff. This provides information to aid the development of the framework.	Michael Rees, Professor	Evan Moore, Executive Medical Director	31/01/2018		0	As noted on status update	Closed - Not Verified
951	Medical Equipment Management	2016	N/A	N/A	WA345	Policies and Procedures Prioritise the completion of updated procedure documents to support the Medical Devices and Equipment Management Policy.	The Medical Device Oversight Group has identified the following supporting procedures as being the initial priorities for development in the organisation. Phase 1 When things go wrong. 31/01/17 Selection and Procurement. 31/01/17 Commissioning. 31/01/17 Phase 2 Maintenance and Repair 31/04/17 User Training and Normal Use 31/04/17 Cleaning and Decontamination 31/04/17 Phase 3 Records and Instructions Disposal 30/06/17 November 2016 update - work in progress - policies being written. February 2017 update - - Phase 1 completed - 3 BCU Procedures produced and approved on time. (MP02a, MP02b, and MP02c) - Phase 2 - work in progress - BCU Procedures being written	Patrick Hill, Deputy Director Medical Physics	Adrian Thomas, Executive Director of Therapies & Health Sciences (Interim)	06/04/2017	30/06/2017	1	As reported in Status Update - all actions completed, and recommendations implemented on time	Closed - Verified
952	Medical Equipment Management	2016	N/A	N/A	WA346	Medical Equipment Inventory Scope the need for, and potential benefits of, a single inventory of medical equipment which brings together all the key data items and assesses clinical risk	We will progress discussions regarding this and the potential benefits with the All Wales Medical Equipment Management Group and the Medical Physics and Clinical Engineering sub Committee of the Welsh Scientific Advisory Committee. The Wales Audit Office are also currently contacting Cardiff and Vale regarding their single inventory. November 2016 update - work in progress. February 2017 update - work in progress	Patrick Hill, Deputy Director Medical Physics	Adrian Thomas, Executive Director of Therapies & Health Sciences (Interim)	30/06/2017	30/09/2017	1	This action has now been completed.	Closed - Not Verified
953	Medical Equipment Management	2016	N/A	N/A	WA347	Medical Equipment Libraries Explore the possibility of standardising the equipment library services across the three sites by bringing them under the same managing department.	We will review the equipment library provision across the Health Board and make recommendations regarding service provision on the major sites to the Executive Management Group. November 2016 update - work in progress. February 2017 update - work in progress - early stage	Bethan Jones, Area Director (Central)	Adrian Thomas, Executive Director of Therapies & Health Sciences (Interim)	30/05/2017		0	last description is current updated position	Closed - Not Verified
960	Financial Contribution to the 'Lap of Wales'	2016	N/A	N/A	New Recommendation	Our review taken together with the Health Boards own post project review reaffirms many of the important challenges that public sector bodies face in the delivery of projects and services collaboratively with the private and voluntary sectors. Both the Health Board and Cerddwn Ymlaen are taking steps to improve their governance arrangements in the light of the experience gaining in delivering the Lap of Wales challenge.	The Health Board and Cerddwn Ymlaen have learnt a number of important lessons from the Lap of Wales and important challenges have been made to the governance arrangements	Helen Macarthur, Head Of Financial Services	Russell Favager, Executive Director Of Finance	11/04/2017				Closed - Verified

962	Managing Medicines in Primary and Secondary Care	2016	N/A	High	R9	The Welsh Government and NWIS should continue to work with GP representatives to ensure their concerns about information governance are addressed; Facilitate wider access to the GP Re cord so that all pharmacists and pharmacy technicians that deliver clinical services on the wards can access the system for patients who are admitted for an elective procedure, as well as those admitted as emergencies; and Facilitate wider access to, and use of, the GP Record in community pharmacies so that whenever it is clinically appropriate, patients can have their medicines managed in the community without accessing a GP or other NHS services.	Health Boards and WG are continuing to work with NWIS to secure wider access to the Welsh GP Record (WGPR). On 21 November 2016, NWIS announced that access to the WGPR would be extended to hospital pharmacists and pharmacy technicians in planned care settings including outpatients. This builds on the access in emergency care settings which has been available for some time. The Chief Pharmaceutical Officer is working directly with the Medical Director at NWIS to put in place appropriate information governance arrangements which will allow use of the WGP R by community pharmacists in specified circumstances to support patient care. We envisage this work will be completed early in 2017.	Berwyn Owen, Chief Pharmacist	Evan Moore, Executive Medical Director	30/06/2017	01/12/2017	1	Access to GP record implemented	Closed - Not Verified
963	Managing Medicines in Primary and Secondary Care	2016	N/A	High	R8	The Welsh Government, supported by 1000 Lives Improvement, should work with pharmacy teams, clinical coding staff and clinicians across Wales to develop a programme aimed at identifying and preventing medicines related admissions (MRAs).	This work will be scoped with 1000 Lives Improvement during the early part of 2017-18 with a view to establishing a medication safety programme in 2018-19.	Berwyn Owen, Chief Pharmacist	Evan Moore, Executive Medical Director	08/08/2017	25/10/2018	1	Initiated at Wrexham and rolled out across BCU	Closed - Not Verified
964	Managing Medicines in Primary and Secondary Care	2016	N/A	High	R10	Where the Welsh Government makes a decision to make a new medicine available outside the current national appraisal process, it should clearly explain the rationale underpinning its decision and ensure that health bodies are given sufficient time to plan for the financial implications and service changes associated with introducing those new medicines.	From time to time it may be necessary for the Welsh Government to make medicines available outside the current national appraisal process. We recognise that this should happen by exception and only where the rationale for so doing is clear. As has been the case with agreements to date, we expect agreements will continue to be made only where there is strong support for the availability of the medicine(s) both from clinicians and patients across Wales. BCUHB will work with WG to ensure we are more closely involved in the planning arrangements and afforded an appropriate period in which to prepare for the service and financial implications	Berwyn Owen, Chief Pharmacist	Evan Moore, Executive Medical Director	30/04/2018		0	Health Board compliance with WG new medicines policy audited and implemented	Closed - Not Verified
965	Managing Medicines in Primary and Secondary Care	2016	N/A	High	R2	The Chief Pharmaceutical Officer for Wales should lead national reviews to assess each health body's compliance with the MARRS policy, to assess the effectiveness of the new mandatory training programme on medicines management and to assess the long-term sustainability of actions taken in each health body to address all medicines-related findings from Trusted to Care; and Each health body should develop a time-bound plan for improving storage and security of medicines on hospital wards, including specific consideration of the benefits of implementing automated vending machines	The Chief Pharmaceutical Officer for Wales will re-convene the Medicine Administration, Recording, Review and Storage (MARRS) working group to undertake a review of each health board's compliance with the MARRS policy. Due to unforeseen circumstances there has been a delay in implementing the e-learning programme on medicines administration. The working group will therefore give further considerations as to how the e-learning programme can be rolled out most effectively. We envisage the first meeting of the re-convened MARRS working group will be in April 2017 and that it will complete its review by March 2019. Patient Safety Notice PSN 030 , issued in April 2016 set out the expected standards for safe and secure storage of medicines on hospital wards. WG have identified the need to review the requirements contained in the notice in light of concerns that the cost of replacing the storage on all hospital wards, regardless of current condition, would be disproportionate to the anticipated benefit; given the low level of risk presented by storage facilities on the majority of wards. The MARRS working group will, as part of its work, review PSN 030 and updated guidance will be issued before the end of 2017. The Chief Pharmaceutical Officer will, with the Chief Pharmacists in local health boards and Velindre Cancer Centre, complete an audit of the current use of automated ward vending machines in NHS hospitals in Wales and develop a prioritised list of sites in which automated ward vending should be implemented. This work will be completed by June 2017. Identify a BCU representative including nursing and pharmacy for the national MARRS working group by May 2017. Repeat the BCUHB storage and security of medicines 2016 audit to update on compliance and present to QSG by September 2017 . Evaluate the benefits realization with the automated vending machines across BCUHB and present at QSG by Sept 2017. Initial report prepared by Don Hughes and Mediwell in 2016	Berwyn Owen, Chief Pharmacist	Evan Moore, Executive Medical Director	30/09/2017	14/12/2017	1	MARRS policy audited and action plan implemented via QSG March 2018	Closed - Not Verified
966	Managing Medicines in Primary and Secondary Care	2016	N/A	High	R3	Health bodies should ensure their Chief Pharmacist is, or reports directly to, an executive director; and Health bodies should have an annual agenda item at the Board to discuss an annual report covering pharmacy services, medicines management, primary care prescribing, homecare medicines services and progress in addressing the issues identified in Trusted to Care.	The Board of every health body in Wales should regularly scrutinise all aspects of medicines management. To that end, and prior to the publication of your report, the NHS Outcomes Framework included six national prescribing indicators, covering a range of areas including antimicrobial prescribing, adverse drug reaction reporting, high risk medicines and the efficient use of resources. To maintain focus on improving medicines management within NHS Wales, WG will raise medicines management issues through the Joint Executive Team meetings between Welsh Government and NHS Wales bodies. The UK-wide rebalancing medicines legislation and pharmacy regulation programme, supported by the Department of Health in England on behalf of the four UK administrations, is considering various changes to medicines legislation which are likely to impact on the role of health body Chief Pharmacists. We anticipate the implications for Chief Pharmacists will be clearer in early 2018. In preparation WG will undertake an audit of the reporting arrangements for NHS Chief Pharmacists in Wales and this will be completed by September 2017. Identify the Executive lead director for Medicines Management by April 2017. Chief Pharmacist to attend QSG & EMG – action complete. National indicators to be included in the BCU performa nce report accountability process by May 2017. Annual cycle of business identified for MM report to QSE and Board – Oct/Dec 2017.	Berwyn Owen, Chief Pharmacist	Evan Moore, Executive Medical Director	31/12/2017	15/03/2018	1	Annual report presented and approved by Board March 2018. Accountability of Chief Pharmacist confirmed to the Executive Medical Director	Closed - Not Verified
967	Managing Medicines in Primary and Secondary Care	2016	N/A	High	R4	Chief Pharmacists should seek the support of the NHS Wales Shared Services Partnership's Workforce , Education and Development Services to strengthen current resource mapping approaches to facilitate robust comparisons of pharmacy staffing levels across Wales and to produce a generic service specification. The specification should set out the typical resources required to deliver key pharmacy services, such as clinical pharmacy input and patient education on wards. The specification should also be flexible enough to recognise that different types of wards will require different levels of resource.	During 2017-18 BCUHB will work with other Health Boards and the NHS Wales Shared Services Partnership's Workforce, Education and Development Service to undertake a robust assessment of the current and future needs for the pharmacy workforce. Pharmacy workforce group established and initial plan submitted to WEDS April 2017.	Berwyn Owen, Chief Pharmacist	Evan Moore, Executive Medical Director	30/04/2018	19/09/2018	2	Workforce paper presented and accepted by EMG July 2018. Invest to save to be determined by WG October 2018.	Closed - Not Verified

968	Managing Medicines in Primary and Secondary Care	2016	N/A	High	R5	To drive further improvements in prescribing, health bodies should ensure they have a targeted plan of action to achieve cost and quality improvements in prescribing in primary care and in secondary care, in line with prudent healthcare principles. The plan of action should be informed by regular analysis of prescribing data to ensure that attention is focused on the areas where the greatest scope exists to secure cost and quality improvements; In line with the need to increase the profile of medicines management at Board level, health bodies should ensure that performance against the National Prescribing Indicators is considered regularly by the Board, alongsi de progress in delivering wider cost and quality improvements in primary care prescribing; The Welsh Government should ensure the work of the Efficiency, Healthcare Value and Improvement Group takes an all-Wales view on the cost and quality improvements that should be achievable through better prescribing and medicines management, and uses mechanisms such as the twice-yearly Joint Executive Team meeting between government officials and each individual health body to ensure that the necessary progress is being made in securing these improvements. The Welsh Government should work with NHS bodies to develop and implement a clear national plan of action aimed at reducing medicines wastage,	The Efficiency, Healthcare Value and Improvement Group have agreed an all-Wales approach to cost and quality improvement in medicines management in primary and secondary care will be a key area for 2017-18. During 2017-18 health board Chief Pharmacists and other stakeholders have agreed key priorities in the following six areas: driving efficiency; reducing medicines related harm; improving patient experience and outcomes; workforce modernisation; collaborative working, better use of technology and improved estates; and benchmarking. These priorities will be taken forward on an all-Wales basis and progress overseen through regular meetings between the Chief Pharmaceutical Officer and health board Chief Pharmacists, and Joint Executive Team meetings. NHS bodies will develop and implement a clear plan of action aimed at reducing medicines waste. Primarily this will be achieved by encouraging NHS bodies to adopt the elements of the Your Medicines, Your Health campaign which the ongoing evaluation, once completed, demonstrates are successful. We will also implement evidence based approaches which reduce medicines waste. These will include implementing improved repeat prescribing systems such as those which have been tested through the Prudent Prescribing Implementation Group or evaluated in other parts of the UK. We envisage this work will begin in 2017-18 with a time-bound plan agreed by March 2018. Divisional PMO & CRES plans identified and presented to EMG April 2017. Action completed. Monthly PMO monitoring established including savings tracker during 2017/18. March 2018 Executive lead sponsor identified – complete.	Berwyn Owen, Chief Pharmacist	Evan Moore, Executive Medical Director	30/03/2018		0	Implemented for 2017/18 and registered with PMO for 2018/19	Closed - Not Verified
969	Managing Medicines in Primary and Secondary Care	2016	N/A	High	R6	The Welsh Government should develop a plan, in partnership with All Wales Medicines Strategy Group (AWMSG), health bodies and GPs, to evolve the National Prescribing Indicators so that they begin to consider measures of whether the right patients are receiving the right medicines and whether medicines are making a difference to people's outcomes.	The National Prescribing Indicators are currently too focused on the quantity and cost of medicines prescribed with inadequate consideration given to clinical appropriateness and outcomes. The availability of data to support more sensitive indicators has been a significant constraint. Whilst significant improvements have been made to reduce variation in prescribing, the rate of improvement has slowed in recent years in part as a result of this approach. We will work with the Wales Analytical Prescribing Support Unit (WAPSU) to establish a project in 2017-18 the purpose of which will be to define a new suite of National Prescribing Indicators utilizing additional data sources. The indicators will be developed during 2017-18 with the intention they are approved by the All Wales Medicines Strategy Group (AWMSG) prior to their use from April 2018. Ensure national indicators are included within the performance and accountability process – complete. Establish local reports for key indicators to enable peer comparisons by June 2017.	Berwyn Owen, Chief Pharmacist	Evan Moore, Executive Medical Director	30/06/2017	02/04/2018	1	Implementation outside remit of the HB	Closed - Not Verified
970	Managing Medicines in Primary and Secondary Care	2016	N/A	High	R7	The All Wales Chief Pharmacists' Committee should lead a national audit of compliance with the measures set out in the all-Wales handbook on the safe and effective delivery of homecare services.	This recommendation is aimed at the All Wales Chief Pharmacist's Committee. We will ensure work to improve the safe and effective delivery of homecare services, including an audit of compliance with the measures set out in the all-Wales handbook, forms part of the key priorities agreed with all health board Chief Pharmacists and other stakeholders in 2017-18. Review Homecare governance arrangements across BCUHB including pharmacy support and report findings to QSG by July 2017.	Berwyn Owen, Chief Pharmacist	Evan Moore, Executive Medical Director	30/07/2017	09/04/2018	1	Action completed. Homecare team established and national review ongoing	Closed - Not Verified
971	Review of Emergency Ambulance Services Commissioning Arrangements	2017	N/A	High	R10	Chief Executives of all NHS bodies should increase the visibility of decisions taken by EASC through greater inclusion of EASC minutes, compliance with EASC agreements and consideration of Ambulance Quality Indicators (AQI) performance data in Board meetings, utilising opportunities to seek assurance through respective Board sub-committee processes.	This work is being undertaken through annual presentations to each Health board, a single databank of performance and activity measure is being developed within the commissioning framework and consideration of the development of audience specific AQI's is being undertaken.	Kate Dunn, Head Of Corporate Affairs	Grace Lewis-Parry, Assistant Director Primary and Community Services	30/09/2017		0	Recommended for closure	Closed - Not Verified
972	Review of Emergency Ambulance Services Commissioning Arrangements	2017	N/A	High	New Recommendation	a. The Commissioner should ensure EASC members are aware of and understand the requirements of CAREMORE® and the five-step model. b. Health board Chief Executives should ensure that the Commissioner is given opportunity to comment on draft IMTPs to ensure that they are consistent with the commissioner framework.	The CAREMORE® Five-step pathway is being increasingly used as wider understanding improves. Commissioner feedback was provided on Health Board Integrated Medium Term Plan's and it was notable that one Health Board this year included the specific actions they are delivering at each step of the pathway. We will continue to work with all Health Boards to improve this.	Kate Dunn, Head Of Corporate Affairs	Grace Lewis-Parry, Assistant Director Primary and Community Services	30/03/2018		0	b. Plan in place for engaging EASC in reviewing draft IMTP	Closed - Not Verified
973	Radiology Service	2017	N/A	High	R1	By mid-2017, the radiology service should communicate with all GPs in the West to raise awareness that radiologists are prepared to consider patient access to imaging without an outpatient appointment beforehand. The communication should include details on how best to contact radiologists.	Area medical director has already initiated to set up quarterly GP engagement meetings with locality leads. Also whole service GP engagement meeting. Will remain as live action until fully embedded.	Kakali Mitra, Consultant Radiologist	Adrian Thomas, Executive Director of Therapies & Health Sciences (Interim)	31/08/2017		0	Implemented October 2017	Closed - Not Verified
974	Radiology Service	2017	N/A	High	R2	By the end of 2017, the radiology service should identify and implement ways to reinforce the need for other services to communicate with them about changes and initiatives that will affect the provision of radiology services.	Discussions have taken place to start aligning the radiology service with the strategic and operational objectives of BCUHB. Radiology need to inform and be informed by the work streams established to deliver BCUHB's strategic aims of: 'Improving Health and Reducing Inequalities', providing 'Care Closer to Home' and 'Acute Clinical Services'. Representatives from radiology will, therefore, be invited to participate. It is noted that there are four particular key work streams for the service – these are: Stroke, Emergency Care, Surgery and Women's Services. BCUHB will establish a process for radiology, and other support services, to review business cases before formal sign off. The business case template will be assessed to establish its suitability for this purpose. A suitable mechanism or forum, possibly the Hospital Management Team meetings, will be explored to advise the service of planned medical appointments. This will help ensure that the impact of non-radiology medical appointments on imaging services is understood and, as required, escalated.	John Darlington, Assistant Director, Corporate Planning	Gill Harris, Executive Director Nursing And Midwifery	31/12/2017			completed	Closed - Not Verified
975	Radiology Service	2017	N/A	High	R3	By the end of 2017, the radiology service should review the co-ordination of radiology appointments within and across sites, and set out an action plan to offer greater patient choice while respecting preferences, to help distribute demand effectively and to reduce variations in waiting times.	Radiology aims to provide patients with access to services close to home, in line with the RTT rules. However, the service will discuss with NWIS the proposal to move to a single instance of RadIS across the Health Board - this will improve mechanisms for cross site bookings. GPs will also be provided with information regarding opening times and access policies for all of the radiology departments in North Wales. Service expansion will include the consideration of additional evenings and weekend access to imaging. A census has been sent to all GPs about access to imaging – radiology will respond to the feedback.	John Collins, Head Of Systems & Information Management	Adrian Thomas, Executive Director of Therapies & Health Sciences (Interim)	30/12/2017	31/03/2018	1	This has been implemented	Closed - Not Verified

976	Radiology Service	2017	N/A	High	R4	The Health Board should, by the end of 2017, ensure that it includes data regarding statutory and mandatory training compliance for all radiology staff groups as part of its Electronic Staff Record.	At the time the Radiology Service was being evaluated, it was not possible to observe the compliance of the Radiologists as a staff group on ESR – this has been rectified.	Pat Youds, Associate Chief Of Staff - Radiography	Gill Harris, Executive Director Nursing And Midwifery	30/12/2017			Completed	Closed - Not Verified
977	Radiology Service	2017	N/A	High	R5	The radiology service should establish a radiology strategic plan, by the end of 2017, to: • show where it is now in terms of demand, capacity and available resources; • set out a view of where it needs to be; and • inform the development of annual operational plans.	In developing its strategy, radiology will review: • modality and sub-specialty demand • workforce capacity • equipment capacity • implications of incoming technology • strategic planning workstream outcomes (see R2) • NICE and other clinical guidelines The radiology strategic plan will be influenced by the Health Board's clinical services strategy which will be considered in Q4 2016-17.	Pat Youds, Associate Chief Of Staff - Radiography	Gill Harris, Executive Director Nursing And Midwifery	30/12/2017	31/03/2018	1	This has been completed	Closed - Not Verified
978	Radiology Service	2017	N/A	High	R6	By the end of 2017, the radiology service should set out a clear financial plan to inform annual operational plans.	The financial plan will be developed in parallel with the strategic plan. Although an activity based funding model would be highly desirable, it has been established that this is not currently possible. Therefore, going forward, the radiology budget will roll over. In developing and meeting its financial strategy, Radiology will establish regular meetings with the relevant Director of Finance, Chief and Deputy Chief Finance Officers. Radiology will also seek to establish a process for the service to work with primary and secondary care clinicians to influence demand and develop clinical pathways that optimise access to radiology. Radiology will review its cost pressures annually. The financial plan for radiology will inform the strategic plan and link in with the IMTP which will be finalised in March/April 2018.	Eric Gardiner, Finance Director - Provider Services	Gill Harris, Executive Director Nursing And Midwifery	30/12/2017	31/03/2018	2	The budget has been reviewed as part of the 2018/19 budget setting process in line with the IMTP.	Closed - Not Verified
979	Radiology Service	2017	N/A	High	R7	The Health Board should, by mid-2017, establish clear executive accountability for the delivery of the radiology strategic plan.	It has been determined that the Chief Operating Officer has executive accountability for the delivery of the radiology strategic plan. There is, in addition, a line of accountability to the Secondary Care Hospital Director - this post holder assumes operational responsibility for secondary care services including radiology.	Nigel Lee, Director Of Secondary Care		31/08/2017			It has been determined that the Chief Operating Officer has executive accountability for the delivery of the radiology strategic plan. There is, in addition, a line of accountability to the Secondary Care Hospital Director - this post holder assumes operational responsibility for secondary care services including radiology.	Closed - Not Verified
980	Radiology Service	2017	N/A	High	R8	The Health Board should ensure clear representation of the radiology service on its key committees, by mid-2017.	Committee structures are established at corporate and secondary level and there is now radiology representation at a number of key committees. At a corporate level, these include 'Listening and Learning', 'Clinical Effectiveness' and 'Health and Safety'. The site based radiology services represent themselves at local 'Quality & Safety', HMT and Estates meetings. In keeping with hosting arrangements, radiology is also represented 'corporately' at Quality	David Fletcher, Directorate General Manager, Nwmcss		31/08/2017	07/09/2017	1	Directorate committee structure in place, including representation at all hosting YGC groups. additional representation at Secondary Care F&P / QSE meetings, and links to corporate clinical effectiveness / QSE established.	Closed - Not Verified
981	Review of GP Out of Hours Service	2017	N/A	High	R1	Planning: The Health Board has a GP out-of-hours action plan but only 16% of staff feel they have been able to influence the planning of GP out-of-hours. The Health Board should: a. Refresh the out-of-hours action plan to take account of the recommendations in this report. b. Consult with staff as part of the refresh process for the action plan, in order to improve staff engagem ent and involvement in planning. c. Ensure that work to draft a specific documented GP out-of-hours strategy is done in consultation with staff, to develop clear priorities and a strategic direction for the short-to-medium term	Actions identified: a. The action plan will be refreshed in line with a quarterly report to address those actions that remain outstanding. b. See also comments in c below – many of these actions have now been addressed and the focus of consultation with staff will be on the future development of the service. c. The GP Out of Hours Future Service Model Task and Finish Group held its first meeting on 8th May 2017. This group is overseeing the development of a strategy that will determine the future service model across the Health Board. As part of this process, we will engage with staff through workshops and direct staff engagement and these discussions will contribute to the development of a strategy that will help the service meet the standards for the delivery of out of hours services and ensure that we have a sustainable service. It is anticipated that this work will supersede the previous action plan and will look to the future rather than the past.	Meinir Williams, Hospital Director - YG	Gill Harris, Executive Director Nursing And Midwifery	31/03/2018		0	The status update reflects the actions taken to date.	Closed - Not Verified
982	Review of GP Out of Hours Service	2017	N/A	High	R2	Workforce: The service has a largely traditional staffing model that relies on GPs and there are difficulties in filling GP shifts. Our survey suggests scope to improve morale and collective ownership for the service by the Health Boards divisions. The Health Board should: a. Carry out work to understand the reasons for low morale. b. Develop a specific workforce plan for GP out-of-hours that sets out sustainable, medium-term actions to move away from a traditional staffing model by making use of a wider range of clinical professionals within the service.	a. We will carry out work to understand the reasons for low morale and improve the way we engage with staff. We will undertake PADRs across GPOoHS, improve management support generally and for sickness absence and ensure grievances/ disciplinaries are concluded in a timely way. b. The workforce plan will be linked to the development of a future model/sustainable strategy as described in R1. Depending on the direction decided at that stage, we wi ll then be in a position to move away from a more traditional model to one which can be sustained in the future.	Meinir Williams, Hospital Director - YG	Gill Harris, Executive Director Nursing And Midwifery	31/03/2018		0	This has been implemented	Closed - Not Verified
983	Review of GP Out of Hours Service	2017	N/A	High	R3	Public messaging: Our mystery shopping of the Health Board website, GP websites and GP phone lines highlighted scope to improve signposting to the GP out-of-hours service. The Health Board should: a. Refresh and re-disseminate a standardised wording for GP answerphone messages and practice websites that guide pa tients to out-of-hours services only when they have urgent conditions. b. Use the implementation of 111 as a key opportunity to improve its public messaging about GP out-of-	a. We will request support from the BCU communications team to develop a communications strategy for the Future Service Model Task and Finish Group, which will include the development/ revisions of all aspects of communications with the public – whether via telephone or website. b. We will contribute positively to the 111 pro ject ' s implementation.	Meinir Williams, Hospital Director - YG		31/03/2018		0	The status update reflects the actions taken to date.	Closed - Not Verified

984	Review of GP Out of Hours Service	2017	N/A	High	R4	Home visit performance: While the number of urgent home visits are low for the Health Board and it faces geographical challenges in reaching patients, the Health Board should undertake work to understand and address the reasons why less than half (9 of 31) of Betsi Cadwaladr UHB patients categorised as 'very urgent' receive a home visit within one hour.	The GPOoHs service will undertake an analysis of those "very urgent" patients who do not receive a home visit within one hour. This issue will also feed into the work of the Task and Finish Group as an area to be addressed and possible alternatives to the current delivery of care identified.	Meinir Williams, Hospital Director - YG	Gill Harris, Executive Director Nursing And Midwifery	30/09/2017		0	Management action implemented.	Closed - Not Verified
985	Review of GP Out of Hours Service	2017	N/A	High	R5	Interface with other services: Only 73% of GP practices in Betsi Cadwaladr are open for their entire core hours. Similarly, only 12% of practices regularly offer appointments before 8.30am. Difficulties in accessing in-hours primary care may be impacting out-of-hours services. The Health Board should work with local GP practices to understand and address the reasons for relatively poor performance on core hours opening and availability of early appointments.	The GPOoHs service will work with colleagues within primary care (through the Task and Finish Group structure) to identify opportunities for improving access for patients within core hours.	Ffion Johnstone, IHC Director (West)	Chris Stockport, Executive Director of Transformation and Strategic Planning	31/03/2018	30/06/2018	1	ok	Closed - Not Verified
986	Review of GP Out of Hours Service	2017	N/A	High	R6	Risk management: At the time of our fieldwork the service's corporate GP out-of-hours risk register contained 24 risks. However, over half of the risks featured on the register had been on the register for a number of years. The Health Board should ensure that it builds on constructive work undertaken to improve its divisional level risk registers to: a. Ensure risks included on the corporate-level risk register are up-to-date and review ed regularly; and; b. That the Health Board are taking sufficient action to mitigate, reduce and eliminate risks. Where this is not possible, the service must be confident that it can contain these long-standing risks effectively.	a. As noted in the main body of the report, the recent focus has been upon the Divisional Risk Registers and the constructive work undertaken to improve these is recognised. The service will now move to further develop its corporate level risk register and a workshop will be arranged with Divisional Leads and Risk Management colleagues to further develop the corporate register. b. This will be picked up as part of the work to develop the corporate risk register as noted above.	Meinir Williams, Hospital Director - YG	Gill Harris, Executive Director Nursing And Midwifery	30/09/2017		0	Recommendation implemented - please see attached document.	Closed - Not Verified
987	Review of GP Out of Hours Service	2017	N/A	High	R7	Financial planning: The Health Board use a simplistic approach to setting its budget for GP out-of-hours by rolling over the previous year's budget with some amendments to take into account service developments and separation into divisions. Given the challenging context the service faces with regard to real terms budget reductions, the Health Board should consider alternative methods for budget-setting such as zero-based budget setting that prioritises delivery of an appropriately resourced and sustainable service.	A Finance Manager is a key member of the Task and Finish Group, and as we move to identify a future, sustainable model, this will be costed as part of this work.	Eric Gardiner, Finance Director - Provider Services	Gill Harris, Executive Director Nursing And Midwifery	31/03/2018	31/03/2018	1	The GPOoH budget has been reviewed as part of the 2018/19 budget setting process. Additional resource was added during 2017/18 and at the year end the budgets were underspent.	Closed - Not Verified
988	Review of Discharge Planning	2017	N/A	High	R1	Training on discharge planning. We found that despite plans to organise multi-agency and multi-disciplinary training on discharge planning policy and protocol, training is not consistently available. The Health Board should: a) broaden the availability of discharge planning as part of induction training to include new medical staff; b) provide refresher training on the discharge policy and protocol for all relevant staff; and c) provide training on the Health Board's simple and complex discharge pathways	Self assessment/Bench marking on all aspects of Discharge Planning and Protocols across the 3 Areas and 3 Secondary Care Hospitals. • Self assessment/Bench marking on all aspects of training of staff for Discharge. • Self assessment/Bench marking on simple and complex Discharge Pathways. • Develop and Implement a standard BCUHB wide Discharge Process, and Protocol to include training and pathways.	Ffion Johnstone, IHC Director (West)	Chris Stockport, Executive Director of Transformation and Strategic Planning	01/07/2018			1.Self assessment of Areas and Sites have been completed and a plan developed to address the challenges and issues to each and to the organisation. This will be reported back on a monthly basis.. 2. Training resource pack has been developed and shared with Sites and Areas - containing information on the discharge vision, discharge processes, discharge to assess, SAFER, complex and simple discharges.	Closed - Not Verified
989	Review of Discharge Planning	2017	N/A	High	R2	Discharge policy compliance. Although the discharge policy and protocol includes the use of clinical audit to monitor compliance, we found that there has been no recent audit undertaken. The Health Board should introduce a regular cycle of audit to ensure compliance with its discharge policy and protocol.	Self assessment/Bench marking on staff awareness of all Discharge Resources that are available. • Self assessment/Bench marking of current Accountability Framework on Discharge compliance, etc. • Develop and Implement a BCUHB wide Discharge Accountability Framework, which includes data and information gathering and key intelligent performance indicators plus a reporting system to the appropriate Transformation Group.	Ffion Johnstone, IHC Director (West)	Gill Harris, Executive Director Nursing And Midwifery	01/06/2018		0	as per response	Closed - Not Verified

990	Review of Discharge Planning	2017	N/A	High	R3	Discharge pathways. The Health Board uses two generic discharge pathways: simple and complex, however there is inconsistency in application across the three hospital sites and some aspects of good practice are not included. To improve its use of pathways, the Health Board should: a) ensure consistent application of its discharge pathways across its three hospital sites; and b) further develop its simple and complex discharge pathways by including: • agreed standards for response times; • quality and safety information; • processes for sharing information; and • signposting for patients with end of life care needs	• Self assessment/Bench marking on approaches across all sites on simple and complex Discharges. • Develop and implement a standard BCUHB plan for Simple Discharge AND Complex Discharge. • Develop and Implement a Training plan for new and existing staff and refresher training. • Develop and implement a standard BCUHB wide process for; agreed standards for response times; quality and safety information; processes for sharing information; signposting for patients with end of life care needs.	Ffion Johnstone, IHC Director (West)	Gill Harris, Executive Director Nursing And Midwifery	01/06/2018		0	as per response	Closed - Not Verified
991	Review of Discharge Planning	2017	N/A	High	R4	Timely discharge. We found that staff are encouraged to discharge patients by 11am (referred to as the 'golden hour programme'), but this may result in patients who are potentially safe to be discharged the previous afternoon or evening having their discharge delayed to the following day in order to meet the 11am target. Information reported to the Finance, Performance Committee on discharges by time of day did not differentiate between appropriate and inappropriate discharges as all discharges between midnight, and 11am are included in a single category. While we found no current evidence that perverse behaviour is occurring, the Health Board should take steps to mitigate this risk, by: a) reporting more in-depth data on patients discharged between 12am and 7am, and those that discharged between 7am and 11am ; and b) introducing additional measures that will allow it to understand whether patient discharges under the 'golden hour programme' are appropriate, or whether patients are being delayed overnight unnecessarily in order to comply with this target	• Self assessment/Bench marking on Timely Discharge. • Develop and Implement Discharges in accordance with the 'golden hour ' programme, with key performance management of activity. • Develop and implement processes to feedback on performance during 12am – 7am and 7am – 11am discharges	Ffion Johnstone, IHC Director (West)	Gill Harris, Executive Director Nursing And Midwifery	01/05/2018		0	Implemented as part of 90 day USC plans	Closed - Not Verified
992	Review of Discharge Planning	2017	N/A	High	R5	Single point of access (SPoA). When reviewing staff's awareness of community services to support discharge, we found inconsistency. The Health Board must ensure that each of the local SPoA models established during 2016-17 are implemented effectively. The Health Board should: a) work with its local authority partners to ensure the consistency and quality of information held on each SPoA; b) ensure that staff across each of its hospital sites receive adequate training on the range of services available through the three SPoA models; and c) ensure information on the new SPoA models is easily accessible to staff.	• Self assessment/Bench marking on the Community Services that are available to support Discharge Planning. • Develop and implement consistency and quality of information held on each SPOA • Develop and implement a consistent approach to ensure that staff are trained and have access to information on appropriate SPOA models	Ffion Johnstone, IHC Director (West)	Gill Harris, Executive Director Nursing And Midwifery	01/08/2018		0	90 day plans taking forward discharge planning and discharge to assess	Closed - Not Verified
993	Review of Discharge Planning	2017	N/A	High	R6	Discharge reporting. We found that the Board, Executive Team and the Finance and Performance Committee receives regular information relating to delayed transfers of care, but receives limited information specific to discharge planning that would support a better understanding of the reasons behind the Health Board's performance. The Health Board should strengthen its performance reporting by including the following measures within its routine performance report: • number and % of patients who have an estimated discharge date; • readmissions within 28 days of discharge from hospital; • % of discharges before midday; • % of unplanned discharges at night; and • % of discharges within 24 hours and 72 hours of being declared 'medically fit'	• Self assessment/Bench marking on performance on; estimated discharge date; readmissions; timely discharging. • Develop and implement key performance measurement on ; % who have a discharge date; % readmission; % discharged before 12am; % unplanned night discharges; % discharged within 24hours of being declared medically fit; number of medically fit patients; number of patients with LOS over 21 days.	Chris Lynes, Deputy Executive Director of Nursing	Chris Stockport, Executive Director of Transformation and Strategic Planning	01/07/2018			1. Development and implementation of key performance, key quality and key process indicators. This information is shared each month with Sites and Areas. 2 Details of discharge performance is included with a % change recorded on the previous month's performance. 3. Process and quality indicators are measured using a RAG rating.	Closed - Not Verified
994	Review of Estates	2018	N/A	High	R1	Allocate an Independent Member to represent Estates issues at Board level to: • ensure that estates issues receive sufficient focus at Board level; and • provide an advocate for estate issues at board level	An Independent Board Member will be agreed through the Board Secretary.	Grace Lewis-Parry, Assistant Director Primary and Community Services	Mark Wilkinson, Executive Director Of Planning And Performance	16/01/2018	01/01/2019	4	the chairman has agreed to undertake the role of Board champion for Estates	Closed - Not Verified
995	Review of Estates	2018	N/A	High	R2	Allocate a committee to formally receive specific estates information on a regular basis. This information should include but not be limited to: • Estates performance information, including complaints, concerns and compliments; and • Estates workforce information, including staff sickness, mandatory training and PADR rates.	The Finance and Performance Committee has been confirmed as responsible for receiving Estates information and reports.	Rod Taylor, Director Of Estates And Facilities	Mark Wilkinson, Executive Director Of Planning And Performance	16/01/2018	02/01/2019	2	Implemented as per status updated received at F&P	Closed - Not Verified

996	Review of Estates	2018	N/A	High	R3	Develop a fully costed estates strategy which supports the achievement of the clinical strategy for the Health Board	The Board is currently engaging on its clinical strategy, which is due for publication in February 2018. This will then require detailed analysis of capital requirements to meet the future service need across primary and community settings, mental health and hospital care. A full estate strategy will then be developed to reflect this detail during 2018/19	Rod Taylor, Director Of Estates And Facilities	Mark Wilkinson, Executive Director Of Planning And Performance	31/12/2018	28/03/2019	3	The Health Board has recently approved the 2019/22 Estates Strategy which sets the strategic contect, considers the current estate and proposes delivering the vision. To drive and implement the Strategy the health Board has established the Estates improvement group. Copies of both documents are attached as evidence	Closed - Not Verified
997	Review of Estates	2018	N/A	High	R4	Strengthen monitoring of the delivery of savings delivery targets through the year	Estates and Facilities have implemented 6 No strategic savings plans and 10 No service specific savings plans which are reported through the PMO Programme Review Group. Monitoring also in place through the Divisional Performance Management and Accountability meetings for Q1/2/3 & 4 Annual budget setting will be reviewed in line with CIBSE zero based approach set against the current methodology of historical allocation.	Rod Taylor, Director Of Estates And Facilities	Mark Wilkinson, Executive Director Of Planning And Performance	31/03/2018	29/03/2019	2	Implemented as per previous status update	Closed - Not Verified
998	Review of Estates	2018	N/A	High	R5	Ensure that following the planned stock condition survey, a programme of regular monitoring and updating of the data is put in place to maintain the integrity, validity and completeness of this survey on a rolling three to five year basis	The specification for the six facet condition appraisal includes the implementation of Micad an asset management software system currently in use in a number of other Welsh Health Boards	Rod Taylor, Director Of Estates And Facilities	Mark Wilkinson, Executive Director Of Planning And Performance	31/12/2018	13/11/2019	4	The recommendation to include re appraisals as part of the six facet survey work has been included within the specification for MICAD and funding will be sort to employ dedicated staff to manage the data system of MICAD.	Closed - Not Verified
999	Review of Estates	2018	N/A	High	R6	Improve customer focus and clinical engagement by making better use of multi-disciplinary forum for discussion of estates matters, for example, community area teams and meetings with the North Wales Community Health Council	Estates and Facilities currently attend three acute HMT's, three Area locality teams and has presented at BCUHB's Healthcare Professional Forum. Presentations have also been made to the local CHC. Estates and Facilities also attend the recently establish Acute based Safety Huddles.	Rod Taylor, Director Of Estates And Facilities	Sally Baxter, Assistant Director - Health Strategy	16/01/2018	11/09/2018	3	This Action has been implemented and Estates and Facilities attend Secondary Care (HMT) meetings , Area Teams and MH&LD.	Closed - Not Verified
1000	Review of Estates	2018	N/A	N/A	R7	Strengthen performance management of estates by developing and monitoring a series of Key Performance indicators (KPIs)	Estates and Facilities currently report annually through the All Wales EFPMS - this includes the National Key Performance Indicators for Estates and Facilities Services and functions. . Operational Estates are developing a Quarterly performance report for repair and maintenance activity which will be reported through the quarterly Performance and Accountability Reports.	Rod Taylor, Director Of Estates And Facilities	Mark Wilkinson, Executive Director Of Planning And Performance	31/03/2018	31/03/2019	2	Implemented as per last status update	Closed - Not Verified
1001	Management of Follow-up Outpatients Across Wales	2019	N/A	High	R4: Plan sustainable services	Ensure there are clear plans to improve follow-up performance and modernise outpatient services within health board Integrated Medium Term Plans (IMTP) and annual plans.	The Health Board has ensured that the IMTP has a focus on planned care considering RTT, cancer pathways as well as follow up. The plan outlines the intention to stabilise current services and ensure that a recovery plan is in place.	Kate Clark, Secondary Care Medical Director	Deborah Carter, Associate Director Of Quality Assurance	30/06/2019	31/10/2019	1	As part of the national planned care programme the HB has developed an improvement plan to implement SOS virtual FU and PROMS virtual FU in ortho. PROMS has gone live in YGC and WXM in aug 18 and YG will go live in sept. these interventions are expected to deliver sustainable reduction on face to face follow up apts. with some funding from WG the board has committed to reduce FU waiting list by 15% by march 2020. Due to BCUHB not having an IMTP, propose to close this recommendation. PROMS has provided modernisation. The Tendering exercise will evidence FU waiting list reduction as per other Internal Audit Recommendations.	Closed - Not Verified
1002	Management of Follow-up Outpatients Across Wales	2019	N/A	High	R6: Strengthen and focus performance accountability	Build on the developing focus at Quality and Delivery meetings with health boards, by strengthening the focus on holding health boards to account for delivering improvements to reduce follow-up outpatient waiting lists in the short, medium and long term.	The Planned Care Board chaired by the executive Medical Director will have oversight of work streams including follow up. The outpatient PRG function is being reviewed to ensure that it meets the needs of the Health Board to review how follow up appointments are currently managed. A project plan is being implemented to stratify the approach to manage this activity which will be monitored through the follow up clinical safety and improvement group.	Kate Clark, Secondary Care Medical Director	Deborah Carter, Associate Director Of Quality Assurance	30/06/2019	31/10/2019	1	As part of the Planned Care Improvement group a monthly dashboard has been developed and is now operational. This includes an improvement trajectory for FU supported by monthly monitoring. Any under delivery will be managed through Planned Care Improvement group with teams being held to account on a monthly basis.	Closed - Not Verified

1003	Management of Follow-up Outpatients Across Wales	2019	N/A	High	R7: Strengthen Clinical Accountability	Raise awareness amongst health board Medical Directors of their professional roles and responsibilities in driving through the required clinical changes and adherence to national follow-up outpatient guidance.	The Secondary Care Medical Director (SCMD) is leading the outpatient and follow up workstreams. As chair of the follow up clinical safety and improvement group, the SCMD will monitor the implementation of the project plans as well as supporting clinical and operational teams to manage their clinical risk. This work stream also includes a review of the current models of care to reduce the number of follow up appointments offered by introducing self care and shared care models as well as improving efficiency through the use of virtual clinics, straight to test and nurse led pathways.	Pradip Karanjit, Head Of Planned Care Improvement	Deborah Carter, Associate Director Of Quality Assurance	13/11/2019		0	Awareness has been raised amongst health board Medical Directors of their professional roles and responsibilities in driving through the required clinical changes and adherence to national follow-up outpatient guidance. This is being monitored through the planned care improvement programme.	Closed - Not Verified
1012	GP Out of Hours (OOH) Compliance with National Standards	2019	N/A	High	R1	Clinician audit in place using a recognised and accredited template e.g. RCGP toolkit. A minimum of 1% of clinical contacts to be audited by the service with a minimum of 4 calls/cases per clinician per year using a recognised and accredited template e.g. RCGP toolkit	Since January 2018, East Division has had 14,192 GP/NP contacts. The RCGP audit has been carried out on 128 GP contacts at 8 contacts per GP (0.901%). Central and West Division have not completed this level of audit, and their management teams are reviewing options for delivering this standard. Nurse audits were also carried out during the year.	Chris Stockport, Executive Director of Transformation and Strategic Planning	Grace Lewis-Parry, Assistant Director Primary and Community Services	30/06/2019		0	operational manager has confirmed that audits completed across North Wales and included in the annual reporting	Closed - Not Verified
1013	GP Out of Hours (OOH) Compliance with National Standards	2019	N/A	High	R2	The service will be able to flexibly adjust to meet periods of high demand without detriment to service provision. Business continuity plans in place to include reporting to Welsh Government.	As per BCU policy	Chris Stockport, Executive Director of Transformation and Strategic Planning	Grace Lewis-Parry, Assistant Director Primary and Community Services	30/06/2019		0	regular reporting to WG . GP OOH now taken out of special measures by Welsh government . Multi professional teams in place . Staff consultation underway which will continue to build resilience in the system as part of business continuity.	Closed - Not Verified
1014	Primary Care Services: BCUHB	2019	N/A	High	R1	The Health Board has recently developed a Care Closer to Home Framework but has not yet described how this framework will be implemented. The Health Board should therefore develop a costed implementation plan to support delivery of its Care Closer to Home Framework.	The Care Closer to Home Transformation Group is being refreshed following the commencement in post of the Director of Primary & Community Care services, and part of this work involves the creation of greater detail of the steps required to implement the Framework. A key element of this Delivery Plan will be the costed implications including savings. The first draft will be completed in November 2018.	Stephanie O'Donnell, Senior Health Planning Manager	Chris Stockport, Executive Director of Transformation and Strategic Planning	14/02/2019	15/04/2019	1	Considerable work has been undertaken to meet this recommendation, with the CCTH programme reporting through SPPH and to the RPB as part of the Community Transformation Programme, including £6million of transformation funding. Monitoring will continue at both SPPH and RPB.	Closed - Not Verified
1015	Primary Care Services: BCUHB	2019	N/A	High	R5b	Review the membership of clusters and attendance at cluster meetings to assess whether there is a need to increase representation from local authorities, third sector, lay representatives and other stakeholder groups.	See response R5a. All clusters are being supported to form multi-partner, multi-disciplinary meeting structures.	Bethan Jones, Area Director (Central)	Chris Stockport, Executive Director of Transformation and Strategic Planning	30/04/2019	02/09/2019	2	The membership of clusters has been reviewed and expanded to form multiagency multi partner meetings as part of the care closer to home programme linked to the new transformation fund.	Closed - Not Verified
1016	Primary Care Services: BCUHB	2019	N/A	High	R5c	Support clusters to improve their procurement processes. Actions could include nominating individuals in the procurement team to link with specific clusters and developing specific procurement guidance for clusters to clarify timescales, accountabilities and processes.	The Health Board recognises that opportunities exist to improve procurement opportunities. Guidance will be provided, and links, alongside best practice national guidance.	Rob Nolan, Finance Director - Commissioning & Strategy	Chris Stockport, Executive Director of Transformation and Strategic Planning	30/04/2019			CFOs provide procurement advice and support and link with central procurement team	Closed - Not Verified
1017	Primary Care Services: BCUHB	2019	N/A	High	R5d	Clarify and publicise the governance and leadership arrangements for clusters, to ensure better understanding of the responsibilities for decision-making.	Arrangements are being clarified via the Care Closer to Home Framework, with a specific sub-group focused around the governance and leadership of clusters. This will build upon national guidance to create local clarity and facilitate decision-making in line with evolving cluster maturity.	Bethan Jones, Area Director (Central)	Chris Stockport, Executive Director of Transformation and Strategic Planning	30/04/2019		0	Work to clarify and publicise the governance and leadership arrangement for clusters has taken place as part of the care closer to home framework. These arrangements will be kept under review and updated in line with emerging national guidance which will be available later this year. As this has become business as usual it is proposed that this recommendation be closed on the tracker.	Closed - Not Verified
1018	Primary Care Services: BCUHB	2019	N/A	High	R5e	Ensure all cluster leads attend the Confident Primary Care Leaders course.	Two cohorts have now attended the Confident Primary Care Leaders course, and those cluster leads that have not attended will be encouraged and supported to do so.	Janet Ellis, Assistant Area Director Primary Care & Commissioning East	Chris Stockport, Executive Director of Transformation and Strategic Planning	30/06/2019			Course attendance is dependant on spaces available and suitability of dates.	Closed - Not Verified

1019	Primary Care Services: BCUHB	2019	N/A	High	R5f	Consider introducing a locum cluster lead post, to work across all clusters providing additional capacity and backfill for cluster leads. The post could also be valuable in sharing learning across clusters.	This will be discussed with existing cluster leads, in order to establish the best way forwards.	Janet Ellis, Assistant Area Director Primary Care & Commissioning East	Chris Stockport, Executive Director of Transformation and Strategic Planning	14/02/2019	31/05/2019	1	This has been implemented as far as possible - the context has since progressed, and this will be taken forward as part of a general review of cluster support in order to move clusters to the next level of maturity.	Closed - Not Verified
1020	Primary Care Services: BCUHB	2019	N/A	High	R6	We found scope to raise the profile of primary care in the Health Board, particularly at Board and committee level. There is also scope to improve the way that primary care performance is monitored and reported at Board and committee level. The Health Board should therefore develop an action plan to ensure the Board and committees are adequately informed on the following key issues: a. Primary care performance; b. Delivery of primary care plans; c. Key risks to primary care, including GP practice sustainability; and patient experience of primary care.	The commencement of a Director for Primary and Community Care services, with consistent support from the Health Board vice-chair (holding a lead role to champion this area) will increase the visibility of Primary Care at Board and committee level. An action plan is being prioritised as part of the entry strategy for the new Director.	Chris Stockport, Executive Director of Transformation and Strategic Planning	Grace Lewis-Parry, Assistant Director Primary and Community Services	31/12/2019		0	Action complete	Closed - Not Verified
1021	Primary Care Services: BCUHB	2019	N/A	High	R2a	Calculate a baseline position for its current investment and resource use in primary and community care.	In support of the financial planning for 2019-20 to 2021-22 IMTP, the extent of resources invested in primary and community care will be calculated to establish a baseline against which future investment and disinvestment decisions will be made against.	Rob Nolan, Finance Director - Commissioning & Strategy	Chris Stockport, Executive Director of Transformation and Strategic Planning	14/02/2019	12/07/2019	3	Baseline calculated	Closed - Not Verified
1022	Primary Care Services: BCUHB	2019	N/A	High	R2b	Review and report, at least annually, its investment in primary and community care, to assess progress since the baseline position and to monitor the extent to which it is succeeding in shifting resources towards primary and community care.	In support of the financial planning for 2019-20 to 2021-22 IMTP the extent of resources invested in primary and community care will be calculated to establish a baseline against which future investment and disinvestment decisions will be made against. Currently, comparison between years expenditure split between secondary care, mental health and primary care is analysed as part of AGM presentation.	Rob Nolan, Finance Director - Commissioning & Strategy	Chris Stockport, Executive Director of Transformation and Strategic Planning	14/02/2019	12/07/2019	3	Baseline calculated	Closed - Not Verified
1023	Primary Care Services: BCUHB	2019	N/A	High	R3	The Health Board's workforce planning is inhibited by having limited data about the number and skills of staff working in primary care, particularly community dentistry, optometry and pharmacy. The Health Board should develop and implement an action plan for ensuring it has regular, comprehensive, standardised information on the number and skills of staff, from all professions working in all primary care settings.	The Health Board recognises that data related to the Primary Care contractor workforce is limited, and that the Care Closer to Home Framework would benefit from more extensive workforce data. The Health Board will continue to work with contractor service providers to improve our baseline data set and seek their help in identifying anticipated future requirements. The Care Closer to Home Framework has a number of important workforce dataset requirements, with a sub-group being convened to support workforce planning.	Clare Darlington, Assistant Area Director Primary Care & Commissioning	Chris Stockport, Executive Director of Transformation and Strategic Planning	30/06/2019	30/09/2019	1	The Health Board's action is to implement the workforce data software currently being commissioned by WG. This will then be used routinely to support workforce planning.	Closed - Not Verified
1024	Primary Care Services: BCUHB	2019	N/A	High	R4a	Work with the clusters to agree a specific framework for evaluating new ways of working, to provide evidence of beneficial outcomes and inform decisions on whether to expand these models.	Workstream leads have been appointed to oversee key pieces of work within the Care Closer to Home Framework, including the development of clusters, the development of Community Resource Teams within clusters, and the development of new ways of working within Primary Care. These pieces of work are complementary and will provide frameworks focused to allow the evaluation and propagation of beneficial new ways of working.	Wyn Thomas, Assistant Area Director Of Primary Care	Chris Stockport, Executive Director of Transformation and Strategic Planning	30/04/2019	31/12/2019	1	Each cluster is supported in the evaluation of individual projects, service developments and new ways of working. Outcomes are shared across the clusters, along with lessons learnt. Submissions to the national RCGP awards have recently been made. A recent example of where good practice is being rolled out to all clusters is where the WG funding has been secured to implement the CAMHS Family Practitioner role across all 14 clusters.	Closed - Not Verified
1025	Primary Care Services: BCUHB	2019	N/A	High	R4b	Centrally collate evaluations of new ways of working and share the learning by publicising the key messages across all clusters.	Cluster coordinators are in post with workplans that are aligned to sharing good practice and experience across Clusters. Collation of evaluations will be included within ongoing work currently bringing together an Academy framework for Primary Care services.	Wyn Thomas, Assistant Area Director Of Primary Care	Chris Stockport, Executive Director of Transformation and Strategic Planning	30/04/2019		0	Workstream in place to establish academy. Sharing of evaluation between areas in place.	Closed - Not Verified

1026	Primary Care Services: BCUHB	2019	N/A	High	R4c	Subject to positive evaluation, begin to fund these new models from mainstream funding, rather than from the Primary Care Development Fund.	This will be specifically included within the work referred to in responses R1 and R2a	Bethan Jones, Area Director (Central)	Chris Stockport, Executive Director of Transformation and Strategic Planning	14/02/2019	31/12/2019	2	The schemes funded via the primary care development fund have been evaluated. One scheme has subsequently reverted to mainstream funding, the other schemes remain under review and it is expected that a number of these will require separate business cases if they are to be included within the HB's corporate planning arrangements. This is now considered business as usual and as such it is proposed that this action be closed on the tracker.	Closed - Not Verified
1027	Primary Care Services: BCUHB	2019	N/A	High	R4d	Work with the public to promote successful new ways of working, particularly new alternative first points of contact in primary care that have the potential to reduce demand for GP appointments.	The Health Board is committed to developing opportunities built around the all Wales new model for Primary Care, and has created a major workstream within the Care Closer to Home Framework dedicated to doing this.	Clare Darlington, Assistant Area Director Primary Care & Commissioning	Chris Stockport, Executive Director of Transformation and Strategic Planning	30/04/2019	31/03/2020	1	Please see status report - this action is now embedded as core business with all clusters and Area plans ensuring engagement with the public in terms of alternative services and pathways.	Closed - Not Verified
1028	Primary Care Services: BCUHB	2019	N/A	High	R5	Review the relative maturity of clusters, to develop and implement a plan to strengthen its support for clusters where necessary.	The Health Board is committed to prioritising and developing clusters. Work is now underway to scope out a blueprint for focused support to develop cluster maturity, led by a cluster lead, and supported by Area Teams who are exploring ways of better supporting clusters as Area building blocks. The Health Board wishes to support clusters as multi-organisation, multi-disciplinary constructs, and has indicated a wish to work collaboratively with partners to ensure this. The development of a cluster blueprint is proceeding in partnership.	Bethan Jones, Area Director (Central)	Chris Stockport, Executive Director of Transformation and Strategic Planning	30/04/2019	30/06/2019	1	In with 'A Healthier Wales', GMS contract 2019/20 and utilisation of the transformation fund, cluster leads are being supported in the development of integrated locality teams eg pacesetter projects to test maturity such as devolved budgets, shared IT etc.	Closed - Not Verified
1029	Clinical Coding Follow up Review	2019	N/A	High	R1	R1: Ensure that performance on coding is reporting into the newly formed information governance informatics committee to ensure that monitoring performance against the Welsh Government target is maintained	R1: In May 2019, the IGIC agenda items will include an Informatics Quarterly Assurance Report this report includes a summary of this audit and its action along with coding performance against Welsh Government targets. Coding completeness will be recorded quarterly via the mechanism.	Dafydd Ap Gwyn, Head Of Clinical Coding	David Fearnley, Executive Medical Director	02/10/2019			Action completed 12/0/72019 Coding Performance reported now to DGIC	Closed - Not Verified
1030	Clinical Coding Follow up Review	2019	N/A	High	R3d	R3d: Strengthen engagement with medical staff to ensure that the positive role that doctors have within the coding process is recognised: Improve clinical engagement in the validation of coded data to drive improvements in quality and awareness of potential use of information Summary of progress as at 2019 follow up review: The Health Board recognises the need to improve clinical engagement and the Coding Manager is confident that this can improve now they have tackled the coding backlog. The clinical coding department at Wrexham Maelor has run ten clinical engagement events over the past 12 months. Since our last review the staff at Ysbyty Gwynedd have moved to a larger space to place all the staff and the additional staff in one location. This is positive. However, the relocation of staff at Ysbyty Glan Clwyd to outside of the main hospital building is felt by the team to have impacted on their ability for the coding staff to engage with clinical staff. The role of the Medical Information Officer is also seen as a key enabler of this recommendation. From their role description there is a clear commitment for them to focus on improving clinical engagement with clinical coding and promoting the clinical coding services.	R3d: As noted by WAO during the 2019 follow up review the clinical engagement has increased by the Coding Department. It is noted that the location of the Clinical Coding Department outside of the main building has hindered engagement.	Dafydd Ap Gwyn, Head Of Clinical Coding	David Fearnley, Executive Medical Director	07/10/2019			Medical Information Officers have been appointed to the Informatics Management structure to support clinical engagement. Engagement continues through attendance at Junior Doctors Induction etc. An Engagement log has been created to evidence ad hoc engagement thus allowing all activities to be captured and will be reviewed and assessed to identify any gaps for future engagement. The Clinical Coding presentation has been standardised for all sites and the pack now includes an overview of coding function and is being made available to all coding management staff this is the basis for all clinical engagement/training opportunities. The department would welcome a move back to the Main Hospital building and agree that it would help improve Clinical engagement however the location of the Glan Clwyd Coding Office is outside the scope of the	Closed - Not Verified

1031	Clinical Coding Follow up Review	2019	N/A	High	R4a	R4a: Improve the arrangements surrounding medical records, to ensure that accurate and timely clinical coding can take place. This should include: Improving engagement between the clinical coding department and medical records Summary of progress as at 2019 follow up review: Our last review highlighted there was no formal coding engagement on the Health Records Group. This has now been addressed. The group has changed name to the Patient Record Group and there is regular attendance from the Head of Coding or his deputy. A review of minutes for this group show good attendance and issues with casenotes being discussed. However, these meetings appear infrequent. A review of minutes for this group show good attendance and issues with casenotes being discussed. However, these meetings appear infrequent.	R4a: The Head of Clinical Coding will regularly attend the Patient Records Group and has the opportunity to escalate any issues.	Dafydd Ap Gwyn, Head Of Clinical Coding	David Fearnley, Executive Medical Director	07/10/2019			The Head of Clinical Coding regularly attends the Patient Records Group and has the opportunity to escalate any issues. No further progress possible from Coding department perspective, Progress will be dependent upon Patient Record group / achievement of remit subject to Governance approval via DTG	Closed - Not Verified
1032	Clinical Coding Follow up Review	2019	N/A	High	R4c	R4c: Improve the arrangements surrounding medical records, to ensure that accurate and timely clinical coding can take place. This should include: Addressing the size of casenotes by clarifying roles and responsibilities Summary of progress as at 2019 follow up review: Issues with medical records remain. The medical records team have responsibility to setting up the record and ensuring that it is stored appropriately. However, the responsibility for filing information and the quality of information recorded in the medical records rest with other staff. One area in our last review was regarding results slips and this is a topic on the Health Records Group which they are trying to address. The Health Records department remain responsible for the policy entitled Health Records Management procedure. The procedure outlines the definition of a health record as well as responsibilities. There are also standards of record keeping and good record keeping principles, which although are not the Royal College of Physicians standards, they are similar in their nature. There is no evidence of any additional work on casenotes to tackle their size. Staff within the focus groups at Wrexham Maelor and Ysbyty Glan Clwyd raised concerns around the poor quality of casenotes. As well as that, deceased patient records are not being filed correctly and there was not enough effort to ensure the files were a complete record.	R4c: Roles and responsibilities are clearly defined within a range of Health Board Policies and Procedures. Training is also mandatory and responsibility for records management is included in all Job descriptions. Whilst this recommendation has therefore been met the size of the case notes is not affected by it. A Head of Digital records is an established role within the Health Board and Programmes of work are being defined to digitise records which should reduce the size of case notes over a long period of time. A case for a local Digital Health Record has recently received support from a variety of groups and committees with the Health Board. Resources will be required to deliver this.	Dafydd Ap Gwyn, Head Of Clinical Coding	David Fearnley, Executive Medical Director	07/10/2019			Roles and responsibilities are clearly defined within a range of Health Board Policies and Procedures. Training is also mandatory and responsibility for records management is included in all Job descriptions. Whilst this recommendation has therefore been met the size of the case notes is not affected by it. A Head of Digital records is an established role within the Health Board and Programmes of work are being defined to digitise records which should reduce the size of case notes over a long period of time. A case for a local Digital Health Record has recently received support from a variety of groups and committees with the Health Board. Resources will be required to deliver this.	Closed - Not Verified
1033	Clinical Coding Follow up Review	2019	N/A	High	R4d	R4d: Improve the arrangements surrounding medical records, to ensure that accurate and timely clinical coding can take place. This should include: Ensuring the availability of training on the importance of good quality medical records to all staff Summary of progress as at 2019 follow up review: There is a policy in place in relation to health records, and staff receive induction on this. Processes are in place for the Health Board to regularly audit records management systems, and as a minimum there must be an annual record keeping audit. Through mortality reviews, issues with record keeping are identified as well and fed back to staff. Arrangements are in place through the new Medical Information Officer role to support improvements in medical records. Part of the role description is to work with health records and promote the need for good record keeping.	R4d: As notes in the summary of progress, training is mandatory for all new Health Board staff. A Health Records Management Resource site is also available "on line" for all existing staff. This contains links to various documents and eLearning which are all designed to support good record keeping and ensure that staff have the appropriate skills and knowledge to so.	Dafydd Ap Gwyn, Head Of Clinical Coding	David Fearnley, Executive Medical Director	07/10/2019			training is mandatory for all new Health Board staff. A Health Records Management Resource site is also available "on line" for all existing staff. This contains links to various documents and eLearning which are all designed to support good record keeping and ensure that staff have the appropriate skills and knowledge to do so.	Closed - Not Verified
1034	Clinical Coding Follow up Review	2019	N/A	High	R2	R2: Revisit training materials and standardise across the Health Board, ensuring that the materials reflect the totality of the Health Boards coding not just site based.	R2: Clinical Coding training materials are currently being updated to assist with engagement and knowledge, once completed these will be released as part of a wider engagement strategy	Dafydd Ap Gwyn, Head Of Clinical Coding	David Fearnley, Executive Medical Director	01/01/2020	01/01/2020	1	coding Training document to standardise training across all BCU sites has been completed. The document was approved at the Coding management meeting on the 06/02/2020 to go live and be used as of that date.	Closed - Not Verified

1035	Clinical Coding Follow up Review	2019	N/A	High	R2a	R2a: Introduce a single coding policy and procedure across the heath board which brings together all practices and processes to ensure consistency. The policy and procedure should include: ensuring coding practices are well described; Summary of progress as at 2019 follow up review: At our last review we found that the Health Board did not have a clinical coding policy which covered all sites and activities. There were historical policies in place for Wrexham Maelor and Glan Clwyd, with no policy in place in Ysbyty Gwynedd. The Health Board recognised the need for a single policy to address potential inconsistencies in practice and to provide more clarity for staff as to what is expected of them. A single coding policy is now in place, however there is further work to be done to fully complete implementation of this. Through our interviews, awareness of the policy was low amongst coding staff. Additionally, there are some elements that need to be changed to reflect the changes in the Welsh Government targets. The coding manager is currently developing standard operational procedures (SOP) to support the clinical coding procedure. This is positive and will provide additional information to support the coding policy and should address inconsistencies as well as clearly identify the routine validation checks which have been introduced.	R2a: The Health board has a single coding policy and procedure. The document is under review and is scheduled to be approved and recirculated for implementation by 31.08.19 to cover points highlighted. The coding policy has been subject to circulation to all coding staff. Coding staff and Team Leaders have been encouraged to suggest amendments to support ownership. Awareness will be achieved from final dissemination and discussion at site meetings which are scheduled.	Dafydd Ap Gwyn, Head Of Clinical Coding	David Fearnley, Executive Medical Director	02/10/2019	29/02/2020	2	Coding Policy completed	Closed - Not Verified
1036	Clinical Coding Follow up Review	2019	N/A	High	R2b	R2b: Introduce a single coding policy and procedure across the heath board which brings together all practices and processes to ensure consistency. The policy and procedure should include: Providing guidance and feedback to staff to enable consistent practices across the health board; Summary of progress as at 2019 follow up review: The Health Board uses the PDP process and at the time of our review, the coding department were near 100% compliance with only one member of staff waiting for their review. Arrangements are in place for routine validation checks and if issues are identified these are fed back to the individuals. However, there could be more consistency in feeding back issues to the whole team across sites.	R2b: To support consistent coding practices across the Health Board, any diversions from coding standards when identified are highlighted to all sites via emails which are sent to the Coding Managers/ Team Leader. This is cascaded this way to ensure understanding. "coding validation checks / lessons learnt" will be a standard team meeting agenda item from 01.08.19 enabling lessons learnt / further discussion to support standardisation.	Dafydd Ap Gwyn, Head Of Clinical Coding	David Fearnley, Executive Medical Director	02/10/2019			To support consistent coding practitioners across the Health Board, any diversions from coding standards when identified are highlighted to all sites via e-mails which are sent to coding managers and team leaders. This is cascaded this way to ensure understanding. "Coding Validation checks/lessons learnt will be a standard team meeting agenda ite, from 01/08/2019 enabling lessons learnt further discussion to support standardisation.	Closed - Not Verified
1037	Clinical Coding Follow up Review	2019	N/A	High	R2d	R2d: Introduce a single coding policy and procedure across the heath board which brings together all practices and processes to ensure consistency. The policy and procedure should include: Address variations in practices across the three sites; and Summary of progress as at 2019 follow up review: Work is ongoing to address any variations in practices across sites, and the coding management team meet to discuss any issues highlighted through routine validation checks. However due to pressures of work local team meetings do not always happen, and opportunities for the coding team to get together as a whole group are difficult to organise. Currently standard operational procedures are being developed by the coding manager, and these should help remove any variations in coding practices by providing more detailed instructions. In our last review we found variations in policies between the three DGH sites relating to mental health and community hospital coding. At Ysbyty Gwynedd coders within the team were coding activity relating to mental health and community hospital, whereas in Wrexham Maelor coding staff did not code mental health but did code community provision. At Ysbyty Glan Clwyd, they did not code either mental health or community. Positively all mental health activity across the Health Board is now coded by the coding departments, following changes in April 2015.	R2d: Standard Operating Procedure to supplement the coding policy and procedure are being developed. A prioritised list of SOPS required and named "developers" of these has been created. All SOP's are scheduled for completion by the end of March 2020	Dafydd Ap Gwyn, Head Of Clinical Coding	David Fearnley, Executive Medical Director	31/03/2020			All SOPs are scheduled for completion by end of March 2020	Closed - Not Verified

1038	Clinical Coding Follow up Review	2019	N/A	High	R2e	R2e: Introduce a single coding policy and procedure across the heath board which brings together all practices and processes to ensure consistency. The policy and procedure should include: Strengthen internal coding audits. Summary of progress as at 2019 follow up review: In our last review we highlighted that ensuring the consistent application of coding rules across the Health Board was a challenge, and one recognised by the Head of Coding. We recommended that the Health Board strengthen their own internal coding audits. The Health Board has two accredited clinical coding auditors; however, their qualification has now lapsed. There are no plans in place to renew their qualifications although they are aware of the audit methodology. The Health Board places reliance on the external audit conducted by NWIS at each of the three sites every other year as part of the National Audit Programme. They note that additional external audit may be commissioned additionally if required. The results from the NWIS accuracy audits are positive, and the Health Board are showing improvements. The Health Board has recently recruited a staff member who can undertake audit work, however they were not employed for this purpose, so it is unclear if they will undertake this role going forward. The Health Board recognises this position but reflects that the coding audits are very time consuming. A	R2e: The coding policy incudes the Health Boards approach to audit and validation - this will be updated with the policy by 31.08.19. Whilst we note the recommendation to review physical case notes more frequently a "digital by default principle" is adopted. This will receive review / validation with the policy review. Benchmarking BCU's approach against other Healthcare organisations will support this.	Dafydd Ap Gwyn, Head Of Clinical Coding	David Fearnley, Executive Medical Director	02/10/2019	15/11/2019	1	please see update 3/12/2019	Closed - Not Verified
1039	Clinical Coding Follow up Review	2019	N/A	High	R3a	R3a: Strengthen engagement with medical staff to ensure that the positive role that doctors have within the coding process is recognised: Embedding a consistent approach to clinical coding training for medical staff across the health board Summary of progress as at 2019 follow up review: There is a recognition from coding staff that this work will never be completed, and that clinical engagement remains an ongoing challenge. During our last review we found that clinical coding positively featured as part of the induction for junior doctors. These arrangements have continued, and coders continue to attend the junior doctors inductions with the last ones being in September 2018. Further work in this area has been affected by capacity within the team. Although there is recognition by the team they want to do more.	R3a: As noted in the "summary of progress" Medical Information Officers have been appointed to the Informatics Management structure to support clinical engagement. Engagement continues through attendance at Junior Doctors Induction etc. Engagement log has been created to evidence ad hock engagement.	Dafydd Ap Gwyn, Head Of Clinical Coding	David Fearnley, Executive Medical Director	02/10/2019		0	Medical Information Officers have been appointed to the Informatics Management structure to support clinical engagement. Engagement continues through attendance at Junior Doctors Induction etc. An Engagement log has been created to evidence ad hoc engagement thus allowing all activities to be captured and will be reviewed and assessed to identify any gaps for future engagement. The Clinical Coding presentation has been standardised for all sites and the pack now includes an overview of coding function and is being made available to all coding management staff this is the basis for all clinical engagement/training opportunities.	Closed - Not Verified

1040	Clinical Coding Follow up Review	2019	N/A	High	R3b	R3b: Strengthen engagement with medical staff to ensure that the positive role that doctors have within the coding process is recognised: Ensuring a consistent approach to medical staff induction across the health board Summary of progress as at 2019 follow up review: We noted in our previous report that there were different approaches to medical staff induction at different sites. This has continued. There is evidence of clinical engagement events being undertaken, such as meeting junior doctors in Wrexham Maelor and providing information on the importance of coding and data quality. However, the approaches remain inconsistent across the Health Board, and the presentation shared with us for this review could helpfully be updated as it appears not to have been reviewed for some time. The training slides do not give an overview of the Health Board coding function, which would be helpful.	R3b: The Clinical Coding presentation which is used for induction is under review. It will be standardised so that a standard core message is delivered. Some tailoring may be required depending on audience but core training material will be consistent	Dafydd Ap Gwyn, Head Of Clinical Coding	David Fearnley, Executive Medical Director	02/10/2019			Medical Information Officers have been appointed to the Informatics Management structure to support clinical engagement. Engagement continues through attendance at Junior Doctors Induction etc. An Engagement log has been created to evidence ad hoc engagement thus allowing all activities to be captured and will be reviewed and assessed to identify any gaps for future engagement. The Clinical Coding presentation has been standardised for all sites and the pack now includes an overview of coding function and is being made available to all coding management staff this is the basis for all clinical engagement/training opportunities.	Closed - Not Verified
1041	Clinical Coding Follow up Review	2019	N/A	High	R3c	R3c: Strengthen engagement with medical staff to ensure that the positive role that doctors have within the coding process is recognised: Encourage the use of coding information for uses other than mortality statistics Summary of progress as at 2019 follow up review: In our last review we highlighted the potential for the data produced through coding to be used for other purposes such as service transformation and planning. There have been some examples of this however its usage remains adhoc. Since our previous work, the Health Board has expanded the activity which is coded. Following a request from clinicians within the clinical decision unit, this activity is now coded to accurately reflect the nature of their work and inform job planning. Some work has also been undertaken in speciality areas such as Urology to understand prevalence of particular illnesses. One positive aspect that could improve this is the new Medical Information Officer roles which have been appointed across the organisation. This role supports the work of the Chief Medical Information Officer, and engagement with coding is part of their role with a responsibility for improving clinical engagement for clinical coding.	R3c: On the 11.07.19 a presentation was given to the Health Board Members (including the Chief executive) on clinical coding. The presentation included the importance of clinical coding, timeliness, its accuracy and its potential uses. We will continue to promote the use of clinical coding data when possible and Medical Information officers will assist with this	Dafydd Ap Gwyn, Head Of Clinical Coding	David Fearnley, Executive Medical Director	02/10/2019			On the 11.07.19 a presentation was given to the Health Board Members (including the Chief executive) on clinical coding. The presentation included the importance of clinical coding, timeliness, its accuracy and its potential uses. We will continue to promote the use of clinical coding data when possible and Medical Information officers will assist with this Clinical Coded data is constantly use within the Health Board for a variety of uses. Example of use include Mortality Reviews, Service development , Board reports including assurance and by Clinicians who consistently require information from coding e.g. Urology service development.	Closed - Not Verified
1042	Integrated Care Fund	2019	N/A	High	R4	Regional Partnership Board scrutiny arrangements: We recommend that the Welsh Government works with NHS bodies and local authorities to ensure that appropriate scrutiny arrangements are in place for decisions made by the RPBs on behalf of those bodies.	ICF proposals are developed through Area Integrated Services Boards, consistent with HB priorities, and reported through RPB, where our HB Executive Team members are sighted and have opportunity to contribute. ICF capital proposals are now linked into the BCU capital planning process. We will complete the accountability process by taking a formal update report to SPPH in February 2020 and thereafter use that route for future proposals.	Sally Baxter, Assistant Director - Health Strategy	Mark Wilkinson, Executive Director Of Planning And Performance	29/02/2020	30/04/2020	1	report submitted to SPPH n March. now just part of on-going reporting	Closed - Not Verified
1043	Operating Theatres Review	2019	N/A	High	R1 (West)	Develop and commence a time-bound plan to improve surgical productivity, prioritising those specialties where patient waits or productivity gain is highest.	The Directorate has committed to a programme of further improvement with focus on productivity at specialty level. Specialty level reports have been developed reviewing all key indicators. In addition benchmarking is undertaken via BCU Theatre Performance reporting information. Specialty performance is also discussed at monthly Surgical Turnaround meetings which are chaired by Site Medical Director, and weekly Theatre Planning Cell which is chaired by Theatre Manager	Andrew Kent, Head Of Planned Care Improvement (interim)	Gill Harris, Executive Director Nursing And Midwifery	31/03/2020	31/12/2020	5		Closed - Not Verified

1044	Operating Theatres Review	2019	N/A	High	R4	Modernise the day of surgery admission unit in Wrexham Maelor to ensure patient flow and to minimise the impact of unscheduled care and medical outliers	Plans developed, agreed and a business case submitted to planning department for 2019/20 investment.	Nikki Foulkes, Outsourcing And Insourcing Manager	Gill Harris, Executive Director Nursing And Midwifery	31/03/2020	31/05/2022	15	All internal moves with surgical directorate concluded within Q2. This included a redesign of pathways between, Arrivals / SAU / ENT & SDEC and relocation to the new Critical Care Unit template. Clinical pathways have all been reviewed and updated to align. We continue to further explore Orthopaedic recovery solutions across the network. Action closed 13.10.22.	Implemented - Final Client Approved
1045	Operating Theatres Review	2019	N/A	High	R5	Where there are differences in process across the three hospital sites in respect of the surgical pathway, the Health Board should ensure that such differences are acceptable and that	A system wide approach to this will be addressed through the SPPTG. Sharing of best practice has become common place, and will continue.	Andrew Kent, Head Of Planned Care Improvement (interim)	Gill Harris, Executive Director Nursing And Midwifery	31/03/2020	30/11/2020	7		Closed - Not Verified
1046	Operating Theatres Review	2019	N/A	High	R2a (West)	Monitor patient experience through the roll out of patient experience surveys and take action to address any issues but also feedback positive responses to staff.	This has now been addressed at Ysbyty Gwynedd via the patient experience team, this incorporates the feedback for Tudno ward (surgical day ward). First results should be available September 2019 and outcomes will be shared across the BCU.	Andrew Kent, Head Of Planned Care Improvement (interim)	Deborah Carter, Associate Director Of Quality Assurance	07/10/2019	29/11/2019	1	The patient experience of theatres is now incorporated into the patient pathway experience and is co-ordinated through the patient experience team, any positive or negative patient experiences are then feedback through into the theatre process where trends are monitored and corrective action taken	Closed - Not Verified
1047	Operating Theatres Review	2019	N/A	High	R2a (Centre)	Monitor patient experience through the roll out of patient experience surveys and take action to address any issues but also feedback positive responses to staff.	Patient experience team working closely with central management team to capture experiences at various stages of Surgical pathway. Day of Surgery arrivals, POAC, wards. This is also monitored through Datix incident and complaints/concerns within the directorate.	Andrew Kent, Head Of Planned Care Improvement (interim)	Gill Harris, Executive Director Nursing And Midwifery	31/12/2019		0	there is now monthly feedback from the patient liaison team, this is feedback to the theatre team where any improvements or communication issues are discussed and addressed	Closed - Not Verified
1048	Operating Theatres Review	2019	N/A	High	R2 (East)	Monitor patient experience through the roll out of patient experience surveys and take action to address any issues but also feedback positive responses to staff.	Work started to repeat the survey this year – and the same survey will be used across all 3 sites to give a consistent approach.	Andrew Kent, Head Of Planned Care Improvement (interim)	Deborah Carter, Associate Director Of Quality Assurance	31/12/2019		0	this has now been implemented and all relevant information on patient satisfaction is feed back to the theatre team as appropriate	Closed - Not Verified
1049	Operating Theatres Review	2019	N/A	High	R3a	Improve patient experience by standardising pre-operative processes across the Health Board to ensure equity of access for all patients.	There still remain variations in practice across the three sites. The Wrexham pre op model was previously presented to Nursing Director for Secondary Care with a recommendation was made that this model be used across the 3 depts. Also a scoping exercise was completed April 2018 by Service Improvement team to compare practice and highlight differences. We will continue to work across all 3 sites and expand on not only the Pre op documentation has been standardised across the Health Board since 2016 but also best practice.	Andrew Kent, Head Of Planned Care Improvement (interim)	Gavin MacDonald, Interim Chief Operating Officer	31/03/2020	31/12/2020	4		Closed - Not Verified
1050	Operating Theatres Review	2019	N/A	High	R4b (West)	Focus on improving debriefings as this is the area of most concern identified by improving monitoring of the whole process of WHO implementation.	Debriefings are undertaken as and when required. Each member of the team are aware that they can request debrief if they feel necessary. Any untoward event automatically instigates debrief to ensure all relevant information is captured and staff wellbeing established.	Andrew Kent, Head Of Planned Care Improvement (interim)	Deborah Carter, Associate Director Of Quality Assurance	07/10/2019	27/03/2020	1	All sites have implemented WHO checklists with regular audits being undertaken and feeding into secondary care quality group	Closed - Not Verified
1051	Operating Theatres Review	2019	N/A	High	R4b (Centre)	Focus on improving debriefings as this is the area of most concern identified by improving monitoring of the whole process of WHO implementation.	Debriefing is carried out when an untoward event or incident occurs, or as requested by any member of the surgical teams. This is in line with the All Wales Theatre Managers group position. Theatre Manager is planning to visit other health boards outside of Wales.	Andrew Kent, Head Of Planned Care Improvement (interim)	Deborah Carter, Associate Director Of Quality Assurance	07/10/2019		0	All sites have implemented WHO checklists with regular audits being undertaken and feeding into secondary care quality group	Closed - Not Verified
1052	Operating Theatres Review	2019	N/A	High	R4b (East)	Focus on improving debriefings as this is the area of most concern identified by improving monitoring of the whole process of WHO implementation.	The All Wales position is that debrief will occur where an untoward event has happened during the list. Any staff member can ask for debrief following an event which has affected them.	Andrew Kent, Head Of Planned Care Improvement (interim)	Deborah Carter, Associate Director Of Quality Assurance	07/10/2019	31/01/2020	1	All sites have implemented WHO checklists with regular audits being undertaken and feeding into secondary care quality group	Closed - Not Verified
1053	Operating Theatres Review	2019	N/A	High	R1 (Centre)	Develop and commence a time-bound plan to improve surgical productivity, prioritising those specialties where patient waits or productivity gain is highest.	A plan for 2019/20 is in place through the Surgical Patient pathway transformation group. There is a specific improvement focus on Orthopaedics, scheduling and implementation of PACU	Andrew Kent, Head Of Planned Care Improvement (interim)	Gill Harris, Executive Director Nursing And Midwifery	31/03/2020	31/12/2020	4		Closed - Not Verified
1054	Operating Theatres Review	2019	N/A	High	R1 (East)	Develop and commence a time-bound plan to improve surgical productivity, prioritising those specialties where patient waits or productivity gain is highest.	A plan for 2019/20 has been developed and is attached. This is monitored weekly at our planning cells and monthly at SPPTG	Andrew Kent, Head Of Planned Care Improvement (interim)	Gill Harris, Executive Director Nursing And Midwifery	31/03/2020	31/12/2020	4		Closed - Not Verified
1055	Operating Theatres Review	2019	N/A	High	R2 (West)	Prepare and publish an operating theatres workforce development plan. This should be based on capacity and demand modelling and workforce demographics.	We currently have a workforce plan for theatre West, this is in addition to the annual WFP which takes into account turnover rate and demographics all theatre staffing is based on AFPP guidelines taking into account capacity and planning. The plan has been accepted by the West Finance and Performance Committee. The plan will be reviewed twice annually to ensure it aligns to revised demand modelling projections.	Andrew Kent, Head Of Planned Care Improvement (interim)	Gill Harris, Executive Director Nursing And Midwifery	31/03/2020	30/11/2020	6		Closed - Not Verified

1056	Operating Theatres Review	2019	N/A	High	R2 (Centre)	Prepare and publish an operating theatres workforce development plan. This should be based on capacity and demand modelling and workforce demographics	Site-specific recruitment and retention plan developed.(See attached.) Task and finish group established, Theatre managers, vocational education manager, deputy director Nursing improve recruitment opportunities and training opportunities for existing staff.	Andrew Kent, Head Of Planned Care Improvement (interim)	Gavin MacDonald, Interim Chief Operating Officer	31/03/2020	31/08/2020	3		Closed - Not Verified
1057	Operating Theatres Review	2019	N/A	High	R2 (East)	Prepare and publish an operating theatres workforce development plan. This should be based on capacity and demand modelling and workforce demographics	Task and finish group established with Theatre Managers, Vocational Education Manager and Deputy Director of Nursing to consider alternative options for training and increasing the number of learners in theatre.	Andrew Kent, Head Of Planned Care Improvement (interim)	Gill Harris, Executive Director Nursing And Midwifery	31/03/2020	31/08/2020	3		Closed - Not Verified
1058	Operating Theatres Review	2019	N/A	High	R3 (West)	Develop a long-term plan for theatre estate to support improved surgical productivity and align this to clinical strategy and specialty level plans where these are available.	The clinical services strategy will take cognisance of the work required to improve efficiencies and productivity across the theatre estate. Localised plans are in development which will inform the more strategic approach: The future development of Llandudno Theatres is part of the Llandudno Re-development Group. In addition a Llandudno Stakeholders working group to be established to maximise the use of the site. Development and expansion of Ysbyty Gwynedd Theatre Capacity is included within Orthopaedic Plan	Andrew Kent, Head Of Planned Care Improvement (interim)	Gill Harris, Executive Director Nursing And Midwifery	31/03/2020	31/08/2020	3		Closed - Not Verified
1060	Operating Theatres Review	2019	N/A	High	R3 (Centre)	Develop a long-term plan for theatre estate to support improved surgical productivity and align this to clinical strategy and specialty level plans where these are available.	The clinical services strategy will take cognisance of the work required to improve efficiencies and productivity across the theatre estate. Localised plans are in development which will inform the more strategic approach: 3 year Orthopaedic plan to be developed including Theatre and ward.	Paul Andrew, Theatre Manager (central)	Gill Harris, Executive Director Nursing And Midwifery	31/03/2020	31/10/2020	6		Closed - Not Verified
1061	Operating Theatres Review	2019	N/A	High	R3 (East)	Develop a long-term plan for theatre estate to support improved surgical productivity and align this to clinical strategy and specialty level plans where these are available.	The clinical services strategy will take cognisance of the work required to improve efficiencies and productivity across the theatre estate. Localised plans are in development which will inform the more strategic approach: Specialty service reviews at Health Board level are ongoing. The Site redevelopment of Wrexham Maelor will take into consideration those review outcomes. Theatres will form part of the WMH site redevelopment	Andrew Kent, Head Of Planned Care Improvement (interim)	Gill Harris, Executive Director Nursing And Midwifery	31/03/2020	30/10/2020	3		Closed - Not Verified
1062	ICT Asset Management Review	2019	N/A	High	R1	Strengthen the ICT asset management procedure by: update the high-value capital asset value to £250; review, date and update the document revision history; define the process and requirements for ICT asset tagging; determining requirements for whole life-cycle cost assessment as a basis for informing technology replacement requirements; and ensuring all relevant staff receive appropriate training on the procedure.	The ICT Asset Management procedure has been updated fully and is now in operational use. However, final approval from Informatics Senior Management and Counter Fraud will be complete by December 2019. The life-cost element will be managed via normal capital and revenue planning process and complete by March 2020. We have trained the majority ensuring staff on the procedure but formal acknowledgment of training by individuals will be complete by January 2019 once the procedure is formally approved.	Sion Jones, Assistant Director/Chief Technology Officer	David Fearnley, Executive Medical Director	31/12/2019		0	Asset Management Policy updates and approved by SMT	Closed - Not Verified
1063	ICT Asset Management Review	2019	N/A	High	R2	Complete the data migration of all ICT assets onto Tracmor.	Although work is well underway on this further work is required for other items eg Video Conferencing (VC) equipment onto Tracmor.	Sion Jones, Assistant Director/Chief Technology Officer	David Fearnley, Executive Medical Director	30/06/2020		0	Outstanding servers now updated on new system	Closed - Not Verified
1064	ICT Asset Management Review	2019	N/A	High	R4	Replace de-supported desktop devices (XP) and server operating systems (Windows Server 2003) urgently as a priority.	Windows XP devices: The remaining 22 XP devices are predominantly located in the Laboratories running analysers. Discussions have taken place to decommission and isolate these from the core network. These devices are not considered to be high risk as they are running up to date anti-virus and are not used for email or internet browsing where malicious code could be executed. Windows 2003 Operating system: Plans are in place to finalise the migration of the remaining Windows 2003 servers to the latest supported server operating system subject to supplier application software availability & compatibility. All Windows 2003 servers have up to date anti-virus software installed.	Nick Husbands, ICT Systems Manager	David Fearnley, Executive Medical Director	31/07/2020			appropriate plans in place and mitigation also in place for residual legacy operating systems.	Closed - Not Verified
1065	ICT Asset Management Review	2019	N/A	High	R5	Replace Windows Server 2008 by January 2020 or procure additional supplier support.	Plans are being developed to upgrade the remaining Windows 2008 Servers subject to supplier application software availability and compatibility in later releases of server operating systems. Extended Support has been put in place. All current Servers running Windows 2008 have been protected by up to date anti-virus software.	Nick Husbands, ICT Systems Manager	David Fearnley, Executive Medical Director	31/12/2019	30/06/2020	1	Updates in place and extended cover. Working with departments to mitigate legacy systems	Closed - Not Verified
1066	ICT Asset Management Review	2019	N/A	High	R6	Strengthen the ICT patch management procedure by: finalising the procedure and update the revision history; and establish, where applicable, a patch compliance target for data communications equipment.	The Patch Management procedure has been reviewed by the System Owners Group and been updated pending formal approval by Informatics Senior Management Team. Patch management procedure (and compliance) for data communications equipment has been updated and is planned to be tabled at the Information Governance Group meeting for approval.	Sion Jones, Assistant Director/Chief Technology Officer	David Fearnley, Executive Medical Director	31/12/2019	31/01/2021	1	procedure approved	Closed - Not Verified
1067	ICT Asset Management Review	2019	N/A	High	R7	Update ICT department Job Descriptions for the accountabilities and responsibilities for staff who handle and manage ICT assets.	Job Descriptions (JDs) are planned to be updated to ensure a clearly defined responsibility and accountability for managing ICT Asset lifecycles. Advice has already been sought from staff side union representatives and staff to be affected by this change to their current JDs will be fully consulted prior to amendments taking place. Staff will also be reminded of their ongoing responsibilities as part of their annual Personal Development Review	Sion Jones, Assistant Director/Chief Technology Officer	David Fearnley, Executive Medical Director	31/03/2020			process in place, with appropriate consultation, to update JDs	Closed - Not Verified
1068	ICT Asset Management Review	2019	N/A	High	R8	Develop and regularly present an ICT asset performance indicator report to the Digital and Information Governance (DIG) Committee, as part of wider performance reporting.	A summary assurance report was provided to DIGC in September 2019 and this report will be developed further	Sion Jones, Assistant Director/Chief Technology Officer	David Fearnley, Executive Medical Director	31/03/2020			Now part of assurance reporting to DIGC	Closed - Not Verified
1069	ICT Asset Management Review	2019	N/A	High	R9	Complete audit visits at the IT disposal company more frequently, for example, at least annually.	Annual Visits will now be undertaken. The most recent audit visit to Stone Limited took place on 10 September 2019. Regular annual visits are to be scheduled for the month of September with the next audit confirmed for 9 September 2020.	Nick Husbands, ICT Systems Manager	David Fearnley, Executive Medical Director	31/12/2019	30/09/2020	1	audit visit complete and planned visits arranged	Closed - Not Verified
1070	ICT Asset Management Review	2019	N/A	High	R10	Document the reconciliations completed on a monthly and six monthly basis for new ICT assets and those completed to match assets sent for disposal to the IT disposal company destruction reports	Monthly reconciliation checkpoints have been added to Team Leaders and Senior Engineers calendars. Quarterly asset compliance checkpoints have also been added to the calendars of Team Managers. First quarterly compliance checkpoint to take place 15 January 2020. Quarterly checkpoint to be scrutinised by Head and Assistant Head of ICT. Further oversight and audits will be undertaken by the Informatics Performance and Improvement Team. A digital proforma is being created to assist with and document all checkpoint activity	Sion Jones, Assistant Director/Chief Technology Officer	David Fearnley, Executive Medical Director	31/12/2019		0	Audits complete Jan 2020	Closed - Not Verified

1071	Primary Care Services in Wales	2019	N/A	High	R7	The Welsh Government should consult with health boards, to agree an approach to clarifying and standardising the way that primary care expenditure is recorded and reported.	WG Response: Welsh Government is working with health boards to clarify and standardise the expenditure recorded in annual NHS accounts as "Other Primary Health Care Expenditure". Combined with the other elements of primary care expenditure included in note 3.1 of the accounts, this will ensure a more consistent analysis of total primary care expenditure between health boards. BCUHB Response: On completion of this, Primary Care Asst Directors will review the outcome with finance colleagues.	Clare Darlington, Assistant Area Director Primary Care & Commissioning	Chris Stockport, Executive Director of Transformation and Strategic Planning	30/06/2020	31/03/2022	4	Primary Care financial reporting is directed by WG and there is a standardised format across all health boards. There is also a standard set of Primary care supplementary returns (known as LFR returns). Over the last 12 months there have been a number of examples of further internal funding to support primary care services. These include: * the ongoing allocation of ring fenced funds to clusters * the development of a transformation fund for clusters to implement new proposals (non-recurring at present) * the approval of the business case for further develop the Primary & Community Care Academy * the approval of the business case to roll out the award winning Advanced Audiology service to all GP practices * the implementation of digital platforms in primary care * the development of urgent primary care centres	Implemented - Audit Approved
1072	Primary Care Services in Wales	2019	N/A	High	R8	The Welsh Government should work with health boards to evaluate, and if necessary, improve the effectiveness of the financial framework in supporting a shift in resources towards primary and community care.	WG Response: Health boards are required to quantify the funding, and also the services and workforce, which they plan to re-provide in the community in their IMTPs. There is a specific template for this purpose. We monitor and evaluate the effectiveness of the financial framework issued (under cover of WHC 025 2018) in strengthening this shift through our IMTP scrutiny and approval process. The Welsh Government issued the first National IMTP on 20 September 2019. This is a stocktake of the 2019-22 IMTPs and includes commentary on the pace and scale of this shift towards more preventative care closer to home. This National IMTP was issued alongside and sets the tone and context for the NHS Planning Framework for 2020-23. This reflects strengthened requirements designed to increase the pace and scale at which health boards, with their partners, transform the health and care system towards the vision in A Healthier Wales. So that people access the majority of the care and support they need at or close to home. BCUHB Response: Primary Care Asst Area Directors will continue to support the production of the Area Plans feeding into the IMTPs and work with the Area Teams and partners to demonstrate progress in the delivery of the vision in A Healthier Wales	Clare Darlington, Assistant Area Director Primary Care & Commissioning	Chris Stockport, Executive Director of Transformation and Strategic Planning	30/06/2020	31/03/2022	7	As noted in the original WG response and subsequent health board updates, there is already an financial framework in place to record how resources are utilised. In addition the Heath Board's IMTP must demonstrate plans to support this shift. Examples in the draft IMTP 23/25 include the refreshed focus on transformation, with a focus on new integrated care pathways and programmes of work. Other specific examples are, the investment in advanced audiology in primary care, the further development of the Primary Care Academy and transformation bids being led by clusters.	Implemented - Audit Approved
1073	Primary Care Services in Wales	2019	N/A	High	R9	As part of the Joint Executive Team process, the Welsh Government should require health boards to report annually on their progress in shifting resources towards primary care. The coverage of these reports should not be limited to financial resources and should include other resources such as staff and services. Through this process, the Welsh Government should hold to account the entire executive team of health boards, not just the executive directors for primary care.	WG Response: I (AG) accept responsibility for planning and implementing the shift of services, funding, financial and workforce resources out of hospitals rests with all members of the Board. From 2020-21 on, I will require specific reports from each health board for the Joint Executive Team process setting out progress with its plans to move services and resources into the community as set out in its IMTP or equivalent plan. BCUHB Response: Reports and presentations prepared for JET meetings will provide progress updates as requested by WG.	Clare Darlington, Assistant Area Director Primary Care & Commissioning	Chris Stockport, Executive Director of Transformation and Strategic Planning	30/06/2020	31/03/2022	5	Included at JET meetings as noted in previous response.	Implemented - Audit Approved

APPENDIX 2 - ALL EXTERNAL AUDIT 2022/2024 RECOMMENDATIONS

Excludes Structured Assessments

ID	Report Title	Year	Assurance Level	Priority	Recommendation Title	Recommendation	Management Response	Action Owner	Final Approver	Original implementation date	Revised implementation date	Number of Revisions
367	Review of Quality Governance Arrangements	2022	N/A	N/A	Quality and patient safety priorities	R1: Audit Wales found that the Health Board did not formally review its quality improvement priorities in light of the consequences of COVID-19. The Health Board should ensure its new Quality Improvement Strategy sets out how the Health Board will manage and mitigate the potential harms associated with the COVID-19 pandemic	R1: The Health Board accept the priorities were not formally reviewed although we did seek to prioritise the mitigation of the four harms from COVID as part of our organisational strategy. We will ensure the new Quality Strategy under development reflects this recommendation. We have set interim quality priorities while the strategy is being developed which are based on the key quality risks and concerns that have been identified.	Matthew Joyes, Deputy Director of Quality	Angela Wood, Executive Director of Nursing and Midwifery	30/09/2022		
368	Review of Quality Governance Arrangements	2022	N/A	N/A	Risk management training	R2: Audit Wales found that not all operational staff are trained to record clinical and non clinical risks and compile risk registers. The Health Board should ensure staff have adequate levels of risk management training so that they can confidently contribute to the risk identification and escalation process.	R2: The Health Board has updated its Risk Management Strategy and training has been made available. The Risk Management Group has refreshed terms of reference and a new executive lead has been appointed (the Executive Medical Director). The Health Board is also working to implement the new Once for Wales Risk Register module as part of the Datix Cymru system and is likely to be the pilot site	Nesta Collingridge, Head of Risk Management	Pam Wenger, Director of Corporate Governance			
369	Review of Quality Governance Arrangements	2022	N/A	N/A	Quality improvement support	R3: The Health Board's Quality Improvement Hub (BCUQI) has developed a quality improvement database to allow staff to share, adopt and learn from existing quality improvement projects. However, we found that the database is not well used. The Health Board should promote and encourage routine use of the database by setting targets for participation, by keeping the level of engagement under regular review and by taking action if engagement is too low.	R3: The Heath Board has created a new Transformation and Improvement Directorate bringing together the different teams involved in quality improvement, service improvement, transformation and programme management. This will replace the BCUQI Hub. The team will develop a fundamentally different approach to sharing improvement opportunity and which will be overseen by the Executive Delivery Group for Transformation.	Chris Stockport, Executive Director of Transformation and Strategic Planning	Chris Stockport, Executive Director of Transformation and Strategic Planning			
370	Review of Quality Governance Arrangements	2022	N/A	N/A	Clinical Audit	R4: The Health Board has restarted clinical audits after most activity was paused during the pandemic. The Health Board should look to use its programme of clinical audit work to focus on the risk of harm as a result of the pandemic. For example, to better understand the consequences of long waits or exacerbation of chronic conditions. The audits could be targeted at high-risk specialities.	R4: The Health Board will develop a quality and risk informed programme of clinical audit. The Quality Department and Clinical Effectiveness Department are working to develop proposals on closer collaboration and a new clinical audit system is in the process of roll-out.	Joanne Shillingford, Head of Clinical Effectiveness	Nick Lyons, Executive Medical Director	30/06/2022		
371	Review of Quality Governance Arrangements	2022	N/A	N/A	Mortality reviews	R5: Audit Wales found that mortality reviews are not reported to the QSE Committee in a timely manner. The Health Board should ensure the QSE committee receives a quarterly mortality review report, which highlights learning and what action has been taken.	R5: The Health Board will introduce reporting on mortality reviews to the QSE Committee either through a dedicated report or the Patient Safety Report.	Matthew Joyes, Deputy Director of Quality; James Risley, Deputy Executive Medical Director and Jim McGuigan, Deputy Executive Medical Director (covering Associate Medical Director of Mortality Review role)	Nick Lyons, Executive Medical Director	30/06/2022		
372	Review of Quality Governance Arrangements	2022	N/A	N/A	Mortality reviews	R6: We found that, generally, mortality reviews are medically led, but there is an appetite for multidisciplinary mortality reviews. The Health Board should look to establish a system where a multidisciplinary mix of staff are routinely involved in mortality reviews.	R6: The Health Board has appointed a new Associate Medical Director for Mortality Review to provide strategic leadership and is in the process of embedding the new Learning from Deaths Framework. The Reducing Avoidable Mortality Group has been reformed and the Health Board is working with the national work stream for the new Mortality Module of Datix Cymru. The overall new system will enhance multi-professional involvement.	James Risley, Deputy Executive Medical Director; Jim McGuigan, Deputy Executive Medical Director (covering Associate Medical Director of Mortality Review role)	Nick Lyons, Executive Medical Director	30/09/2022		
373	Review of Quality Governance Arrangements	2022	N/A	N/A	Sharing learning and good practice	R7: The Health Board recognises that it does not yet have a process to systematically share learning across the organisation. The Health Board should use the new integrated governance framework and the Quality Improvement Hub (BCUQI) as tools to support organisational learning and sharing good practice across the organisation	R7: The Health Board will implement a learning library through its new Intranet, BetsiNet rather than the external BCUQI Hub web site which will become part of the new Transformation and Improvement Service. In addition, the revised Incident Policy and Complaints Policy will set out new approaches to sharing learning systematically including Learning Events and a Learning Bulletin. The Safety Alert process is also to be revised. These actions form part of the mitigation actions for the risk on the Board Assurance Framework.	Matthew Joyes, Deputy Director of Quality	Angela Wood, Executive Director of Nursing and Midwifery	30/09/2022		

374	Review of Quality Governance Arrangements	2022	N/A	N/A	Values and behaviours	R8: Only 37.9% of Health Board staff responding to the NHS staff survey agreed or strongly agreed that the organisation takes effective action when bullying harassment or abuse occurred. The Health Board should review its systems for managing, addressing, and learning from the concerns of staff in relation to bullying, harassment and abuse.	R8: The Health Board has adopted the all-Wales Respect and Resolution Policy. The Health Board has launched a new Speak out Safely Policy and framework including the appointment of Speak out Safely Guardians, a Multi Disciplinary Team to oversee concerns and a new secure platform for staff to anonymously raise concerns. Additionally, significant work is underway as part of Stronger Together to explore and improve staff engagement and support.	Lesley Hall, Assistant Director	Jason Brannan, Deputy Director of People			
375	Review of Quality Governance Arrangements	2022	N/A	N/A	Complaint handling	R9: Audit Wales found that operational teams did not know what proportion of staff had been trained to investigate complaints, incidents, and root cause analysis. The Health Board should review levels of complaints handling training across the organisation. If this shows shortfalls, the programme of training should be expanded.	R9: The Health Board has refreshed its complaint handling training, and this was re-launched in spring 2022 (following deferment over post-winter pressures). Training will be recorded within the ESR system. In addition, virtual complaint support clinics are held weekly to support staff.	Matthew Joyes, Deputy Director of Quality	Angela Wood, Executive Director of Nursing and Midwifery			
376	Review of Quality Governance Arrangements	2022	N/A	N/A	Flows of information and assurance	R10: Less than half (42%) of respondents responding to our survey agreed or strongly agreed that they receive regular updates on patient feedback for their work area. Whilst patient feedback is shared with wards monthly, the Health Board needs to ensure all ward staff are aware of this feedback and that it is easily accessible to staff.	R10: The Health Board has implemented the new all-Wales Civica Real Time Feedback System. All services are available in this system with all team/ward managers and above given access to the dashboard. Monthly Reports are also sent to services. Patient and Carer Champions are being recruited with over 100 now in place. To complement this a new framework for collecting and acting on patient feedback is being developed setting out standards and good practice for teams to follow.	Matthew Joyes, Deputy Director of Quality	Angela Wood, Executive Director of Nursing and Midwifery	30/09/2022		
377	Review of Quality Governance Arrangements	2022	N/A	N/A	Flows of information and assurance	R11: The Health Board introduced a new reporting format (triple A) to improve the flow of quality assurance. But we found some variation in the levels of detail provided in the reports. To reduce the risk of quality and safety issues being missed or not correctly escalated the Health Board should provide staff with guidance on using the new template, especially setting out how much detail is expected and how to agree which issues are escalated	R11: As part of the new Operating Model being developed as part of the Stronger Together programme, a new integrated governance and assurance framework will be developed setting out a new governance framework, and standards and principles for governance across the organisation including reporting, escalation, and accountability.	Angela Wood, Executive Director of Nursing and Midwifery	Carol Shillabeer, Chief Executive	30/06/2022		
378	Review of Quality Governance Arrangements	2022	N/A	N/A	Quality and patient safety performance measures	R12: Audit Wales found that whilst the measures in the integrated performance report aligns with the NHS delivery framework, there are no locally agreed quality measures or wider measures such as for community services. Through the new Quality Improvement Strategy, the Health Board should review current quality measures with a view to developing measures that reflects the services it provides and commissions across primary, community and secondary care.	R12: A new Quality Highlight Report has been produced for the Board. New quality measures will be included in the new Quality Strategy	Matthew Joyes, Deputy Director of Quality	Angela Wood, Executive Director of Nursing and Midwifery	30/09/2022		
405	Review of Workforce Planning Arrangements	2024	N/A	High	Delivery of the People Strategy	R1a: The Health Board should strengthen and further develop their current implementation plan for delivery of the People Strategy that: a) Sets out clear goals and targets and prioritised activities, with clear delivery timelines and accountabilities.	R1a: The Health Board has sat out clear goals, targets and prioritised activities as part of its special measures programme in 2023-24 and has built them into the annual plan for 2024-25. Clear delivery timelines and accountabilities will be set out as part of the delivery of the annual plan	Jason Brannan, Deputy Director of People	Jason Brannan, Deputy Director of People	31/07/2024		
406	Review of Workforce Planning Arrangements	2024	N/A	High	Delivery of the People Strategy	R1b: The Health Board should strengthen and further develop their current implementation plan for delivery of the People Strategy that: b) Incorporates actions to deliver the 30 recommendations made in the Assessment of key areas of workforce agenda.	R1b: The identified recommendations will be reviewed in light of the work already carried out under Special Measures and will be developed into actions as part of the ongoing work with the Annual Plan and as part of the delivery work overseen by the Organisation Development Steering Group chaired by the CEO and reporting into the newly established People and Culture Committee.	Nick Graham, Associate Director of Workforce Optimisation	Jason Brannan, Deputy Director of People	30/09/2024	31/12/2024	1
407	Review of Workforce Planning Arrangements	2024	N/A	High	Service level workforce planning	R2a In order to better understand its current and future workforce requirements the Health Board should: a) Undertake analysis to understand its current workforce requirement and future service models to determine the workforce needed to create sustainable and efficient acute and community services. This will require: – forecasting of service demand – service modelling; and – analysis of capacity requirements, by specialism and profession	R2a: There is a baseline position now in place as a result of the work done on the workforce dashboards and development of local plans as part of the annual plan development; further analysis will be carried out through 2024 to ascertain demand and capacity requirements across services by specialism and profession.	Nick Graham, Associate Director of Workforce Optimisation	Jason Brannan, Deputy Director of People	31/12/2024		

408	Review of Workforce Planning Arrangements	2024	N/A	High	Service level workforce planning	R2b In order to better understand its current and future workforce requirements the Health Board should: b) Ensure there is sufficient capacity and capability within the Health Board to support effective workforce planning; this should include identifying where scope exists to re-deploy existing staff resources and ensure there are clearer remits within existing job specifications. (High priority)	R2b: This work will be picked up as part of the ongoing embedding of the new people services structure with dedicated resource identified to support specialised workforce planning and further development via a specified training programme of the People Service Business Partners and identified planning leads across the organisation. Job Descriptions across these key roles will be made clearer in the relevant job specifications associated with the identified roles.	Nick Graham, Associate Director of Workforce Optimisation	Jason Brannan, Deputy Director of People	31/12/2024		
409	Review of Workforce Planning Arrangements	2024	N/A	Medium pre 01/10/2024	Support and training	R3: The Health Board should develop an evaluation framework to measure the success of the workforce planning training programme it intends to roll out. The evaluation of the training programme should incorporate an early assessment of whether the training is achieving it's intended aims	R3: This action will be built into the training programme outlined in R2b	Nick Graham, Associate Director of Workforce Optimisation	Jason Brannan, Deputy Director of People	31/12/2024		
410	Review of Workforce Planning Arrangements	2024	N/A	Medium pre 01/10/2024	Exit and pulse surveys	R4a To better understand issues affecting staff turnover the Health Board should: a) Develop an approach to increase exit survey response rates and ensure feedback from the surveys informs retention activities	R4a: Develop an approach to increase exit survey response rates and ensure feedback from the surveys informs retention activities.	Rebecca Testa, Head of OD	Jason Brannan, Deputy Director of People	31/12/2024		
411	Review of Workforce Planning Arrangements	2024	N/A	Medium pre 01/10/2024	Exit and pulse surveys	R4b To better understand issues affecting staff turnover the Health Board should: b) Conduct regular pulse surveys/stay interviews to gauge how staff are feeling and identify any improvements it can make to support retention and manage staff turnover	R4b: Conduct regular pulse surveys/stay interviews to gauge how staff are feeling and identify any improvements it can make to support retention and manage staff turnover.	Rebecca Testa, Head of OD	Jason Brannan, Deputy Director of People	31/03/2025		
412	Review of Workforce Planning Arrangements	2024	N/A	Medium pre 01/10/2024	Monitoring and oversight	R5: The Health Board should strengthen its approach to monitoring delivery of the People Strategy and associated implementation plans and workforce programmes. The monitoring approach should have a focus on whether the Strategy is achieving its desired aims and outcome, include engagement with the new People and Culture Committee and incorporate implementation of the recommendations from the external 'assessment of key areas of workforce agenda review.'	R5: The monitoring of the delivery of the Health Board's workforce priorities will be overseen through the revised governance structures now in place. These will outlined as part of this management response and the new People Report being developed for the People and Culture Committee will incorporate this monitoring	Jason Brannan, Deputy Director of People	Jason Brannan, Deputy Director of People	30/09/2024		
413	Follow Up Review of Follow Up Outpatient Services	2023	N/A	N/A	2015 recommendation R1 - Welsh Government data requirements	R1 (2015): Comply with Welsh Government reporting requirements by reporting on the numbers of both booked and unbooked follow-up outpatients, in line with the revised all Wales template	No management response within report	Rhys Blake, Associate Director of Planned Care	Imran Devji, Interim Chief Operating Officer			
414	Follow Up Review of Follow Up Outpatient Services	2023	N/A	N/A	2015 recommendation R2 - Information to support decision making	R2 (2015): Develop the business information warehouse approach for follow-up outpatients by: • expanding the scope, depth, and detail of information available to ensure management and staff can access operational information relevant to their departmental business need.	We have established a set of planned care dashboards which now allow drill through to individual patient level detail ensuring we can manage our areas of challenge in a consistent way and with a single approach thereby reducing potential variation.	Rhys Blake, Associate Director of Planned Care	Imran Devji, Interim Chief Operating Officer			
415	Follow Up Review of Follow Up Outpatient Services	2023	N/A	N/A	2015 recommendation R2 - Information to support decision making	R2 (2015): Develop the business information warehouse approach for follow-up outpatients by: • use the information to reduce clinical variation across sites, clinical conditions and amongst clinicians	Through the establishment of a focussed follow up reduction programme, we now use this information to drive improvement and consistency of approach between sites, and to understand and mange where variance may be warranted (eg specific workforce or service issues locally).	Rhys Blake, Associate Director of Planned Care	Imran Devji, Interim Chief Operating Officer			
416	Follow Up Review of Follow Up Outpatient Services	2023	N/A	N/A	2015 recommendation R3 - Clinical risk assessment and quality reporting	R3 (2015): Identify clinical conditions across all specialties where patients could come to irreversible harm if delays occur in follow-up appointments. Develop targeted interventions to minimise the risk to patients with these conditions who are delayed beyond their follow-up target date	We continually review our areas of risk and our follow up reduction programme is working to ensure that we maximise the use of PIFU and SOS pathway options to ensure that only the patients requiring follow up are being done so on clinical need. Individual specialties manage their patients according to RTT rules in terms of risk – e.g. Cancer, Urgent, and Routine. For follow up appointments either as part of treatment or following a clinical intervention, clinical risk will be stratified by the treating clinician in accordance to national guidance. For example, in the case of eye care, in order to manage and mitigate against irreversible sight loss, patients with identified risk conditions (Retinopathy, Macular Degeneration and Glaucoma), patients are followed up according to the national Welsh risk stratification (R1 & R2 cohorts). In this instance, we are working with community optometry to expand our available follow up capacity to ensure that we maintain timely pathway management and that patients at risk of irreversible sight loss are not overdue for follow up appointments. We have also undertaken an extensive review of overdue follow ups in plastics services to provide assurance that no patients are coming to harm as a consequence of extended waits.	Rhys Blake, Associate Director of Planned Care	Imran Devji, Interim Chief Operating Officer	Need implementation date		
417	Follow Up Review of Follow Up Outpatient Services	2023	N/A	N/A	2015 recommendation R4 - Clinical risk assessment and quality reporting	R4 (2015): Improve the reporting of clinical risk information in relation to delayed follow-up outpatients to ensure that: • incidents of harm resulting from delays are analysed, escalated, and reported; and • scrutiny and assurance focus on the high-risk specialties and clinical conditions	All clinical incidents are reported via Datix in accordance with the Health Boards Risk and Incident management protocol. This activity will sight the trust management to areas of concern and is only one aspect of clinical risk. Other assurance processes are in place, specifically: • Cancer & other clinical MDTs (to ensure clinical risk is being appropriately managed at a patient level). • Clinical Audit and routine clinical governance meetings (to ensure that systems are operating to expected outcomes and that patterns and trend data can be identified and appropriate intervention taken where necessary). • Routine Health Board weekly corporate access meeting where performance on delivery against RTT standards and elective waiting times are actively managed and any issues escalated through to PFIG and the Executive Team.	Rhys Blake, Associate Director of Planned Care	Imran Devji, Interim Chief Operating Officer	Need implementation date		

418	Follow Up Review of Follow Up Outpatient Services	2023	N/A	N/A	2015 recommendation R5 - Outpatient transformation	R5 (2015): Identify and put in place the change management arrangements and resources needed to accelerate the pace of delivery for long-term outpatient transformation, including: • clinical resources, including medical, nursing, and allied health practitioners; • change management capacity and capability; • internal and external engagement with stakeholders; • primary and community care leadership capacity to support outpatient modernisation; • the need to start health economy care pathway redesign early, and deliver this concurrently with other improvement initiatives (Superseded); and • applying lessons learnt from other recent related projects (Superseded).	The establishment of the BCU Planned Care Programme brings together clinicians and managers across specialties supported by our transformation and improvement team, digital and planning and communications and engagement. Project Board as representatives from Primary Care and the Associate Director for Planned Care sits on the Primary Care Programme Group to ensure improved join up.	N/A	Imran Devji, Interim Chief Operating Officer			
419	Follow Up Review of Follow Up Outpatient Services	2023	N/A	N/A	Clinical leadership	R1 (2023) Take immediate steps to strengthen the clinical leadership for the programme of work to improve follow up outpatient performance	R1 (2023): A refreshed Planned Care Programme has been initiated which covers outpatient transformation initiatives. The programme has 5 core workstreams which are: • Diagnostics • Digital Transformation and Patient Experience • Informatics, Data and Planning • Pathways and GiRFT • Communication and Engagement All supporting workstreams have a clinical and managerial lead appointed and the programme has an overall senior clinical lead from the Executive Medical Director's Office.	N/A	Imran Devji, Interim Chief Operating Officer			
420	Follow Up Review of Follow Up Outpatient Services	2023	N/A	N/A	Refresh management response to 2015 recommendations	R2 (2023) Develop a refreshed management response to the outstanding 2015 audit recommendations that identifies clear actions to fully implement the recommendations, timescales for implementation and the officers responsible	See 2015 recommendations	Glesni Driver, Head of Covid-19 Inquiry and Thirlwall Inquiry	Pam Wenger, Director of Corporate Governance	N/A		
480	Special Measures – Contract and Procurement Review	2024	N/A	N/A	Contracting and Procurement across the Health Board	The Health Board needs to understand why these four services did not respond by the timeline set	N/A	Carol Shillabeer, Chief Executive	Carol Shillabeer, Chief Executive	N/A		
481	Special Measures – Contract and Procurement Review	2024	N/A	N/A	Policies and Procedures	The Executive Director of Finance ensures the current finance procedures are reviewed with urgency and a full review of the SFIs is undertaken to identify gaps in published procedures to guide/instruct the Health Board in complying with the SFIs	N/A	Russell Caldicott, Interim Director of Finance	Carol Shillabeer, Chief Executive	N/A		
482	Special Measures – Contract and Procurement Review	2024	N/A	N/A	EY report action plan	To detail the actions taken / planned actions to address the specific recommendations detailed in the Ernst & Young report.	N/A	Carol Shillabeer, Chief Executive	Carol Shillabeer, Chief Executive	N/A		
620	Equality Impact Assessments: more than a tick box exercise?	2022	N/A	N/A	Reviewing public bodies' current approach for conducting EIAs	R4 While there are examples of good practice related to distinct stages of the EIA process, all public bodies have lessons to learn about their overall approach. Public bodies should review their overall approach to EIAs considering the findings of this report and the detailed guidance available from the EHRC and the Practice Hub. We recognise that developments in response to our other recommendations and the Welsh Government's review of the PSED Wales specific regulations may have implications for current guidance in due course.		Ceri Harris, Head of Equality and Diversity	Jason Brannan, Deputy Director of People	N/A		
626	Orthopaedic Services in Wales – Tackling the Waiting List Backlog	2023	N/A	N/A	R3	R3 The Getting It Right First Time reports set out clearly a range of recommendations which will help drive improvements in efficiencies and productivity in orthopaedics at a local level. We recommend that health boards need to: a ensure they maintain oversight and scrutiny of implementation of the Getting It Right First Time recommendations as part of their governance arrangements; and b ensure that clear action plans are in place to address the things that get in the way of improvement	No management response within report	Rhys Blake, Associate Director of Planned Care	Imran Devji, Interim Chief Operating Officer	N/A		

627	Orthopaedic Services in Wales – Tackling the Waiting List Backlog	2023	N/A	N/A	R4	R4 Clinical Musculoskeletal Assessment and Triage Services (CMATS) are having a positive impact on managing demand and providing support. But services are struggling with capacity and are inconsistent in their delivery with examples of duplication of effort where First Contact Practitioners (FCPs) exist. We recommend that health boards need to: a ensure that local CMATS are appropriately staffed, and at a minimum, reflect previous Welsh Government guidance; and b ensure that where First Contact Practitioners (FCP) exist, there are clear pathways between FCPs and CMATS to reduce duplication and minimise waits.	No management response within report	Rhys Blake, Associate Director of Planned Care	Imran Devji, Interim Chief Operating Officer	N/A		
628	Orthopaedic Services in Wales – Tackling the Waiting List Backlog	2023	N/A	N/A	R5	R5 There needs to be a greater focus on outcomes across health boards and while people are deteriorating on orthopaedic waiting lists, limited progress has been made by health boards to provide ongoing support and monitor and report harms. We recommend that health boards need to: a ensure that Patient Reported Outcome Measures (PROMS) and Patient Reported Experience Measures (PREMS) are fully rolled out in all orthopaedic services and used to inform decision making both at a service and patient level; b ensure that local clinical leadership arrangements and performance information are used to identify opportunities for minimising interventions that are unlikely to result in improved outcomes; and c put arrangements in place to monitor people waiting, provide communication, support and advice when needed, and report openly and honestly, through their existing governance arrangements, the extent to which people are coming to harm whilst waiting for orthopaedic treatment.	No management response within report	Rhys Blake, Associate Director of Planned Care	Imran Devji, Interim Chief Operating Officer	N/A		
1289	Discharge Planning Progress Update - June 2024	2024	N/A	N/A	New recommendations arising from this follow up work	R1 1.1: The Health Board, to support its focus on increasing morning discharges, should: 1.1. ensure learning is captured from previous initiatives, such as the 'golden hour programme' and mitigate the creation of perverse incentives.	R1 1.1: Identify areas of good practice and areas of learning / improvement from poor compliance demonstrated through monthly performance reporting	Jane Trowman, Acting Assistant Director Care Homes Support and CHC Commissioning	Imran Devji, Interim Chief Operating Officer	30/06/2024	31/03/2025	1
1290	Discharge Planning Progress Update - June 2024	2024	N/A	N/A	New recommendations arising from this follow up work	R1 1.2: The Health Board, to support its focus on increasing morning discharges, should: 1.2. introduce routine reporting of the time of discharge to ensure that morning discharges are maximised where appropriate	R1 1.2: Produce monthly reports for IHCs on time of discharge for review and monitoring at IHC UEC meetings and scrutiny at the 6 Goals programme board	Clare Brennan, Programme Manager for Urgent & Emergency Care	Imran Devji, Interim Chief Operating Officer	30/06/2024	30/09/2024	1
1291	Discharge Planning Progress Update - June 2024	2024	N/A	N/A	New recommendations arising from this follow up work	R2 1.1: The Health Board should ensure that all relevant staff are aware of the role of the Home First Team (Hub) and that the team operate consistently across the three acute hospital sites.	R2 1.1: Feedback on process mapping of Home First Bureau processes	Jane Trowman, Acting Assistant Director Care Homes Support and CHC Commissioning	Imran Devji, Interim Chief Operating Officer	30/06/2024	30/09/2024	1
1292	Discharge Planning Progress Update - June 2024	2024	N/A	N/A	New recommendations arising from this follow up work	R2 1.2: The Health Board should ensure that all relevant staff are aware of the role of the Home First Team (Hub) and that the team operate consistently across the three acute hospital sites.	R2 1.2: Develop Comms and engagement plan, refocus and raise awareness to increase focus & awareness on D2RA pathways, STREAM, including raising awareness of the Home First Teams	Clare Brennan, Emergency Care until Programme Manager for Urgent & Emergency Care; IHCs	Imran Devji, Interim Chief Operating Officer	30/09/2024		
1293	Discharge Planning Progress Update - June 2024	2024	N/A	N/A	New recommendations arising from this follow up work	R3 1.1: The Health Board should strengthen its performance reporting by including the following measures within its routine performance report to Board and/or committees: • number and percentage of patients who have an estimated discharge date;	R3 1.1: Identify baseline position and agree trajectory for improvement	Goal 6 Lead; Jane Trowman, Acting Assistant Director Care Homes and Continuing Health Care Commissioning; Clare Brennan, Programme Manager for Urgent & Emergency Care; IHCs	Imran Devji, Interim Chief Operating Officer	31/12/2024		

1294	Discharge Planning Progress Update - June 2024	2024	N/A	N/A	Recommendation included in the regional report on discharge planning replacing previous 2017 recommendations	R3 1.2: The Health Board should strengthen its performance reporting by including the following measures within its routine performance report to Board and/or committees: • readmissions within 28 days of discharge from hospital;	R3 1.2: This is one of the revised D2RA Measures which are in pilot phase until September 2024	Goal 6 Lead; Jane Trowman, Acting Assistant Director Care Homes and Continuing Health Care Commissioning; Clare Brennan, Programme Manager for Urgent & Emergency Care; IHCs	Imran Devji, Interim Chief Operating Officer	30/06/2024	31/12/2024	1
1295	Discharge Planning Progress Update - June 2024	2024	N/A	N/A	Recommendation included in the regional report on discharge planning replacing previous 2017 recommendations	R3 1.3: The Health Board should strengthen its performance reporting by including the following measures within its routine performance report to Board and/or committees: • percentage of discharges before midday;	R3 1.3: Identify baseline position and agree trajectory for improvement. Priority area will be discharges to Care Homes. Review the time of discharge number / % of patients discharged before midday by D2RA Pathway	Goal 6 Lead; Jane Trowman, Acting Assistant Director Care Homes and Continuing Health Care Commissioning; Clare Brennan, Programme Manager for Urgent & Emergency Care; IHCs	Imran Devji, Interim Chief Operating Officer	31/12/2024		
1296	Discharge Planning Progress Update - June 2024	2024	N/A	N/A	Recommendation included in the regional report on discharge planning replacing previous 2017 recommendations	R3 1.4: The Health Board should strengthen its performance reporting by including the following measures within its routine performance report to Board and/or committees: • percentage of unplanned discharges at night	R3 1.4: Identify baseline position and agree trajectory for improvement	Goal 6 Lead; Jane Trowman, Acting Assistant Director Care Homes and Continuing Health Care Commissioning; Clare Brennan, Programme Manager for Urgent & Emergency Care; IHCs	Imran Devji, Interim Chief Operating Officer	30/06/2024	31/12/2024	1
1297	Discharge Planning Progress Update - June 2024	2024	N/A	N/A	Recommendation included in the regional report on discharge planning replacing previous 2017 recommendations	R3 1.5: The Health Board should strengthen its performance reporting by including the following measures within its routine performance report to Board and/or committees: • percentage of discharges within 24 hours and 72 hours of being declared 'medically fit'	R3 1.5: STREAM development group established and a key priority will be to support increasing the compliance of recording when patient is Clinically optimised in line with D2RA reporting. Monthly reporting will be re-established in May and will be reported as part of the D2RA Measures (Pilot phase until September)	Goal 6 Lead; Jane Trowman, Acting Assistant Director Care Homes and Continuing Health Care Commissioning; Clare Brennan, Programme Manager for Urgent & Emergency Care; IHCs	Imran Devji, Interim Chief Operating Officer	31/12/2024		
1298	Discharge Planning Progress Update - June 2024	2024	N/A	N/A	Regional recommendations	R1 - Regional recommendations - The Health Board and local authorities should develop jointly agreed guidance to provide clarity to all staff on how the discharge planning process should work across the region. This should be based on the national guidance issued in December 2023 and should set out clearly defined roles and responsibilities, and expectations, including when referrals for ongoing care should be made.	No management response within report	Libby Ryan-Davies, IHC Director - Central; Michelle Green, IHC Director - East; Ffion Johnstone, IHC Director - West	Imran Devji, Interim Chief Operating Officer	Need implementation date		
1299	Discharge Planning Progress Update - June 2024	2024	N/A	N/A	Regional recommendations	R2 - Regional recommendations - The Health Board and local authorities should ensure processes are in place to communicate discharge planning guidance to all relevant health and social services staff, including those working on a temporary basis, supported by an ongoing programme of refresher training and induction training for new staff.	No management response within report	Libby Ryan-Davies, IHC Director - Central; Michelle Green, IHC Director - East; Ffion Johnstone, IHC Director - West	Imran Devji, Interim Chief Operating Officer	Need implementation date		
1300	Discharge Planning Progress Update - June 2024	2024	N/A	N/A	Regional recommendations	R3 - Regional recommendations - The Health Board should embed a regular cycle of audit to assess the effectiveness and consistency of the application of discharge policies and guidance, including the application of D2RA.	No management response within report	Libby Ryan-Davies, IHC Director - Central; Michelle Green, IHC Director - East; Ffion Johnstone, IHC Director - West	Imran Devji, Interim Chief Operating Officer	Need implementation date		
1301	Discharge Planning Progress Update - June 2024	2024	N/A	N/A	Regional recommendations	R5 - Regional recommendations - *(there is no R4 included within the report)* The Health Board, working with local authorities, should ensure that all relevant staff have access to up-to-date information on services available in the community that support hospital discharge.	No management response within report	Libby Ryan-Davies, IHC Director - Central; Michelle Green, IHC Director - East; Ffion Johnstone, IHC Director - West	Imran Devji, Interim Chief Operating Officer	Need implementation date		

1349	Urgent and Emergency Care: Flow out of Hospital – North Wales Region	2024	N/A	N/A	Improving training and guidance	R1. The Health Board, working with local authorities, should develop jointly agreed guidance to provide clarity to all staff on how the discharge planning process should work across the region. This should be based on the national guidance issued in December 2023 and should set out clearly defined roles and responsibilities, and expectations, including when referrals for ongoing care should be made.	**Sub-regional:** The national guidance document will be utilised to create a summary of the key considerations. This summary will provide a reference to the full document on-line and refer to additional support and guidance available for specific circumstances such as when Best Interest Decisions are required which has been a focus of recent activity. The guidance will focus on the imperative for effective MDT and multi-agency working and incorporate references to support avoidance of adverse discharges. Central Denbighshire Conwy and Flintshire County Council and BCUHB will work together to develop a guidance adhering to the national guidance, in line with optimal patient Flow. Considering any existing guidance that may already be in place across BCUHB to support consistency across the Health Board with pathway of care delay reporting. Ynys Môn Council, Cyngor Gwynedd, and BCUHB West will further develop such a guidance adhering to the national guidance, having considered existing guidance that may already be in place in other parts of north Wales. Building upon existing arrangements the Local Authorities and Health Board will share all new guidance on transfer of care from hospitals to home. This will be an integral part of the development in response to R1 above.	Community Services Transformation Manager, East IHC		31/07/2024		
1350	Urgent and Emergency Care: Flow out of Hospital – North Wales Region	2024	N/A	N/A	Improving training and guidance	R2. The Health Board and local authorities should ensure processes are in place to communicate discharge planning guidance to all relevant health and social services staff, including those working on a temporary basis, supported by an ongoing programme of refresher training and induction training for new staff.	**Sub-regional:** The East area guidance document referred to in relation to R1 will be: • Distributed to all social workers who support discharge planning in Wrexham and Flintshire • Incorporated into return to work discussions, supervision and other management approaches to ensure that team members are informed by the most up to date guidance. • Guidance will be referenced in induction information and staff bulletins and similar. • Home First leads will provide a constant reminder to all key staff members within East Area hospitals who support and lead on discharge planning. • Opportunities explored to include guidance within training programme for all staff including wider teams such as Safeguarding and Commissioning. Building upon existing arrangements and those noted previously, the Local Authorities (East, Central & West) and Health Board will share all new guidance on transfer of care from hospitals to home. This will be an integral part of the development in response to R1	Senior Manager for Adults FCC, Heads of Service for Older People WCBC, Associate Directors, Community Services BCUHB East		30/09/2024		
1351	Urgent and Emergency Care: Flow out of Hospital – North Wales Region	2024	N/A	N/A	Improving compliance with policies and guidance	R3 (3.1). The Health Board should embed a regular cycle of audit to assess the effectiveness and consistency of the application of discharge policies and guidance, including the application of D2RA	**Health Board:** 3.1 Draft revised BCUHB Hospital Discharge policy has been developed to replace the Covid discharge requirements. The revised draft policy will be presented through the Health Board's governance process for approval, this will include a consultation period on the BCUHB website and sign off by relevant Health Board committee. Other supporting documentation including Choice & Reluctant Discharge Guidance and Criteria Led discharge is also being reviewed as part of this review of discharge documentation. As part of the discharge policy an audit cycle will be agreed and implemented	Jane Trowman, Acting Assistant Director – Care Homes Support & CHC Commissioning	Imran Devji, Interim Chief Operating Officer	30/09/2024		
1352	Urgent and Emergency Care: Flow out of Hospital – North Wales Region	2024	N/A	N/A	Improving compliance with policies and guidance	R3 (3.2). The Health Board should embed a regular cycle of audit to assess the effectiveness and consistency of the application of discharge policies and guidance, including the application of D2RA	**Health Board:** 3.2 As part of the discharge policy an audit cycle will be agreed and implemented	Jane Trowman, Acting Assistant Director – Care Homes Support & CHC Commissioning	Imran Devji, Interim Chief Operating Officer	31/12/2024		
1353	Urgent and Emergency Care: Flow out of Hospital – North Wales Region	2024	N/A	N/A	Improving compliance with policies and guidance	R4. The Health Board should establish controls to prevent staff adding patients to multiple waiting lists, such as for reablement, home care packages and residential care to facilitate a speedy discharge, regardless of need. This will ensure that only those who need the services are on the relevant waiting lists	**Health Board:** As part of the D2RA Audit plan Management establish formal overarching policy or Standard Operating Procedure to support the operational management and controls to prevent patients on multiple waiting lists	Jane Trowman, Acting Assistant Director – Care Homes Support & CHC Commissioning	Imran Devji, Interim Chief Operating Officer	31/12/2024		
1354	Urgent and Emergency Care: Flow out of Hospital – North Wales Region	2024	N/A	N/A	Ensuring patient safety while awaiting care packages	R5. The Health Board should ensure processes are in place to notify social services before patients are discharged home, where those patients require ongoing support in their own home, and where such support is not in place at the time of discharge.	**Health Board:** Review of process and ensure this is included in the Discharge SOP	Jane Trowman, Acting Assistant Director – Care Homes Support & CHC Commissioning	Imran Devji, Interim Chief Operating Officer	31/12/2024		
1355	Urgent and Emergency Care: Flow out of Hospital – North Wales Region	2024	N/A	N/A	Ensuring patient safety while awaiting care packages	R6 (6.1). The Health Board and local authorities should ensure mechanisms are in place to regularly monitor patients who are discharged home without arranged ongoing social care and to escalate issues to the appropriate service where necessary	**Sub-regional:** 6.1 Where appropriate and capacity allows, Home First support patients with an assessed need for a package of care who are awaiting the start of an arranged POC as a bridging the gap	Head of Nursing; Community Senior Manager for Adults; Heads of Service for Older People	Imran Devji, Interim Chief Operating Officer	Ongoing		
1356	Urgent and Emergency Care: Flow out of Hospital – North Wales Region	2024	N/A	N/A	Ensuring patient safety while awaiting care packages	R6 (6.2). The Health Board and local authorities should ensure mechanisms are in place to regularly monitor patients who are discharged home without arranged ongoing social care and to escalate issues to the appropriate service where necessary	**Sub-regional:** 6.2 Where family/friends provide short term support or where patients self-discharge, telephone numbers are provided to report escalated needs. All people with assessed needs will have a point of contact once home and will be supported as soon as capacity is available.	Head of Nursing; Community Senior Manager for Adults; Heads of Service for Older People	Imran Devji, Interim Chief Operating Officer	30/06/2024		
1357	Urgent and Emergency Care: Flow out of Hospital – North Wales Region	2024	N/A	N/A	Ensuring patient safety while awaiting care packages	R6 (6.3). The Health Board and local authorities should ensure mechanisms are in place to regularly monitor patients who are discharged home without arranged ongoing social care and to escalate issues to the appropriate service where necessary	**Sub-regional:** 6.3 If individuals are transferred home from hospital without an assessment and required care package in place, the Local Authorities will monitor those situations. Completing adverse discharge form where required to support Learning across the services and improved patient journey cross ref R16	Head of Nursing; Community Senior Manager for Adults; Heads of Service for Older People	Imran Devji, Interim Chief Operating Officer	Ongoing		
1358	Urgent and Emergency Care: Flow out of Hospital – North Wales Region	2024	N/A	N/A	Improving the quality and sharing of information	R7 (7.1). The Health Board and local authorities should ensure that all relevant staff across each organisation has consistent access to up-to-date information on services available in the community that support hospital discharge. This will ensure that opportunities to discharge earlier with support from services beyond social care are not missed.	**Sub-regional:** 7.1 Dewis as the central point of information will continue to be promoted across all organisations.	BCU Associate Directors; Community Services and LA Heads of Service for Older People.	Imran Devji, Interim Chief Operating Officer	Ongoing		

1359	Urgent and Emergency Care: Flow out of Hospital – North Wales Region	2024	N/A	N/A	Improving the quality and sharing of information	R7 (7.2). The Health Board and local authorities should ensure that all relevant staff across each organisation has consistent access to up-to-date information on services available in the community that support hospital discharge. This will ensure that opportunities to discharge earlier with support from services beyond social care are not missed.	**Sub-regional:** 7.2 Guidance developed in response to R1 will refer to the fact that there are a broad range of community-based support on discharge and where to find information – direct to Dewis	BCU Associate Directors; Community Services and LA Heads of Service for Older People.	Imran Devji, Interim Chief Operating Officer	31/07/2024		
1360	Urgent and Emergency Care: Flow out of Hospital – North Wales Region	2024	N/A	N/A	Improving the quality and sharing of information	R7 (7.3). The Health Board and local authorities should ensure that all relevant staff across each organisation has consistent access to up-to-date information on services available in the community that support hospital discharge. This will ensure that opportunities to discharge earlier with support from services beyond social care are not missed.	**Sub-regional:** 7.3 Councils operating sub-regionally operating together with the Health Board share such information on a regular basis via integrated working within the SPOA's of the Community Resource Teams, clinically optimised and length of stay and will continue to do so.	BCU Associate Directors; Community Services and LA Heads of Service for Older People.	Imran Devji, Interim Chief Operating Officer	Ongoing		
1361	Urgent and Emergency Care: Flow out of Hospital – North Wales Region	2024	N/A	N/A	Improving the quality and sharing of information	R8. The Health Board should improve record keeping by: 8.1. ensuring all staff involved in discharge planning fully understand the importance of documenting comprehensive information in patient case notes to support effective discharge planning	**Health Board:** 8.1 As noted in R3, a draft revised BCUHB Hospital Discharge policy has been developed to replace the Covid discharge requirements. The revised draft policy will be presented through the Health Board's governance process for approval, this will include a consultation period on the BCUHB website and sign off by relevant Health Board committee. Other supporting documentation including Choice & Reluctant Discharge Guidance and Criteria Led discharge is also being reviewed as part of this review of discharge documentation	Jane Trowman, Acting Assistant Director – Care Homes Support & CHC Commissioning	Imran Devji, Interim Chief Operating Officer	30/09/2024		
1362	Urgent and Emergency Care: Flow out of Hospital – North Wales Region	2024	N/A	N/A	Improving the quality and sharing of information	R8. The Health Board should improve record keeping by: 8.2. establishing a programme of case-note audits focused on the quality of record keeping	**Health Board:** 8.2 As part of the discharge policy an audit cycle will be agreed and implemented	Jane Trowman, Acting Assistant Director – Care Homes Support & CHC Commissioning	Imran Devji, Interim Chief Operating Officer	31/12/2024		
1363	Urgent and Emergency Care: Flow out of Hospital – North Wales Region	2024	N/A	N/A	Improving the quality and sharing of information	R9. The Health Board and local authorities should implement ways in which information can be shared more effectively, including opportunities to provide wider access to organisational systems and ultimately joint IT solutions.	**Sub-regional:** Cyngor Sir Ynys Môn, Cyngor Gwynedd and the Health Board already have an information sharing pilot in place awaiting evaluation. Conwy, Denbighshire & Flintshire local authorities and the Health Board have a WASPI in place since the implementation of the SPOAs Further work required to improve information sharing on presentation in ED due to organisational systems not available to all. An integrated information sharing system is required to support this. Central Area will consider how this can be incorporated into the scope of the new Connecting Care procurement process. Seek options for Home First to be able to access Council WCCIS system in the East. Revisit schedule of multi-agency meetings to verify that those contact points achieve a shared position re updates on discharge planning as part of the ongoing Home First Review in the East Consider how the use of STREAM is consistently updated with potential for local authority access Actively seek ways to increase local authority access for systems held within BCUHB.	Heads of Services for Older People; Steve Grayston, Director of Allied Health Professionals - Centre; Carys Norgain, Director of Allied Health Professionals - West; Nesta McCluskey, Director of Allied Health Professionals - East	Imran Devji, Interim Chief Operating Officer	31/10/2024		
1364	Urgent and Emergency Care: Flow out of Hospital – North Wales Region	2024	N/A	N/A	Addressing key gaps in capacity	R10. The Health Board and local authorities need to work together to develop joint solutions to address key gaps in service capacity, in particular, domiciliary care and reablement services which would enable timelier discharge of patients to their own home.	**Sub-regional:** Utilise Further Faster Funding and action planning In Central, D2RA team at the front door working as Trusted Assessors to address the gaps in assessment capacity working together with local authorities to support reablement provision ongoing work to support more timely discharge required for POC with agreed Trusted assessment pathways Central Area Integrated Services Board considers the development of joint solutions to address key gaps in service capacity e.g the Denbigh Health and Social Care Programme. The Health Board have developed the Tuag Adref service in the West to provide for a reablement service and domiciliary care is now jointly commissioned by Local Authorities and the Health Board.	Leadership Group		Ongoing		
1365	Urgent and Emergency Care: Flow out of Hospital – North Wales Region	2024	N/A	N/A	Maximising the use of the Regional Integration Fund	R11. The Health Board and local authorities, through the Regional Partnership Board (RPB), should demonstrate how it is working to increasingly mainstream long-standing schemes funded through RIF which are considered core services	**Regional Partnership Board:** RPB and partners continue to make progress to mainstream long standing schemes funded through RIF. In 2023/24 there was £16.9m of investment in mainstreamed schemes.	Gethin Morgan, Regional Head of Collaboration		Ongoing		
1366	Urgent and Emergency Care: Flow out of Hospital – North Wales Region	2024	N/A	N/A	Maximising the use of the Regional Integration Fund	R12. The Health Board and local authorities, through the Regional Partnership Board, should agree a process for utilising any future RIF slippage monies, ensuring that appropriate value and benefit is obtained from such spending.	**Regional Partnership Board:** The importance of appropriate use of slippage has been acknowledged and in response the 'Change Notification' process was developed. The process is being audited and will be reviewed by the RPB's Leadership Group.	Gethin Morgan, Regional Head of Collaboration		On-going. Process to be reviewed Autumn 2024		
1367	Urgent and Emergency Care: Flow out of Hospital – North Wales Region	2024	N/A	N/A	Maximising the use of the Regional Integration Fund	R13. To help inform decision-making and discussions, the Health Board and local authorities should: 13.1. ensure that the Regional Partnership Board has routine access to key performance indicators relevant to effective and timely flow out of hospital, including urgent and emergency care performance within the Health Board and waiting lists for social services and care packages; and	**Regional Partnership Board:** Quarterly data re: flow out of hospital to be presented to the RPB's Leadership Group (inclusive of IHC Directors)	Gethin Morgan, Regional Head of Collaboration; Jane Trowman, Assistant Director – Care Homes Support & CHC Commissioning	Imran Devji, Interim Chief Operating Officer	On-going quarterly		

1368	Urgent and Emergency Care: Flow out of Hospital – North Wales Region	2024	N/A	N/A	Maximising the use of the Regional Integration Fund	R13. To help inform decision-making and discussions, the Health Board and local authorities should: 13.2 use the Regional Partnership Board working arrangement to develop a regional risk register which pulls together the risks associated with delayed discharges	**Regional Partnership Board:** Risk register related to delayed discharges to be completed and presented to RPB twice annually	Gethin Morgan, Regional Head of Collaboration		October / April annually		
1369	Urgent and Emergency Care: Flow out of Hospital – North Wales Region	2024	N/A	N/A	Improving oversight and impact	R14. The Health Board and local authorities should ensure that information setting out progress with significant activities and initiatives being undertaken to support effective and timely discharge is routinely available at a corporate and partnership level. This should include activities and initiatives undertaken individually and jointly, both within and outside of the RPB structure, their impact and how they collectively contribute to addressing the challenges. This will help to provide assurance that resources are being invested to best effect.	**Sub-regional:** The Pan Cluster Planning Group will become the leadership group to oversee partnership activity in this regard in the East. In addition to circulation of Key Performance Indicators outside of meetings (e.g Pathway of Care Delays Census Information), a standing item will be added to each agenda to consider current position, trends and responses required. Regular reporting mechanisms and performance and progress monitoring across the Local Authorities and Health Boards to continue with added focus in the West & Central. This information is also considered at strategic integrated planning meetings. Work is ongoing to improve data analysis and reporting in order to provide further assurance across Local Authority governance.	Pan Cluster Planning Group Chair		From September 2024 onwards		
1370	Urgent and Emergency Care: Flow out of Hospital – North Wales Region	2024	N/A	N/A	Embedding learning from actions taken to address delayed discharges	R15. The Health Board and local authorities should ensure that mechanisms are in place to implement learning from actions taken to address delayed discharges, such as the Multi Agency Discharge Events (MADE), and to maintain regular oversight to ensure the learning is being implemented.	**Regional Partnership Board:** Aligned to R13. and the associated work, regular learning events and sharing of good practice to be considered regularly.	Gethin Morgan, Regional Head of Collaboration; Jane Trowman, Assistant Director – Care Homes Support & CHC Commissioning	Imran Devji, Interim Chief Operating Officer	On-going quarterly		
1371	Urgent and Emergency Care: Flow out of Hospital – North Wales Region	2024	N/A	N/A	Embedding learning from actions taken to address delayed discharges	R16. The Health Board should strengthen escalation arrangements for reporting adverse incidents or concerns relating to discharge by: 16.1 addressing any outstanding adverse incidents or concerns, communicating clearly with the relevant local authority; and	**Health Board:** Each IHC to establish an Adverse Discharge Group with clear ToRs	Jane Trowman, Acting Assistant Director – Care Homes Support & CHC Commissioning	Imran Devji, Interim Chief Operating Officer	31/10/2024		
1372	Urgent and Emergency Care: Flow out of Hospital – North Wales Region	2024	N/A	N/A	Embedding learning from actions taken to address delayed discharges	R16. The Health Board should strengthen escalation arrangements for reporting adverse incidents or concerns relating to discharge by: 16.2 ensuring a consistent approach to reporting adverse incidents and concerns relating to discharge is in place across the Health Board.	**Health Board:** Hold Discharge webinars with Care Homes across each IHC to improve communication and build trust between Health and Providers	Jane Trowman, Acting Assistant Director – Care Homes Support & CHC Commissioning	Imran Devji, Interim Chief Operating Officer	31/10/2024		

APPENDIX 3 - REVIEW OF BOARD EFFECTIVENESS AND FOLLOW UP REVIEW OF BOARD EFFECTIVENESS, INCLUDING COMMENTS FROM AUDIT WALES

ID	Report Title	Year	Assurance Level	Priority	Recommendation Title	Recommendation	Management Response	Action Owner	Final Approver	Original implementation date	Revised implementation date	Number of Revisions	Audit Wales comments
421	Review of Board Effectiveness	2023	N/A	N/A	Responding to independent reviews and investigations	1a: Take the necessary action in response to the findings from the investigations into whistleblowing disclosures that relate to Executive Directors and senior management (noting that any actions in respect of concerns about Independent Members would be matters for the Minister).	No management response within report	Pam Wenger, Director of Corporate Governance	Carol Shillabeer, Chief Executive	N/A			AW nothing to add - Outside of the scope of Structured Assessment 2024
422	Review of Board Effectiveness	2023	N/A	N/A	Responding to independent reviews and investigations	1b: Resolve quickly any issues arising from the Ernst Young review.	No management response within report	Pam Wenger, Director of Corporate Governance	Carol Shillabeer, Chief Executive	N/A			Commentary included in SA 2024 - paragraph 119 (AW view is that the associated rec R8 from 2023 is ongoing)
423	Review of Board Effectiveness	2023	N/A	N/A	Responding to independent reviews and investigations	1c: Fully support any investigations the National Counter Fraud Service need to undertake in response to the Auditor General's audit of the 2021-22 accounts and the subsequent Ernst Young review.	No management response within report	Pam Wenger, Director of Corporate Governance	Carol Shillabeer, Chief Executive	N/A			Commentary included in SA 2024 - paragraph 119 (AW view is that the associated rec R8 from 2023 is ongoing)
424	Review of Board Effectiveness	2023	N/A	N/A	Rebuilding and strengthening senior leadership capacity	2a: Expedite plans to recruit a substantive Chief Executive Officer as a matter of urgency.	No management response within report	N/A	N/A	N/A			Complete.
425	Review of Board Effectiveness	2023	N/A	N/A	Rebuilding and strengthening senior leadership capacity	2b: Critically review the use of interim senior appointments and management consultants with a view to reducing reliance on such appointments within the senior leadership structures.	No management response within report	Jason Brannan, Deputy Director of People	Carol Shillabeer, Chief Executive	N/A			Paragraph 16-18 of the SA covers absence of some substantive staff within the Exec team. While use of external agency interim has significantly reduced, there remain interim arrangements. (AW view that this ongoing)
426	Review of Board Effectiveness	2023	N/A	N/A	Rebuilding and strengthening senior leadership capacity	2c: Act urgently to bolster senior staff capacity in the Finance Team to mitigate the impact on business continuity.	No management response within report	Jason Brannan, Deputy Director of People	Carol Shillabeer, Chief Executive	N/A			AW nothing to add - Outside of the scope of Structured Assessment 2024
427	Review of Board Effectiveness	2023	N/A	N/A	Building a more cohesive and effective board and Executive Team	3a: Take urgent action to create a more collegiate and unified approach to leadership of the organisation, which involves: • Repairing / addressing the working relationships within the Executive Team.	No management response within report	Pam Wenger, Director of Corporate Governance	Carol Shillabeer, Chief Executive	N/A			Paragraph 16-18 of the SA (AW view that this is ongoing)
428	Review of Board Effectiveness	2023	N/A	N/A	Building a more cohesive and effective board and Executive Team	3b: Take urgent action to create a more collegiate and unified approach to leadership of the organisation, which involves: • Ensuring the Executive Team understand the concerns held by Independent Members over performance and assurances received, including issues relating to the quality of papers presented to the board and its committees.	No management response within report	Pam Wenger, Director of Corporate Governance	Carol Shillabeer, Chief Executive	30/09/2024			AW view that this is superseded due to changes to the Board made in February 2023
429	Review of Board Effectiveness	2023	N/A	N/A	Building a more cohesive and effective board and Executive Team	3c: Take urgent action to create a more collegiate and unified approach to leadership of the organisation, which involves: • Ensuring that Independent Members understand Executive team concerns about the impact of overly robust challenge, with the aim of moving to a 'high support and high challenge' leadership approach.	No management response within report	Pam Wenger, Director of Corporate Governance	Carol Shillabeer, Chief Executive	Need implementation date			AW view that this is superseded due to changes to the Board made in February 2023
430	Review of Board Effectiveness	2023	N/A	N/A	Building a more cohesive and effective board and Executive Team	3d: Take urgent action to create a more collegiate and unified approach to leadership of the organisation, which involves: • Establishing an agreed level of risk appetite and tolerance between Executives and Independent Members.	No management response within report	Pam Wenger, Director of Corporate Governance	Carol Shillabeer, Chief Executive				Whilst we are aware that the Board set its risk appetite at a board development session in 2024 we have not reviewed this work in detail (AW nothing to add at this time)
431	Review of Board Effectiveness	2023	N/A	N/A	Building a more cohesive and effective board and Executive Team	3e: Take urgent action to create a more collegiate and unified approach to leadership of the organisation, which involves: • Establishing a working environment and culture at board and its committees that promotes transparency and maintains the correct balance between scrutiny, challenge and support, reflecting the organisation's expected values and behaviours.	No management response within report	Pam Wenger, Director of Corporate Governance	Carol Shillabeer, Chief Executive	Need implementation date			Transparency of board business covered in paragraphs 26-30 of the Structured Assessment. Positive view on the commitment to transparency. Paragraphs 38-39 also comment on how the committees are maturing and there was evidence of constructive challenge during our fieldwork. (AW view that has been achieved but will clearly need to be maintained)
432	Review of Board Effectiveness	2023	N/A	N/A	Building a more cohesive and effective board and Executive Team	3f: Take urgent action to create a more collegiate and unified approach to leadership of the organisation, which involves: • Using appropriate external facilitators and mediators to work through the above issues as part of a wider board development programme which is informed by the King's Fund's reflections on the previous board development programme.	No management response within report	Pam Wenger, Director of Corporate Governance	Carol Shillabeer, Chief Executive	Need implementation date			Positive feedback on the SilverMaple work and specifically how it encourages a collegiate approach which was expressed during the fieldwork for this year's SA, but we cannot comment on the extent to which they have delved into detail on historical challenges. (AW nothing to add)

433	Review of Board Effectiveness	2023	N/A	N/A	Building a more cohesive and effective board and Executive Team	3g: Take urgent action to create a more collegiate and unified approach to leadership of the organisation, which involves: • Aligning Independent Member portfolios to Executive Director portfolios to support information and knowledge sharing	No management response within report	Pam Wenger, Director of Corporate Governance	Carol Shillabeer, Chief Executive	N/A			AW nothing to add - Outside of the scope of Structured Assessment 2024
1419	Follow Up Review of Board Effectiveness	2024	N/A	N/A	Leadership	There is an immediate need to continue, and to conclude the work aimed at stabilising the board and the wider senior leadership of the organisation. That includes getting to a position where the board has a full complement of substantive Executive Directors	No management response within report	Carol Shillabeer, Chief Executive	Carol Shillabeer, Chief Executive	Need implementation date			Paragraphs 16-18 highlight need to fill remaining gaps on the Executive team (AW view that this is ongoing)
1420	Follow Up Review of Board Effectiveness	2024	N/A	N/A	Independent Members	There is an immediate need to continue, and to conclude the work aimed at stabilising the board and the wider senior leadership of the organisation. That includes getting to a position where the board has a full complement of substantive Independent Members	No management response within report	Carol Shillabeer, Chief Executive	Carol Shillabeer, Chief Executive	Need implementation date			Complete.
1421	Follow Up Review of Board Effectiveness	2024	N/A	N/A	Substantive Chair	There is an immediate need to continue, and to conclude the work aimed at stabilising the board and the wider senior leadership of the organisation. That includes getting to a position with a substantive Chair in place.	No management response within report	Carol Shillabeer, Chief Executive	Carol Shillabeer, Chief Executive	Need implementation date			Complete.
1422	Follow Up Review of Board Effectiveness	2024	N/A	N/A	Committee structure	There is an urgent need to re-establish a committee structure below the board that provides the necessary oversight, scrutiny, and support across all aspects of the organisation's business	No management response within report	Carol Shillabeer, Chief Executive	Carol Shillabeer, Chief Executive	Need implementation date			Covered in paragraphs 37-41 (AW view this is complete but of course will need to be maintained)
1423	Follow Up Review of Board Effectiveness	2024	N/A	N/A	Board Development	The raft of disclosures that were received towards the end of 2022 should be used to inform the programme of board development that the new board will need to put in place. In particular, it should inform the work that is underway on organisational culture and compassionate leadership, and ensure that this starts with the right 'tone from the top'.	No management response within report	Carol Shillabeer, Chief Executive	Carol Shillabeer, Chief Executive	Need implementation date			AW nothing to add - Outside of the scope of Structured Assessment 2024
1424	Follow Up Review of Board Effectiveness	2024	N/A	N/A	Executive Team	A key priority for the new Chief Executive will be to build a stable, cohesive, and appropriately skilled Executive Team that can provide the organisation with the operational leadership it needs. This will include settling on the right mix of Executive Director portfolios, reducing reliance on interim arrangements for senior leadership roles, and building leadership capacity and capability for the Health Board's corporate governance arrangements	No management response within report	Carol Shillabeer, Chief Executive	Carol Shillabeer, Chief Executive	Need implementation date			Paragraphs 16-18 highlight need to fill remaining gaps on the Executive team (AW view that this is ongoing)
1425	Follow Up Review of Board Effectiveness	2024	N/A	N/A	Executive Team - link to operational model	The Executive Team must also be appropriately connected to the leadership structures that sit below it, something which will need to be supported by ensuring the Health Board's operational model is fit for purpose.	No management response within report	Carol Shillabeer, Chief Executive	Carol Shillabeer, Chief Executive	Need implementation date			Commented in paragraphs 21-24 of the SA 2024. AW view that this is ongoing
1426	Follow Up Review of Board Effectiveness	2024	N/A	N/A	Building internal capacity and capability	The Health Board must also look to get itself as quickly as possible to a position where it has the necessary internal capacity and capability to sustain improvement and avoid the need to continually look to the outside for support to achieve the improvements which are necessary.	No management response within report	Carol Shillabeer, Chief Executive	Carol Shillabeer, Chief Executive	Need implementation date			AW nothing to add - Outside of the scope of Structured Assessment 2024

Teitl adroddiad: ***Report title:***	WRP Penalties - Learning from Events Report (LFER)
Adrodd i: ***Report to:***	Audit Committee
Dyddiad y Cyfarfod: ***Date of Meeting:***	16 January 2025
Crynodeb Gweithredol: ***Executive Summary:***	Learning from Events Report (LFER) forms are a mandatory part of the national claims and redress process to evidence learning, within deadlines for submission set by the Welsh Risk Pool (WRP) – reimbursement of a claim is conditional on this form being accepted by WRP and penalties are applied for delayed forms. This report provides the Audit Committee with an update on overdue Learning from Events Report (LfER) forms alongside recovery plans.
Argymhellion: ***Recommendations:***	The Audit Committee is asked to **NOTE** this report.
Arweinydd Gweithredol: ***Executive Lead:***	Pam Wenger, Director of Corporate Governance
Awdur yr Adroddiad: ***Report Author:***	Matthew Joyes, Deputy Director for Legal Services

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

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

Cyfiawnhad dros y gyfradd sicrwydd uchod. Lle bo sicrwydd 'Rhannol' neu 'Dim Sicrwydd' wedi'i nodi uchod, nodwch gamau i gyflawni sicrwydd 'Derbyniol' uchod, a'r terfyn amser ar gyfer cyflawni hyn: ***Justification for the above assurance rating. Where 'Partial' or 'No' assurance has been indicated above, please indicate steps to achieve 'Acceptable' assurance or above, and the timeframe for achieving this:***
N/A

Cyswllt ag Amcan/Amcanion Strategol: ***Link to Strategic Objective(s):***	Objective 1 - Building an effective organisation

Goblygiadau rheoleiddio a lleol: ***Regulatory and legal implications:***	Claims in NHS Wales are governed by the National Health Service (Concerns, Complaints and Redress Arrangements) (Wales) Regulations 2011 as well as standards set by the Welsh Risk Pool and UK wide requirements for litigation such as the Civil Procedure Rules.
Yn unol â WP7, a oedd EqIA yn angenrheidiol ac a gafodd ei gynnal? ***In accordance with WP7 has an EqIA been identified as necessary and undertaken?***	N/A
Yn unol â WP68, a oedd SEIA yn angenrheidiol ac a gafodd ei gynnal? ***In accordance with WP68, has an SEIA identified as necessary been undertaken?***	N/A
Manylion am risgiau sy'n gysylltiedig â phwnc a chwmpas y papur hwn, gan gynnwys risgiau newydd (croesgyfeirio at y BAF a'r CRR) ***Details of risks associated with the subject and scope of this paper, including new risks(cross reference to the BAF and CRR)***	Risk 5435 - Financial penalties and inability to recover money from the Welsh Risk Pool due to delayed submissions – Current score = 15
Goblygiadau ariannol o ganlyniad i roi'r argymhellion ar waith ***Financial implications as a result of implementing the recommendations***	The WRP levies penalties at its discretion for delayed submissions with a range from £2,500 to £25,000 per case.
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)*	N/A
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:*** New LFER Process	

INTRODUCTION

Learning from Events Report (LFER) forms are a mandatory part of the national claims and redress process to evidence learning, within deadlines for submission set by the Welsh Risk Pool (WRP) – reimbursement of a claim is conditional on this form being accepted by WRP and penalties are applied for delayed forms.

At the November 2024 meeting of the WRP Committee, 25 penalties were levied (at £2,500 each). This builds on 3 penalties were levied (at £2,500 each) levied earlier in the year.

This report provides the Audit Committee with an update on overdue Learning from Events Report (LfER) forms alongside recovery plans.

BACKGROUND

All Health Boards in Wales contribute to a liability fund and have a risk share agreement, known as the Welsh Risk Pool (WRP). The WRP is part of the NHS Wales Shared Services Partnership (NWSSP) Legal & Risk Services Department (L&R). It provides the means by which all Health Boards and Trusts in Wales are able to indemnify against risk. The role of the WRP is to have an integrated approach towards risk assessment, claims management, reimbursement and learning.

The WRP will reimburse the Health Board for losses incurred above an excess of £25,000. They reserve the right to not reimburse if the WRP Procedures have not been followed or if a claim falls outside of the scope of the indemnity scheme.

WRP operate a detailed set of reimbursement procedures that all organisations must follow in respect of its claims handling and management. They also undertake regular (almost annual) assessments of Health Boards and Trusts in Wales against those procedures and against the requirements of the National Health Service (Concerns, Complaints and Redress Arrangements) (Wales) Regulations.

To ensure that learning and improvement is commenced and implemented at the earliest possible stage, the WRP has reimbursement procedures to bring the scrutiny of learning much earlier in the lifecycle of a case.

The WRP procedures require a **Learning from Events Report (LfER)** and a **Case Management Report (CMR)**. These are used by the Health Board to report the issues that have been identified from a claim and to determine how these have been addressed in order to reduce the risk of reoccurrence and reduce the impact of a future event.

The LFER needs to provide a sufficient explanation of the circumstances and background to the events which have led to the case, in order for the WRP Committee to scrutinise and identify the links to the findings and learning outcomes. Supporting information, such as action plans with embedded evidence, expert reports and review findings are appended to the LFER to evidence the learning activity.

PENALTIES AND CURRENT POSITION

The WRP levies penalties at its discretion for delayed submissions with a range from £2,500 to £25,000 per case. The application of these penalties commenced in 2023.

The Health Board has recurring issues with the timeliness of Learning from Events Report submissions, with these often delayed within services struggling to find evidence of learning and sustained improvement. In some cases, the internal Legal Services Team have not identified an LFER was due at the correct time resulting in a delay.

In 2023/24, 4 penalties were levied (at £2,500 each).

In spring of 2024/25, 3 penalties were levied (at £2,500 each).

At the November 2024 meeting of the WRP Committee, 25 penalties were levied (at £2,500 each).

The breakdown of penalties is as follows:

East Integrated Health Community – 2 = £5,000
Central Integrated Health Community – 7 = £17,500
West Integrated Health Community – 5 = £12,500
Mental Health and Learning Disability – 1 = £2,500
Women's and Midwifery – 2 = £5,000
Cancer – 0
Diagnostics and Clinical Support – 1 = £2,500
Dental – 1 = £2,500
Corporate (all) – 6 = £15,000

The total cost of penalties in the financial year to date is £70,000.

It is clear that urgent action is now needed to address the timely completion of LFERs and the recovery of the overdue position. Although of note, the Health Board is not alone in dealing with this issue.

There are 79 overdue LFERs at the time of writing (with 74 being overdue at the time of the last report to the Committee in November 2024). Overall, there has been limited improvement in this number during the financial year to date. This represents a maximum (albeit unlikely) financial risk of £1,925,000, with a more likely financial risk of £192,500.

The breakdown of the current overdue LFER position is as follows:

East Integrated Health Community – 4
Central Integrated Health Community – 35
West Integrated Health Community – 6
Mental Health and Learning Disability – 2
Women's and Midwifery – 15
Cancer – 10
Diagnostics and Clinical Support – 2
Dental – 0
Corporate (all) – 5

PROPOSED NEW LFER PROCESS

The Deputy Director for Legal Services has conducted a review of the existing LFER process. It has been identified that improvement is needed to simplify and reduce effort and duplication, as well as improving oversight and accountability within services.

This review has involved a workshop with Legal Services Managers, a consultation with Legal Services staff, engagement with the Welsh Risk Pool and a consultation with all IHCs and Divisions.

The new process is enclosed at Appendix 1.

The main changes proposed are:

- LFERs will be tracked via one single system – Datix. This will eliminate multiple separate tracking spreadsheets.
- Clear timescales have been set for every stage of the process which will be monitored. These timescales align to the national WRP deadlines.
- New LFERs will be issued to a single point within IHCs/Divisions – namely the director (copied to any central mailbox for tracking, i.e. a business team or local clinical governance team). This will enable a single oversight by IHCs/Divisions.
- LFERs will be signed off by an IHC/Division director (or member of the wider director team i.e. nursing or medical director). This will ensure appropriate senior sign off for the learning and evidence.
- A single weekly oversight report will be produced.

The process was approved by the Executive Team in December 2024.

It is proposed this new process would come into effect from January 2025.

Additionally, changes have been made within the Legal Services Department to support improvement. The department has moved from a locality based structure to a functional one, creating a new Ligation Team under a Senior Legal Services Manager. The administrate support roles have been moved together as one team. These changes will allow greater professional focus and improve the consistency of service across North Wales.

RECOVERY TRAJECTORY FOR OVERDUE LFERs

To address the overdue LFERs, and return to a position of zero overdue forms, a recovery trajectory will be set for IHCs/Divisions.

The Executive Team (in December 2024) have requested this trajectory is a maximum of six months. The Deputy Director for Legal Services has attended the Operational Leadership Forum led by the Chief Operating Officer, and has written to all IHCs/Divisions requesting their recovery plans to meet this trajectory are submitted by the end of January 2025.

A weekly report will be sent to each IHC/Division, copied to the relevant Executive Directors, to monitor progress.

The WRP will be advised of this trajectory, and an exemption sought for further penalties whilst this recovery plan is delivered. Any exemption would be solely at the discretion of the WRP Committee.

CONCLUSION AND RECOMMENDATION(S)

This paper outlines the background to Learning from Events Report (LFER) forms – they are a mandatory part of the national claims and redress process to evidence learning, within deadlines for submission set by the Welsh Risk Pool (WRP). The reimbursement of a claim is conditional on this form being accepted by WRP and penalties are applied for delayed forms.

At the November 2024 meeting of the WRP Committee, 25 penalties were levied (at £2,500 each). This builds on 3 penalties were levied (at £2,500 each) levied earlier in the year. The total cost of penalties in the financial year to date is £70,000.

This report provides the Audit Committee with an update on overdue Learning from Events Report (LfER) forms alongside recovery plans.

The Audit Committee is asked to **NOTE** this report.

LFER process

Cycle repeats until LFER approved by WRP

Legal Services Department (LSD)

- LSD Case Manager drafts the LFER (except boxes 6-9 and actions column of Box 5) and signs Box 11 within 3 weeks
- LSD Case Manager issues the draft to the IHC/Division Director from the LFER mailbox
- LSD Case Manager adds progress details to the central tracker hosted on Datix

IHC/Division

- IHC/Division Director to allocate to relevant service lead
- Service lead to complete Boxes 6-9 and actions column of Box 5 with supporting evidence
- IHC/Division Director to approve LFER (sign Box 11) and return with evidence to LFER mailbox within 8 weeks – the LFER and evidence must be returned to LSD in one single email

Legal Services Department (LSD)

- LSD Case Manager to undertake a formatting check
- LSD Case Manager to send to WRP within 1 week from LFER mailbox
- LSD Case Manager adds progress details to the central tracker hosted on Datix

Welsh Risk Pool (WRP)

- Assessment of LFER and evidence by WRP at Learning Assurance Panel and WRP Committee
- **If approved: process completed**
- **If deferred: process continues** - WRP inform LSD of any deferred cases to LFER mailbox providing feedback on the additional work needed

Legal Services Department (LSD)

- LSD Case Manager will complete deferred forms (U8/U9) (NB: U8 issued for all deferred cases, U9 only issued for Red deferred cases)
- LSD Case Manager sends U8/U9 to IHC/Division Director within 1 week from LFER mailbox
- LSD Case Manager adds progress details to the central tracker hosted on Datix

IHC/Division

- IHC/Division Director to allocate to relevant service lead
- Service lead to update U8/U9 with supporting evidence
- IHC/Divisional Director to approve U8/U9 and return to LFER mailbox within 4 weeks – the U8/U9 and evidence must be returned to LSD in one single email

- IHC/Division Director may nominate another member of the IHC/Division director team or generic mailbox to receive the LFERs in addition to themselves.
- IHC/Division Director may delegate sign off to another member of the IHC/Division director team – as long as an IHC/Division director signs, LSD will accept.
- A weekly report will be sent to all IHC/Division directors to support extracted form the central tracker hosted on Datix to provide an overview of performance.
- A Weekly LFER Clinical will be hosted by LSD Senior Managers for IHCs/Divisions to seek support on the process. LSD cannot comment on the suitability of evidence.
- Any penalties applied by WRP will be recharged to IHCs/Divisions where they have exceeded the timescales stated above (8 weeks/4 weeks).

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

Teitl adroddiad: ***Report title:***	Update on Health Board policies and written control documents, and risk impact of overdue policies and written control documents
Adrodd i: ***Report to:***	Audit Committee
Dyddiad y Cyfarfod: ***Date of Meeting:***	Thursday, 16 January 2025
Crynodeb Gweithredol: ***Executive Summary:***	The purpose of this report is to provide the Audit Committee with: • an update on all policies and written control documents (WCDs) that were listed for review in quarter 2 of 2024/25 by the owner or Executive lead • an update on all corporate policies and WCDs overdue their review date • an update on the policies and WCDs that carry the biggest risks, and progress being made against them • an update on the confidence level of review being completed in quarter listed.
Argymhellion: ***Recommendations:***	The Audit Committee is asked to: • NOTE the position on all policies/WCDs due for review in quarter 2 of 2024/25, as at 2nd October 2024 • NOTE the current status of all out-of-date policies and WCDs • NOTE the categorisation of risks around overdue policies and WCDs, and the progress being made to update these; • AGREE the focus over the next 6 months should be on WCD assessed as 'high risk' and policies that are overdue as shown in Appendix 3.
Arweinydd Gweithredol: ***Executive Lead:***	Pam Wenger, Director of Corporate Governance
Awdur yr Adroddiad: ***Report Author:***	Glesni Driver, Head of Covid-19 Inquiry and Thirlwall Inquiry

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

Lefel sicrwydd: ***Assurance level:***	Arwyddocaol *Significant*	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:***	
A considerable amount of work has taken place to date by the Corporate Governance Directorate to work with and support policy owners and Executive Directors who have overdue policies or WCDs. However, despite this, as can be seen from the review of progress over the last few months contained within this report, there still remains a large number of overdue policies and WCDs. The Corporate Governance Directorate will continue to provide support and guidance to policy owners and Executive Directors to progress this work.	
Cyswllt ag Amcan/Amcanion Strategol: ***Link to Strategic Objective(s):***	Not applicable, other than those relating to individual policies and written control documents
Goblygiadau rheoleiddio a lleol: ***Regulatory and legal implications:***	It is essential that the Health Board has up to date and accurate policies and written control documents in order to comply with relevant legislation and minimise any associated risk
Yn unol â WP7, a oedd EqIA yn angenrheidiol ac a gafodd ei gynnal? ***In accordance with WP7 has an EqIA been identified as necessary and undertaken?***	The Equality duty is not applicable. This report is purely administrative in nature and submitted for information only. The associated public sector duties are not engaged (there are no associated impacts on any of the protected groups).
Yn unol â WP68, a oedd SEIA yn angenrheidiol ac a gafodd ei gynnal? ***In accordance with WP68, has an SEIA identified as necessary been undertaken?***	The Socio-Economic duty is not applicable. This report is purely administrative in nature and submitted for information only. The associated public sector duties are not engaged (the report does not relate to a decision, strategic or otherwise).
Manylion am risgiau sy'n gysylltiedig â phwnc a chwmpas y papur hwn, gan gynnwys risgiau newydd (croesgyfeirio at y BAF a'r CRR) ***Details of risks associated with the subject and scope of this paper, including new risks (cross reference to the BAF and CRR)***	There are risks relating to policies and written control documents that have passed their 1-year or 3-year mandatory review period following initial approval. It is essential that the Health Board has up-to-date and accurate policies and written control documents in order to comply with relevant legislation and minimise any associated risk
Goblygiadau ariannol o ganlyniad i roi'r *argymhellion ar waith* ***Financial implications as a result of implementing the recommendations***	Not applicable, other than those relating to individual policies or written control documents
Goblygiadau gweithlu o ganlyniad i roi'r argymhellion ar waith ***Workforce implications as a result of implementing the recommendations***	There will be a resource implementation due to the need to update outdated policies and written control documents
Adborth, ymateb a chrynodeb dilynol ar ôl ymgynghori ***Feedback, response, and follow up summary following consultation***	This paper forms an update on Health Board policies to the Executive Team

Cysylltiadau â risgiau BAF: (neu gysylltiadau â'r Gofrestr Risg Gorfforaethol) ***Links to BAF risks:*** *(or links to the Corporate Risk Register)*	Not applicable, other than those relating to individual policies and written control documents.
Rheswm dros gyflwyno adroddiad i fwrdd cyfrinachol (lle bo'n berthnasol) ***Reason for submission of report to confidential board (where relevant)***	Not applicable

Camau Nesaf:
Gweithredu argymhellion

Next Steps:
Implementation of recommendations

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

Work will continue to identify changes to process to be incorporated into the Health Board's Policy around the management of policies and written control documents.

Rhestr o Atodiadau:

List of Appendices:

Appendix 1 – All overdue policies and WCDs at end of Q2 2024/25, by Executive lead
Appendix 2 – Update on all policies due a review by end of Q2 2024,25, by Executive Director lead
Appendix 3 - Overdue policies, including risk level and categorisation
Appendix 4 - Overdue Written Control Documents, including risk level and categorisation

UPDATE ON HEALTH BOARD POLICIES AND WRITTEN CONTROL DOCUMENTS, AND RISK IMPACT OF OVERDUE POLICIES AND WRITTEN CONTROL DOCUMENT

1. INTRODUCTION AND BACKGROUND

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

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

This report provides a position update on policies/WCDs due for review by end of quarter 2, as well as an update on the risk impact of overdue policies/WCDs.

2 POSITION UPDATE AS AT END OF Q2 2024/25

As at 2nd October 2024, there has been some progress to date on overdue policies and WCDs, but it is unlikely that the Health Board will be able to review and approve all its out-of-date policies and WCDs by the end of this financial year.

As at 2nd October 2024, there were 331 policies or WCD overdue their review date. This total excludes All-Wales policies, as these are often outside of our control, appendices to policies/WCD, and only includes one version of a policy/WCD where it is available bilingually. A list of these is included in **Appendix 1**.

As at 2nd October 2024, a total of 104 policies/WCDs were identified for review by either the policy owner or Executive Director in quarter 2, and updates on progress have been sought by the Corporate Governance Directorate.

Even though some policies/WCDs were submitted to the Corporate Governance Directorate for quality assurance towards the end of quarter 1, many of these have been challenged and returned to the policy owners for further work in order to comply with requirements, such as completion of an IAST or EqIA, or incorrect approval process.

Due to this, of the policies/WCDs that were due to be reviewed in quarter 2, none of these had reached the final stage of being uploaded onto the intranet in that quarter, with the majority moving to quarter 3 for review, some to quarter 4, and others into 2025. A list of all WCDs overdue a review in quarter 2 is included in **Appendix 2**.

3 POSITION UPDATE ON OVERDUE POLICIES

The summary position as at 2nd October 2024 is as per Table 1 below.

Executive Lead	Number of WCDs	Number of overdue WCDs	% total overdue	Total overdue with no updated review date	Total all WCDs with no author	Total with no risk level	Total with no risk category
Chief Digital Information Officer	28	7	25%	-	-	-	-
Chief Operating Officer	159	80	50.3%	38	13	68	80
Director of Corporate Governance	10	4	40%	-	-	-	-
Chief Executive	1	1	100%	1	-	-	-
Executive Director of Finance	25	22	88%	-	-	-	-
Executive Director of Nursing	96	16	16.7%	1	-	-	-
Executive Director of Public Health	11	0	0%	-	-	-	-
Executive Director of Therapies and Health Sciences (now included in Executive Director of Allied Health Professions and Health Science)	-	-	-	-	-	-	-
Executive Director of Transformation, Strategic Planning and Commissioning	1	1	100%	-	-	-	-
Executive Director of Workforce and Organisational Development	87	39	44.8%	3	20	10	11
Executive Medical Director	192	108	56.3%	4	2	6	8
Executive Director of Allied Health Professions and Health Science (incl MHLD and Welsh Language)	93	50	53.8%	1	1	7	5
Grand total	**703**	**328**		**48**	**36**	**91**	**104**

In order to reflect the WCDs that the Health Board has within its gift to update, the total number in Table 1 excludes all-Wales policies. Also excluded from this total are any appendices to WCDs, and only one document is counted where there is both a Welsh and English version of the same document. Full details of all the overdue WCDs, their risk level and categorisation, together with an update on progress as at 2nd October 2024 is included in **Appendix 3**.

Since the last update, all Womens WCDs have been included within the Interim Chief Operating Officer portfolio.

2.1 Summary of overdue WCDs

Since the information was captured on 2nd October 2024, work has been undertaken to source review update information relating to overdue WCDs, and Table 2 below reflects the information as at 18th December 2024.

Executive Lead	Number of WCDs	Number of overdue WCDs	% total overdue	Total overdue with no updated review date	Total all WCDs with no author	Total with no risk level	Total with no risk category
Chief Digital Information Officer	28	11	39%	-	-	5	-
Chief Operating Officer	149	69	46.3%	2	6	2	-
Director of Corporate Governance	13	4	31%	-	-	-	-
Chief Executive	2	1	50%	1	-	-	-
Director of Environment and Estates	4	4	100%	-			
Executive Director of Allied Health Professions and Health Science (incl MHLD and Welsh Language)	92	46	50.0%	2	1	7	-
Executive Director of Finance	21	18	86%	-	-	-	-
Executive Director of Nursing	97	14	14.4%	3	-	2	-
Executive Director of Public Health	12	1	8%	-	-	-	-
Executive Director of Therapies and Health Sciences (to be reassigned)	7	2	-	1	-	1	-
Executive Director of Transformation, Strategic Planning and Commissioning	1	1	100%	-	-	-	-
Executive Director of Workforce and Organisational Development	87	36	41.4%	4	18	10	-
Executive Medical Director	195	95	48.7%	3	1	6	-
Grand total	**708**	**302**		**16**	**26**	**33**	**0**

Table 3 below shows the comparisons between the position in January 2024, and the current position, as at 18th December 2024.

Number of WCDs					Number of overdue WCDs					% total overdue				
January 2024	May 2024	June 2024	October 2024	At 18.12.24	January 2024	May 2024	June 2024	October 2024	At 18.12.24	January 2024	May 2024	June 2024	October 2024	At 18.12.24
958	964	973	703	708	422	451	446	327	302	44.1%	46.8%	45.8%	46.5%	42.7%
-	↑	↑	↓	↑	-	↑	↓	↓	↓	-	↑	↓	↑	↓

The data for January, May and June 2024 include all WCD documentation listed on the Policy Management System at that time – this data includes all appendices, all-Wales policies, and both English and Welsh versions of a WCD. The data for October and as at 18th December 2024 does not include any appendices or any all-Wales policies, and includes only one version of a translated version of the WCD.

As can be seen from the 18th December 2024 update, there is an improvement in the total number of overdue WCDs from 2nd October 2024 to 18th December 2024, and percentage total of those overdue, and an increase in the total number of WCDs.

2. RISKS OF OVERDUE WCDs

The Audit Committee has requested an update as to which overdue policies/WCDs carry the biggest risk (financial, legal compliance, safety etc), and the progress being made against to review them.

A request for updates on overdue WCDs listed on the Policy Management System as at 2nd October 2024 was submitted to the Executives, with a deadline for submission of updates by 31st October 2024. Below in Table 4 is a summary of all overdue policies (excluding WCDs) by Executive Lead, showing the number of policies by risk category and risk level of being overdue.

Responsible Director	Risk category	Number of policies in risk category	Risk level of being overdue
Chief Digital Information Officer	IT	2	Medium
	No update provided	2	*No update provided*
Chief Operating Officer	Patient safety	3	High
	Patient safety	3	Medium
	Patient safety	1	Low
Director of Corporate Governance	Legal; Financial	1	Low
	Legal	1	Low
Director of Environment and Estates	Health and Safety	2	Low
Executive Director of Allied Health	Patient safety	3	Low
Professions and Health Science	Patient safety; Joint working/Collaboration	2	Low
	Patient safety; Legal	2	Low
	Legal	5	Low
	Patient safety; Health and Safety	1	Low
	No update provided	1	*No update provided*
Executive Director of Finance	Financial	2	Low
Executive Director of Nursing	HR/Staff	1	Low
Executive Director of Transformation, Strategic Planning and Commissioning	Financial	1	Low
Executive Director of Workforce and	*No update provided*	3	*No update provided*
Organisational Development	HR/Staff	1	Medium
	Legal; Health and Safety	1	Low
	Legal; HR/Staff	2	Low
	HR/Staff; IT	1	Medium
Executive Medical Director	Financial	1	High
	HR/Staff	2	Medium
	No update provided	1	Medium
	Patient safety	1	Medium
	HR/Staff	2	Low
	Patient safety	6	Low
	Medical Research	2	Low
	No update provided	1	*No update provided*

Full details of all the overdue policies, their risk level and categorisation, together with an update on progress is included in **Appendix 3**.

Below in Table 5 is a summary of the responses received against a number of risk categories. A number of updates are still outstanding, and the Corporate Governance Directorate have made several attempts to obtain the missing information.

	Risk Level			
Main risk category	**Low Risk**	**Medium Risk**	**High Risk**	**No risk level provided**
Financial	16		1	
Legal	17	2		
Patient safety	107	27	29	5
Health and Safety	6	4	1	1
HR/Staff	13	10	1	2
Contractors	1			
Joint working/ collaboration	3	1		
IT	1	2		
Medical Research	18			
Reputational	3			
Risk level provided, but no corresponding risk category selected		3		
Total with no progress update	35			

Full details of all the overdue WCDs, their risk level and categorisation, together with an update on progress is included in **Appendix 4**.

3. CONFIDENCE LEVELS OF REVIEW

The Corporate Governance Directorate has reviewed the updates provided, and assessed this against the proposed review quarter in order to provide a confidence level of the review being completed by the timeline provided. If the progress remains in line with the update, Table 6 below is the summary of the confidence levels for the overdue WCDs:

	Confidence level			
Main risk category	**Low confidence**	**Medium confidence**	**High confidence**	**Unable to classify**
Low Risk	81	79	18	7
Medium Risk	8	17	21	3
High Righ	6	12	14	0
No risk level but update provided	6	2	0	1
No review qtr or update	5			
No review qtr	6			
No progress update	35			

The confidence level is very subjective, and based on the update provided, taking into consideration the ongoing consultation work, the approximate timelines around approval routes, the Christmas period (for those for review in Qtr 3 and 4) and the quality assurance and upload work required to finalise the review.

4. NEXT STEPS

As usual, the Corporate Governance Directorate will continue to engage and support Executive Directors and policy and WCD owners in order to ensure that any overdue documentation is updated as timely as possible but will in particular ensure that there is a focus on those overdue policies that are rated as 'high risk'. It is recommended that future reports to the Audit Committee focus initially on the 'high risk' assessed policies.

It is also recommended that the focus over the next 6 months is on 'Policies' and not all Written Control Documents as detailed in **Appendix 3**.

Work is also ongoing to review the approval process around policies and WCDs in order to simplify the process but ensure good governance, and an update on options will be presented at a future meeting.

5. BUDGETARY/FINANCIAL IMPLICATIONS

There are no budgetary implications associated with this paper.

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

6. RISK MANAGEMENT

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

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

7. EQUALITY AND DIVERSITY IMPLICATIONS

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

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

APPENDIX 1 – ALL OVERDUE POLICIES AND WCDs AT END OF Q2 2024/25, BY EXECUTIVE LEAD

APPENDIX 2 – UPDATE ON ALL POLICIES AND WCDs DUE A REVIEW BY END OF Q2 2024,25, BY EXECUTIVE DIRECTOR LEAD

APPENDIX 3 - OVERDUE POLICIES. INCLUDING RISK LEVEL AND CATEGORISATION

APPENDIX 4 - OVERDUE WRITTEN CONTROL DOCUMENTS, INCLUDING RISK LEVEL AND CATEGORISATION

ALL POLICIES AND WRITTEN CONTROL DOCUMENT OVERDUE THEIR REVIEW DATE

AS AT 02/10/2024

Excluding All Wales policies; appendices to policies/WCDs

Includes only one bilingual version of a policy/WCD

	Name	Category	Policy type	Effective Date	Review Date	Author	Responsible Director
1	AL01 - Financial Procedures - V1.11.pdf	Charities and Volunteers	Procedure	09/09/2019	09/09/2022	Neil Williams (BCUHB - Finance)	Executive Director of Finance
2	AL02 - Fund Advisor Handbook & Accountability Agreements - V1.pdf	Charities and Volunteers	Other	01/01/2017	01/01/2018	Kirsty Thomson (BCUHB - Corporate Services)	Executive Director of Finance
3	AL03 - Collaborative Working Protocol - V0.1.pdf	Charities and Volunteers	Protocol	12/09/2016	12/09/2017	Kirsty Thomson (BCUHB - Corporate Services)	Executive Director of Finance
4	AN01 - Guideline for Acupuncture as Pain Relief in Adults - V0.2.pdf	Anaesthetics, Critical Care and Pain Management	Guideline	04/12/2013	01/01/2020	Lucy Jones (BCUHB - Pain Management)	Chief Operating Officer
5	B02 - Risk Assessment of Health Research - Health Research - Standard Operating Procedure.pdf	Research and Development	Procedure	14/07/2021	14/04/2024	Lona Tudor Jones (BCUHB - Research & Development)	Executive Medical Director
6	B04 - SOP for Fraud and Misconduct in Research.pdf	Research and Development	Procedure	02/08/2022	02/08/2024	Lynne Grundy (BCUHB - Research & Development)	Executive Medical Director
7	B05 - Identifying Participants in Clinical Trials – Patient Medical Casenotes - Health Research - Standard Operating Procedure.pdf	Research and Development	Procedure	14/04/2022	14/04/2024	Lona Tudor Jones (BCUHB - Research & Development)	Executive Medical Director
8	BCU Criteria Led Discharge Protocol.pdf	Nursing	Protocol	14/09/2021	01/10/2022	Claire Brennan (BCUHB - Corporate Office)	Executive Director of Nursing and Midwifery
9	BCUHB - Claims Governance Policy Clinical Negligence and Personal Injury - V8.pdf	Quality, Patient safety and Experience	Policy	12/12/2019	01/07/2021	Matthew Joyes (BCUHB - Quality Directorate)	Director of Corporate Governance
10	BCUHB - Legal Services Department - Claims Governance & Management Procedure.pdf	Quality, Patient safety and Experience	Procedure	12/12/2018	16/07/2021	Matthew Joyes (BCUHB - Quality Directorate)	Director of Corporate Governance
11	BCUHB SACT Prescribing Competency Passport.pdf	Cancer and Clinical Haematology	Other	01/08/2015	01/08/2018	Tracy Parry (BCUHB - Pharmacy)	Chief Operating Officer
12	CA02 - Adult Breaking Bad News Policy - V0.1.pdf	Cancer and Clinical Haematology; Palliative and End of Life Care	Policy	10/06/2014	01/07/2016	Imran Devji (BCUHB - Corporate Office)	Chief Operating Officer
13	CA04 - Guidance for the Management of Metastatic Spinal Cord Compression in Adults - V0.1.pdf	Cancer and Clinical Haematology	Other	01/06/2016	01/07/2018	Claire Fuller (BCUHB - Medical Oncology)	Chief Operating Officer
14	CA05 - Acute Oncology Operational Guidance - V0.1.pdf	Cancer and Clinical Haematology	Other	01/10/2016	01/10/2018	Beryl Roberts (BCUHB - Cancer Services)	Chief Operating Officer
15	CA06 - Guidelines for Treatment of Oral Mucositis in Oncology & Haematology Patients - V0.1.pdf	Cancer and Clinical Haematology	Guideline	01/11/2016	01/11/2019	Imran Devji (BCUHB - Corporate Office)	Chief Operating Officer
16	CA3 - Cancer & Specialist Palliative Medicine Guideline for Management of Neutropenic Sepsis - V0.3.pdf	Cancer and Clinical Haematology; Palliative and End of Life Care	Guideline	01/12/2014	01/04/2016	Beryl Roberts (BCUHB - Cancer Services)	Chief Operating Officer
17	Contractors Safety Guidance - V9.pdf	Estates	Other	01/04/2019	01/12/2020	Tanya Coppack (BCUHB - Estates)	Executive Director of Finance
18	Corporate Health & Safety Guidance on the Control of Noise in the Workplace - V7.pdf	Health and Safety	Other	01/04/2021	01/04/2024	Jason Brannan (BCUHB - Workforce & Organisational Development)	Executive Director of Workforce and Organisational Development
19	CSPM01 - Guidance for Ensuring Safety and Quality of Chemotherapy Services - V0.1.pdf	Cancer and Clinical Haematology	Other	22/07/2013	01/04/2016	Catherine Bale (BCUHB - Cancer Services)	Chief Operating Officer
20	CSPM02 - Guidelines for the Management of Tumour Lysis Syndrome in Haematological & Solid Tumour Malignancies - V2.pdf	Cancer and Clinical Haematology	Guideline	01/11/2018	01/12/2021	Imran Devji (BCUHB - Corporate Office)	Chief Operating Officer

21	CSPM03 - Precautionary Measures in the Event of Spillage Involving Cytotoxics - V1.0.pdf	Cancer and Clinical Haematology	Guideline	13/02/2019	01/02/2022	Katherine White (BCUHB - Pharmacy and Medicines Management)	Chief Operating Officer
22	CSPM04 - Guideline for Requesting Non-Formulary or Off-Protocol SACT - V2.0.pdf	Cancer and Clinical Haematology	Guideline	01/08/2017	01/10/2017	Tracy Parry (BCUHB - Pharmacy)	Chief Operating Officer
23	CSPM1 - Clinical Guidelines for the Management of Chemotherapy & Radiotherapy Induced Nausea & Vomiting - V1.2.pdf	Cancer and Clinical Haematology	Guideline	30/09/2014	01/10/2017	Tracy Parry (BCUHB - Pharmacy)	Chief Operating Officer
24	CSPM2 - Hydration Protocol for Cisplatin Chemotherapy - V1.3.pdf	Cancer and Clinical Haematology	Protocol	16/06/2015	01/07/2018	Tracy Parry (BCUHB - Pharmacy)	Chief Operating Officer
25	CSPM3 - Guidelines for the use of Granulocyte Colony Stimulating Factors (G-CSF) in Adult Haematology & Oncology Patients - V2.pdf	Cancer and Clinical Haematology	Guideline	01/12/2017	01/11/2020	Imran Devji (BCUHB - Corporate Office)	Chief Operating Officer
26	CSPM4 - Guidelines for the Management of Chemotherapy Induced Diarrhoea in Adult Patients with Cancer - V1.0.pdf	Cancer and Clinical Haematology	Guideline	01/10/2018	01/10/2021	Anne Marie Humphreys (BCUHB - Cancer Services)	Chief Operating Officer
27	CW01 - BCUHB Paediatric Escalation Policy - V3.pdf	Children and Young People's services	Policy	01/09/2018	01/09/2019	Martin Mcspadden (BCUHB - Paediatrics)	Chief Operating Officer
28	DEM PHOT 01 - BCUHB Phototherapy Guideline.pdf	Nursing; Therapies and Health Sciences	Guideline	20/05/2021	20/05/2023	Sali Anderson (BCUHB - Dermatology)	Executive Director of Therapies and Health Sciences
29	Early Identification and Management of In-patients with Dysphagia Process.pdf	Therapies and Health Sciences; Nursing	Other	13/04/2021	01/12/2023	Cara Spencer (BCUHB - Speech & Language Therapy)	Executive Director of Therapies and Health Sciences
30	EH01 - Protocol for Support of Registered Children's & other Nurses working within CAMHS - V0.1.pdf	Children and Young People's services	Protocol	01/01/2013	13/12/2015	Patrick Howells (BCUHB - Child & Adolescent Health)	Chief Operating Officer
31	ES03 - Waste Management Policy - V5.pdf	Estates	Policy	01/09/2020	01/09/2023	Natalie Scott-Lakey (BCUHB - Estates)	Executive Director of Finance
32	ES04 - Policy for the Managment of Fire Safety - V0.4.pdf	Estates	Policy	01/11/2020	01/04/2022	Rod Taylor (BCUHB - Estates)	Executive Director of Finance
33	F01 - Patients Property and Monies - Wards and Departments.pdf	Finance	Procedure	08/01/2020	01/11/2022	Simon Weaver (BCUHB - Finance)	Executive Director of Finance
34	F017 - Revenue Business Case Policy Approved.pdf	Finance	Policy	24/10/2019	24/10/2022	Ian Howard (BCUHB - Planning)	Executive Director of Transformation, Strategic Planning and Commissioning
35	F02 - Lease Car & Pool Vehicle Policy and Procedure - V.03.pdf	Finance	Policy	12/08/2021	15/08/2024	Denise Roberts (BCUHB - Finance)	Executive Director of Finance
36	F03 - Local Counter Fraud, Bribery and Corruption Policy.pdf	Finance	Policy	16/03/2022	01/08/2024	Karl Woodward (BCUHB - Finance)	Executive Director of Finance
37	F04 - Cash Collection Receipting and Banking Arrangements - V0.2.pdf	Finance	Procedure	14/07/2017	19/07/2019	Simon Weaver (BCUHB - Finance)	Executive Director of Finance
38	F05 - Income and Debt Recovery - V0.2.pdf	Finance	Procedure	02/02/2017	15/02/2019	Simon Weaver (BCUHB - Finance)	Executive Director of Finance
39	F06 - Losses and Special Payments - V0.2.pdf	Finance	Procedure	02/02/2017	15/02/2019	Simon Weaver (BCUHB - Finance)	Executive Director of Finance
40	F07 - Petty Cash Procedure- V0.2.pdf	Finance	Procedure	25/07/2017	19/07/2019	Simon Weaver (BCUHB - Finance)	Executive Director of Finance
41	F08 - Purchasing Card Procedure - V0.2.pdf	Finance	Procedure	02/02/2017	15/02/2019	Simon Weaver (BCUHB - Finance)	Executive Director of Finance
42	F09 - Reimbursement of Travel to Hospital Costs - V3.pdf	Finance	Procedure	19/02/2020	17/02/2023	Simon Weaver (BCUHB - Finance)	Executive Director of Finance
43	F10 - Retention and Disposal of Property Found on Health Board Premises - V0.2.pdf	Finance	Procedure	28/03/2018	20/03/2020	Simon Weaver (BCUHB - Finance)	Executive Director of Finance
44	F13 - Procedure For Use and Completion of Request To Waive SFIs - V0.1.pdf	Finance	Procedure	07/03/2018	17/01/2020	Neil Williams (BCUHB - Finance)	Executive Director of Finance

45	F14 - Financial Procedure Salary Overpayments and Underpayments - V2.pdf	Finance	Procedure	24/02/2021	16/02/2024	Simon Weaver (BCUHB - Finance)	Executive Director of Finance
46	F15 - Patients Property and Monies - General Office - V0.1.pdf	Finance	Guideline	31/10/2018	16/10/2020	Simon Weaver (BCUHB - Finance)	Executive Director of Finance
47	F16 - Arranging a Hospital Funeral - V0.1.pdf	Finance	Procedure	14/12/2018	18/12/2020	Simon Weaver (BCUHB - Finance)	Executive Director of Finance
48	F18 - Intermediaries Legislation (IR35) Procedure - V1.0.pdf	Finance	Procedure	12/02/2020	13/02/2023	Denise Roberts (BCUHB - Finance)	Executive Director of Finance
49	GC05 - Procedure for Accessing Legal Advice - V0.2.pdf	Corporate Governance Directorate	Procedure	01/01/2016	01/02/2018	Matthew Joyes (BCUHB - Quality Directorate)	Director of Corporate Governance
50	Guidance on Administration of End of Life Care Medications if no Syringe Pumps Available - Covid-19 Response (to be read with MM58).pdf	Pharmacy and Medicines Management; Palliative and End of Life Care	Other	24/04/2020	24/04/2022	Jenny Sparks (BCUHB - Pharmacy)	Executive Medical Director
51	Guidance on Intravenous Fluid Prescribing for Adults in Hospital & Community Setting - V1.pdf	Pharmacy and Medicines Management	Guideline	01/12/2019	01/12/2022	Catrin Roberts (BCUHB - Pharmacy)	Executive Medical Director
52	Gyn 03 - Ovarian Hyperstimulation Syndrome - V3.pdf	Women's Directorate	Guideline	01/12/2020	01/12/2023	Arpana Jain (BCUHB - Obstetrics & Gynaecology)	Chief Operating Officer
53	Gyn 08 - Gynaecology Escalation Procedure - V3.pdf	Women's Directorate	Procedure	16/03/2021	30/03/2024	Melissa Hewlett (BCUHB - Nursing, Midwifery & Patient Services)	Chief Operating Officer
54	Gyn 09 - Emergency Gynaecology Unit Miscarriage and Ectopic Pregnancy - V2.pdf	Women's Directorate	Guideline	01/12/2020	01/12/2023	Nick Clerk (BCUHB - Obstetrics & Gynaecology)	Chief Operating Officer
55	Gyn 11 - BCUHB Fertility Service.pdf	Women's Directorate	Protocol	01/12/2020	01/12/2023	Jayne Beattie (BCUHB - Family Services)	Chief Operating Officer
56	Gyn 12 - Uterine Artery Embolisation - V2.pdf	Women's Directorate	Guideline	01/12/2020	01/12/2023	Gudrun Rieck (BCUHB - Obstetrics & Gynaecology)	Chief Operating Officer
57	HCSW SOP Administration of Ear Drops.pdf	Pharmacy and Medicines Management	Procedure	29/11/2019	29/11/2022	Lisa Morris (BCUHB - Pharmacy and Medicines Management)	Executive Medical Director
58	HCSW SOP Administration of Enemas and Suppositories.pdf	Pharmacy and Medicines Management	Procedure	29/11/2019	29/11/2022	Lisa Morris (BCUHB - Pharmacy and Medicines Management)	Executive Medical Director
59	HCSW SOP Administration of Eye Drops.pdf	Pharmacy and Medicines Management	Procedure	29/11/2019	29/11/2022	Lisa Morris (BCUHB - Pharmacy and Medicines Management)	Executive Medical Director
60	HCSW SOP Administration of Inhalers.pdf	Pharmacy and Medicines Management	Procedure	29/11/2019	29/11/2022	Lisa Morris (BCUHB - Pharmacy and Medicines Management)	Executive Medical Director
61	HCSW SOP Administration of LMWH.pdf	Pharmacy and Medicines Management	Procedure	04/12/2019	01/11/2022	Lisa Morris (BCUHB - Pharmacy and Medicines Management)	Executive Medical Director
62	HCSW SOP Administration of Nebules.pdf	Pharmacy and Medicines Management	Procedure	29/11/2019	29/11/2022	Lisa Morris (BCUHB - Pharmacy and Medicines Management)	Executive Medical Director
63	HCSW SOP Administration of Non Medicated Topicals.pdf	Pharmacy and Medicines Management	Procedure	29/11/2019	29/11/2022	Lisa Morris (BCUHB - Pharmacy and Medicines Management)	Executive Medical Director
64	HCSW SOP Administration of Nose Drops.pdf	Pharmacy and Medicines Management	Procedure	29/11/2019	29/11/2022	Lisa Morris (BCUHB - Pharmacy and Medicines Management)	Executive Medical Director
65	HCSW SOP Administration of Oral Medicines.pdf	Pharmacy and Medicines Management	Procedure	29/11/2019	29/11/2022	Lisa Morris (BCUHB - Pharmacy and Medicines Management)	Executive Medical Director
66	HCSW SOP Administration of Oxygen.pdf	Pharmacy and Medicines Management	Procedure	29/11/2019	29/11/2022	Lisa Morris (BCUHB - Pharmacy and Medicines Management)	Executive Medical Director
67	HCSW SOP Administration Removal and Disposal Transdermal Patches.pdf	Pharmacy and Medicines Management	Procedure	29/11/2019	29/11/2022	Lisa Morris (BCUHB - Pharmacy and Medicines Management)	Executive Medical Director
68	HCSW SOP Gastrostomy Administration of Medication.pdf	Pharmacy and Medicines Management	Procedure	29/11/2019	29/11/2022	Lisa Morris (BCUHB - Pharmacy and Medicines Management)	Executive Medical Director

69	HCSW SOP Ordering Stock Medication.pdf	Pharmacy and Medicines Management	Procedure	29/11/2019	29/11/2022	Lisa Morris (BCUHB - Pharmacy and Medicines Management)	Executive Medical Director
70	HCSW SOP Removal and Disposal of Subcut Infusions.pdf	Pharmacy and Medicines Management	Procedure	29/11/2019	29/11/2022	Lisa Morris (BCUHB - Pharmacy and Medicines Management)	Executive Medical Director
71	HCSW SOP Second Check of Insulin Administration.pdf	Pharmacy and Medicines Management	Procedure	29/11/2019	29/11/2022	Lisa Morris (BCUHB - Pharmacy and Medicines Management)	Executive Medical Director
72	HCSW SOP Second Check of Oral CDs in Community Hospitals.pdf	Pharmacy and Medicines Management	Procedure	29/11/2019	29/11/2022	Lisa Morris (BCUHB - Pharmacy and Medicines Management)	Executive Medical Director
73	HCSW SOP Second Checker of CD Stock Levels.pdf	Pharmacy and Medicines Management	Procedure	29/11/2019	29/11/2022	Lisa Morris (BCUHB - Pharmacy and Medicines Management)	Executive Medical Director
74	HCSW SOP Second Checker SC Fluids (No Additives).pdf	Pharmacy and Medicines Management	Procedure	29/11/2019	29/11/2022	Lisa Morris (BCUHB - Pharmacy and Medicines Management)	Executive Medical Director
75	HCSW SOP Storage Meds in Automated Cupboard.pdf	Pharmacy and Medicines Management	Procedure	29/11/2019	29/11/2022	Lisa Morris (BCUHB - Pharmacy and Medicines Management)	Executive Medical Director
76	HS01 - Occupational Health and Safety Policy.pdf	Health and Safety	Policy	09/12/2021	09/12/2023	Peter Bohan (BCUHB - Corporate Office)	Executive Director of Workforce and Organisational Development
77	HS02 - Protecting Employees from Violence & Aggression - V2.pdf	Health and Safety	Other	01/03/2021	01/03/2024	Susan Morgan (BCUHB - Health & Safety); David Baker (BCUHB - Health & Safety)	Executive Director of Workforce and Organisational Development
78	HS04 - Procedure Guidance Workplace Health, Safety & Welfare - V1.pdf	Health and Safety	Procedure	01/06/2017	01/07/2021	Jason Brannan (BCUHB - Workforce & Organisational Development)	Executive Director of Workforce and Organisational Development
79	HS09 - Control of Noise at Work Procedure.pdf	Health and Safety	Procedure	01/01/2021	01/01/2023	Clare Jones (BCUHB - Health & Safety)	Executive Director of Workforce and Organisational Development
80	HS17 - Procedure & Guidance Document for Display Screen Equipment Use - V1.pdf	Health and Safety	Procedure	01/06/2018	01/06/2020	Clare Jones (BCUHB - Health & Safety)	Executive Director of Workforce and Organisational Development
81	HS19 - Staff Health Surveillance Screening Procedure - V0.2.pdf	Health and Safety	Procedure	10/03/2020	10/01/2023	Peter Bohan (BCUHB - Corporate Office)	Executive Director of Workforce and Organisational Development
82	IG07 - Procedure for Dealing with SARs Under Data Protection Legislation - V9.pdf	Information Governance	Procedure	19/08/2021	01/07/2024	Lisa Parry (BCUHB - Digital, Data and Technology)	Chief Digital Information Officer
83	IG1 - Information Governance Strategy.pdf	Information Governance	Strategy	30/06/2023	01/04/2024	Carol Johnson (BCUHB - Digital, Data and Technology)	Chief Digital Information Officer
84	IG10 - Procedure for Requesting Approval and Review of an Information System for Investigation Purposes.pdf	Information Governance	Procedure	25/05/2022	01/04/2024	Carol Johnson (BCUHB - Digital, Data and Technology)	Chief Digital Information Officer
85	IG24 - Notification of Personal Data Breach Procedure.pdf	Information Governance	Procedure	30/06/2022	01/05/2024	Lisa Parry (BCUHB - Digital, Data and Technology)	Chief Digital Information Officer
86	IG28 - Bring Your Own Device (BYOD) Procedure.pdf	Information Governance	Procedure	30/05/2022	30/05/2023	Lisa Parry (BCUHB - Digital, Data and Technology)	Chief Digital Information Officer
87	INF03 - Informatics Change Management Policy - V1.pdf	Informatics	Policy	21/01/2020	13/01/2023	John Thomas (BCUHB - Digital, Data and Technology)	Chief Digital Information Officer
88	INF04 - Informatics Change Management Procedure - V1.pdf	Informatics	Policy	08/05/2019	19/05/2023	John Thomas (BCUHB - Digital, Data and Technology)	Chief Digital Information Officer
89	ISU02 - Patient, Service User & Carer Procedure for the Production of Written Information - V4.02.pdf	Quality, Patient safety and Experience	Procedure	12/06/2020	16/06/2023	Leon Marsh (BCUHB - Nursing, Midwifery & Patient Services)	Executive Director of Nursing and Midwifery
90	ISU03 - Volunteering Policy - V0.1.pdf	Charities and Volunteers	Policy	09/12/2014	12/01/2017	Susan Marriott (BCUHB - Workforce & Organisational Development)	Executive Director of Workforce and Organisational Development
91	ISUE01 - Undertaking Patient Experience Stories - V2.0.pdf	Quality, Patient safety and Experience	Other	29/04/2021	14/04/2023	Leon Marsh (BCUHB - Nursing, Midwifery & Patient Services)	Executive Director of Nursing and Midwifery
92	LAC04 - Procedure for the Recovery of Costs associated with Looked After Children placed within BCUHB - V1.0.pdf	Children and Young People's services	Procedure	09/04/2014	01/04/2015	Susan Battery (BCUHB - Child & Adolescent Health)	Chief Operating Officer

93	Mat 06 - Supporting Births in Community Settings - V2.2.pdf	Women's Directorate	Other	01/05/2020	01/06/2021	Imran Devji (BCUHB - Corporate Office)	Chief Operating Officer
94	Mat 13 - Birth Planning When Women Choose Options That Are Outside BCUHB Policies - V1.pdf	Women's Directorate	Guideline	01/01/2021	01/01/2024	Meinir Clayton Evans (BCUHB - Maternity)	Chief Operating Officer
95	Mat 16 - Fetal Medicine Scan on Consultant List - V2.pdf	Women's Directorate	Other	20/12/2019	20/12/2022	Bidyut Kumar (BCUHB - Obstetrics & Gynaecology)	Chief Operating Officer
96	Mat 21 - Prophylactic Anti D - V3.pdf	Women's Directorate	Guideline	01/04/2021	01/04/2024	Cathy Hughes (BCUHB - Antenatal)	Chief Operating Officer
97	Mat 23 - Venous Thromboembolism in Pregnancy - Prevention, Diagnosis and Treatment - V3.pdf	Women's Directorate	Guideline	01/03/2021	01/04/2024	Joseph Mechery (BCUHB - Obstetrics & Gynaecology)	Chief Operating Officer
98	Mat 24 - Women Who Present In Labour Who Are Not Booked or Have Received No Antenatal Care or Initial Assessment - V3.pdf	Women's Directorate	Guideline	01/12/2020	01/12/2023	Eleri Pritchard (BCUHB - Maternity)	Chief Operating Officer
99	Mat 25 - Acceptance or Assessment of Maternal and Fetal Wellbeing on the Outpatient Assessment Unit (MOAU) - V5.pdf	Women's Directorate	Guideline	01/06/2021	01/06/2024	Kizzy Williams (BCUHB - Maternity)	Chief Operating Officer
100	Mat 28 - Small for Gestational Age and Fetal Growth Restricted Babies - Antenatal Management - V1.1.pdf	Women's Directorate	Other	01/06/2021	01/06/2024	Bidyut Kumar (BCUHB - Obstetrics & Gynaecology)	Chief Operating Officer
101	Mat 29 - Twin and Triplet Pregnancies in the Antetnatal Period - V2.pdf	Women's Directorate	Guideline	01/12/2020	01/12/2023	Bidyut Kumar (BCUHB - Obstetrics & Gynaecology)	Chief Operating Officer
102	Mat 33 - Amniotic Fluid Embolism - V2.pdf	Women's Directorate	Guideline	01/12/2020	01/12/2023	Lynda Verghese (BCUHB - Obstetrics & Gynaecology)	Chief Operating Officer
103	Mat 34 - Antepartum Haemorrhage - V2.pdf	Women's Directorate	Other	01/12/2020	01/12/2023	Mian Khurshid (BCUHB - Obstetrics & Gynaecology)	Chief Operating Officer
104	Mat 35 - Assisted Vaginal Birth (formerly Operative Vaginal Delivery) - V3.pdf	Women's Directorate	Other	01/07/2021	01/07/2024	Neelam Singh (BCUHB - Obstetrics & Gynaecology)	Chief Operating Officer
105	Mat 40 - Cord Prolapse - V2.pdf	Women's Directorate	Guideline	01/08/2021	01/08/2024	Niladri Sengupta (BCUHB - Obstetrics & Gynaecology)	Chief Operating Officer
106	Mat 42 - Epilepsy in Pregnancy - V1.pdf	Women's Directorate	Policy	01/10/2018	01/10/2021	Maggie Armstrong (BCUHB - Obstetrics & Gynaecology); Sheila Shepley (BCUHB - Outpatient Services); Janet Quarmby (BCUHB - Maternity);	Chief Operating Officer
107	Mat 43 - External Cephalic Version at Term - V2.pdf	Women's Directorate	Guideline	01/12/2020	01/12/2023	Devjani Das (BCUHB - Obstetrics & Gynaecology); Masroor Cheema (Ysbyty Gwynedd - W042)	Chief Operating Officer
108	Mat 45 - Intermittent Auscultation of the Fetal Heart in Labour - V1.pdf	Women's Directorate	Other	01/01/2021	01/01/2024	Imran Devji (BCUHB - Corporate Office)	Chief Operating Officer
109	Mat 54 - ROM Plus Point of Care Testing for Rupture of Membranes - Standard Operating Procedure - V1.pdf	Women's Directorate	Procedure	27/03/2020	27/03/2023	Niladri Sengupta (BCUHB - Obstetrics & Gynaecology)	Chief Operating Officer
110	Mat 56 - Shoulder Dystocia - V3.pdf	Women's Directorate	Guideline	01/07/2021	01/07/2024	Niladri Sengupta (BCUHB - Obstetrics & Gynaecology)	Chief Operating Officer
111	Mat 58 - Swab, Instrument and Needle Count within Maternity Care Settings - V4.pdf	Women's Directorate	Guideline	01/03/2020	01/03/2023	Julie Reeve (BCUHB - Obstetrics & Gynaecology)	Chief Operating Officer
112	Mat 59 - Uterine Inversion - V2.pdf	Women's Directorate	Guideline	01/08/2021	01/08/2024	Niladri Sengupta (BCUHB - Obstetrics & Gynaecology)	Chief Operating Officer
113	Mat 63 - Umbilical Cord Blood Collection for the Harvesting of Stem Cells - V3.pdf	Women's Directorate	Other	01/12/2020	01/12/2023	Bethan Evans (BCUHB - Maternity)	Chief Operating Officer
114	Mat 70 - Neonatal Examination of the Newborn by Midwives - V3.pdf	Women's Directorate	Guideline	24/05/2019	01/06/2022	Meinir Clayton Evans (BCUHB - Maternity)	Chief Operating Officer

115	Mat 74 - BCUHB Breastfeeding Policy.pdf	Children and Young People's services; Women's Directorate; Workforce	Policy	01/12/2020	01/12/2023	Sharon Breward (BCUHB - Maternity)	Chief Operating Officer
116	Mat 75 - Healthy Term Babies who are Reluctant to Feed in the Early Postnatal Period - V6.pdf	Women's Directorate	Guideline	01/12/2020	01/12/2023	Sharon Breward (BCUHB - Maternity)	Chief Operating Officer
117	Mat 77 - Infant Feeding Guideline (Unicef Baby Friendly Care Standards) - V2.pdf	Women's Directorate	Guideline	01/12/2020	01/12/2023	Sharon Breward (BCUHB - Maternity)	Chief Operating Officer
118	Mat 79 - Breastfeeding Peer Supporters as Volunteers in BCUHB - V4.pdf	Women's Directorate	Guideline	01/07/2020	01/08/2023	Sharon Breward (BCUHB - Maternity)	Chief Operating Officer
119	Mat 80 - Antenatal Hand Expressing of Colostrum - V3.pdf	Women's Directorate	Guideline	01/12/2020	01/12/2023	Sharon Breward (BCUHB - Maternity)	Chief Operating Officer
120	Mat 81 - Expressing and Handling Mothers' Own Breast Milk in Hospital - V1.1.pdf	Women's Directorate	Guideline	23/07/2021	01/08/2024	Sharon Breward (BCUHB - Maternity)	Chief Operating Officer
121	Mat 82 - Handover of Care Guideline - V3.pdf	Women's Directorate	Guideline	01/02/2021	01/03/2024	Julie Reeve (BCUHB - Obstetrics & Gynaecology)	Chief Operating Officer
122	Mat 86 - Maternal Mental Health Guideline.pdf	Women's Directorate; Mental Health and Learning Disabilities	Guideline	01/01/2020	01/01/2023	Imran Devji (BCUHB - Corporate Office)	Chief Operating Officer
123	Mat 87 - Maternal Death Guideline - V3.pdf	Women's Directorate	Guideline	01/12/2020	01/12/2023	Heledd Jones (BCUHB - Maternity)	Chief Operating Officer
124	Mat 88 - Perinatal Bereavement Guideline - V3.pdf	Women's Directorate	Guideline	29/06/2021	29/06/2024	Lucy Dobbins (BCUHB - Maternity)	Chief Operating Officer
125	Mat 89 - Bereavement Follow Up Appointments following Pregnancy Loss - Standard Operating Procedure - V1.pdf	Women's Directorate	Procedure	01/11/2020	01/12/2023	Lucy Dobbins (BCUHB - Maternity)	Chief Operating Officer
126	Mat 91 - Preceptorship Protocol for Newly Registered Midwives - V3.pdf	Women's Directorate	Protocol	01/12/2020	01/12/2023	Becky Ferneyhough (BCUHB - Maternity)	Chief Operating Officer
127	Mat 97 - Reduced or Altered Fetal Movements - V1.pdf	Women's Directorate	Guideline	01/08/2021	01/08/2024	Niladri Sengupta (BCUHB - Obstetrics & Gynaecology); Julie Reeve (BCUHB - Obstetrics & Gynaecology)	Chief Operating Officer
128	MD07 - Protocol for Using Bed Rails Safety and Effectively.pdf	Nursing	Protocol	22/06/2023	01/08/2024	Diane Read (BCUHB - Nursing, Midwifery & Patient Services)	Executive Director of Nursing and Midwifery
129	MD09 - Medical & Dental Staff - Sabbatical Leave Policy - V0.2.pdf	Office of the Medical Director	Policy	31/03/2017	31/03/2018	James Risley (BCUHB - Office of the Medical Director)	Executive Medical Director
130	MD10 - Medical & Dental Staff Study Leave Policy - V0.1.pdf	Office of the Medical Director	Policy	20/10/2014	20/10/2017	James Risley (BCUHB - Office of the Medical Director); Joanne Shillingford (BCUHB - Office of the Medical Director)	Executive Medical Director
131	MD11 - Medical & Dental Staff Professional Leave Policy - V0.1.pdf	Office of the Medical Director	Policy	20/10/2014	20/10/2017	James Risley (BCUHB - Office of the Medical Director); Joanne Shillingford (BCUHB - Office of the Medical Director)	Executive Medical Director
132	MD13 - Annual Leave & Special Leave Policy for Medical & Dental Staff - V0.1.pdf	Office of the Medical Director	Policy	20/10/2014	20/10/2017	James Risley (BCUHB - Office of the Medical Director); Joanne Shillingford (BCUHB - Office of the Medical Director)	Executive Medical Director
133	MD14 - Private Practice Policy - V0.1.pdf	Office of the Medical Director	Policy	27/07/2016	27/07/2018	James Risley (BCUHB - Office of the Medical Director)	Executive Medical Director
134	MD17 - Interventions Not Normally Undertaken (INNU) Policy - V1.1.pdf	Office of the Medical Director	Policy	24/07/2018	01/09/2021	Mark Walker (BCUHB - Corporate Office)	Executive Medical Director

135	MD23 - Procedure to Mitigate the Risks due to Failure to Act on Diagnostic Results - V1.pdf	Nursing; Office of the Medical Director; Radiology	Procedure	10/08/2016	15/08/2018	Conor Corr (BCUHB - Radiology)	Executive Medical Director
136	MD24 - Recognition of Life Extinct for Adults in the Community - V1.0.pdf	Office of the Medical Director	Guideline	10/07/2020	10/07/2021	Melanie Maxwell (BCUHB - Office of the Medical Director)	Executive Medical Director
137	MH02 - Procedure for Exceptional Admission of Children under 18 to an Acute Psychiatric Inpatient Unit.pdf	Mental Health and Learning Disabilities; Safeguarding	Procedure	01/12/2020	01/12/2023	Adrian Jones (BCUHB - Mental Health & Learning Disabilities)	Executive Director of Therapies and Health Sciences
138	MH2 - Guidance for Crisis Care Pathway for Children & Young People Presenting with Mental Health Issues - V0.6.pdf	Children and Young People's services	Other	01/12/2016	01/12/2019	Lesley Bayley (BCUHB - Community Child Health)	Chief Operating Officer
139	MHLD 0002 DRAFT - Seclusion & Long Term Segregation Policy - V0.2.pdf	Mental Health and Learning Disabilities	Policy	01/09/2020	01/09/2023	Teresa Owen (BCUHB - Corporate Office)	Executive Director of Therapies and Health Sciences
140	MHLD 0005 - Ty Llywelyn Patients Visitors Procedure.pdf	Mental Health and Learning Disabilities	Procedure	21/03/2019	01/10/2022	Simon Allen (BCUHB - Mental Health & Learning Disabilities)	Executive Director of Therapies and Health Sciences
141	MHLD 0008 - Threats to the Person and Environment within Forensic Establishments Policy (Ty Llywelyn Medium Secure Unit).pdf	Mental Health and Learning Disabilities	Policy	15/01/2021	01/01/2024	Ian Jones (BCUHB - Mental Health & Learning Disabilities)	Executive Director of Therapies and Health Sciences
142	MHLD 0009 - Major Incident Protocol - Ty Llywelyn Medium Secure Unit.pdf	Mental Health and Learning Disabilities	Protocol	15/01/2021	15/01/2022	Ian Jones (BCUHB - Mental Health & Learning Disabilities)	Executive Director of Therapies and Health Sciences
143	MHLD 0020 - S-CAMHS to Adult Transition Policy - V3.pdf	Mental Health and Learning Disabilities; Children and Young People's services	Policy	01/06/2021	01/03/2024	Kathryn Thomas (BCUHB - Child & Adolescent Health)	Executive Director of Therapies and Health Sciences
144	MHLD 0024 - Adults with a Learning Disability Requiring Admission to Acute Psychiatric In-patient Services - V0.1.pdf	Mental Health and Learning Disabilities	Other	21/03/2017	01/03/2020	Simon Meadowcroft (BCUHB - Learning Disability Services)	Executive Director of Therapies and Health Sciences
145	MHLD 0027 - BCUHB Mental Health Division - Open Door Policy - V0.1pdf.pdf	Mental Health and Learning Disabilities	Policy	01/07/2017	01/07/2020	Sean Gallagher (BCUHB - Learning Disability Services); Matthew Jarvis (BCUHB - Mental Health & Learning Disabilities)	Executive Director of Therapies and Health Sciences
146	MHLD 0029 - Perinatal Mental Health Operational Policy - V0.1.pdf	Mental Health and Learning Disabilities	Policy	01/06/2017	01/06/2019	Deborah Griffin (BCUHB - Mental Health & Learning Disabilities)	Executive Director of Therapies and Health Sciences
147	MHLD 0030 - Policy for Information to Patients (S132 3 MHA).pdf	Mental Health and Learning Disabilities	Policy	01/06/2021	01/06/2024	Wendy Lappin (BCUHB - Quality Directorate)	Executive Director of Therapies and Health Sciences
148	MHLD 0033 - MHLD Policy for the Implementation of Section 5(4) Nurses Holding Power.pdf	Mental Health and Learning Disabilities	Policy	01/06/2021	01/06/2024	Wendy Lappin (BCUHB - Quality Directorate)	Executive Director of Therapies and Health Sciences
149	MHLD 0034 - MHLD Policy for Section 5(2) Doctors Holding Power in Psychiatric Units.pdf	Mental Health and Learning Disabilities	Policy	01/06/2021	01/10/2023	Wendy Lappin (BCUHB - Quality Directorate)	Executive Director of Therapies and Health Sciences
150	MHLD 0035 - Home Treatment Team Operational Policy - V0.5 (a).pdf	Mental Health and Learning Disabilities	Policy	09/04/2018	01/04/2021	Huw Jones (BCUHB - Adult Mental Health & Social Care)	Executive Director of Therapies and Health Sciences
151	MHLD 0036 - Needle Syringe Provisions for Young People Guidelines - V0.1.pdf	Mental Health and Learning Disabilities	Guideline	22/08/2018	01/08/2021	Jodie Morgan (BCUHB - Substance Misuse Services)	Executive Director of Therapies and Health Sciences
152	MHLD 0038 - Substance Misuse Service Allocation Waiting List Protocol - V0.3.pdf	Mental Health and Learning Disabilities	Protocol	22/08/2018	22/08/2021	Jodie Morgan (BCUHB - Substance Misuse Services)	Executive Director of Therapies and Health Sciences
153	MHLD 0040 - Ty Llywelyn Postal Packets & Section 134 (MHA 1983 2007) Policy - V0.1.pdf	Mental Health and Learning Disabilities	Policy	22/08/2018	01/08/2021	Simon Allen (BCUHB - Mental Health & Learning Disabilities)	Executive Director of Therapies and Health Sciences
154	MHLD 0041 - MHLD Policy for Use of Handcuffs (specific to Ty Llywelwyn Medium Secure Unit).pdf	Mental Health and Learning Disabilities	Policy	15/01/2021	15/01/2024	Paul Hanna (PTHB - Mental Health)	Executive Director of Therapies and Health Sciences
155	MHLD 0045 - Bed Escalation Procedure - MHLD - V1.3.pdf	Mental Health and Learning Disabilities	Procedure	13/07/2021	01/07/2024	Paul Hanna (PTHB - Mental Health)	Executive Director of Therapies and Health Sciences
156	MHLD 0048 - Operational Procedure for Community Forensic Mental Health Services -V3.pdf	Mental Health and Learning Disabilities	Procedure	01/02/2019	01/02/2021	Greg Yates (BCUHB - Mental Health & Learning Disabilities)	Executive Director of Therapies and Health Sciences

157	MHLD 0051 - Community Treatment Order Policy MHA 1983 - V0.1.pdf	Mental Health and Learning Disabilities	Policy	16/07/2019	01/05/2022	Wendy Lappin (BCUHB - Quality Directorate)	Executive Director of Therapies and Health Sciences
158	MHLD 0052 - Standard Operating Procedure for the use of Gyms & Sports Facilities.pdf	Mental Health and Learning Disabilities	Procedure	11/09/2019	01/07/2022	Lucy Clarke (BCUHB - Occupational Therapy); Leanne Gill (BCUHB - Mental Health & Learning Disabilities)	Executive Director of Therapies and Health Sciences
159	MHLD 0053 - Meeting the Physical Health Care Needs of People Admitted to an Older Persons Mental Health Ward - V0.1.pdf	Mental Health and Learning Disabilities	Guideline	13/09/2019	13/09/2022	Premraj Muthuvelu (BCUHB - Mental Health & Learning Disabilities)	Executive Director of Therapies and Health Sciences
160	MHLD 0057 - North Wales Section 135 & 136 Mental Health Act 1983 Protocol.pdf	Mental Health and Learning Disabilities; Safeguarding	Protocol	01/04/2021	01/04/2024	Ruth Joyce (BCUHB - Mental Health & Learning Disabilities)	Executive Director of Therapies and Health Sciences
161	MHLD 0058 - Hafod Mental Health Resource Centre - PocHi Operational Procedure - V0.1.pdf	Mental Health and Learning Disabilities	Procedure	01/03/2020	01/02/2023	Iain Dawson (BCUHB - Pharmacy)	Executive Director of Therapies and Health Sciences
162	MHLD 0059 - Memory Services Operational Protocol.pdf	Mental Health and Learning Disabilities	Protocol	01/11/2020	01/11/2022	Joanne Kelly-Rhind (BCUHB - Clinical Psychology)	Executive Director of Therapies and Health Sciences
163	MHLD 0060 - Criminal Justice Liaison Service Standard Operating Procedure.pdf	Mental Health and Learning Disabilities	Procedure	01/08/2020	01/08/2023	Ruth Joyce (BCUHB - Mental Health & Learning Disabilities)	Executive Director of Therapies and Health Sciences
164	MHLD 0067 - Patient Anti Bullying Procedure - Ty Llywelyn Medium Secure Unit - V1.pdf	Mental Health and Learning Disabilities	Procedure	01/10/2020	01/10/2023	Simon Allen (BCUHB - Mental Health & Learning Disabilities)	Executive Director of Therapies and Health Sciences
165	MHLD 0068 - Perinatal Guidelines for Pain Control in Women on Opioid Substitution Therapy - V4.3.pdf	Mental Health and Learning Disabilities	Guideline	13/11/2020	16/11/2023	Lis Hughes (BCUHB - Substance Misuse Services)	Executive Director of Therapies and Health Sciences
166	MHLD 0071 - Clinical Risk Management Procedure - V6.pdf	Mental Health and Learning Disabilities	Procedure	01/10/2021	01/11/2023	Robyn Jones (BCUHB - Mental Health & Learning Disabilities); Joanne Kendrick (BCUHB - Mental Health & Learning Disabilities)	Executive Director of Therapies and Health Sciences
167	MHLD 0073 - Guidelines for the use of Buvidal® Injection within the Substance Misuse Service.pdf	Mental Health and Learning Disabilities	Guideline	04/11/2020	03/11/2020	Luxman Parimelalagan (BCUHB - Substance Misuse Services);	Executive Director of Therapies and Health Sciences
168	MHLD 0076 - SOP for End of Life Care for the Person with Dementia under the Care of In-patient Mental Health Services.pdf	Mental Health and Learning Disabilities; Palliative and End of Life Care	Procedure	01/09/2019	01/09/2022	Joanne Kendrick (BCUHB - Mental Health & Learning Disabilities); Sharmi Bhattacharyya (BCUHB - Mental Health & Learning Disabilities)	Executive Director of Therapies and Health Sciences
169	MHLD 0078 - Nicotine Replacement Therapy (NRT) Supplementary Guidance for MHLD inpatients.pdf	Mental Health and Learning Disabilities	Guideline	16/09/2022	01/09/2022	Elizabeth Bond (BCUHB - Pharmacy)	Executive Director of Therapies and Health Sciences
170	MHLD AC006 - Electroconvulsive Therapy Service Specification - DRAFT.pdf	Mental Health and Learning Disabilities	Other	01/06/2020	01/07/2023	Linda Mcarthur (BCUHB - Mental Health & Learning Disabilities); Sheryl Cave (BCUHB - Mental Health & Learning Disabilities)	Executive Director of Therapies and Health Sciences
171	MHLD RM04 - Risk Managment Procedure.pdf	Mental Health and Learning Disabilities	Procedure	01/06/2019	01/12/2020	Francine Moore (BCUHB - Quality Directorate)	Executive Director of Therapies and Health Sciences
172	MM01 - BCUHB Medicines Policy.pdf	Pharmacy and Medicines Management	Policy	18/03/2019	11/07/2022	Judith Green (BCUHB - Pharmacy)	Executive Medical Director
173	MM02 - Injectable Medicines Policy.pdf	Pharmacy and Medicines Management	Policy	08/07/2019	08/07/2022	Andrew Merriman (BCUHB - Pharmacy)	Executive Medical Director
174	MM05 - Intrathecal Chemotherapy Policy - V3.pdf	Pharmacy and Medicines Management; Cancer and Clinical Haematology	Policy	07/03/2018	01/03/2021	Andrew Merriman (BCUHB - Pharmacy)	Executive Medical Director
175	MM10 - Antimicrobial Prescribing Policy - V4.pdf	Pharmacy and Medicines Management	Policy	11/05/2021	01/05/2024	Charlotte Makanga (BCUHB - Pharmacy and Medicines Management)	Executive Medical Director

176	MM15 - Policy for Administration & Use of Emergency & Non Emergency Oxygen in Adults in Managed Services - V2.1.pdf	Pharmacy and Medicines Management	Policy	22/05/2019	01/02/2022	Pam Lloyd (BCUHB - Respiratory Medicine)	Executive Medical Director
177	MM16 - Guidance on the Transcription of Medicines by Registered Nurses in Exceptional Circumstances - V0.1.pdf	Pharmacy and Medicines Management	Guideline	04/03/2015	04/03/2017	Sioned Rees (BCUHB - Pharmacy)	Executive Medical Director
178	MM17 - Guidelines for the Management of Delirium in Adults 18 years and older in Acute Care and Long Term Care Settings.pdf	Pharmacy and Medicines Management; Mental Health and Learning Disabilities	Guideline	14/04/2022	14/04/2024	Elizabeth Bond (BCUHB - Pharmacy)	Executive Director of Therapies and Health Sciences
179	MM20 - Guideline for the Administration of Subcutaneous Fluids in Adult Palliative Care Patients.pdf	Nursing; Cancer and Clinical Haematology; Office of the Medical Director	Guideline	14/03/2022	01/06/2023	Caroline Usborne (BCUHB - Palliative Care)	Executive Medical Director
180	MM23 - Guidelines for Prescribing Steroids for Adults in Palliative Care - V1.1.pdf	Office of the Medical Director; Pharmacy and Medicines Management	Guideline	20/01/2022	01/02/2023	Tracy Parry (BCUHB - Pharmacy)	Executive Medical Director
181	MM25 - Standard Operating Procedure for the Supply of Take Home Naloxone Preparations - V1.0.pdf	Pharmacy and Medicines Management; Mental Health and Learning Disabilities	Procedure	12/09/2019	12/09/2022	Elizabeth Bond (BCUHB - Pharmacy)	Executive Director of Therapies and Health Sciences
182	MM26 - Guidelines on the Use of Antipsychotics in Children and Adolescents - V0.1.pdf	Pharmacy and Medicines Management	Guideline	01/11/2016	01/11/2018	Suzanne Cotter (BCUHB - Pharmacy)	Executive Medical Director
183	MM27 - Procedure for the Use of Alteplase & Urokinase via a Dysfunctional Tunnelled Haemodialysis CVC - V2.pdf	Office of the Medical Director	Procedure	01/09/2020	01/09/2022	Nick Lyons (BCUHB - Corporate Office); Stephen Stanaway (BCUHB - Diabetes & Endocrinology); Rachel Brogan (BCUHB - Renal)	Executive Medical Director
184	MM30 - Procedure for the preparation, observation, assessment & supervision of non-registered practitioners(HCSW) to undertake the administration of insulin for clinically stable named adults in community nursing.pdf	Pharmacy and Medicines Management	Procedure	01/12/2021	01/09/2024	Lisa Morris (BCUHB - Pharmacy and Medicines Management)	Executive Medical Director
185	MM36 - BCUHB Adult Lipid Modification Guideline.pdf	Pharmacy and Medicines Management	Guideline	14/03/2022	01/03/2024	Catrin Roberts (BCUHB - Pharmacy)	Executive Medical Director
186	MM37 - Medical Gases - Staff Responsibilities across BCUHB - V1.1.pdf	Pharmacy and Medicines Management	Policy	28/11/2018	01/05/2021	Andrew Merriman (BCUHB - Pharmacy)	Executive Medical Director
187	MM40 - Influenza Pandemic Plan for Distribution of Antivirals.pdf	Pharmacy and Medicines Management	Other	21/05/2019	21/05/2021	Kailey Ben-Sassi (BCUHB - Covid Vaccination Programme)	Executive Medical Director
188	MM41 - Covert Administration of Medication Clinical Policy.pdf	Pharmacy and Medicines Management	Policy	01/07/2019	01/06/2022	Elizabeth Bond (BCUHB - Pharmacy)	Executive Medical Director
189	MM42 - Unlicensed Medicines Policy - V1.pdf	Pharmacy and Medicines Management	Policy	21/05/2019	01/07/2022	Christopher Pritchard (BCUHB - Pharmacy)	Executive Medical Director
190	MM44 - Guideline for Prescribing, Preparation & Administration of Single Dose Mitomycin-C Bladder Instillations - V0.1.pdf	Pharmacy and Medicines Management	Guideline	13/03/2019	01/03/2021	Haimon Chaudhry (BCUHB - Pharmacy)	Executive Medical Director
191	MM45- Pharmacist Discharge Prescription Writing Guideline - V1.0.pdf	Pharmacy and Medicines Management	Guideline	08/11/2019	01/11/2022	Elena Jones (BCUHB - Pharmacy)	Executive Medical Director
192	MM47 - Guidance for the Use of bDMARDS & Small Molecule Agents within Rheumatology during Peri-Operative Period - V0.1.pdf	Pharmacy and Medicines Management	Guideline	18/09/2019	01/09/2022	Beccy Houston (BCUHB - Pharmacy)	Executive Medical Director
193	MM48 - Acute Management of Parkinson's Disease in Patients with Compromised Swallow or Nil by Mouth - V1.0.pdf	Pharmacy and Medicines Management	Other	12/12/2019	01/11/2022	Sue Lord (BCUHB - Pharmacy)	Executive Medical Director

194	MM49 - Protocol for the Control & Administration of Depot & Long Acting Antipsychotic Injections - V0.1.pdf	Pharmacy and Medicines Management; Mental Health and Learning Disabilities	Protocol	12/02/2015	01/02/2017	Elizabeth Bond (BCUHB - Pharmacy)	Executive Medical Director
195	MM50 - Medicines Management Guidelines for the Adult Mental Health Home Treatment Teams - V0.1.pdf	Pharmacy and Medicines Management; Mental Health and Learning Disabilities	Guideline	01/06/2016	01/01/2019	Elizabeth Bond (BCUHB - Pharmacy)	Executive Director of Therapies and Health Sciences
196	MM51 - Guideline for Monitoring Physical Health in Adults with Psychosis or Schizophrenia - V0.1.pdf	Pharmacy and Medicines Management; Mental Health and Learning Disabilities	Guideline	01/11/2017	01/11/2019	Elizabeth Bond (BCUHB - Pharmacy)	Executive Director of Therapies and Health Sciences
197	MM52 - Guideline for the Use of Antipsychotics in the Management of Behavioural & Psychological Symptoms of Dementia - V0.2.pdf	Pharmacy and Medicines Management; Mental Health and Learning Disabilities	Guideline	06/06/2018	01/07/2021	Elizabeth Bond (BCUHB - Pharmacy)	Executive Director of Therapies and Health Sciences
198	MM55 - Hafen Wen (BCUHB SMS) Inpatient Detoxificaiton Prescribing Guidelines.pdf	Pharmacy and Medicines Management; Mental Health and Learning Disabilities	Guideline	16/05/2019	01/05/2022	Elizabeth Bond (BCUHB - Pharmacy)	Executive Director of Therapies and Health Sciences
199	MM56 - Out Patient Parental Antimicrobial Therapy (OPAT) Governance Framework Guidelines - V1.0.pdf	Pharmacy and Medicines Management	Guideline	18/03/2020	01/03/2023	Charlotte Makanga (BCUHB - Pharmacy and Medicines Management);	Executive Medical Director
200	MM58 - BCUHB Guideline for the Administration of Medicines via the Subcutaneous Route in Adult Palliative Care Patients - V1.0.pdf	Pharmacy and Medicines Management	Guideline	24/04/2020	01/04/2023	Jenny Sparks (BCUHB - Pharmacy)	Executive Medical Director
201	MM60 - BCU Management of Acute Nausea & Vomiting in Adult Surgical Inpatients - V0.1.pdf	Pharmacy and Medicines Management	Guideline	14/07/2020	01/02/2023	Haimon Chaudhry (BCUHB - Pharmacy)	Executive Medical Director
202	MM64 - Clinical Guideline for the Prescribing & Administration of Intravenous Morphine in Adults with Acute Sever Pain - V1.1.pdf	Pharmacy and Medicines Management	Guideline	01/09/2020	01/09/2023	Haimon Chaudhry (BCUHB - Pharmacy)	Executive Medical Director
203	MM64A - IV Morphine in Adults Presciption Chart - V1.1.pdf	Pharmacy and Medicines Management	Other	01/01/2021	01/07/2023	Haimon Chaudhry (BCUHB - Pharmacy)	Executive Medical Director
204	MM66 - BCUHB Iloprost Infusion for Treatment of Severe Chronic Ischaemia of Lower Limb in Adults - V1.0.pdf	Pharmacy and Medicines Management	Guideline	01/09/2020	01/08/2023	Haimon Chaudhry (BCUHB - Pharmacy)	Executive Medical Director
205	MM67 - Vitamin D Deficiency & Nutritional Rickets Supplementation & Treatment in Infants and Children - V1.pdf	Pharmacy and Medicines Management	Guideline	01/09/2020	01/09/2022	Suzanne Cotter (BCUHB - Pharmacy)	Executive Medical Director
206	MM68 - Guidelines for the Use of Rapid Tranquillisation (RT) in Children aged 12 years to 17 years.pdf	Pharmacy and Medicines Management	Guideline	01/07/2020	01/07/2022	Suzanne Cotter (BCUHB - Pharmacy)	Executive Medical Director
207	MM69 - Intravenous (IV) Potassium Procedure - V1.pdf	Pharmacy and Medicines Management	Procedure	13/11/2020	01/11/2023	Karen Pritchard (BCUHB - Pharmacy)	Executive Medical Director
208	MM70 - Remifentanil Patient Controlledanalgesia (PCA) in Labour & Covid-19 Pandemic Guideline - V1.pdf	Pharmacy and Medicines Management; Mental Health and Learning Disabilities	Guideline	13/11/2020	01/11/2023	Malen Gwilym (BCUHB - Pharmacy)	Executive Medical Director
209	MM71 - Warfarin Management in Adults to Enable Safe Admission & Discharge - V2.pdf	Pharmacy and Medicines Management	Procedure	21/12/2020	01/01/2023	Catherine Strong (BCUHB - Pharmacy)	Executive Medical Director
210	MM72 - Guideline for the Use of Methoxyflurane (Penthrox) in Acute Moderate to Severe Pain in Trauma, Orthopaedics & ED - V1.pdf	Pharmacy and Medicines Management	Guideline	20/01/2021	02/12/2023	Elaine Sturman (BCUHB - Pharmacy)	Executive Medical Director
211	MM73 - Bone Health Management for Children at Risk of Fractures for Health Professionals working in Secondary Care - V1.pdf	Pharmacy and Medicines Management	Guideline	05/03/2021	01/12/2023	Suzanne Cotter (BCUHB - Pharmacy)	Executive Medical Director
212	MM74 - BCUHB Acute Pain Guidelines for Adults in Acute Care Setting - V1.0.pdf	Pharmacy and Medicines Management	Guideline	01/07/2021	01/09/2023	Haimon Chaudhry (BCUHB - Pharmacy)	Executive Medical Director

213	MM75 - Hypophosphataemia Management for Adults Inpatients.pdf	Pharmacy and Medicines Management	Guideline	01/12/2021	01/12/2023	Anest Jones (BCUHB - Pharmacy)	Executive Medical Director
214	MM76 - BCUHB Guidelines for Inpatient Management of Acute Pain or Opioid Withdrawal in Adults Dependant on Opioids.pdf	Pharmacy and Medicines Management; Mental Health and Learning Disabilities	Guideline	01/10/2021	01/11/2023	Haimon Chaudhry (BCUHB - Pharmacy); Ceri Thompson (BCUHB - Pharmacy)	Executive Director of Therapies and Health Sciences
215	MM85 - Vancomycin Dosing and Monitoring in Children Guideline - For Use on Children's Wards within Betsi Cadwaladr University Health Board.pdf	Children and Young People's services; Pharmacy and Medicines Management	Guideline	12/09/2022	01/07/2024	Suzanne Cotter (BCUHB - Pharmacy)	Executive Medical Director
216	MP01 - Chemotherapy Protocol Validation - V1.pdf	Cancer and Clinical Haematology	Protocol	01/03/2018	01/03/2020	Tracy Parry (BCUHB - Pharmacy)	Chief Operating Officer
217	MP02d - Procedure for the use of Medical Devices - V1.0.pdf	Medical Devices	Procedure	24/04/2017	01/04/2020	Patrick Hill (BCUHB - North Wales Medical Physics (inc EBME))	Executive Medical Director
218	MP02f - Disposal of Medical Devices Procedure - V1.pdf	Medical Devices	Procedure	26/06/2017	01/07/2020	Patrick Hill (BCUHB - North Wales Medical Physics (inc EBME))	Executive Medical Director
219	NST03 - Parenteral Nutrition Clinical Protocol for Adults.pdf	Nursing	Protocol	13/04/2021	13/04/2024	Ruth Davies (BCUHB - Nursing, Midwifery & Patient Services)	Executive Director of Nursing and Midwifery
220	NU01 - Discharge Policy & Protocol - V0.2.pdf	Nursing	Policy	16/01/2015	21/09/2018	Lowri Welnitschuk (BCUHB - Patient Safety)	Chief Operating Officer
221	NU05 - Student Supervison and Assessment in Practice - V1.9.pdf	Nursing	Procedure	20/09/2021	20/09/2024	Neirian Jennings (BCUHB - Corporate Nursing)	Executive Director of Nursing and Midwifery
222	NU10 - Urinary Catheterisation (Adults) Protocol - V0.1.pdf	Nursing	Protocol	13/01/2016	12/01/2018	Lisa Borders (BCUHB - Continence Service)	Executive Director of Nursing and Midwifery
223	NU16 - Guidance for Alcohol Detoxification in ED & Adult Inpatient Wards.pdf	Nursing	Other	01/10/2019	01/05/2024	Akwasi Mintah (BCUHB - Pharmacy)	Executive Director of Nursing and Midwifery
224	NU19 - Patient Transfer Procedure - V3.pdf	Nursing	Procedure	03/07/2018	09/02/2024	Eleri Roberts (BCUHB - Community Hospitals)	Executive Director of Nursing and Midwifery
225	NU21 - Levels of Enhanced Care for Adult Inpatients Policy.pdf	Nursing	Policy	15/07/2019	08/12/2023	Tracey Harris (BCUHB - Patient Safety)	Executive Director of Nursing and Midwifery
226	NU25 - Health Care Support Worker Development Framework - V5.pdf	Nursing	Other	20/09/2021	20/09/2024	Ade Evans (BCUHB - Corporate Nursing)	Executive Director of Nursing and Midwifery
227	NU32 - Guideline for Managing Continuous Subcutaneous Insulin Infusion (CSII, or 'Insulin Pump') Therapy in Adults.pdf	Nursing	Guideline	23/06/2021	01/06/2024	Iona Collins (BCUHB - Diabetes & Endocrinology)	Chief Operating Officer
228	NWCRF SOP02 - Standard Operating Procedure for Volunteer Screening and Recruitment.pdf	Research and Development	Procedure	04/10/2022	01/07/2024	Lona Tudor Jones (BCUHB - Research & Development)	Executive Medical Director
229	NWCRF SOP03 - Standard Operating Procedure for Medical Emergencies.pdf	Research and Development	Procedure	04/10/2022	01/07/2024	Orod Osanlou (BCUHB - Acute Medicine)	Executive Medical Director
230	NWCRF SOP06 - Standard Operating Procedure for Training.pdf	Research and Development	Procedure	04/10/2022	01/07/2024	Lona Tudor Jones (BCUHB - Research & Development)	Executive Medical Director
231	NWCRF SOP07 - Standard Operating Procedure - Management of Volunteer Master File.pdf	Research and Development	Procedure	04/10/2022	01/08/2024	Elizabeth Harrison (BCUHB - Research & Development)	Executive Medical Director
232	NWCRF SOP08 - Standard Operating Procedure - The Over Volunteering Prevention Scheme (TOPS).pdf	Research and Development	Procedure	04/10/2022	01/08/2024	Elizabeth Harrison (BCUHB - Research & Development)	Executive Medical Director
233	NWCRF SOP09 - Standard Operating Procedure - Consent 4 Consent (C4C) Database.pdf	Research and Development	Procedure	04/10/2022	01/07/2024	Elizabeth Harrison (BCUHB - Research & Development)	Executive Medical Director
234	NWCRF SOP11 - Standard Operating Procedure - For the Monika Prime Temperature Monitoring System.pdf	Research and Development	Procedure	04/10/2022	01/07/2024	Katharine Burton (Abergele - The Surgery (Abergele))	Executive Medical Director
235	NWCRF SOP13 - Standard Operating Procedure - for Drug and Alcohol Testing in Clinical Trials.pdf	Research and Development	Procedure	04/10/2022	01/08/2024	Katharine Burton (Abergele - The Surgery (Abergele))	Executive Medical Director

236	NWCRF SOP15 - Standard Operating Procedure - for Requesting Access to GP Records for Trial Participants.pdf	Research and Development	Procedure	04/10/2022	01/07/2024	Elizabeth Harrison (BCUHB - Research & Development)	Executive Medical Director
237	NWCRF SOP17 - North Wales Clinical Research Facility - Standard Operating Procedure - Laboratory Procedures.pdf	Research and Development	Procedure	17/01/2023	01/07/2024	Rhiannon Mackay (BCUHB - Research & Development)	Executive Medical Director
238	OBS03 - Procedure for Naming Buildings & Units of BCUHB - V2.pdf	Corporate Governance Directorate	Procedure	17/03/2021	01/03/2024	Glesni Driver (BCUHB - Corporate Office)	Director of Corporate Governance
239	OBS04 - Procedure for Co-ordinating Cabinet Secretary, Ministerial or VIP Visits & Official Openings .pdf	Communications	Procedure	28/02/2018	28/02/2021	Helen Stevens-Jones (BCUHB - Corporate Office); Elin Gwynedd (BCUHB - Corporate Office)	Chief Executive
240	OHW02 - Staff Health and Wellbeing Guidelines - V0.1.pdf	Workforce	Guideline	01/10/2017	01/10/2020	Christina Billingham (BCUHB - Child & Adolescent Health)	Executive Director of Workforce and Organisational Development
241	OP01 - Protocol for the Management of Emergency Pressures & Escalation - V0.2.pdf	Operational Management	Protocol	13/11/2014	13/10/2015	Daniel Menzies (BCUHB - Respiratory Medicine)	Chief Operating Officer
242	OP02 - Protocol for the Safe Management of Patients During Ambulance Handover- V0.1.pdf	Operational Management	Protocol	10/11/2014	10/11/2015	Imran Devji (BCUHB - Corporate Office)	Chief Operating Officer
243	OPD HTM02-01 - Medical Gas Pipeline Systems - V1.pdf	Estates	Procedure	17/07/2019	01/08/2020	Tanya Coppack (BCUHB - Estates)	Executive Director of Finance
244	OPH01 - SOP Intravitreal Injections of Anti-VEGF Medication for Macluar Disease by Non-Medical HC Practitioners - V9.pdf	Ophthalmology	Procedure	11/10/2016	11/06/2018	Alison Birch (BCUHB - Ophthalmology)	Chief Operating Officer
245	OPH02 - Protocol for Ophthalmic Nurse Practitioners alongside Medical Officer to Monitor Patients with Advanced Glaucoma - V1.pdf	Ophthalmology	Protocol	05/12/2019	05/11/2020	Lucy Bubb (BCUHB - Ophthalmology)	Chief Operating Officer
246	OPH03 - Protocol for Ophthalmic Nurse Practitioners Working in Glaucoma Operational Diagnostic Treatment Centre Clinic - V1.pdf	Ophthalmology	Protocol	05/12/2019	05/12/2020	Lucy Bubb (BCUHB - Ophthalmology)	Chief Operating Officer
247	PA01 - Procedure for Point of Care Testing (PoCT) - V0.1.pdf	Pathology	Procedure	11/02/2014	05/01/2017	Geoffrey Armstrong (BCUHB - Clinical Biochemistry Services)	Chief Operating Officer
248	PA04 - Pathology Standard Operating Procedure for Research & Development Studies & Clinical Trials - V7.pdf	Research and Development	Procedure	08/10/2020	01/09/2022	Bernadette Astbury (BCUHB - Pathology)	Executive Medical Director
249	PCSM01 - Clinical Protocol for Shingles Vaccination by Community Nurses - V0.1.pdf	Primary Care and Specialist Medicine	Protocol	01/02/2015	01/06/2018	Leigh Pusey (BCUHB - Health Visiting)	Chief Operating Officer
250	PCSM02 - Clinical Protocol for Influenza & Pneumococcal Vaccination by Nurses - V0.1.pdf	Primary Care and Specialist Medicine	Protocol	01/02/2015	01/06/2018	Leigh Pusey (BCUHB - Health Visiting)	Chief Operating Officer
251	PCT01 - SOP for Clinical Trials - Pharmacy Clinical Trials Procedure - V1.5.pdf	Pharmacy and Medicines Management; Research and Development	Procedure	01/06/2021	01/06/2024	Geraldine Mccaffrey (BCUHB - Pharmacy)	Executive Medical Director
252	PCT02 - SOP for Clinical Trials - Emergency Code Breaking Procedure - V1.1.pdf	Research and Development; Pharmacy and Medicines Management	Procedure	01/09/2020	01/08/2023	Geraldine Mccaffrey (BCUHB - Pharmacy)	Executive Medical Director
253	PCT03 - SOP for Clinical Trials - Writing & Testing of Emergency Unblinding Procedures - V1.1.pdf	Research and Development; Pharmacy and Medicines Management	Procedure	01/09/2020	01/08/2023	Nick Lyons (BCUHB - Corporate Office)	Executive Medical Director
254	PCT05 - SOP for Clinical Trials - Storage of Clinical Trials Medication Outside a Pharmacy Department - V1.0.pdf	Pharmacy and Medicines Management	Procedure	01/10/2020	01/10/2023	Geraldine Mccaffrey (BCUHB - Pharmacy)	Executive Medical Director
255	PCT06 - SOP for Clinical Trials - Clinical Trials Prescriptions - V1.0.pdf	Pharmacy and Medicines Management	Procedure	01/06/2021	01/03/2024	Geraldine Mccaffrey (BCUHB - Pharmacy)	Executive Medical Director
256	PCT08 - SOP for Clinical Trials - Pharmacy Van Transport of Investigational Medicinal Products between BCUHB Pharmacy Departments - V1.0.pdf	Pharmacy and Medicines Management	Procedure	01/06/2021	01/04/2024	Geraldine Mccaffrey (BCUHB - Pharmacy)	Executive Medical Director
257	PCT09 - SOP for Clinical Trials - Code Break Envelopes - V1.0.pdf	Pharmacy and Medicines Management	Procedure	01/06/2021	01/06/2024	Geraldine Mccaffrey (BCUHB - Pharmacy)	Executive Medical Director

258	PCT10 - SOP for Clinical Trials - Pharmacist Clinical Validation of Clinical Trials Prescriptions - V1.0.pdf	Pharmacy and Medicines Management	Procedure	01/06/2021	01/04/2024	Geraldine Mccaffrey (BCUHB - Pharmacy)	Executive Medical Director
259	PCT11 - SOP for Clinical Trials - Dispensing Clinical Trials Prescriptions - V1.0.pdf	Pharmacy and Medicines Management	Procedure	01/06/2021	01/06/2024	Geraldine Mccaffrey (BCUHB - Pharmacy)	Executive Medical Director
260	PCT12 - SOP for Clinical Trials - Accuracy Checking Clinical Trials Prescriptions - V1.0.pdf	Pharmacy and Medicines Management	Procedure	01/06/2021	01/06/2024	Geraldine Mccaffrey (BCUHB - Pharmacy)	Executive Medical Director
261	PCTF01 - Emergency Unbinding Form - V1.doc	Pharmacy and Medicines Management	Other	01/06/2021	01/06/2024	Geraldine Mccaffrey (BCUHB - Pharmacy)	Executive Medical Director
262	PCTF02 - Pharmacy Research CV - V1.doc	Pharmacy and Medicines Management	Other	01/09/2020	01/08/2023	Geraldine Mccaffrey (BCUHB - Pharmacy)	Executive Medical Director
263	PCTF03 - Remote Storage Assessment Form - V1.docx	Pharmacy and Medicines Management	Other	01/09/2020	01/08/2023	Geraldine Mccaffrey (BCUHB - Pharmacy)	Executive Medical Director
264	PCTF04 - Remote IMP Monitoring Log - V1.docx	Pharmacy and Medicines Management	Other	01/09/2020	01/08/2023	Geraldine Mccaffrey (BCUHB - Pharmacy)	Executive Medical Director
265	PCTF05 - Production of Code Break Envelopes Form - V1.doc	Pharmacy and Medicines Management	Other	01/10/2020	01/10/2023	Geraldine Mccaffrey (BCUHB - Pharmacy)	Executive Medical Director
266	PCTF06 - Receipt of Code Break Envelopes Form - V1.doc	Pharmacy and Medicines Management	Other	01/06/2021	01/03/2024	Geraldine Mccaffrey (BCUHB - Pharmacy)	Executive Medical Director
267	PCTF07 - Distribution of Code Break Envelopes Form - V1.doc	Pharmacy and Medicines Management	Other	01/04/2021	01/02/2024	Geraldine Mccaffrey (BCUHB - Pharmacy)	Executive Medical Director
268	PCTF08 - Investigational Medicinal Product Site to Site Transfer Form - V1.doc	Pharmacy and Medicines Management	Other	01/06/2021	01/04/2024	Geraldine Mccaffrey (BCUHB - Pharmacy)	Executive Medical Director
269	PCTF09 - ACT File Note - V1.doc	Pharmacy and Medicines Management	Other	01/06/2021	01/06/2024	Geraldine Mccaffrey (BCUHB - Pharmacy)	Executive Medical Director
270	PCTT01 - Clinical Trials Prescription Template - V1.doc	Pharmacy and Medicines Management	Other	01/06/2021	01/06/2024	Geraldine Mccaffrey (BCUHB - Pharmacy)	Executive Medical Director
271	Procedure for the Placement and Removal of a Nasal Bridle.pdf	Nursing	Procedure	30/09/2021	30/09/2024	Jennifer Wykes (BCUHB - Nursing, Midwifery & Patient Services)	Executive Director of Nursing and Midwifery
272	Procedure for the Transfer of Blood & Blood Components between Hospitals - V4.0.pdf	Pathology	Policy	01/06/2019	01/06/2022	Imran Devji (BCUHB - Corporate Office)	Chief Operating Officer
273	PTH-TR-1008 - Blood and Blood Component Requesting and Authorisation Procedure - V2.0.pdf	Pathology	Procedure	23/09/2020	23/09/2022	Imran Devji (BCUHB - Corporate Office)	Chief Operating Officer
274	PTH-TR-POL602 - Blood and Blood Components Transfusion Collection & Administration Policy - V2.0.pdf	Pathology	Policy	17/11/2021	17/11/2022	Imran Devji (BCUHB - Corporate Office)	Chief Operating Officer
275	PTR02 - Claims Management Policy.pdf	Quality, Patient safety and Experience	Policy	02/05/2013	05/06/2017	Matthew Joyes (BCUHB - Quality Directorate)	Executive Director of Nursing and Midwifery
276	QA04 - Research Contracts & Vendors - Health Research - Standard Operating Procedure.pdf	Research and Development	Procedure	14/04/2022	14/04/2024	Lona Tudor Jones (BCUHB - Research & Development)	Executive Medical Director
277	R01 - SOP for Reporting of Deviations and breaches of protocol or GCP.pdf	Research and Development	Procedure	02/08/2022	02/08/2024	Lynne Grundy (BCUHB - Research & Development)	Executive Medical Director
278	RAD 036 - Operation of Mobile Mini C-Arm X-Ray Fluroscopy Equipment Outside Radiology - V2.pdf	Radiology	Other	12/09/2019	12/08/2021	Pat Youds (BCUHB - Radiology)	Chief Operating Officer
279	RAD IR 083 - Procedure for Entitlement of IR(ME)R Functions to Perform Endovascular Procedures by Vascular Surgeons without a Consultant Radiologist being Present and Use of the Hybrid Theatre.pdf	Radiology	Procedure	14/04/2022	01/02/2024	Helen Hughes (BCUHB - Radiology)	Chief Operating Officer
280	RAD NM 024 - Transport of Radioactive Materials within BCUHB Joint Working Procedure - V1.pdf	Radiology	Procedure	12/09/2020	14/01/2021	David Jones (BCUHB - Radiology)	Chief Operating Officer
281	RD03 - Policy for Intellectual Property - V2.pdf	Research and Development	Policy	02/09/2020	01/08/2022	Lona Tudor Jones (BCUHB - Research & Development)	Executive Medical Director

282	RD04 - NHS R&D Finance Policy - V1.0.pdf	Research and Development	Policy	28/07/2017	20/07/2019	Lona Tudor Jones (BCUHB - Research & Development)	Executive Medical Director
283	RP01 - Ionising Radiation Protection Policy - V4.pdf	Radiation Protection	Policy	07/09/2021	03/06/2024	Peter Hiles (BCUHB - North Wales Medical Physics (inc EBME))	Executive Director of Therapies and Health Sciences
284	S01 - SOP for Urgent Safety Measures in Research.pdf	Research and Development	Procedure	02/08/2022	02/08/2024	Lynne Grundy (BCUHB - Research & Development)	Executive Medical Director
285	S02 - SOP for Safety Reporting in Research.pdf	Research and Development	Procedure	02/08/2022	02/08/2024	Nick Lyons (BCUHB - Corporate Office)	Executive Medical Director
286	Safe Use of Step Ladders and Kick Stools - V7.pdf	Health and Safety	Other	01/04/2021	01/04/2024	Jason Brannan (BCUHB - Workforce & Organisational Development)	Executive Director of Workforce and Organisational Development
287	SCH03 - SOP for the Management of Children & Young People at a Hospital Setting due to Self Harm & Suicidal Behaviour - V1.pdf	Children and Young People's services; Mental Health and Learning Disabilities	Procedure	01/03/2012	01/08/2013	Marilyn Wells (BCUHB - Child & Adolescent Health)	Chief Operating Officer
288	SCH14 - Procedure for the Safeguarding Children and Young People Admitted to Adult Wards & Environments - V1.pdf	Safeguarding	Procedure	20/09/2021	20/09/2024	Chris Weaver (BCUHB - Safeguarding)	Executive Director of Nursing and Midwifery
289	SCH18 - Coping with Crying Guidance - V2.pdf	Safeguarding; Women's Directorate	Other	14/09/2020	14/09/2023	Anna Davies (BCUHB - Safeguarding)	Chief Operating Officer
290	SFHCC09 - Enable Individuals to Effectively Evacuate their Bowels.pdf	Nursing	Other	01/07/2019	01/07/2021	Lisa Borders (BCUHB - Continence Service)	Executive Director of Nursing and Midwifery
291	SH09 - SOP for School Nursing Service for Children who are on Elective Home Education - V0.1.pdf	Children and Young People's services	Procedure	06/12/2013	01/01/2016	Imran Devji (BCUHB - Corporate Office)	Chief Operating Officer
292	SOP for Cleaning & Disinfection of JSP Force 8 Corpro Respirator Half Mask with Filters - V1.02.pdf	Health and Safety; Infection Prevention and Control	Procedure	04/06/2020	31/05/2022	Jason Brannan (BCUHB - Workforce & Organisational Development)	Executive Director of Workforce and Organisational Development
293	SOP1 - Referral, Triage and Allocation process for Stroke Rehabilitation Pathway- Early Supported Discharge (ESD) & Stroke Specialist Inpatient Rehabilitation (SSIR).pdf	Therapies and Health Sciences	Procedure	14/02/2023	03/11/2023	Sushmita Mohapatra (BCUHB - Therapies & Health Science)	Executive Director of Therapies and Health Sciences
294	SOP2 - Early Supported Discharge Multi-Disciplinary Team process for Stroke Rehabilitation Pathway.pdf	Therapies and Health Sciences	Procedure	14/02/2023	03/11/2023	Sushmita Mohapatra (BCUHB - Therapies & Health Science)	Executive Director of Therapies and Health Sciences
295	SOP3 - Discharge process for Stroke Rehabilitation Pathway- Early Supported Discharge (ESD).pdf	Therapies and Health Sciences	Procedure	14/02/2023	03/11/2023	Sushmita Mohapatra (BCUHB - Therapies & Health Science)	Executive Director of Therapies and Health Sciences
296	SOP4 - Multi-Disciplinary Team (MDT) process for Stroke Rehabilitation Pathway- Stroke Specialist Inpatient Rehabilitation (SSIR).pdf	Therapies and Health Sciences	Procedure	14/02/2023	03/11/2023	Karl Jackson (BCUHB - Stroke Unit)	Executive Director of Therapies and Health Sciences
297	SOP5 - Discharge process for Stroke Rehabilitation Pathway- SSIR.pdf	Therapies and Health Sciences	Procedure	14/02/2023	03/11/2023	Sushmita Mohapatra (BCUHB - Therapies & Health Science)	Executive Director of Therapies and Health Sciences
298	Steroid Tapering Guidance.pdf	Cancer and Clinical Haematology	Other	20/12/2018	20/12/2021	Imran Devji (BCUHB - Corporate Office)	Chief Operating Officer
299	Stroke Thrombolysis Protocol - V4.pdf	Nursing; Office of the Medical Director	Protocol	08/09/2018	04/09/2021	Janet Michell (BCUHB - Corporate Office)	Executive Director of Nursing and Midwifery
300	TM01 - Participant Information Sheets and Informed Consent - Health Research - Standard Operating Procedure.pdf	Research and Development	Procedure	14/04/2022	14/04/2024	Lona Tudor Jones (BCUHB - Research & Development)	Executive Medical Director
301	TM04 - Procedure for Delegating Duties in Research - Health Research - Standard Operating Procedure.pdf	Research and Development	Procedure	14/04/2022	14/04/2024	Lona Tudor Jones (BCUHB - Research & Development)	Executive Medical Director
302	TM14 - SOP for Study Version and Document Control.pdf	Research and Development	Procedure	02/08/2022	02/08/2024	Alice Jones-Blunt (BCUHB - Research & Development)	Executive Medical Director
303	TU1 - Policy & Procedure for Top up Payments - V0.2.pdf	Pharmacy and Medicines Management	Policy	28/08/2012	01/05/2017	Hannah Greaves (BCUHB - Pharmacy)	Executive Medical Director

304	Welsh Language Standards Regulations 2018.pdf	Welsh Language	Other	14/09/2018	14/09/2023	Eleri Hughes-Jones (BCUHB - Welsh Language Services)	HB Lead for MHLD and Welsh Language
305	WP11 - NHS Wales Managing Attendance at Work Policy - V0.1.pdf	Workforce	Policy	01/10/2018	01/10/2021	Jason Brannan (BCUHB - Workforce & Organisational Development)	Executive Director of Workforce and Organisational Development
306	WP14a - Interim Protocol on Pay While Undertaking Jury Service and the Recovery of Loss of Earnings - V1.pdf	Workforce	Protocol	01/03/2015	01/04/2016	Jason Brannan (BCUHB - Workforce & Organisational Development)	Executive Director of Workforce and Organisational Development
307	WP14c - BCU Shared Parental Leave Procedure Final v1 (Dec15).pdf	Workforce	Procedure	01/12/2015	01/12/2018	Christina Billingham (BCUHB - Child & Adolescent Health)	Executive Director of Workforce and Organisational Development
308	WP15 - BCUHB Partnership and Recognition Agreement - V1.pdf	Workforce	Other	01/02/2010	01/04/2011	Jason Brannan (BCUHB - Workforce & Organisational Development)	Executive Director of Workforce and Organisational Development
309	WP2 - Retirement Policy Procedure - V6 .pdf	Workforce	Procedure	01/11/2015	01/11/2021	Jason Brannan (BCUHB - Workforce & Organisational Development)	Executive Director of Workforce and Organisational Development
310	WP21 - Working Time Procedure.pdf	Workforce	Procedure	01/03/2015	01/03/2018	Llinos Jones (BCUHB - Workforce & Organisational Development)	Executive Director of Workforce and Organisational Development
311	WP22 - BCU Mufti Allowance Procedure - Final v1 (Oct14).pdf	Workforce	Procedure	01/10/2014	01/10/2017	Jason Brannan (BCUHB - Workforce & Organisational Development)	Executive Director of Workforce and Organisational Development
312	WP23-BCUHB Procedure for Checking of Registrations & Qualifications V3.pdf	Workforce	Procedure	01/11/2015	01/10/2018	Jason Brannan (BCUHB - Workforce & Organisational Development)	Executive Director of Workforce and Organisational Development
313	WP24b - BCUHB Gateway Protocol for the NHS Knowledge & Skills Framework- V1.pdf	Workforce	Protocol	12/09/2013	01/10/2014	Jason Brannan (BCUHB - Workforce & Organisational Development)	Executive Director of Workforce and Organisational Development
314	WP29 - BCU Relocation Expenses Policy V0.3.pdf	Workforce	Policy	05/12/2016	05/12/2019	Karen Walker (BCUHB - Workforce & Organisational Development)	Executive Director of Workforce and Organisational Development
315	WP2b - BCUHB Options for staff considering accessing their NHS pension and continuing working in the Health Board - V1 .pdf	Workforce	Other	01/11/2013	01/11/2021	Jason Brannan (BCUHB - Workforce & Organisational Development)	Executive Director of Workforce and Organisational Development
316	WP30 - Statutory Mandatory Training Policy and Procedure - V0.3.pdf	Workforce	Policy	22/03/2016	01/02/2022	Tracey Eccles (BCUHB - Workforce & Organisational Development)	Executive Director of Workforce and Organisational Development
317	WP41 - Recruitment and Retention Payment Protocol - V3.pdf	Workforce	Protocol	01/11/2020	01/11/2023	Jason Brannan (BCUHB - Workforce & Organisational Development)	Executive Director of Workforce and Organisational Development
318	WP42 - Guidance on Dealing with Hate Incidents Crimes Against BCUHB Staff.pdf	Workforce	Guideline	01/08/2021	01/06/2024	Nick Such (BCUHB - Workforce & Organisational Development)	Executive Director of Workforce and Organisational Development
319	WP43 - Guidelines to Support Trans and gender diverse Staff in BCUHB .pdf	Workforce	Guideline	20/08/2021	20/08/2024	Nick Such (BCUHB - Workforce & Organisational Development)	Executive Director of Workforce and Organisational Development
320	WP46 - BCU Additional Annual Leave Purchase Scheme Procedure - V4.pdf	Workforce	Procedure	01/07/2018	01/08/2021	Jason Brannan (BCUHB - Workforce & Organisational Development)	Executive Director of Workforce and Organisational Development
321	WP47 - BCUHB Telephone Line Rental Procedure - V1.pdf	Workforce	Procedure	01/06/2015	01/04/2018	Claire Waddicor-Evans (BCUHB - Transformation & Improvement)	Executive Director of Workforce and Organisational Development
322	WP4A - Procedure for NHS Staff to Raise Concerns - V5.pdf	Workforce	Procedure	01/06/2021	01/06/2024	Jason Brannan (BCUHB - Workforce & Organisational Development)	Executive Director of Workforce and Organisational Development

323	WP51 - Bilingual Skills Policy & Procedure -V0.1.doc.pdf	Welsh Language	Policy	18/12/2020	15/09/2023	Eleri Hughes-Jones (BCUHB - Welsh Language Services)	HB Lead for MHLD and Welsh Language
324	WP52 - Study Leave Policy - (Applies to all staff apart from Medical & Dental) - V0.2.pdf	Workforce	Policy	11/04/2016	01/01/2018	Nia Thomas (BCUHB - Workforce & Organisational Development)	Executive Director of Workforce and Organisational Development
325	WP54 - Study Leave Process (Applies to all staff apart from Medical & Dental) - V0.2.pdf	Workforce	Other	11/04/2016	01/01/2018	Nia Thomas (BCUHB - Workforce & Organisational Development)	Executive Director of Workforce and Organisational Development
326	WP56 - Procedure for the Management of the Larger Person.pdf	Workforce; Health and Safety	Procedure	01/02/2016	01/06/2020	Tracey Eccles (BCUHB - Workforce & Organisational Development)	Executive Director of Workforce and Organisational Development
327	WP58 - Electronic Staff Record (ESR) System Policy - V0.1.pdf	Workforce	Policy	01/05/2016	01/06/2019	Jason Brannan (BCUHB - Workforce & Organisational Development)	Executive Director of Workforce and Organisational Development
328	WP59 - Personal Employee Record Management Procedure - V0.1.pdf	Workforce	Procedure	01/10/2017	01/10/2020	Jason Brannan (BCUHB - Workforce & Organisational Development)	Executive Director of Workforce and Organisational Development
329	WP60 - Exit Interview Procedure & Questionnaire V7.1 - Read only.doc	Workforce	Procedure	12/11/2018	01/10/2020	Angela Johnson (BCUHB - Workforce & Organisational Development)	Executive Director of Workforce and Organisational Development
330	WP62 - BCUHB Dress Code Guidelines.pdf	Workforce	Guideline	22/07/2021	22/07/2024	Anne-Marie Rowlands (BCUHB - Corporate Nursing)	Executive Director of Workforce and Organisational Development
331	WP9 - Disciplinary Policy.pdf	Workforce	Policy	01/11/2015	01/03/2020	Jason Brannan (BCUHB - Workforce & Organisational Development)	Executive Director of Workforce and Organisational Development

POLICIES AND WRITTEN CONTROL DOCUMENTS FOR REVIEW IN Q2 2024/25
AS AT 02/10/2024

	Name	Category	Policy type	Effective Date	Review Date	Author	Responsible Director	Qtr for Review	Amended Qtr for review	Updates received
1	AL01 - Financial Procedures - V1.11.pdf	Charities and Volunteers	Procedure	09/09/2019	09/09/2022	Neil Williams (BCUHB - Finance)	Executive Director of Finance	Q2 2024/25	To be removed	No longer exists - incorporated into AL02 - need Exec approval to remove from System
2	AL02 - Fund Advisor Handbook & Accountability Agreements - V1.pdf	Charities and Volunteers	Other	01/01/2017	01/01/2018	Kirsty Thomson (BCUHB - Corporate Services)	Executive Director of Finance	Q2 2024/25	Q3 2024/25	Consultation on BetsiNet - renamed to 'Your Charity Procedures'. Now incorporates AL01 - therefore moved to Q3 2024/25.
3	B02 - Risk Assessment of Health Research - Health Research - Standard Operating Procedure.pdf	Research and Development	Procedure	14/07/2021	14/04/2024	Lona Tudor Jones (BCUHB - Research & Development)	Executive Medical Director	Q2 2024/25	Q3 2024/25	For November CEG meeting - therefore moved to Q3 2024/25
4	B04 - SOP for Fraud and Misconduct in Research.pdf	Research and Development	Procedure	02/08/2022	02/08/2024	Lynne Grundy (BCUHB - Research & Development)	Executive Medical Director	Q2 2024/25	Q3 2024/25	For November CEG meeting - therefore moved to Q3 2024/25
5	B05 - Identifying Participants in Clinical Trials – Patient Medical Casenotes - Health Research - Standard Operating Procedure.pdf	Research and Development	Procedure	14/04/2022	14/04/2024	Lona Tudor Jones (BCUHB - Research & Development)	Executive Medical Director	Q2 2024/25	Q3 2024/25	For November CEG meeting - therefore moved to Q3 2024/25
6	DEM_PHOT 01 - BCUHB Phototherapy Guideline.pdf	Nursing; Therapies and Health Sciences	Guideline	20/05/2021	20/05/2023	Sali Anderson (BCUHB - Dermatology)	Executive Director of Allied Health Professions and Health Science	Q2 2024/25	Q4 2024/25	Updated to Q4 2024/25
7	F04 - Cash Collection Receipting and Banking Arrangements - V0.2.pdf	Finance	Procedure	14/07/2017	19/07/2019	Simon Weaver (BCUHB - Finance)	Executive Director of Finance	Q2 2024/25	Q3 2024/25	Awaiting Executive Director of Finance sign-off - therefore moved to Q3 2024/25.
8	F05 - Income and Debt Recovery - V0.2.pdf	Finance	Procedure	02/02/2017	15/02/2019	Simon Weaver (BCUHB - Finance)	Executive Director of Finance	Q2 2024/25	Q3 2024/25	Awaiting Executive Director of Finance sign-off - therefore moved to Q3 2024/25.
9	F07 - Petty Cash Procedure- V0.2.pdf	Finance	Procedure	25/07/2017	19/07/2019	Simon Weaver (BCUHB - Finance)	Executive Director of Finance	Q2 2024/25	Q3 2024/25	Awaiting Executive Director of Finance sign-off - therefore moved to Q3 2024/25.
10	F08 - Purchasing Card Procedure - V0.2.pdf	Finance	Procedure	02/02/2017	15/02/2019	Simon Weaver (BCUHB - Finance)	Executive Director of Finance	Q2 2024/25	Q3 2024/25	Currently for consultation on the Draft policies page, end date of 06/10/2024, then sent to the Directors of Finance for review / sign off next week- therefore moved to Q3 2024/25.
11	F13 - Procedure For Use and Completion of Request To Waive SFIs - V0.1.pdf	Finance	Procedure	07/03/2018	17/01/2020	Neil Williams (BCUHB - Finance)	Executive Director of Finance	Q2 2024/25	Q3 2024/25	Awaiting Executive Director of Finance sign-off - therefore moved to Q3 2024/25.
12	F16 - Arranging a Hospital Funeral - V0.1.pdf	Finance	Procedure	14/12/2018	18/12/2020	Simon Weaver (BCUHB - Finance)	Executive Director of Finance	Q2 2024/25	Q4 2024/25	Review has been 'swapped' with that of F09 - 'Reimbursement of hospital travel costs', which was down to be updated later in the year. F09 was considered more pressing and has been through the various consultation stages as per the 4 procedures above and is also with the Directors of Finance for review / sign off. F16 will now be updated later in the year. Now for Q4 2024/25 review
13	IG07 - Procedure for Dealing with SARs Under Data Protection Legislation - V9.pdf	Information Governance	Procedure	19/08/2021	01/07/2024	Lisa Parry (BCUHB - Digital, Data and Technology)	Chief Digital Information Officer	Q2 2024/25	Q3 2024/25	It one of quite a few which are being reviewed and sent for consultation imminently with a view to being presented for approval at the next IGG in November - therefore moved to Q3 2024/25.
14	ISU02 - Patient, Service User & Carer Procedure for the Production of Written Information - V4.02.pdf	Quality, Patient safety and Experience	Procedure	12/06/2020	16/06/2023	Leon Marsh (BCUHB - Nursing, Midwifery & Patient Services)	Executive Director of Nursing and Midwifery	Q2 2024/25	Q3 2024/25	Due to be submitted to Patient & Carer Experience Group on 17/10/24 for approval - therefore moved to Q3 2024/25.
15	ISUE01 - Undertaking Patient Experience Stories - V2.0.pdf	Quality, Patient safety and Experience	Other	29/04/2021	14/04/2023	Leon Marsh (BCUHB - Nursing, Midwifery & Patient Services)	Executive Director of Nursing and Midwifery	Q2 2024/25	Q3 2024/25	Due to be submitted to Patient & Carer Experience Group on 17/10/24 for approval- therefore moved to Q3 2024/25.
16	Mat 06 - Supporting Births in Community Settings - V2.2.pdf	Women's Directorate	Other	01/05/2020	01/06/2021	Imran Devji (BCUHB - Corporate Office)	Chief Operating Officer	Q2 2024/25	Q3 2024/25	Fully complete through the approvals process, just awaiting EQIA to be completed for an All Wales WCD that's embedded within the document - therefore moved to Q3 2024/25.
17	Mat 29 - Twin and Triplet Pregnancies in the Antetnatal Period - V2.pdf	Women's Directorate	Guideline	01/12/2020	01/12/2023	Bidyut Kumar (BCUHB - Obstetrics & Gynaecology)	Chief Operating Officer	Q2 2024/25	Q3 2024/25	Fully complete through the approvals process, just at BCU Policies QA stage - IAST date to be included on front cover - therefore moved to Q3 2024/25.
18	Mat 43 - External Cephalic Version at Term - V2.pdf	Women's Directorate	Guideline	01/12/2020	01/12/2023	Devjani Das (BCUHB - Obstetrics & Gynaecology); Masroor Cheema (Ysbyty Gwynedd - W042)	Chief Operating Officer	Q2 2024/25	Q3 2024/25	Currently out for full peer review consultation closing on 01/11/24 - therefore moved to Q3 2024/25.

19	Mat 45 - Intermittent Auscultation of the Fetal Heart in Labour - V1.pdf	Women's Directorate	Other	01/01/2021	01/01/2024	Imran Devji (BCUHB - Corporate Office)	Chief Operating Officer	Q2 2024/25	Q3 2024/25	Author working on review of WCD ASAP - therefore moved to Q3 2024/25.
20	Mat 54 - ROM Plus Point of Care Testing for Rupture of Membranes - Standard Operating Procedure - V1.pdf	Women's Directorate	Procedure	27/03/2020	27/03/2023	Niladri Sengupta (BCUHB - Obstetrics & Gynaecology)	Chief Operating Officer	Q2 2024/25	Q3 2024/25	Awaiting Equality Team to review EQIA then ready for BCU Policies to load as been approved at local Womens Services Board meeting - therefore moved to Q3 2024/25.
21	Mat 58 - Swab, Instrument and Needle Count within Maternity Care Settings - V4.pdf	Women's Directorate	Guideline	01/03/2020	01/03/2023	Julie Reeve (BCUHB - Obstetrics & Gynaecology)	Chief Operating Officer	Q2 2024/25	Q3 2024/25	Fully complete through the approvals process, just at BCU Policies QA stage - IAST date to be included on front cover - therefore moved to Q3 2024/25.
22	Mat 63 - Umbilical Cord Blood Collection for the Harvesting of Stem Cells - V3.pdf	Women's Directorate	Other	01/12/2020	01/12/2023	Bethan Evans (BCUHB - Maternity)	Chief Operating Officer	Q2 2024/25	Q3 2024/25	Fully complete through the approvals process, just at BCU Policies QA stage - IAST date to be included on front cover - therefore moved to Q3 2024/25.
23	Mat 70 - Neonatal Examination of the Newborn by Midwives - V3.pdf	Women's Directorate	Guideline	24/05/2019	01/06/2022	Meinir Clayton Evans (BCUHB - Maternity)	Chief Operating Officer	Q2 2024/25	Q3 2024/25	WCD been updated and started to go through governance meetings for review/ approval but query regarding All Wales document - therefore moved to Q3 2024/25.
24	Mat 74 - BCUHB Breastfeeding Policy.pdf	Children and Young People's services; Women's Directorate; Workforce	Policy	01/12/2020	01/12/2023	Sharon Breward (BCUHB - Maternity)	Chief Operating Officer	Q2 2024/25	Q3 2024/25	Fully complete through the approvals process, just at BCU Policies QA stage - IAST date to be included on front cover - therefore moved to Q3 2024/25.
25	Mat 75 - Healthy Term Babies who are Reluctant to Feed in the Early Postnatal Period - V6.pdf	Women's Directorate	Guideline	01/12/2020	01/12/2023	Sharon Breward (BCUHB - Maternity)	Chief Operating Officer	Q2 2024/25	Q3 2024/25	Fully complete through the approvals process, been QA'd by BCU Policies - queries sent back to author - therefore moved to Q3 2024/25.
26	Mat 77 - Infant Feeding Guideline (Unicef Baby Friendly Care Standards) - V2.pdf	Women's Directorate	Guideline	01/12/2020	01/12/2023	Sharon Breward (BCUHB - Maternity)	Chief Operating Officer	Q2 2024/25	Q3 2024/25	Awaiting SCEG meeting review/ approval - therefore moved to Q3 2024/25.
27	Mat 79 - Breastfeeding Peer Supporters as Volunteers in BCUHB - V4.pdf	Women's Directorate	Guideline	01/07/2020	01/08/2023	Sharon Breward (BCUHB - Maternity)	Chief Operating Officer	Q2 2024/25	Q3 2024/25	Awaiting Childrens Services review/ approval - therefore moved to Q3 2024/25.
28	Mat 80 - Antenatal Hand Expressing of Colostrum - V3.pdf	Women's Directorate	Guideline	01/12/2020	01/12/2023	Sharon Breward (BCUHB - Maternity)	Chief Operating Officer	Q2 2024/25	Q3 2024/25	Fully complete through the approvals process, just at BCU Policies QA stage - IAST date to be included on front cover - therefore moved to Q3 2024/25.
29	Mat 82 - Handover of Care Guideline - V3.pdf	Women's Directorate	Guideline	01/02/2021	01/03/2024	Julie Reeve (BCUHB - Obstetrics & Gynaecology)	Chief Operating Officer	Q2 2024/25	Q3 2024/25	Currently out for full peer review consultation - author reviewing comments and updating WCD - therefore moved to Q3 2024/25.
30	Mat 86 - Maternal Mental Health Guideline.pdf	Women's Directorate; Mental Health and Learning Disabilities	Guideline	01/01/2020	01/01/2023	Imran Devji (BCUHB - Corporate Office)	Chief Operating Officer	Q2 2024/25	Q3 2024/25	Awaiting Pharmacy review/ approval - therefore moved to Q3 2024/25.
31	Mat 87 - Maternal Death Guideline - V3.pdf	Women's Directorate	Guideline	01/12/2020	01/12/2023	Heledd Jones (BCUHB - Maternity)	Chief Operating Officer	Q2 2024/25	Q3 2024/25	WCD has been updated - I have requested document to progress to peer review consultation for comment - therefore moved to Q3 2024/25.
32	Mat 89 - Bereavement Follow Up Appointments following Pregnancy Loss - Standard Operating Procedure - V1.pdf	Women's Directorate	Procedure	01/11/2020	01/12/2023	Lucy Dobbins (BCUHB - Maternity)	Chief Operating Officer	Q2 2024/25	Q3 2024/25	WCD fully approved - just awaiting EQIA document completion and date to add to front cover - therefore moved to Q3 2024/25.
33	Mat 91 - Preceptorship Protocol for Newly Registered Midwives - V3.pdf	Women's Directorate	Protocol	01/12/2020	01/12/2023	Becky Ferneyhough (BCUHB - Maternity)	Chief Operating Officer	Q2 2024/25	Q3 2024/25	To be archived once 'Once for Wales' document is live on intranet - therefore moved to Q3 2024/25.
34	MD07 - Protocol for Using Bed Rails Safety and Effectively.pdf	Nursing	Protocol	22/06/2023	01/08/2024	Diane Read (BCUHB - Nursing, Midwifery & Patient Services)	Executive Director of Nursing and Midwifery	Q2 2024/25	Q3 2024/25	Lowri reviewing the amendments prior to coming to the HB PSG with her expertise. The risk assessment has been streamlined and shared with membership with the Falls group and bed and mattress group for comment. We are expecting will be ready for the October Health Board PSG for approval - therefore moved to Q3 2024/25.
35	MD09 - Medical & Dental Staff - Sabbatical Leave Policy - V0.2.pdf	Office of the Medical Director	Policy	31/03/2017	31/03/2018	James Risley (BCUHB - Office of the Medical Director)	Executive Medical Director	Q2 2024/25	Q3 2024/25	On intranet under consultation now should be going through process and meetings soon - move to Q3 please
36	MD24 - Recognition of Life Extinct for Adults in the Community - V1.0.pdf	Office of the Medical Director	Guideline	10/07/2020	10/07/2021	Melanie Maxwell (BCUHB - Office of the Medical Director)	Executive Medical Director	Q2 2024/25	Removed	Written specifically for the Covid pandemic - superseded with VOD policy, approval to remove received from James Risley.

37	MH02 - Procedure for Exceptional Admission of Children under 18 to an Acute Psychiatric Inpatient Unit.pdf	Mental Health and Learning Disabilities; Safeguarding	Procedure	01/12/2020	01/12/2023	Adrian Jones (BCUHB - Mental Health & Learning Disabilities)	Executive Director of Allied Health Professions and Health Science	Q2 2024/25	Q3 2024/25	Submitted to OBS 19/09 for upload - therefore moved to Q3 2024/25.
38	MHLD 0002 DRAFT - Seclusion & Long Term Segregation Policy -V0.2.pdf	Mental Health and Learning Disabilities	Policy	01/09/2020	01/09/2023	Teresa Owen (BCUHB - Corporate Office)	Executive Director of Allied Health Professions and Health Science	Q2 2024/25	Q3 2024/25	03/10 submitted to OBS for upload - therefore moved to Q3 2024/25.
39	MHLD 0008 - Threats to the Person and Environment within Forensic Establishments Policy (Ty Llywelyn Medium Secure Unit).pdf	Mental Health and Learning Disabilities	Policy	15/01/2021	01/01/2024	Ian Jones (BCUHB - Mental Health & Learning Disabilities)	Executive Director of Allied Health Professions and Health Science	Q2 2024/25	Q3 2024/25	IAST and EqIA requested prior to submission to PSG - therefore moved to Q3 2024/25.
40	MHLD 0024 - Adults with a Learning Disability Requiring Admission to Acute Psychiatric In-patient Services - V0.1.pdf	Mental Health and Learning Disabilities	Other	21/03/2017	01/03/2020	Simon Meadowcroft (BCUHB - Learning Disability Services)	Executive Director of Allied Health Professions and Health Science	Q2 2024/25	Q3 2024/25	Not approved at EQDG, awaiting confirmation of approval groups and dates. Therefore moved to Q3 2024/25
41	MHLD 0027 - BCUHB Mental Health Division - Open Door Policy - V0.1pdf.pdf	Mental Health and Learning Disabilities	Policy	01/07/2017	01/07/2020	Sean Gallagher (BCUHB - Learning Disability Services); Matthew Jarvis (BCUHB - Mental Health & Learning Disabilities)	Executive Director of Allied Health Professions and Health Science	Q2 2024/25	Q3 2024/25	03/10 update requested from author - therefore moved to Q3 2024/25.
42	MHLD 0029 - Perinatal Mental Health Operational Policy - V0.1.pdf	Mental Health and Learning Disabilities	Policy	01/06/2017	01/06/2019	Deborah Griffin (BCUHB - Mental Health & Learning Disabilities)	Executive Director of Allied Health Professions and Health Science	Q2 2024/25	Q3 2024/25	03/10 update from author requested - therefore moved to Q3 2024/25.
43	MHLD 0030 - Policy for Information to Patients (S132_3 MHA).pdf	Mental Health and Learning Disabilities	Policy	01/06/2021	01/06/2024	Wendy Lappin (BCUHB - Quality Directorate)	Executive Director of Allied Health Professions and Health Science	Q2 2024/25	Q3 2024/25	On HB PSG Agenda 29/10/24 for approval - therefore moved to Q3 2024/25.
44	MHLD 0033 - MHLD Policy for the Implementation of Section 5(4) Nurses Holding Power.pdf	Mental Health and Learning Disabilities	Policy	01/06/2021	01/06/2024	Wendy Lappin (BCUHB - Quality Directorate)	Executive Director of Allied Health Professions and Health Science	Q2 2024/25	Q3 2024/25	Submitted for inclusion on HB PSG Agenda October - therefore moved to Q3 2024/25.
45	MHLD 0034 - MHLD Policy for Section 5(2) Doctors Holding Power in Psychiatric Units.pdf	Mental Health and Learning Disabilities	Policy	01/06/2021	01/10/2023	Wendy Lappin (BCUHB - Quality Directorate)	Executive Director of Allied Health Professions and Health Science	Q2 2024/25	Q3 2024/25	To be submitted to MHCCC - therefore moved to Q3 2024/25.
46	MHLD 0040 - Ty Llywelyn Postal Packets & Section 134 (MHA 1983_2007) Policy - V0.1.pdf	Mental Health and Learning Disabilities	Policy	22/08/2018	01/08/2021	Simon Allen (BCUHB - Mental Health & Learning Disabilities)	Executive Director of Allied Health Professions and Health Science	Q2 2024/25	Q3 2024/25	Submitted for approval at EDQG 30/08/24 awaiting feedback - therefore moved to Q3 2024/25.
47	MHLD 0045 - Bed Escalation Procedure - MHLD - V1.3.pdf	Mental Health and Learning Disabilities	Procedure	13/07/2021	01/07/2024	Paul Hanna (PTHB - Mental Health)	Executive Director of Allied Health Professions and Health Science	Q2 2024/25	Q3 2024/25	With Assistant Director MHLD to be finalised - therefore moved to Q3 2024/25.
48	MHLD 0051 - Community Treatment Order Policy MHA 1983 - V0.1.pdf	Mental Health and Learning Disabilities	Policy	16/07/2019	01/05/2022	Wendy Lappin (BCUHB - Quality Directorate)	Executive Director of Allied Health Professions and Health Science	Q2 2024/25	Q3 2024/25	To be submitted to MHCCC - therefore moved to Q3 2024/25.
49	MHLD 0052 - Standard Operating Procedure for the use of Gyms & Sports Facilities.pdf	Mental Health and Learning Disabilities	Procedure	11/09/2019	01/07/2022	Lucy Clarke (BCUHB - Occupational Therapy); Leanne Gill (BCUHB - Mental Health & Learning Disabilities)	Executive Director of Allied Health Professions and Health Science	Q2 2024/25	Q3 2024/25	To be submitted to OBS following final QA and completion of IAST - therefore moved to Q3 2024/25.
50	MHLD 0058 - Hafod Mental Health Resource Centre - PocHi Operational Procedure - V0.1.pdf	Mental Health and Learning Disabilities	Procedure	01/03/2020	01/02/2023	Iain Dawson (BCUHB - Pharmacy)	Executive Director of Allied Health Professions and Health Science	Q2 2024/25	Q3 2024/25	SoP in process, to go out for consultation and approval - therefore moved to Q3 2024/25.
51	MHLD 0059 - Memory Services Operational Protocol.pdf	Mental Health and Learning Disabilities	Protocol	01/11/2020	01/11/2022	Joanne Kelly-Rhind (BCUHB - Clinical Psychology)	Executive Director of Allied Health Professions and Health Science	Q2 2024/25	Q3 2024/25	Approved to be submitted to OBS once IAST completed - therefore moved to Q3 2024/25.
52	MHLD 0060 - Criminal Justice Liaison Service Standard Operating Procedure.pdf	Mental Health and Learning Disabilities	Procedure	01/08/2020	01/08/2023	Ruth Joyce (BCUHB - Mental Health & Learning Disabilities)	Executive Director of Allied Health Professions and Health Science	Q2 2024/25	Q3 2024/25	With author for review - therefore moved to Q3 2024/25.
53	MHLD 0067 - Patient Anti Bullying Procedure - Ty Llywelyn Medium Secure Unit - V1.pdf	Mental Health and Learning Disabilities	Procedure	01/10/2020	01/10/2023	Simon Allen (BCUHB - Mental Health & Learning Disabilities)	Executive Director of Allied Health Professions and Health Science	Q2 2024/25	Q3 2024/25	Submitted to OBS 03/10 for upload - therefore moved to Q3 2024/25.
54	MHLD 0068 - Perinatal Guidelines for Pain Control in Women on Opioid Substitution Therapy - V4.3.pdf	Mental Health and Learning Disabilities	Guideline	13/11/2020	16/11/2023	Lis Hughes (BCUHB - Substance Misuse Services)	Executive Director of Allied Health Professions and Health Science	Q2 2024/25	Q3 2024/25	IAST and EqIA to be finalised prior to submission to PSG - therefore moved to Q3 2024/25.
55	MHLD 0071 - Clinical Risk Management Procedure - V6.pdf	Mental Health and Learning Disabilities	Procedure	01/10/2021	01/11/2023	Robyn Jones (BCUHB - Mental Health & Learning Disabilities); Joanne Kendrick (BCUHB - Mental Health & Learning Disabilities)	Executive Director of Allied Health Professions and Health Science	Q2 2024/25	Q3 2024/25	Submitted to PSG on 29/10 agenda for approval - therefore moved to Q3 2024/25.

56	MM15 - Policy for Administration & Use of Emergency & Non Emergency Oxygen in Adults in Managed Services - V2.1.pdf	Pharmacy and Medicines Management	Policy	22/05/2019	01/02/2022	Pam Lloyd (BCUHB - Respiratory Medicine)	Executive Medical Director	Q2 2024/25	Q3 2024/25	Hannah John and Pam Lloyd reviewed the document a while ago and updated the areas they were able to. Some other areas required updating as policies and practices had changed. An educational package is also currently under development. This may impact. Tracey Radcliffe is leading on much of the development work around the educational package. Pam Lloyd leaving the Health Board w/c 14/10/2024. Therefore moved to Q3 2024/25
57	MM41 - Covert Administration of Medication Clinical Policy.pdf	Pharmacy and Medicines Management	Policy	01/07/2019	01/06/2022	Elizabeth Bond (BCUHB - Pharmacy)	Executive Medical Director	Q2 2024/25	Q3 2024/25	There were errors when submitted to OBS on 13.09.24. Will update when Liz responds - therefore moved to Q3 2024/25.
58	MM48 - Acute Management of Parkinson's Disease in Patients with Compromised Swallow or Nil by Mouth - V1.0.pdf	Pharmacy and Medicines Management	Other	12/12/2019	01/11/2022	Sue Lord (BCUHB - Pharmacy)	Executive Medical Director	Q2 2024/25	Q3 2024/25	Approved at DTG 02/10/2024, will go to PSG on 29/10.2024- therefore moved to Q3 2024/25. Author off sick currently.
59	MM50 - Medicines Management Guidelines for the Adult Mental Health Home Treatment Teams - V0.1.pdf	Pharmacy and Medicines Management; Mental Health and Learning Disabilities	Guideline	01/06/2016	01/01/2019	Elizabeth Bond (BCUHB - Pharmacy)	Executive Director of Allied Health Professions and Health Science	Q2 2024/25	Q3 2024/25	For approval at MPPP - therefore moved to Q3 2024/25.
60	MM51 - Guideline for Monitoring Physical Health in Adults with Psychosis or Schizophrenia - V0.1.pdf	Pharmacy and Medicines Management; Mental Health and Learning Disabilities	Guideline	01/11/2017	01/11/2019	Elizabeth Bond (BCUHB - Pharmacy)	Executive Director of Allied Health Professions and Health Science	Q2 2024/25	Q3 2024/25	Submitted to PSG on 29/10 agenda for approval - therefore moved to Q3 2024/25.
61	MM55 - Hafen Wen (BCUHB SMS) Inpatient Detoxificaiton Prescribing Guidelines.pdf	Pharmacy and Medicines Management; Mental Health and Learning Disabilities	Guideline	16/05/2019	01/05/2022	Elizabeth Bond (BCUHB - Pharmacy)	Executive Director of Allied Health Professions and Health Science	Q2 2024/25	Q3 2024/25	Approved to be submitted to OBS once IAST completed - therefore moved to Q3 2024/25.
62	MM69 - Intravenous (IV) Potassium Procedure - V1.pdf	Pharmacy and Medicines Management	Procedure	13/11/2020	01/11/2023	Karen Pritchard (BCUHB - Pharmacy)	Executive Medical Director	Q2 2024/25	Q3 2024/25	Moved to Qtr 3.
63	NST03 - Parenteral Nutrition Clinical Protocol for Adults.pdf	Nursing	Protocol	13/04/2021	13/04/2024	Ruth Davies (BCUHB - Nursing, Midwifery & Patient Services)	Executive Director of Nursing and Midwifery	Q2 2024/25	Q3 2024/25	Nutrition Nurses have sent this out for stakeholders in January and have now collated their feedback, there have been some contentious feedback in relation to Out of hours provision and stock on Critical care. Jane and Ruth are planning to meet next month to update this we then send this to INCH for approval. Just to reassure there is nothing unsafe on the policy currently - therefore moved to Q3 2024/25.
64	NU10 - Urinary Catheterisation (Adults) Protocol - V0.1.pdf	Nursing	Protocol	13/01/2016	12/01/2018	Lisa Borders (BCUHB - Continence Service)	Executive Director of Nursing and Midwifery	Q2 2024/25	Q3 2024/25	Now gaining the support of our Safety Matron to get this updated - therefore moved to Q3 2024/25.
65	NU16 - Guidance for Alcohol Detoxification in ED & Adult Inpatient Wards.pdf	Nursing	Other	01/10/2019	01/05/2024	Akwasi Mintah (BCUHB - Pharmacy)	Executive Director of Nursing and Midwifery	Q2 2024/25	Q3 2024/25	Staff member on leave at present therefore no update available - therefore moved to Q3 2024.25.
66	NU19 - Patient Transfer Procedure - V3.pdf	Nursing	Procedure	03/07/2018	09/02/2024	Eleri Roberts (BCUHB - Community Hospitals)	Executive Director of Nursing and Midwifery	Q2 2024/25	Q3 2024/25	Approved as PSG so awaiting be QA and upload by CGD - therefore moved to Q3 2024/25.
67	NU21 - Levels of Enhanced Care for Adult Inpatients Policy.pdf	Nursing	Policy	15/07/2019	08/12/2023	Tracey Harris (BCUHB - Patient Safety)	Executive Director of Nursing and Midwifery	Q2 2024/25	Q3 2024/25	Approved at business meeting - going to October PSG agenda for approval - therefore moved to Q3 2024/25.
68	NWCRF SOP02 - Standard Operating Procedure for Volunteer Screening and Recruitment.pdf	Research and Development	Procedure	04/10/2022	01/07/2024	Lona Tudor Jones (BCUHB - Research & Development)	Executive Medical Director	Q2 2024/25	Q3 2024/25	Minor changes have been made. For CRF management meeting review then SMT before submission to CEG - therefore moved to Q3 2024/25
69	NWCRF SOP06 - Standard Operating Procedure for Training.pdf	Research and Development	Procedure	04/10/2022	01/07/2024	Lona Tudor Jones (BCUHB - Research & Development)	Executive Medical Director	Q2 2024/25	Q3 2024/25	Minor changes have been made. For CRF management meeting review then SMT before submission to CEG - therefore moved to Q3 2024/25
70	NWCRF SOP07 - Standard Operating Procedure - Management of Volunteer Master File.pdf	Research and Development	Procedure	04/10/2022	01/08/2024	Elizabeth Harrison (BCUHB - Research & Development)	Executive Medical Director	Q2 2024/25	Q3 2024/25	Minor changes have been made. For CRF management meeting review then SMT before submission to CEG - therefore moved to Q3 2024/25

71	NWCRF SOP08 - Standard Operating Procedure - The Over Volunteering Prevention Scheme (TOPS).pdf	Research and Development	Procedure	04/10/2022	01/08/2024	Elizabeth Harrison (BCUHB - Research & Development)	Executive Medical Director	Q2 2024/25	Q3 2024/25	Minor changes have been made. For CRF management meeting review then SMT before submission to CEG - therefore moved to Q3 2024/25
72	NWCRF SOP09 - Standard Operating Procedure - Consent 4 Consent (C4C) Database.pdf	Research and Development	Procedure	04/10/2022	01/07/2024	Elizabeth Harrison (BCUHB - Research & Development)	Executive Medical Director	Q2 2024/25	Q3 2024/25	Minor changes have been made. For CRF management meeting review then SMT before submission to CEG - therefore moved to Q3 2024/25
73	NWCRF SOP11 - Standard Operating Procedure - For the Monika Prime Temperature Monitoring System.pdf	Research and Development	Procedure	04/10/2022	01/07/2024	Katharine Burton (Abergele - The Surgery (Abergele))	Executive Medical Director	Q2 2024/25	Q3 2024/25	Minor changes have been made. For CRF management meeting review then SMT before submission to CEG - therefore moved to Q3 2024/25
74	NWCRF SOP13 - Standard Operating Procedure - for Drug and Alcohol Testing in Clinical Trials.pdf	Research and Development	Procedure	04/10/2022	01/08/2024	Katharine Burton (Abergele - The Surgery (Abergele))	Executive Medical Director	Q2 2024/25	Q3 2024/25	Minor changes have been made. For CRF management meeting review then SMT before submission to CEG - therefore moved to Q3 2024/25
75	NWCRF SOP15 - Standard Operating Procedure - for Requesting Access to GP Records for Trial Participants.pdf	Research and Development	Procedure	04/10/2022	01/07/2024	Elizabeth Harrison (BCUHB - Research & Development)	Executive Medical Director	Q2 2024/25	Q3 2024/25	Minor changes have been made. For CRF management meeting review then SMT before submission to CEG - therefore moved to Q3 2024/25
76	NWCRF SOP17 - North Wales Clinical Research Facility - Standard Operating Procedure - Laboratory Procedures.pdf	Research and Development	Procedure	17/01/2023	01/07/2024	Rhiannon Mackay (BCUHB - Research & Development)	Executive Medical Director	Q2 2024/25	Q3 2024/25	Minor changes have been made. For CRF management meeting review then SMT before submission to CEG - therefore moved to Q3 2024/25
77	OBS03 - Procedure for Naming Buildings & Units of BCUHB - V2.pdf	Corporate Governance Directorate	Procedure	17/03/2021	01/03/2024	Glesni Driver (BCUHB - Corporate Office)	Director of Corporate Governance	Q2 2024/25	Q3 2024/25	No approval route for CGD policies/WCDs, therefore now to go EPOG - 1st meeting of EPOG on 22/08/2024 postponed, therefore delayed until 19/09/2024. Approved by EPOG, now on agenda for approval at ET on 09/10/2024 - therefore moved to Q3 2024/25.
78	QA04 - Research Contracts & Vendors - Health Research - Standard Operating Procedure.pdf	Research and Development	Procedure	14/04/2022	14/04/2024	Lona Tudor Jones (BCUHB - Research & Development)	Executive Medical Director	Q2 2024/25	Q3 2024/25	Awaiting upload onto Betsi Net - currently having QC checks - therefore moved to Q3 2024/25
79	R01 - SOP for Reporting of Deviations and breaches of protocol or GCP.pdf	Research and Development	Procedure	02/08/2022	02/08/2024	Lynne Grundy (BCUHB - Research & Development)	Executive Medical Director	Q2 2024/25	Q3 2024/25	Undergoing departmental review - therefore moved to Q3 2024/25
80	RD03 - Policy for Intellectual Property - V2.pdf	Research and Development	Policy	02/09/2020	01/08/2022	Lona Tudor Jones (BCUHB - Research & Development)	Executive Medical Director	Q2 2024/25	Q3 2024/25	Awaiting ALL WALES IG policy, however BCUHB policy also under local review - therefore moved to Q3 2024/25
81	RD04 - NHS R&D Finance Policy - V1.0.pdf	Research and Development	Policy	28/07/2017	20/07/2019	Lona Tudor Jones (BCUHB - Research & Development)	Executive Medical Director	Q2 2024/25	Q3 2024/25	Awaiting ALL WALES research finance policy - therefore moved to Q3 2024/25
82	RP01 - Ionising Radiation Protection Policy - V4.pdf	Radiation Protection	Policy	07/09/2021	03/06/2024	Peter Hiles (BCUHB - North Wales Medical Physics (inc EBME))	Executive Director of Allied Health Professions and Health Science	Q2 2024/25	Q3 2024/25	Review commenced in Q1 - therefore moved to Q3 2024/25.
83	S01 - SOP for Urgent Safety Measures in Research.pdf	Research and Development	Procedure	02/08/2022	02/08/2024	Lynne Grundy (BCUHB - Research & Development)	Executive Medical Director	Q2 2024/25	Q3 2024/25	Undergoing departmental review - therefore moved to Q3 2024/25
84	S02 - SOP for Safety Reporting in Research.pdf	Research and Development	Procedure	02/08/2022	02/08/2024	Nick Lyons (BCUHB - Corporate Office)	Executive Medical Director	Q2 2024/25	Q3 2024/25	Undergoing departmental review - therefore moved to Q3 2024/25
85	SCH18 - Coping with Crying Guidance - V2.pdf	Safeguarding; Women's Directorate	Other	14/09/2020	14/09/2023	Anna Davies (BCUHB - Safeguarding)	Chief Operating Officer	Q2 2024/25	Q3 2024/25	Safeguarding colleagues are leading on this review - therefore moved to Q3 2024/25.
86	SFHCC09 - Enable Individuals to Effectively Evacuate their Bowels.pdf	Nursing	Other	01/07/2019	01/07/2021	Lisa Borders (BCUHB - Continence Service)	Executive Director of Nursing and Midwifery	Q2 2024/25	Q3 2024/25	Jody is working with Lisa in getting the document uploaded to BetsiNet - therefore moved to Q3 2024/25.
87	SOP1 - Referral, Triage and Allocation process for Stroke Rehabilitation Pathway- Early Supported Discharge (ESD) & Stroke Specialist Inpatient Rehabilitation (SSIR).pdf	Therapies and Health Sciences	Procedure	14/02/2023	03/11/2023	Sushmita Mohapatra (BCUHB - Therapies & Health Science)	Executive Director of Allied Health Professions and Health Science	Q2 2024/25	Q3 2024/25	Approved at CEG 13.08.2024 - therefore moved to Q3 2024/25.
88	SOP2 - Early Supported Discharge Multi-Disciplinary Team process for Stroke Rehabilitation Pathway.pdf	Therapies and Health Sciences	Procedure	14/02/2023	03/11/2023	Sushmita Mohapatra (BCUHB - Therapies & Health Science)	Executive Director of Allied Health Professions and Health Science	Q2 2024/25	Q3 2024/25	Approved at CEG 13.08.2024 - therefore moved to Q3 2024/25.
89	SOP3 - Discharge process for Stroke Rehabilitation Pathway- Early Supported Discharge (ESD).pdf	Therapies and Health Sciences	Procedure	14/02/2023	03/11/2023	Sushmita Mohapatra (BCUHB - Therapies & Health Science)	Executive Director of Allied Health Professions and Health Science	Q2 2024/25	Q3 2024/25	Approved at CEG 13.08.2024 - therefore moved to Q3 2024/25.
90	SOP4 - Multi-Disciplinary Team (MDT) process for Stroke Rehabilitation Pathway- Stroke Specialist Inpatient Rehabilitation (SSIR).pdf	Therapies and Health Sciences	Procedure	14/02/2023	03/11/2023	Karl Jackson (BCUHB - Stroke Unit)	Executive Director of Allied Health Professions and Health Science	Q2 2024/25	Q3 2024/25	Approved at CEG 13.08.2024 - therefore moved to Q3 2024/25.

91	SOP5 - Discharge process for Stroke Rehabilitation Pathway- SSIR.pdf	Therapies and Health Sciences	Procedure	14/02/2023	03/11/2023	Sushmita Mohapatra (BCUHB - Therapies & Health Science)	Executive Director of Allied Health Professions and Health Science	Q2 2024/25	Q3 2024/25	Approved at CEG 13.08.2024 - therefore moved to Q3 2024/25.
92	TM01 - Participant Information Sheets and Informed Consent - Health Research - Standard Operating Procedure.pdf	Research and Development	Procedure	14/04/2022	14/04/2024	Lona Tudor Jones (BCUHB - Research & Development)	Executive Medical Director	Q2 2024/25	Q3 2024/25	For November CEG meeting - therefore moved to Q3 2024/25
93	TM04 - Procedure for Delegating Duties in Research - Health Research - Standard Operating Procedure.pdf	Research and Development	Procedure	14/04/2022	14/04/2024	Lona Tudor Jones (BCUHB - Research & Development)	Executive Medical Director	Q2 2024/25	Q3 2024/25	For November CEG meeting - therefore moved to Q3 2024/25
94	TM14 - SOP for Study Version and Document Control.pdf	Research and Development	Procedure	02/08/2022	02/08/2024	Alice Jones-Blunt (BCUHB - Research & Development)	Executive Medical Director	Q2 2024/25	Q3 2024/25	Undergoing departmental review - therefore moved to Q3 2024/25
95	TU1 - Policy & Procedure for Top up Payments - V0.2.pdf	Pharmacy and Medicines Management	Policy	28/08/2012	01/05/2017	Hannah Greaves (BCUHB - Pharmacy)	Executive Medical Director	Q2 2024/25	Q3 2024/25	Waiting for consultation on All Wales policy - therefore moved to Q3 2024/25.
96	Welsh Language Standards Regulations 2018.pdf	Welsh Language	Other	14/09/2018	14/09/2023	Eleri Hughes-Jones (BCUHB - Welsh Language Services)	Executive Director of Allied Health Professions and Health Science	Q2 2024/25	Q3 2024/25	The All-Wales top up policy was circulated for consultation with a deadline of the 16th August, for which the team have submitted comments. Not heard anything since but will keep you updated as and when we hear back from the national group. This has been chased with Hannah again today. Will update again when a response is received. Update from Eleri Hughes-Jones on 04/10/2024 - "The Welsh Language Standards document has been updated and approved over 9 months ago. We have had some issues with the OBS with getting this uploaded. I will check progress with our Compliance Officer and get back to you." Response from Policies - document hadn't gone to each approving meeting that it was meant to go through, therefore turned back by QA process - therefore moved to Q3 2024/25.
97	WP21 - Working Time Procedure.pdf	Workforce	Procedure	01/03/2015	01/03/2018	Llinos Jones (BCUHB - Workforce & Organisational Development)	Executive Director of Workforce and Organisational Development	Q2 2024/25		*Awaiting update*
98	WP22 - BCU Mufti Allowance Procedure - Final v1 (Oct14).pdf	Workforce	Procedure	01/10/2014	01/10/2017	Jason Brannan (BCUHB - Workforce & Organisational Development)	Executive Director of Workforce and Organisational Development	Q2 2024/25		*Awaiting update*
99	WP30 - Statutory Mandatory Training Policy and Procedure - V0.3.pdf	Workforce	Policy	22/03/2016	01/02/2022	Tracey Eccles (BCUHB - Workforce & Organisational Development)	Executive Director of Workforce and Organisational Development	Q2 2024/25		*Awaiting update*
100	WP41 - Recruitment and Retention Payment Protocol - V3.pdf	Workforce	Protocol	01/11/2020	01/11/2023	Jason Brannan (BCUHB - Workforce & Organisational Development)	Executive Director of Workforce and Organisational Development	Q2 2024/25		*Awaiting update*
101	WP47 - BCUHB Telephone Line Rental Procedure - V1.pdf	Workforce	Procedure	01/06/2015	01/04/2018	Claire Waddicor-Evans (BCUHB - Transformation & Improvement)	Executive Director of Workforce and Organisational Development	Q2 2024/25		*Awaiting update*
102	WP51 - Bilingual Skills Policy & Procedure - V0.1.doc.pdf	Welsh Language	Policy	18/12/2020	15/09/2023	Eleri Hughes-Jones (BCUHB - Welsh Language Services)	Executive Director of Allied Health Professions and Health Science	Q2 2024/25	Q3 2024/25	Previously noted that this document has been updated and awaiting final approval. Final approval will be sought at the Workforce Policies and Procedures Group on 18 October 2024. I will update once approved - therefore moved to Q3 2024/25.

POLICY MANAGEMENT SYSTEM
OVERDUE POLICIES AS AT 2nd OCTOBER 2024
Updated information as at 18/12/2024
Excluding All Wales policies; appendices to policies
Includes only one bilingual version of a policy

Name	Category	Policy type	Effective Date	Review Date	Author	Risk category	Risk level of being overdue	Updated Qtr for review	Qtr for Review as at 02/10/2024	Qtr 2 progress update	Position update at 18/12/2024	Confidence of review finalised in listed quarter
CHIEF DIGITAL INFORMATION OFFICER												
INF03 - Informatics Change Management Policy - V1.pdf	Informatics	Policy	21/01/2020	13/01/2023	John Thomas (BCUHB - Digital, Data and Technology);	IT	Medium		Q4 2024/25		Currently under a major review, working its way through the DDaT approval stages. This will be done by end of Q4.	Medium confidence
INF04 - Informatics Change Management Procedure - V1.pdf	Informatics	Policy	08/05/2019	19/05/2022	John Thomas (BCUHB - Digital, Data and Technology)	IT	Medium		Q4 2024/25		This procedure was listed for a 4-year review - as per current policy, the maximum should be years. However, it is still overdue a review. 3/11/24 Spoke to ICT - This is on the ICT/IG Security Group Agenda for their January meeting, only they can get policies through.	Medium confidence
IG01 - Records Management Policy .pdf	Information Governance	Policy	08/12/2021	01/10/2024	Lisa Parry (BCUHB - Digital, Data and Technology)	*No update provided*	*No update provided*		Q2 2024/25			High confidence
IG04 - Access to Information Policy - V5.pdf	Information Governance	Policy	08/12/2021	01/10/2024	Carol Johnson (BCUHB - Digital, Data and Technology)	*No update provided*	*No update provided*		Q4 2024/25			Medium confidence
CHIEF OPERATING OFFICER												
CW01 - BCUHB Paediatric Escalation Policy - V3.pdf	Children and Young People's services	Policy	01/09/2018	01/09/2019	Martin Mcspadden (BCUHB - Paediatrics)	Patient safety	High	Q4 2024/26			Under review	Medium confidence
Mat 42 - Epilepsy in Pregnancy - V1.pdf	Women's Directorate	Policy	01/10/2018	01/10/2021	Maggie Armstrong (BCUHB - Obstetrics & Gynaecology) Sheila Shepley (BCUHB - Outpatient Services); Janet Quarmby (BCUHB - Maternity)	Patient safety	High	Q1 2025/26			Currently with Pharmacy team for review. Awaiting dates of Pharmacy meetings - Neuroscience.	High confidence
NU01 - Discharge Policy & Protocol - V0.2.pdf	Nursing	Policy	16/01/2015	21/09/2018	Claire Brennan (BCUHB - Corporate Office)	Patient safety	High	Q4 2025/26		This policy is dependent on WG guidance and the risk is considered medium because there are measures in place to address the matters that the guidelines address. A draft has been presented to RPB Leadership Group and feedback considered. This will go to a Quality Delivery Group then Policy Oversight Group.	WG guidance came out in Dec 23 and it has been refreshed in 2 Oct 2024. The Health Board wil use this as the basis for the Policy. It is of note that no Welsh HBs have yet developed their full policy	Medium confidence
Mat 74 - BCUHB Breastfeeding Policy.pdf	Children and Young People's services; Women's Directorate; Workforce	Policy	01/12/2020	01/12/2023	Sharon Breward (BCUHB - Maternity)	Patient safety	Medium	Q3 2024/25		Fully complete through the approvals process, just at BCU Policies QA stage - IAST date to be included on front cover - therefore moved to Q3 2024/25.	Been through approval stage - QAd by BCU Policies, awaiting response to queries following BCU Policies review. Once received, the policy will need to go to EPOG, then ET for approval.	Low confidence
Procedure for the Transfer of Blood & Blood Components between Hospitals - V4.0.pdf	Pathology	Policy	01/06/2019	01/06/2022	Rachael Surridge (BCUHB - Pathology)	Patient safety	Medium	Q2 2025/26			There may be a need to review Welsh Blood Service guidance	High confidence
PTH-TR-POL602 - Blood and Blood Components Transfusion Collection & Administration Policy - V2.0.pdf	Pathology	Policy	17/11/2021	17/11/2022	Rachael Surridge (BCUHB - Pathology)	Patient safety	Medium	Q2 2025/26				High confidence
CA02 - Adult Breaking Bad News Policy - V0.1.pdf	Cancer and Clinical Haematology; Palliative and End of Life Care	Policy	10/06/2014	01/07/2016	Imran Devji (BCUHB - Corporate Office)	Patient safety	Low	Q4 2024/25			Approved at local Governance Group- Awaiting Feedback	Medium confidence
DIRECTOR OF CORPORATE GOVERNANCE												
BCUHB - Claims Governance Policy Clinical Negligence and Personal Injury - V8.pdf	Legal	Policy	12/12/2019	01/07/2021	Matthew Joyes (BCUHB - Legal Services)	Legal; Financial	Low	Q4 2024/25			The transfer of Legal Services from Nursing/Medical to Corporate Governance presents an opportunity to fully review policy, procedure and process. This work is taking place at pace with the aim of a new, integrated legal policy to be developed and ratified. Work continued to review the risk and opportunities from a different approach to Legal Services, which will include a new policy as part of a Transforming Legal Services Plan. Discovery work is underway and this will lead to drafting of a new, integrated legal policy during Q3 for consultation and then approval in Q4.	Medium confidence
PTR02 - Claims Management Policy.pdf	Legal	Policy	02/05/2013	05/06/2017	Matthew Joyes (BCUHB - Legal Services)	Legal	Low		Q3 2024/25		Transfer of Ownership to Director of Corporate Governance. approved.	Low confidence
DIRECTOR OF ENVIRONMENT AND ESTATES												
ES03 - Waste Management Policy - V5.pdf	Estates	Policy	01/09/2020	01/09/2023	Natalie Scott-Lakey (BCUHB - Estates); Cynthia Williams (BCUHB - Estates); Jenny Usher-Jones (BCUHB - Estates)	Health and Safety	Low		Q3 2024/25		HB Environmental Group have reviewed the policy and currently awaiting appointment of Director of Environment and Estates to update roles and responsibilities section of policy	Low confidence
ES04 - Policy for the Managment of Fire Safety - V0.4.pdf	Estates	Policy	01/11/2020	01/04/2022	Rod Taylor (BCUHB - Estates); Gareth Griffiths (BCUHB - Estates)	Health and Safety	Low		Q3 2024/25		Internal Audit review of fire management included review of the policy and a key finding of the audit was to review roles and responsibilities. HB Fire Safety Management Group have reviewed the policy and currently awaiting appointment of Director of Environment and Estates to update roles and responsibilities section of policy	Low confidence
EXECUTIVE DIRECTOR OF ALLIED HEALTH PROFESSIONS AND HEALTH SCIENCE												
MHLD 0002 DRAFT - Seclusion & Long Term Segregation Policy -V0.2.pdf	Mental Health and Learning Disabilities	Policy	01/09/2020	01/09/2023	Teresa Owen (BCUHB - Corporate Office)	Patient safety	Low	Q3 2024/25		03/10 submitted to OBS for upload - therefore moved to Q3 2024/25.	Submitted to OBS on 3/10/24, and queried, now awaiting response. Once queries have been resolved, will be uploaded	Low confidence
MHLD 0008 - Threats to the Person and Environment within Forensic Establishments Policy (Ty Llywelyn Medium Secure Unit).pdf	Mental Health and Learning Disabilities	Policy	15/01/2021	01/01/2024	Ian Jones (BCUHB - Mental Health & Learning Disabilities)	Patient safety	Low	Q3 2024/25		IAST and EqIA requested prior to submission to PSG - therefore moved to Q3 2024/25.	Approved awaiting IAST & EQiA prior to submitting to OBS	Low confidence
MHLD 0020 - S-CAMHS to Adult Transition Policy - V3.pdf	Mental Health and Learning Disabilities; Children and Young People's services	Policy	01/06/2021	01/03/2024	Kathryn Thomas (BCUHB - Child & Adolescent Health)	Patient safety; Joint working/Collaboration	Low	Q4 2024/25				Medium confidence
MHLD 0027 - BCUHB Mental Health Division - Open Door Policy - V0.1pdf.pdf	Mental Health and Learning Disabilities	Policy	01/07/2017	01/07/2020	Sean Gallagher (BCUHB - Learning Disability Services); Matthew Jarvis (BCUHB - Mental Health & Learning Disabilities)	Patient safety; Legal	Low	Q3 2024/25		03/10 update requested from author - therefore moved to Q3 2024/25.		Low confidence
MHLD 0029 - Perinatal Mental Health Operational Policy - V0.1.pdf	Mental Health and Learning Disabilities	Policy	01/06/2017	01/06/2019	Deborah Griffin (BCUHB - Mental Health & Learning Disabilities)	Patient safety; Joint working/Collaboration	Low	Q3 2024/25		03/10 update from author requested - therefore moved to Q3 2024/25.	"Post Consultation Local CEG 22/08/24 03/10 update requested"	Low confidence
MHLD 0030 - Policy for Information to Patients (S132_3 MHA).pdf	Mental Health and Learning Disabilities	Policy	01/06/2021	01/06/2024	Wendy Lappin (BCUHB - Legal Services)	Legal	Low	Q3 2024/25		On HB PSG Agenda 29/10/24 for approval - therefore moved to Q3 2024/25.		Low confidence
MHLD 0033 - MHLD Policy for the Implementation of Section 5(4) Nurses Holding Power.pdf	Mental Health and Learning Disabilities	Policy	01/06/2021	01/06/2024	Wendy Lappin (BCUHB - Legal Services)	Legal	Low	Q3 2024/25		Submitted for inclusion on HB PSG Agenda October - therefore moved to Q3 2024/25.		Low confidence
MHLD 0034 - MHLD Policy for Section 5(2) Doctors Holding Power in Psychiatric Units.pdf	Mental Health and Learning Disabilities	Policy	01/06/2021	01/10/2023	Wendy Lappin (BCUHB - Legal Services)	Legal	Low	Q3 2024/25		To be submitted to MHCCC - therefore moved to Q3 2024/25.	Awaitig EQDG approval	Low confidence
MHLD 0035 - Home Treatment Team Operational Policy - V0.5 (a).pdf	Mental Health and Learning Disabilities	Policy	09/04/2018	01/04/2021	Huw Jones (BCUHB - Adult Mental Health & Social Care)	Patient safety; Legal	Low	Q1 2025/26			Consultation closed 15/10/24	High confidence

MHLD 0040 - Ty Llywelyn Postal Packets & Section 134 (MHA 1983 2007) Policy - V0.1.pdf	Mental Health and Learning Disabilities	Policy	22/08/2018	01/08/2021	Simon Allen (BCUHB - Mental Health & Learning Disabilities)	Patient safety	Low	Q3 2024/25		Submitted for approval at EDQG 30/08/24 awaiting feedback - therefore moved to Q3 2024/25.		Low confidence
MHLD 0041 - MHLD Policy for Use of Handcuffs (specific to Ty Llywelwyn Medium Secure Unit).pdf	Mental Health and Learning Disabilities	Policy	15/01/2021	15/01/2024	Paul Hanna (PTHB - Mental Health)	Patient safety; Health and Safety	Low	Q1 2025/26			Under development	High confidence
MHLD 0051 - Community Treatment Order Policy MHA 1983 - V0.1.pdf	Mental Health and Learning Disabilities	Policy	16/07/2019	01/05/2022	Wendy Lappin (BCUHB - Legal Services)	Legal	Low	Q3 2024/25		To be submitted to MHCCC - therefore moved to Q3 2024/25.		Low confidence
WP51 - Bilingual Skills Policy & Procedure -V0.1.doc.pdf	Welsh Language	Policy	18/12/2020	15/09/2023	Eleri Hughes-Jones (BCUHB - Welsh Language Services); Clair Tipton (BCUHB - Workforce & Organisational Development); Meilyr Emrys (BCUHB - Welsh Language Services)	Legal	Low	Q3 2024/25		Previously noted that this document has been updated and awaiting final approval. Final approval will be sought at the Workforce Policies and Procedures Group on 18 October 2024. I will update once approved - therefore moved to Q3 2024/25.	Item moved to 15 November 2024 meeting of the Workforce Policies and Procedures Group due to full agenda at the October meeting.	Low confidence
RP01 - Ionising Radiation Protection Policy - V4.pdf	Radiation Protection	Policy	07/09/2021	03/06/2024	Peter Hiles (BCUHB - North Wales Medical Physics (inc EBME)); Julian Macdonald (BCUHB - North Wales Medical Physics (inc EBME))	*No update provided*	*No update provided*	Q3 2024/25		"Review commenced in Q1 - therefore moved to Q3 2024/25. New regulations issued in September 2024 and in force October 2024 therefore further review needed will be presented to Radiation Protection Committee for approval in December 2024	This is now having a further revision due to the change in regulations and will be presented at the RPC in December for the approval process to commence	Low confidence
EXECUTIVE DIRECTOR OF FINANCE												
F02 - Lease Car & Pool Vehicle Policy and Procedure - V.03.pdf	Finance	Policy	12/08/2021	15/08/2024	Denise Roberts (BCUHB - Finance)	Financial	Low		Q4 2024/25		Risk considered low as existing procedure already in place and no material changes expected	Medium confidence
F03 - Local Counter Fraud, Bribery and Corruption Policy.pdf	Finance	Policy	16/03/2022	01/08/2024	Karl Woodward (BCUHB - Finance); Sjef Molmans (BCUHB - Finance); Graham Jones (BCUHB - Finance)	Financial	Low		Q4 2024/25		Risk considered low as existing procedure already in place and no material changes expected	Medium confidence
EXECUTIVE DIRECTOR OF NURSING												
NU21 - Levels of Enhanced Care for Adult Inpatients Policy.pdf	Nursing	Policy	15/07/2019	08/12/2023	Tracey Harris (BCUHB - Patient Safety)	HR/Staff	Low	Q3 2024/25		Approved at business meeting - going to October PSG agenda for approval - therefore moved to Q3 2024/25.	Updated protocol on the agenda for approval for the Patient Safety Group 29th October 2024. Request to move NU21 policy to Clinical Operational Services.	Low confidence
EXECUTIVE DIRECTOR OF TRANSFORMATION, STRATEGIC PLANNING AND COMMISSIONING												
F017 - Revenue Business Case Policy Approved.pdf	Finance	Policy	24/10/2019	24/10/2022	Ian Howard (BCUHB - Planning)	Financial	Low		Q4 2024/25		The Director of T&I and Director of Governance met on 17/10/24. No other Health Board maintains a policy; and there is no statutory requirement. The Health Board Business Case Review Group is underway; and will address the review's findings. An approach to retire the policy was agreed and will be reviewed by the Policy Oversight Group; with a recommendation to ratify by the Director of Governance.	Medium confidence
EXECUTIVE DIRECTOR OF WORKFORCE AND ORGANISATIONAL DEVELOPMENT												
HS01 - Occupational Health and Safety Policy.pdf	Health and Safety	Policy	09/12/2021	09/12/2023	Peter Bohan (BCUHB - Corporate Office)	*No update provided*	*No update provided*		Q4 2024/25			Medium confidence
ISU03 - Volunteering Policy - V0.1.pdf	Charities and Volunteers	Policy	09/12/2014	12/01/2017	Susan Marriott (BCUHB - Workforce & Organisational Development); Joy Lloyd (BCUHB - Workforce & Organisational Development)	*No update provided*	*No update provided*		Q3 2024/25			Low confidence
WP29 - BCU Relocation Expenses Policy V0.3.pdf	Workforce	Policy	05/12/2016	05/12/2019	Karen Walker (BCUHB - Workforce & Organisational Development)	HR/Staff	Medium	Q1 2025/26		All Wales Policy is currently in draft which will supersede this document	All Wales Policy due	High confidence
WP30 - Statutory Mandatory Training Policy and Procedure - V0.3.pdf	Workforce	Policy	22/03/2016	01/02/2022	Tracey Eccles (BCUHB - Workforce & Organisational Development)	Legal; Health and Safety	Low	Q4 2024/25		Awaiting update	Minor amendments made in 2021, but as these were only minor amendments, the original review date stands - overdue a review	Medium confidence
WP5 - All Wales Respect and Resolution Policy - V1.pdf	Workforce	Policy	01/04/2021	01/05/2024	Jason Brannan (BCUHB - Workforce & Organisational Development)	Legal; HR/Staff	Low				Policy has been revised and amended by Welsh Partnership forum and is going through the BCUHB approval route.	*Unable to classify*
WP52 - Study Leave Policy - (Applies to all staff apart from Medical & Dental) - V0.2.pdf	Workforce	Policy	11/04/2016	01/01/2018	Nia Thomas (BCUHB - Workforce & Organisational Development)	*No update provided*	*No update provided*		Q4 2024/25			Medium confidence
WP58 - Electronic Staff Record (ESR) System Policy - V0.1.pdf	Workforce	Policy	01/05/2016	01/06/2019	Jason Brannan (BCUHB - Workforce & Organisational Development)	HR/Staff; IT	Medium	Q1 2025/26			Policy in draft ready for December Policy Group	High confidence
WP9 - Disciplinary Policy.pdf	Workforce	Policy	01/11/2015	01/03/2020	Jason Brannan (BCUHB - Workforce & Organisational Development)	Legal; HR/Staff	Low	Q1 2025/26			All Wales Policy, remains extant until replaced by version from Welsh Partnership Forum and BCU approval route	High confidence
EXECUTIVE MEDICAL DIRECTOR												
TU1 - Policy & Procedure for Top up Payments - V0.2.pdf	Pharmacy and Medicines Management	Policy	28/08/2012	01/05/2017	Hannah Greaves (BCUHB - Pharmacy)	Financial	High	Q3 2024/25	Q4 2024/25	Waiting for consultation on All Wales policy - therefore moved to Q3 2024/25.	After discussing with Hannah Greaves she has confirmed that she is still waiting for information back from the national group on the All Wales Top up policy therefore please could I request that the deadline for this one is moved to Qtr 4.	Medium confidence
MD10 - Medical & Dental Staff Study Leave Policy - V0.1.pdf	Office of the Medical Director	Policy	20/10/2014	20/10/2017	James Risley (BCUHB - Office of the Medical Director); Joanne Shillingford (BCUHB - Office of the Medical Director)	HR/Staff	Medium	Q4 2024/25	Q1 2025/26	Due to be discussed with LNC rep as several queries relating to T & C that need checking - then will go on intranet under consultation then to LNC likely to be January	To go through relevant specialist governance groups - aiming for Q4 reality may be Q1 2025. There is a new All Wales for Study Leave which covers some aspects of this - People Services have asked for certain section to be removed and noted of All Wales but still need to double check remainder is correct	High confidence
MD13 - Annual Leave & Special Leave Policy for Medical & Dental Staff - V0.1.pdf	Office of the Medical Director	Policy	20/10/2014	20/10/2017	James Risley (BCUHB - Office of the Medical Director); Joanne Shillingford (BCUHB - Office of the Medical Director)	HR/Staff	Medium	Q1 2025/26		Due to be discussed with LNC rep as several queries relating to T & C that need checking - then will go on intranet under consultation then to LNC likely to be January	Hopefully will then go through Relevant specialist governance groups - aiming for Q4 reality may be Q1 2025. Some changes generally that need updating, changes in legislation that need cross-referencing	High confidence
MD17 - Interventions Not Normally Undertaken (INNU) Policy - V1.1.pdf	Office of the Medical Director	Policy	24/07/2018	01/09/2021	Mark Walker (BCUHB - Corporate Office); Robert Atenstaedt (BCUHB - Public Health); Sarah Davies (BCUHB - Office of the Medical Director); Jill Newman (BCUHB - Performance Directorate)	*No update provided*	Medium			The MD17 INNU looks to be heading to be replaced by a new all Wales policy – namely, Evidence Based Interventions Wales (EBIW); we do not have specific timeline for this - not within our control		*Unable to classify*
MM01 - BCUHB Medicines Policy.pdf	Pharmacy and Medicines Management	Policy	18/03/2019	01/07/2022	Judith Green (BCUHB - Pharmacy)	Patient safety	Medium		Q4 2024/25		On track for review being completed by end of Q4 2024/25	Medium confidence
MD09 - Medical & Dental Staff - Sabbatical Leave Policy - V0.2.pdf	Office of the Medical Director	Policy	31/03/2017	31/03/2018	James Risley (BCUHB - Office of the Medical Director); Joanne Shillingford (BCUHB - Office of the Medical Director)	HR/Staff	Low	Q3 2024/25	Q4 2024/25	On intranet under consultation now should be going through process and meetings soon - move to Q3 please	No comments back from consultation - due to go to LNC 18th November then 1 Relevant Specialist Governance Groups - People Services Policy Group, Strategic Clinical Effectiveness Group then QDG then EPOG may need to be Q4	Medium confidence
MD11 - Medical & Dental Staff Professional Leave Policy - V0.1.pdf	Office of the Medical Director	Policy	20/10/2014	20/10/2017	James Risley (BCUHB - Office of the Medical Director); Joanne Shillingford (BCUHB - Office of the Medical Director)	HR/Staff	Low	Q4 2024/25	Q1 2025/26	Due to be discussed with LNC rep as several queries relating to T & C that need checking - then will go on intranet under consultation then to LNC likely to be January	To go through Relevant specialist governance groups - aiming for Q4 reality may be Q1 2025. Minimal changes the Professional Leave is still the same, just few amendments to alter	High confidence
MM02 - Injectable Medicines Policy.pdf	Pharmacy and Medicines Management	Policy	08/07/2019	08/07/2022	Andrew Merriman (BCUHB - Pharmacy)	Patient safety	Low		Q4 2024/25		On track for Qtr 4 completion	Medium confidence

MM05 - Intrathecal Chemotherapy Policy - V3.pdf	Pharmacy and Medicines Management; Cancer and Clinical Haematology	Policy	07/03/2018	01/03/2021	Andrew Merriman (BCUHB - Pharmacy)	Patient safety	Low		Q3 2024/25	For approval at MPPP - therefore moved to Q3 2024/25.	"Was approved at the September SACT governance meeting with one caveat about digital prescriptions. Waiting on timescales so that decision as to whether the policy can be put through for approval now, and the amendments made later, or wait for amendments now. Either way progress is being made and it will soon go through the next governance stage. ON TRACK"	Low confidence
MM10 - Antimicrobial Prescribing Policy - V4.pdf	Pharmacy and Medicines Management	Policy	11/05/2021	01/05/2024	Aled Hughes (BCUHB - Pharmacy); Suhail Sarwar (BCUHB - Pharmacy); Clara Tam (BCUHB - Pharmacy)	Patient safety	Low		Q4 2024/25		Going to November's MPPP group 20/11/24, then to the D&T meeting for 4th December. On BRAG agenda. Will go to MPPP then DTG. Please could you move the set deadline for MM10 to end of Qtr 4 there is a delay in getting it out for consultation at this time	Medium confidence
MM37 - Medical Gases - Staff Responsibilities across BCUHB - V1.1.pdf	Pharmacy and Medicines Management	Policy	28/11/2018	01/05/2021	Andrew Merriman (BCUHB - Pharmacy)	Patient safety	Low		Q4 2024/25		On track for Qtr 4 completion	Medium confidence
MM42 - Unlicensed Medicines Policy - V1.pdf	Pharmacy and Medicines Management	Policy	21/05/2019	01/07/2022	Christopher Pritchard (BCUHB - Pharmacy)	Patient safety	Low		Q4 2024/25		Approved at PSG on 29/10/24. Unfortunately this policy did not make it onto the EDQG agenda in December so is on for Jan 25 therefore please could you move the deadline at your side from Qtr 3 to Qtr 4.	Medium confidence
RD03 - Policy for Intellectual Property - V2.pdf	Research and Development	Policy	02/09/2020	01/08/2022	Lona Tudor Jones (BCUHB - Research & Development) Lynne Grundy (BCUHB - Research & Development)	Medical Research	Low	Q3 2024/25		Awaiting ALL WALES IG policy, however BCUHB policy also under local review - therefore moved to Q3 2024/25	No update on the All Wales IG policy. Local policy continues to be under review.	Low confidence
RD04 - NHS R&D Finance Policy - V1.0.pdf	Research and Development	Policy	28/07/2017	20/07/2019	Lona Tudor Jones (BCUHB - Research & Development)	Medical Research	Low	Q3 2024/25		Awaiting ALL WALES research finance policy - therefore moved to Q3 2024/25	No updates yet available with regards to All Wales finance policy.	Low confidence
MM15 - Policy for Administration & Use of Emergency & Non Emergency Oxygen in Adults in Managed Services - V2.1.pdf	Pharmacy and Medicines Management	Policy	22/05/2019	01/02/2022	Pam Lloyd (BCUHB - Respiratory Medicine); Hannah John (BCUHB - Pharmacy)	*No update provided*	*No update provided*	Q3 2024/25		Hannah John and Pam Lloyd reviewed the document a while ago and updated the areas they were able to. Some other areas required updating as policies and practices had changed. An educational package is also currently under development. This may impact. Tracey Radcliffe is leading on much of the development work around the educational package. Pam Lloyd leaving the Health Board w/c 14/10/2024. Therefore moved to Q3 2024/25	On track	Low confidence
MM41 - Covert Administration of Medication Clinical Policy.pdf	Pharmacy and Medicines Management	Policy	01/07/2019	01/06/2022	Elizabeth Bond (BCUHB - Pharmacy)	Patient safety	*No update provided*	Q3 2024/2025		There were errors when submitted to OBS on 13.09.24. Therefore moved to Q3 2024/25.	EQIA and IAST now complete, submitted to OBS, but queries outstanding. Once resolved, it will be uploaded	Low confidence

POLICY MANAGEMENT SYSTEM
OVERDUE WRITTEN CONTROL DOCUMENTS AS AT 2nd OCTOBER 2024
Updated information as at 18/12/2024
Includes WCDs only, not policies
Excluding All Wales WCDs; appendices to WCDs
Includes only one bilingual version of a WCD

Name	Category	Policy type	Effective Date	Review Date	Author	Risk category	Risk level of being overdue	Updated Qtr for review	Qtr for Review as at 02/10/2024	Qtr 2 progress update	Position update at 18/12/2024	Confidence of review finalised in listed quarter
CHIEF DIGITAL INFORMATION OFFICER												
IG07 - Procedure for Dealing with SARs Under Data Protection Legislation - V9.pdf	Information Governance	Procedure	19/08/2021	01/07/2024	Lisa Parry (BCUHB - Digital, Data and Technology)	Legal; Reputational	Low	Q3 2024/25		It is one of quite a few which are being reviewed and sent for consultation imminently with a view to being presented for approval at the next IGG in November - therefore moved to Q3 2024/25.	It is one of quite a few which are being reviewed and sent for consultation imminently with a view to being presented for approval at the next IGG in November - therefore moved to Q3 2024/25.	Low confidence
IG10 - Procedure for Requesting Approval and Review of an Information System for Investigation Purposes.pdf	Information Governance	Procedure	25/05/2022	01/04/2024	Carol Johnson (BCUHB - Digital, Data and Technology)	Legal; reputational	Low	Q3 2024/25	Q4 2024/25		This procedure was listed for a 2-year review, as per the front cover sheet of the document. Therefore it is now due for review. 13/11/2024 - Have asked author to amend front cover page to show approved in Nov 2023 at IGG.	Medium confidence
IG24 - Notification of Personal Data Breach Procedure.pdf	Information Governance	Procedure	30/06/2022	01/05/2024	Lisa Parry (BCUHB - Digital, Data and Technology)	Legal; reputational	Low		Q4 2024/25		This procedure was listed for a 2-year review, as per the front cover sheet of the document. Therefore it is now due for review.	Medium confidence
IG28 - Bring Your Own Device (BYOD) Procedure.pdf	Information Governance	Procedure	30/05/2022	30/05/2023	Lisa Parry (BCUHB - Digital, Data and Technology)	IT; Reputational	Low		Q4 2024/25		This procedure was listed for a 1-year review, as per the front cover sheet of the document. Therefore it is now due for review.	Medium confidence
IG02 - Corporate Records Management Procedure.pdf	Information Governance	Procedure	08/12/2021	01/10/2024	Lisa Parry (BCUHB - Digital, Data and Technology)	*No update provided*	*No update provided*		Q2 2024/25			High confidence
IG03 - Procedure for Compliance with the FOI Act 2000 & EIR 2004 - V7.pdf	Information Governance	Procedure	08/12/2021	01/10/2024	Lisa Parry (BCUHB - Digital, Data and Technology)	*No update provided*	*No update provided*		Q4 2024/25			Medium confidence
IG08 - Email Procedure - V7.pdf	Information Governance	Procedure	08/12/2021	01/10/2024	Lisa Parry (BCUHB - Digital, Data and Technology)	*No update provided*	*No update provided*		Q4 2024/25			Medium confidence
CHIEF EXECUTIVE												
OBS04 - Procedure for Co-ordinating Cabinet Secretary, Ministerial or VIP Visits & Official Openings .pdf	Communications	Procedure	28/02/2018	28/02/2021	Helen Stevens-Jones (BCUHB – Partnerships, Engagement and Communication); Elin Gwynedd (BCUHB - Corporate Office)	Reputational	Low				May look at developing a local SOP rather than this being a procedure. Discussions ongoing	*Unable to classify*
CHIEF OPERATING OFFICER												
CA3 - Cancer & Specialist Palliative Medicine Guideline for Management of Neutropenic Sepsis - V0.3.pdf	Cancer and Clinical Haematology; Palliative and End of Life Care	Guideline	01/12/2014	01/04/2016	Imran Devji (BCUHB - Corporate Office)	Patient safety	High	Q4 2024/25			Approved in SACT governance in Oct 2024 - listed for approval at empirical guidelines in December 2024	Medium confidence
CSPM01 - Guidance for Ensuring Safety and Quality of Chemotherapy Services - V0.1.pdf	Cancer and Clinical Haematology	Other	22/07/2013	01/04/2016	Catherine Bale (BCUHB - Cancer Services)	HR/Staff; Patient safety	High	Q2 2025/26	Q4 2024/25		Review in Q4 (Local Governance). Recent H&S visits scored high	Medium confidence
CSPM02 - Guidelines for the Management of Tumour Lysis Syndrome in Haematological & Solid Tumour Malignancies - V2.pdf	Cancer and Clinical Haematology	Guideline	01/11/2018	01/12/2021	Imran Devji (BCUHB - Corporate Office)	Patient safety	High	Q1 2025/26			Adopting National guidance. Approved in Drugs and Therapeutic Group (DTG) Feb 2024 -chasing where up to	High confidence
CSPM2 - Hydration Protocol for Cisplatin Chemotherapy - V1.3.pdf	Cancer and Clinical Haematology	Protocol	16/06/2015	01/07/2018	Tracy Parry (BCUHB - Pharmacy)	Patient safety	High	Q1 2025/26			Adopting National guidance. Approved in DTG (Local Governance) Feb 2024 - chasing where up to	High confidence
CSPM3 - Guidelines for the use of Granulocyte Colony Stimulating Factors (G-CSF) in Adult Haematology & Oncology Patients - V2.pdf	Cancer and Clinical Haematology	Guideline	01/12/2017	01/11/2020	Imran Devji (BCUHB - Corporate Office)	Patient safety	High	Q2 2025/26			Will be reviewed by Local Governance in Q4	High confidence
CSPM4 - Guidelines for the Management of Chemotherapy Induced Diarrhoea in Adult Patients with Cancer - V1.0.pdf	Cancer and Clinical Haematology	Guideline	01/10/2018	01/10/2021	Anne Marie Humphreys (BCUHB - Cancer Services)	Patient safety	High	Q1 2025/26			Policy reviewed and updated -listed for SACT Governance in Jan 2025	High confidence
Gyn 09 - Emergency Gynaecology Unit Miscarriage and Ectopic Pregnancy - V2.pdf	Women's Directorate	Guideline	01/12/2020	01/12/2023	Nick Clerk (BCUHB - Obstetrics & Gynaecology)	Patient safety	High	Q4 2024/25			Mr Clerk is currently reviewing Mrs Kumar's comments then it can go to Womens QSE for service review/ approval.	Medium confidence
Mat 13 - Birth Planning When Women Choose Options That Are Outside BCUHB Policies - V1.pdf	Women's Directorate	Guideline	01/01/2021	01/01/2024	Emma Adamson (BCUHB - Gynae & Obstetrics)	Health and Safety; Patient safety	High	Q4 2024/25			This WCD is currently out for comment until 05/12/24.	Medium confidence
Mat 16 - Fetal Medicine Scan on Consultant List - V2.pdf	Women's Directorate	Other	20/12/2019	20/12/2022	Bidyut Kumar (BCUHB - Obstetrics & Gynaecology)	Patient safety	High	Q4 2024/25			Author Mr Kumar hopes to have a revised version by the end of November for circulating for comment again.	Medium confidence
Mat 23 - Venous Thromboembolism in Pregnancy - Prevention, Diagnosis and Treatment - V3.pdf	Women's Directorate	Guideline	01/03/2021	01/04/2024	Joseph Mechery (BCUHB - Obstetrics & Gynaecology)	Patient safety	High	Q1 2025/26			Author emailed again on 27/11/24 for timeframe of reviewing and updating WCD so can go out for comment.	High confidence
Mat 24 - Women Who Present In Labour Who Are Not Booked or Have Received No Antenatal Care or Initial Assessment - V3.pdf	Women's Directorate	Guideline	01/12/2020	01/12/2023	Eleri Pritchard (BCUHB - Maternity)	Patient safety	High	Q1 2025/26			Awaiting authors to review comments so WCD can go through the meetings approval process. Authors emailed again on 27/11/24.	High confidence
Mat 25 - Acceptance or Assessment of Maternal and Fetal Wellbeing on the Outpatient Assessment Unit (MOAU) - V5.pdf	Women's Directorate	Guideline	01/06/2021	01/06/2024	Kizzy Williams (BCUHB - Maternity)	Patient safety	High	Q1 2025/26			Author was off sick but is reviewing current guideline for updating. Emailed again on 27/11/24.	High confidence
Mat 28 - Small for Gestational Age and Fetal Growth Restricted Babies - Antenatal Management - V1.1.pdf	Women's Directorate	Other	01/06/2021	01/06/2024	Bidyut Kumar (BCUHB - Obstetrics & Gynaecology)	Patient safety	High	Q1 2025/26			Author will review early December due to other guideline commitments.	High confidence
Mat 34 - Antepartum Haemorrhage - V2.pdf	Women's Directorate	Other	01/12/2020	01/12/2023	Mian Khurshid (BCUHB - Obstetrics & Gynaecology)	Patient safety	High	Q1 2025/26			Author has been emailed again on 27/11/24 for a timeframe on when the guideline will be reviewed and updated, to then go out for comment.	High confidence
Mat 35 - Assisted Vaginal Birth (formerly Operative Vaginal Delivery) - V3.pdf	Women's Directorate	Other	01/07/2021	01/07/2024	Neelam Singh (BCUHB - Obstetrics & Gynaecology)	Patient safety	High	Q1 2025/26			Awaiting author to review current guideline and update. Emailed again on 27/11/24.	High confidence
Mat 43 - External Cephalic Version at Term - V2.pdf	Women's Directorate	Guideline	01/12/2020	01/12/2023	Hari Muppala (BCUHB - Obstetrics & Gynaecology)	Patient safety	High	Q3 2024/25		Currently out for full peer review consultation closing on 01/11/24 - therefore moved to Q3 2024/25.	Comments collated and sent to author.	Low confidence
Mat 45 - Intermittent Auscultation of the Fetal Heart in Labour - V1.pdf	Women's Directorate	Other	01/01/2021	01/01/2024	Emma Adamson (BCUHB - Gynae & Obstetrics)	Patient safety	High	Q3 2024/25		Author working on review of WCD ASAP - therefore moved to Q3 2024/25.	Internal meeting being held on 5th December to discuss.	Low confidence
Mat 56 - Shoulder Dystocia - V3.pdf	Women's Directorate	Guideline	01/07/2021	01/07/2024	Sarah Pitts (BCUHB - Obstetrics & Gynaecology)	Patient safety	High	Q1 2025/26			Awaiting author to email revised WCD to go out for comment. Emailed author for update on 27/11/24.	High confidence
Mat 70 - Neonatal Examination of the Newborn by Midwives - V3.pdf	Women's Directorate	Guideline	24/05/2019	01/06/2022	Meinir Clayton Evans (BCUHB - Maternity)	Patient safety	High	Q3 2024/25		WCD been updated and started to go through governance meetings for review/ approval but query regarding All Wales document - therefore moved to Q3 2024/25.	WCD has been reviewed and updated but Consultant Midwife reviewing at present against national standards.	Low confidence
Mat 86 - Maternal Mental Health Guideline.pdf	Women's Directorate; Mental Health and Learning Disabilities	Guideline	01/01/2020	01/01/2023	Deborah Griffin (BCUHB - Mental Health & Learning Disabilities)	Patient safety	High	Q3 2024/25		Awaiting Pharmacy review/ approval - therefore moved to Q3 2024/25.	Awaiting Pharmacy review/ approval and comments will be sent back to authors. FP emailed for update on 27/11/24.	Low confidence
Mat 97 - Reduced or Altered Fetal Movements - V1.pdf	Women's Directorate	Guideline	01/08/2021	01/08/2024	Niladri Sengupta (BCUHB - Obstetrics & Gynaecology); Julie Reeve (BCUHB - Obstetrics & Gynaecology)	Patient safety	High	Q4 2024/25			Author has been emailed again on 27/11/24 for a timeframe on when the guideline will be reviewed and updated, to then go out for comment.	Medium confidence
MH2 - Guidance for Crisis Care Pathway for Children & Young People Presenting with Mental Health Issues - V0.6.pdf	Children and Young People's services	Other	01/12/2016	01/12/2019	Cindy Courtney (BCUHB - Child & Adolescent Health)	Patient safety	High	Q3 2024/26			Policy review completed and ratified under Childrens Governance. Submitted to BCU Policies, further work required by author following QA process. Awaiting updated information from author	Low confidence
MP01 - Chemotherapy Protocol Validation - V1.pdf	Cancer and Clinical Haematology	Protocol	01/03/2018	01/03/2020	Tracy Parry (BCUHB - Pharmacy)	Patient safety	High	Q2 2025/26			Due to be reviewed by local governance in Q4	High confidence
OP01 - Protocol for the Management of Emergency Pressures & Escalation - V0.2.pdf	Operational Management	Protocol	13/11/2014	13/10/2015	David Hutton (BCUHB - Corporate Office);Sharon Scott (BCUHB - Corporate Office)	Patient safety	High	Q4 2025/26			All hospitals have protocols that are confirmed as part of winter planning but this policy should be prioritised.	Medium confidence

OP02 - Protocol for the Safe Management of Patients During Ambulance Handover- V0.1.pdf	Operational Management	Protocol	10/11/2014	10/11/2015	David Hutton (BCUHB - Corporate Office)	Patient safety	High	Q1 2025/26			This required a review of the WAST (Ambulance) handover protocol. This will need to be reviewed and consulted alongside guidance letters from WAST.	High confidence
PCSM01 - Clinical Protocol for Shingles Vaccination by Community Nurses - V0.1.pdf	Primary Care and Specialist Medicine	Protocol	01/02/2015	01/06/2018	Leigh Pusey (BCUHB - Health Visiting)	Patient safety	High	Q4 2024/25			Clinical information is now included in Patient Group Directions as part of legal frameworks for vaccination delivery. This provides clear governance around clinical information rather than including in operational document. This document to be removed from the Policy Management System - awaiting approval by Executive	Medium confidence
PCSM02 - Clinical Protocol for Influenza & Pneumococcal Vaccination by Nurses - V0.1.pdf	Primary Care and Specialist Medicine	Protocol	01/02/2015	01/06/2018	Leigh Pusey (BCUHB - Health Visiting)	Patient safety	High	Q4 2024/25			Clinical information is now included in Patient Group Directions as part of legal frameworks for vaccination delivery. This provides clear governance around clinical information rather than including in operational document. This document to be removed from the Policy Management System - awaiting approval by Executive.	Medium confidence
Steroid Tapering Guidance.pdf	Cancer and Clinical Haematology	Other	20/12/2018	20/12/2021	Imran Devji (BCUHB - Corporate Office)	Patient safety	High	Q3 2025/26			Initiate new review in Q4	Low confidence
CSPM03 - Precautionary Measures in the Event of Spillage Involving Cytotoxics - V1.0.pdf	Cancer and Clinical Haematology	Guideline	13/02/2019	01/02/2022	Katherine White (BCUHB - Pharmacy and Medicines Management)	HR/Staff; patient safety	Medium	Q1 2025/26		Review in local governance in Q4	Little change in guidance from UKONS	High confidence
CSPM04 - Guideline for Requesting Non-Formulary or Off-Protocol SACT - V2.0.pdf	Cancer and Clinical Haematology	Guideline	01/08/2017	01/10/2017	Tracy Parry (BCUHB - Pharmacy)	Patient safety	Medium	Q1 2025/26			Listed at Individual Patient Funding Requests (IPFR) Group in December 2024	High confidence
EH01 - Protocol for Support of Registered Children's & other Nurses working within CAMHS - V0.1.pdf	Children and Young People's services	Protocol	01/01/2013	13/12/2015	Steven Riley (BCUHB - Child & Adolescent Health)	Patient safety	Medium	Q4 2024/26			Under review	Medium confidence
LAC04 - Procedure for the Recovery of Costs associated with Looked After Children placed within BCUHB - V1.0.pdf	Children and Young People's services	Procedure	09/04/2014	01/04/2015	Susan Battery (BCUHB - Child & Adolescent Health); Llinos Edwards (BCUHB - Child & Adolescent Health)	*No update provided*	Medium					*Unable to classify*
Mat 77 - Infant Feeding Guideline (Unicef Baby Friendly Care Standards) - V2.pdf	Women's Directorate	Guideline	01/12/2020	01/12/2023	Sharon Breward (BCUHB - Maternity)	Patient safety	Medium	Q3 2024/25			Awaiting SCEG meeting review/ approval - therefore moved to Q3 2024/25.	Low confidence
Mat 82 - Handover of Care Guideline - V3.pdf	Women's Directorate	Guideline	01/02/2021	01/03/2024	Julie Reeve (BCUHB - Obstetrics & Gynaecology)	Patient safety	Medium	Q3 2024/25		Currently out for full peer review consultation - author reviewing comments and updating WCD - therefore moved to Q3 2024/25.	This WCD is currently out for comment until 05/12/24.	Low confidence
Mat 87 - Maternal Death Guideline - V3.pdf	Women's Directorate	Guideline	01/12/2020	01/12/2023	Fiona Giraud (BCUHB - Maternity)	Patient safety	Medium	Q3 2024/25		WCD has been updated - I have requested document to progress to peer review consultation for comment - therefore moved to Q3 2024/25.	Revised WCD awaited - meeting with Medical Examiners to occur first.	Low confidence
PA01 - Procedure for Point of Care Testing (PoCT) - V0.1.pdf	Pathology	Procedure	11/02/2014	05/01/2017	Geoffrey Armstrong (BCUHB - Clinical Biochemistry Services)	Patient safety	Medium	Q1 2025/26		Local point of care Cttee then will come to Policy Oversight	New version with important changes so being updated	High confidence
PTH-TR-1008 - Blood and Blood Component Requesting and Authorisation Procedure - V2.0.pdf	Pathology	Procedure	23/09/2020	23/09/2022	Rachael Surridge (BCUHB - Pathology)	Patient safety	Medium	Q2 2025/26				High confidence
RAD IR 083 - Procedure for Entitlement of IR(ME)R Functions to Perform Endovascular Procedures by Vascular Surgeons without a Consultant Radiologist being Present and Use of the Hybrid Theatre.pdf	Radiology	Procedure	14/04/2022	01/02/2024	Helen Hughes (BCUHB - Radiology)	Patient safety	Medium	Q1 2025/26				High confidence
SCH18 - Coping with Crying Guidance - V2.pdf	Safeguarding; Women's Directorate	Other	14/09/2020	14/09/2023	Anna Davies (BCUHB - Safeguarding)	Patient safety; Reputational	Medium	Q3 2024/25		Safeguarding colleagues are leading on this review - therefore moved to Q3 2024/25.		Low confidence
SH09 - SOP for School Nursing Service for Children who are on Elective Home Education - V0.1.pdf	Children and Young People's services	Procedure	06/12/2013	01/01/2016	Sharon Gammon (BCUHB - Health Visiting)	Patient safety; HR/Staff	Medium	Q3 2024/26			Remains under Review	Low confidence
AN01 - Guideline for Acupuncture as Pain Relief in Adults - V0.2.pdf	Anaesthetics, Critical Care and Pain Management	Guideline	04/12/2013	01/01/2020	Lucy Jones (BCUHB - Pain Management)	Patient safety; Health and Safety	Low	Q1 2025/26		The vast majority of pain management is carried out via AHPs and follows NICE guidance. There is a guidance document that AHPs have developed and authorised and it has been approved at 9/9/24 by AHP Governance Group. The next stage is for Exec Director to review. This policy will be used to replace the one that is mentioned here. It is considered low risk because there is very limited use of acupuncture for pain relief and the guidelines are in progress.	The process for new guidelines is underway in respect of Acupuncture and the final review and confirmation should comfortably be met by Q1 2025/26	High confidence
BCUHB SACT Prescribing Competency Passport.pdf	Cancer and Clinical Haematology	Other	01/08/2015	01/08/2018	Tracy Parry (BCUHB - Pharmacy)	Patient safety	Low	Q1 2025/26		Will be reviewed in Q4 in the Service	Not a high patient safety risk as all staff undergo Systemic Anti Cancer Therapy (SACT) passport through UK Oncology Nursing Society (UKONS)	High confidence
CA04 - Guidance for the Management of Metastatic Spinal Cord Compression in Adults - V0.1.pdf	Cancer and Clinical Haematology	Other	01/06/2016	01/07/2018	Claire Fuller (BCUHB - Medical Oncology)	Patient safety	Low				Policy reviewed by clinical oncologist -nil changes. Listed for Cancer Governance Group in January 2025	*Unable to classify*
CA05 - Acute Oncology Operational Guidance - V0.1.pdf	Cancer and Clinical Haematology	Other	01/10/2016	01/10/2018	Beryl Roberts (BCUHB - Cancer Services)	Patient safety	Low	Q4 2024/25			Update provided via Phil Meakin 02/12/2024 - "Completed - awaiting to go on intranet". BCU Policies response - no record of this received in the BCU Policies inbox as at 04/12/2024	Medium confidence
CA06 - Guidelines for Treatment of Oral Mucositis in Oncology & Haematology Patients - V0.1.pdf	Cancer and Clinical Haematology	Guideline	01/11/2016	01/11/2019	Imran Devji (BCUHB - Corporate Office)	Patient safety	Low	Q4 2024/25			Policy reviewed. Approved at Systemic Anti Cancer Therapies (SACT) governance. Listed for Medicines Management Group review in Jan 2025.	Medium confidence
CSPM1 - Clinical Guidelines for the Management of Chemotherapy & Radiotherapy Induced Nausea & Vomiting - V1.2.pdf	Cancer and Clinical Haematology	Guideline	30/09/2014	01/10/2017	Tracy Parry (BCUHB - Pharmacy)	Patient safety	Low	Q1 2025/26			Reviewed and approved at SACT governance- nil changes. Listed for Meds Management Review in Jan 2025	High confidence
Gyn 03 - Ovarian Hyperstimulation Syndrome - V3.pdf	Women's Directorate	Guideline	01/12/2020	01/12/2023	Arpana Jain (BCUHB - Obstetrics & Gynaecology)	Patient safety	Low	Q3 2024/25		This WCD will be going to SCEG for final approval on 10/12/24.	If approved by SCEG, WCD will be sent to BCU Policies for loading to the intranet.	Low confidence
Gyn 11 - BCUHB Fertility Service.pdf	Women's Directorate	Protocol	01/12/2020	01/12/2023	Jayne Beattie (BCUHB - Family Services)	Patient safety	Low	Q2 2025/26			The new policy remains under review. Lots of consultation in Wales. BCU to review the Fertility Referral Pathway to align to the new Policy. GK and FG to consider /appoint a colleague to review localised policies to reflect the Policy in Wales. GK to approach Mr Taylor and Karen Ansell. Awaiting JCC updated policy to inform local revision - no date confirmed.	High confidence
Gyn 12 - Uterine Artery Embolisation - V2.pdf	Women's Directorate	Guideline	01/12/2020	01/12/2023	Gudrun Rieck (BCUHB - Obstetrics & Gynaecology)	Patient safety	Low		Q4 2024/25		Pharmacy are reviewing, then FP can send to Cindy R for December 2024 SCEG meeting. SCEG meeting for review on 10/12/24.	Medium confidence
Mat 33 - Amniotic Fluid Embolism - V2.pdf	Women's Directorate	Guideline	01/12/2020	01/12/2023	Lynda Verghese (BCUHB - Obstetrics & Gynaecology)	Patient safety	Low		Q3 2024/25		This has been through approvals process, just awaiting EQIA IAST completion before sending to BCU Policies. Awaiting EQIA.	Low confidence
Mat 40 - Cord Prolapse - V2.pdf	Women's Directorate	Guideline	01/08/2021	01/08/2024	Niladri Sengupta (BCUHB - Obstetrics & Gynaecology)	Patient safety	Low	Q1 2025/26			No changes to make to current version - WCD is out for peer review consultation 27/11/24 - 27/12/24.	High confidence
Mat 59 - Uterine Inversion - V2.pdf	Women's Directorate	Guideline	01/08/2021	01/08/2024	Niladri Sengupta (BCUHB - Obstetrics & Gynaecology)	Patient safety	Low	Q1 2025/26			No changes to make to current version - WCD is out for peer review consultation 27/11/24 - 27/12/24.	High confidence
Mat 79 - Breastfeeding Peer Supporters as Volunteers in BCUHB - V4.pdf	Women's Directorate	Guideline	01/07/2020	01/08/2023	Sharon Breward (BCUHB - Maternity)	Patient safety	Low	Q3 2024/25		Awaiting Childrens Services review/ approval - therefore moved to Q3 2024/25.	Awaiting outstanding approvals from Childrens Services.	Low confidence
Mat 81 - Expressing and Handling Mothers' Own Breast Milk in Hospital - V1.1.pdf	Women's Directorate	Guideline	23/07/2021	01/08/2024	Sharon Breward (BCUHB - Maternity)	Patient safety	Low		Q3 2024/25		Author emailed on 27/11/24 to ask if revised WCD is ready now for Womens meetings review process.	Low confidence
Mat 88 - Perinatal Bereavement Guideline - V3.pdf	Women's Directorate	Guideline	29/06/2021	29/06/2024	Lucy Dobbins (BCUHB - Maternity)	Patient safety	Low	Q4 2024/25			Author has been emailed again on 27/11/24 for a timeframe on when the guideline will be reviewed and updated, to then go out for comment.	Medium confidence
Mat 89 - Bereavement Follow Up Appointments following Pregnancy Loss - Standard Operating Procedure - V1.pdf	Women's Directorate	Procedure	01/11/2020	01/12/2023	Lucy Dobbins (BCUHB - Maternity)	Patient safety	Low	Q3 2024/25		WCD fully approved - just awaiting EQIA document completion and date to add to front cover - therefore moved to Q3 2024/25.	WCD fully approved - just awaiting EQIA document completion and date to add to front cover then will be sent to BCU Policies.	Low confidence
Mat 91 - Preceptorship Protocol for Newly Registered Midwives - V3.pdf	Women's Directorate	Protocol	01/12/2020	01/12/2023	Becky Ferneyhough (BCUHB - Maternity)	HR/Staff; Patient safety	Low	Q3 2024/25		To be archived once 'Once for Wales' document is live on intranet - therefore moved to Q3 2024/25.	To be archived once 'Once for Wales' document is live on intranet - just awaiting EQIA IAST from All Wales to be reviewed then will be sent to BCU Policies for loading.	Low confidence
NU32 - Guideline for Managing Continuous Subcutaneous Insulin Infusion (CSII, or 'Insulin Pump') Therapy in Adults.pdf	Nursing	Guideline	23/06/2021	01/06/2024	Iona Collins (BCUHB - Diabetes & Endocrinology); Timothy Hoe (BCUHB - Dietetics)	Patient safety	Low	Q2 2025/26		Executive approval given for this procedure to be moved to local nutrition page aligned with the suite of nutrition specialists documents for easy access for clinicians.	Guideline only just out of review date	Low confidence
RAD 036 - Operation of Mobile Mini C-Arm X-Ray Fluroscopy Equipment Outside Radiology - V2.pdf	Radiology	Other	12/09/2019	12/08/2021	Helen Hughes (BCUHB - Radiology)	Patient safety	Low	Q1 2025/26				High confidence

RAD NM 024 - Transport of Radioactive Materials within BCUHB Joint Working Procedure - V1.pdf	Radiology	Procedure	12/09/2020	14/01/2021	David Jones (BCUHB - Radiology)	Health and Safety; HR/Staff	Low	Q1 2025/26				High confidence
Mat 17 - Fundal Height Meausurement and Follow Up - V10.pdf	Women's Directorate	Guideline	01/10/2021	01/10/2024	Janet Quarmby (BCUHB - Maternity)	*No update provided*	*No update provided*		Q4 2024/25			Medium confidence
Mat 71 - Identification of the Newborn - V3.pdf	Women's Directorate	Guideline	01/10/2021	01/10/2024	Jane Jones (BCUHB - Maternity)	*No update provided*	*No update provided*	Q4 2024/25				Medium confidence
DIRECTOR OF CORPORATE GOVERNANCE												
BCUHB - Legal Services Department - Claims Governance & Management Procedure.pdf	Legal	Procedure	12/12/2018	16/07/2021	Matthew Joyes (BCUHB - Legal Services)	Legal; Financial	Low	Q4 2024/25			The transfer of Legal Services from Nursing/Medical to Corporate Governance presents an opportunity to fully review policy, procedure and process. This work is taking place at pace with the aim of a new, integrated legal policy to be developed and ratified. Work continued to review the risk and opportunities from a different approach to Legal Services, which will include a new policy as part of a Transforming Legal Services Plan. Discovery work is underway and this will lead to drafting of a new, integrated legal policy during Q3 for consultation and then approval in Q4.	Medium confidence
GC05 - Procedure for Accessing Legal Advice - V0.2.pdf	Corporate Governance Directorate	Procedure	01/01/2016	01/02/2018	Matthew Joyes (BCUHB - Legal Services)	Legal; Financial	Low	Q4 2024/25			The transfer of Legal Services from Nursing/Medical to Corporate Governance presents an opportunity to fully review policy, procedure and process. This work is taking place at pace with the aim of a new, integrated legal policy to be developed and ratified. Work continued to review the risk and opportunities from a different approach to Legal Services, which will include a new policy as part of a Transforming Legal Services Plan. Discovery work is underway and this will lead to drafting of a new, integrated legal policy during Q3 for consultation and then approval in Q4.	Medium confidence
DIRECTOR OF ENVIRONMENT AND ESTATES												
Contractors Safety Guidance - V9.pdf	Estates	Other	01/04/2019	01/12/2020	Tanya Coppack (BCUHB - Estates)	Contractors	Low		Q3 2024/25		Contractors Safety Documents legislative content is compliant and awaiting review, will be completed in Q3	Low confidence
OPD HTM02-01 - Medical Gas Pipeline Systems - V1.pdf	Estates	Procedure	17/07/2019	01/08/2020	Tanya Coppack (BCUHB - Estates)	Health and Safety	Low		Q4 2024/25		HB Medical Gas Group have reviewed the policy and currently awaiting appointment of Director of Environment and Estates to update roles and responsibilities section of policy	Medium confidence
EXECUTIVE DIRECTOR OF ALLIED HEALTH PROFESSIONS AND HEALTH SCIENCE												
MHLD 0005 - Ty Llywelyn Patients Visitors Procedure.pdf	Mental Health and Learning Disabilities	Procedure	21/03/2019	01/10/2022	Simon Allen (BCUHB - Mental Health & Learning Disabilities)	Reputational	Low	Q4 2024/25			Awaiting review	Medium confidence
MHLD 0009 - Major Incident Protocol - Ty Llywelyn Medium Secure Unit.pdf	Mental Health and Learning Disabilities	Protocol	15/01/2021	15/01/2022	Ian Jones (BCUHB - Mental Health & Learning Disabilities)	Patient safety; Health and Safety	Low	Q4 2024/25			Under development	Medium confidence
MHLD 0024 - Adults with a Learning Disability Requiring Admission to Acute Psychiatric In-patient Services - V0.1.pdf	Mental Health and Learning Disabilities	Other	21/03/2017	01/03/2020	Simon Meadowcroft (BCUHB - Learning Disability Services)	Patient safety	Low	Q3 2024/25		Not approved at EQDG, awaiting confirmation of approval groups and dates. Therefore moved to Q3 2024/25		Low confidence
MHLD 0036 - Needle Syringe Provisions for Young People Guidelines - V0.1.pdf	Mental Health and Learning Disabilities	Guideline	22/08/2018	01/08/2021	Jodie Morgan (BCUHB - Substance Misuse Services)	Patient safety; Health and Safety	Low	Q4 2024/25			Submitted to CGD, but as at 08/11/2024, there is no record of this with the CGD	Medium confidence
MHLD 0038 - Substance Misuse Service Allocation Waiting List Protocol - V0.3.pdf	Mental Health and Learning Disabilities	Protocol	22/08/2018	22/08/2021	Jodie Morgan (BCUHB - Substance Misuse Services)	Patient safety	Low		Q3 2024/25		Under development	Low confidence
MHLD 0045 - Bed Escalation Procedure - MHLD - V1.3.pdf	Mental Health and Learning Disabilities	Procedure	13/07/2021	01/07/2024	Paul Hanna (PTHB - Mental Health)	Patient safety	Low	Q3 2024/25		With Assistant Director MHLD to be finalised - therefore moved to Q3 2024/25.	Under review	Low confidence
MHLD 0048 - Operational Procedure for Community Forensic Mental Health Services -V3.pdf	Mental Health and Learning Disabilities	Procedure	01/02/2019	01/02/2021	Greg Yates (BCUHB - Mental Health & Learning Disabilities)	Patient safety; Joint working/Collaboration	Low	Q4 2024/25			IAST and EqIA outstanding	Medium confidence
MHLD 0052 - Standard Operating Procedure for the use of Gyms & Sports Facilities.pdf	Mental Health and Learning Disabilities	Procedure	11/09/2019	01/07/2022	Lucy Clarke (BCUHB - Occupational Therapy); Leanne Gill (BCUHB - Mental Health & Learning Disabilities)	HR/Staff; Health and Safety	Low	Q3 2024/25		To be submitted to OBS following final QA and completion of IAST - therefore moved to Q3 2024/25.		Low confidence
MHLD 0053 - Meeting the Physical Health Care Needs of People Admitted to an Older Persons Mental Health Ward - V0.1.pdf	Mental Health and Learning Disabilities	Guideline	13/09/2019	13/09/2022	Premraj Muthuvelu (BCUHB - Mental Health & Learning Disabilities)	Patient safety	Low	Q1 2025/26			Under development	High confidence
MHLD 0057 - North Wales Section 135 & 136 Mental Health Act 1983 Protocol.pdf	Mental Health and Learning Disabilities; Safeguarding	Protocol	01/04/2021	01/04/2024	Ruth Joyce (BCUHB - Mental Health & Learning Disabilities)	Legal	Low	Q1 2025/26			Pan N.W. document	High confidence
MHLD 0058 - Hafod Mental Health Resource Centre - PocHi Operational Procedure - V0.1.pdf	Mental Health and Learning Disabilities	Procedure	01/03/2020	01/02/2023	Iain Dawson (BCUHB - Pharmacy)	Joint working/Collaboration	Low	Q3 2024/25		SoP in process, to go out for consultation and approval - therefore moved to Q3 2024/25.		Low confidence
MHLD 0059 - Memory Services Operational Protocol.pdf	Mental Health and Learning Disabilities	Protocol	01/11/2020	01/11/2022	Joanne Kelly-Rhind (BCUHB - Clinical Psychology)	Joint working/Collaboration	Low	Q3 2024/25		Approved to be submitted to OBS once IAST completed - therefore moved to Q3 2024/25.		Low confidence
MHLD 0060 - Criminal Justice Liaison Service Standard Operating Procedure.pdf	Mental Health and Learning Disabilities	Procedure	01/08/2020	01/08/2023	Ruth Joyce (BCUHB - Mental Health & Learning Disabilities)	Patient safety; Joint working/Collaboration	Low	Q3 2024/25		With author for review - therefore moved to Q3 2024/25.		Low confidence
MHLD 0067 - Patient Anti Bullying Procedure - Ty Llywelyn Medium Secure Unit - V1.pdf	Mental Health and Learning Disabilities	Procedure	01/10/2020	01/10/2023	Simon Allen (BCUHB - Mental Health & Learning Disabilities)	HR/Staff	Low	Q3 2024/25		Submitted to OBS 03/10 for upload - therefore moved to Q3 2024/25.		Low confidence
MHLD 0068 - Perinatal Guidelines for Pain Control in Women on Opioid Substitution Therapy - V4.3.pdf	Mental Health and Learning Disabilities	Guideline	13/11/2020	16/11/2023	Lis Hughes (BCUHB - Substance Misuse Services)	Patient safety	Low	Q3 2024/25		IAST and EqIA to be finalised prior to submission to PSG - therefore moved to Q3 2024/25.		Low confidence
MHLD 0071 - Clinical Risk Management Procedure - V6.pdf	Mental Health and Learning Disabilities	Procedure	01/10/2021	01/11/2023	Robyn Jones (BCUHB - Mental Health & Learning Disabilities); Joanne Kendrick (BCUHB - Mental Health & Learning Disabilities)	Patient safety; Legal	Low	Q3 2024/25		Submitted to PSG on 29/10 agenda for approval - therefore moved to Q3 2024/25.		Low confidence
MHLD 0073 - Guidelines for the use of Buvidal® Injection within the Substance Misuse Service.pdf	Mental Health and Learning Disabilities	Guideline	04/11/2020	03/11/2020	Luxman Parimelalagan (BCUHB - Substance Misuse Services)	Patient safety	Low		Q3 2024/25		Documents for approval at October 2024 SQDG meeting	Low confidence
MHLD 0078 - Nicotine Replacement Therapy (NRT) Supplementary Guidance for MHLD inpatients.pdf	Mental Health and Learning Disabilities	Guideline	16/09/2022	01/09/2022	Elizabeth Bond (BCUHB - Pharmacy)	Patient safety	Low					*Unable to classify*
MHLD RM04 - Risk Managment Procedure.pdf	Mental Health and Learning Disabilities	Procedure	01/06/2019	01/12/2020	Francine Moore (BCUHB - Quality Directorate)	Reputational	Low	Q1 2025/26				High confidence
MM76 - BCUHB Guidelines for Inpatient Management of Acute Pain or Opioid Withdrawal in Adults Dependant on Opioids.pdf	Pharmacy and Medicines Management; Mental Health and Learning Disabilities	Guideline	01/10/2021	01/11/2023	Haimon Chaudhry (BCUHB - Pharmacy); Ceri Thompson (BCUHB - Pharmacy)	Patient safety	Low				On PSG agenda 29/10	*Unable to classify*
SOP1 - Referral, Triage and Allocation process for Stroke Rehabilitation Pathway- Early Supported Discharge (ESD) & Stroke Specialist Inpatient Rehabilitation (SSIR).pdf	Therapies and Health Sciences	Procedure	14/02/2023	03/11/2023	Sushmita Mohapatra (BCUHB - Therapies & Health Science); Karl Jackson (BCUHB - Stroke Unit); Nia Williams (BCUHB - Stroke Unit)	Patient safety	Low	Q3 2024/25		Approved at CEG 13.08.2024 - therefore moved to Q3 2024/25.	This pan-BCU generic Stroke SOPs will remain in place whilst work is ongoing process of approving local SOPs for each IHC. The current SOP will remain in place whilst the work to review is undertaken, which could take a month or so (end of December).	Low confidence
SOP2 - Early Supported Discharge Multi-Disciplinary Team process for Stroke Rehabilitation Pathway.pdf	Therapies and Health Sciences	Procedure	14/02/2023	03/11/2023	Sushmita Mohapatra (BCUHB - Therapies & Health Science); Karl Jackson (BCUHB - Stroke Unit); Nia Williams (BCUHB - Stroke Unit)	Patient safety	Low	Q3 2024/25		Approved at CEG 13.08.2024 - therefore moved to Q3 2024/25.	This pan-BCU generic Stroke SOPs will remain in place whilst work is ongoing process of approving local SOPs for each IHC. The current SOP will remain in place whilst the work to review is undertaken, which could take a month or so (end of December).	Low confidence
SOP3 - Discharge process for Stroke Rehabilitation Pathway- Early Supported Discharge (ESD).pdf	Therapies and Health Sciences	Procedure	14/02/2023	03/11/2023	Sushmita Mohapatra (BCUHB - Therapies & Health Science); Karl Jackson (BCUHB - Stroke Unit); Nia Williams (BCUHB - Stroke Unit)	Patient safety	Low	Q3 2024/25		Approved at CEG 13.08.2024 - therefore moved to Q3 2024/25.	This pan-BCU generic Stroke SOPs will remain in place whilst work is ongoing process of approving local SOPs for each IHC. The current SOP will remain in place whilst the work to review is undertaken, which could take a month or so (end of December).	Low confidence

SOP4 - Multi-Disciplinary Team (MDT) process for Stroke Rehabilitation Pathway- Stroke Specialist Inpatient Rehabilitation (SSIR).pdf	Therapies and Health Sciences	Procedure	14/02/2023	03/11/2023	Karl Jackson (BCUHB - Stroke Unit); Nia Williams (BCUHB - Stroke Unit); Sushmita Mohapatra (BCUHB - Therapies & Health Science)	Patient safety	Low	Q3 2024/25		Approved at CEG 13.08.2024 - therefore moved to Q3 2024/25.	This pan-BCU generic Stroke SOPs will remain in place whilst work is ongoing process of approving local SOPs for each IHC. The current SOP will remain in place whilst the work to review is undertaken, which could take a month or so (end of December).	Low confidence
SOP5 - Discharge process for Stroke Rehabilitation Pathway- SSIR.pdf	Therapies and Health Sciences	Procedure	14/02/2023	03/11/2023	Sushmita Mohapatra (BCUHB - Therapies & Health Science); Karl Jackson (BCUHB - Stroke Unit); Nia Williams (BCUHB - Stroke Unit)	Patient safety	Low	Q3 2024/25		Approved at CEG 13.08.2024 - therefore moved to Q3 2024/25.	This pan-BCU generic Stroke SOPs will remain in place whilst work is ongoing process of approving local SOPs for each IHC. The current SOP will remain in place whilst the work to review is undertaken, which could take a month or so (end of December).	Low confidence
DEM PHOT 01 - BCUHB Phototherapy Guideline.pdf	Nursing; Therapies and Health Sciences	Guideline	20/05/2021	20/05/2023	Sali Anderson (BCUHB - Dermatology); Heidi Evans (BCUHB - Dermatology); Linda2 Roberts (BCUHB - Dermatology); Fiona Welsh (BCUHB - Physiotherapy); Miriam Williams (BCUHB - Dermatology); Rebecca Leavesley (BCUHB - Dermatology)	*No update provided*	*No update provided*	Q4 2024/25		Updated to Q4 2024/25		Medium confidence
Early Identification and Management of In-patients with Dysphagia Process.pdf	Therapies and Health Sciences; Nursing	Other	13/04/2021	01/12/2023	Cara Spencer (BCUHB - Speech & Language Therapy)	*No update provided*	*No update provided*	Q3 2024/25	Q4 2024/25			Medium confidence
MM17 - Guidelines for the Management of Delirium in Adults 18 years and older in Acute Care and Long Term Care Settings.pdf	Pharmacy and Medicines Management; Mental Health and Learning Disabilities	Guideline	14/04/2022	14/04/2024	Elizabeth Bond (BCUHB - Pharmacy)	*No update provided*	*No update provided*		Q3 2024/25			Low confidence
MM25 - Standard Operating Procedure for the Supply of Take Home Naloxone Preparations - V1.0.pdf	Pharmacy and Medicines Management; Mental Health and Learning Disabilities	Procedure	12/09/2019	12/09/2022	Elizabeth Bond (BCUHB - Pharmacy)	*No update provided*	*No update provided*		Q4 2024/25			Medium confidence
MM51 - Guideline for Monitoring Physical Health in Adults with Psychosis or Schizophrenia - V0.1.pdf	Pharmacy and Medicines Management; Mental Health and Learning Disabilities	Guideline	01/11/2017	01/11/2019	Elizabeth Bond (BCUHB - Pharmacy)	Patient safety	*No update provided*	Q3 2024/25		Submitted to PSG on 29/10 agenda for approval - therefore moved to Q3 2024/25.		Low confidence
MM52 - Guideline for the Use of Antipsychotics in the Management of Behavioural & Psychological Symptoms of Dementia - V0.2.pdf	Pharmacy and Medicines Management; Mental Health and Learning Disabilities	Guideline	06/06/2018	01/07/2021	Elizabeth Bond (BCUHB - Pharmacy);	Patient safety	*No update provided*		Q3 2024/25			Low confidence
MM55 - Hafen Wen (BCUHB SMS) Inpatient Detoxificaiton Prescribing Guidelines.pdf	Pharmacy and Medicines Management; Mental Health and Learning Disabilities	Guideline	16/05/2019	01/05/2022	Elizabeth Bond (BCUHB - Pharmacy);	Patient safety	*No update provided*	Q3 2024/25		Approved to be submitted to OBS once IAST completed - therefore moved to Q3 2024/25.		Low confidence
EXECUTIVE DIRECTOR OF FINANCE												
AL02 - Fund Advisor Handbook & Accountability Agreements - V1.pdf	Charities and Volunteers	Other	01/01/2017	01/01/2018	Kirsty Thomson (BCUHB - Corporate Services)	Financial; Reputational	Low	Q3 2024/25		Consultation on BetsiNet - renamed to 'Your Charity Procedures'. Now incorporates AL01 - therefore moved to Q3 2024/25.	Update 09/12/2024 from the Interim Executive Director of Finance - confirmed that AL02 being reviewed and new versions endorsed	Low confidence
AL03 - Collaborative Working Protocol - V0.1.pdf	Charities and Volunteers	Protocol	12/09/2016	12/09/2017	Kirsty Thomson (BCUHB - Corporate Services)	Joint working/Collaboration; Reputational	Low	Q3 2024/25		For November CEG meeting - therefore moved to Q3 2024/25	Initial draft complete. Revision being made following feedback from EDoF	Low confidence
F01 - Patients Property and Monies - Wards and Departments.pdf	Finance	Procedure	08/01/2020	01/11/2022	Simon Weaver (BCUHB - Finance)	Financial; Reputational	Low		Q3 2024/25		"Draft out for consultation. Risk considered low as existing procedure already in place and no material changes expected"	Low confidence
F04 - Cash Collection Receipting and Banking Arrangements - V0.2.pdf	Finance	Procedure	14/07/2017	19/07/2019	Simon Weaver (BCUHB - Finance)	Financial; HR/Staff	Low	Q3 2024/25		Awaiting Executive Director of Finance sign-off - therefore moved to Q3 2024/25.	Risk considered low as existing procedure already in place and no material changes made to revised procedure	Low confidence
F05 - Income and Debt Recovery - V0.2.pdf	Finance	Procedure	02/02/2017	15/02/2019	Simon Weaver (BCUHB - Finance)	Financial	Low	Q3 2024/25		Awaiting Executive Director of Finance sign-off - therefore moved to Q3 2024/25.	Risk considered low as existing procedure already in place and no material changes made to revised procedure	Low confidence
F06 - Losses and Special Payments - V0.2.pdf	Finance	Procedure	02/02/2017	15/02/2019	Simon Weaver (BCUHB - Finance)	Financial	Low		Q3 2024/25		"Draft out for consultation. Risk considered low as existing procedure already in place and no material changes expected"	Low confidence
F07 - Petty Cash Procedure- V0.2.pdf	Finance	Procedure	25/07/2017	19/07/2019	Simon Weaver (BCUHB - Finance)	Financial; HR/Staff	Low	Q3 2024/25		Awaiting Executive Director of Finance sign-off - therefore moved to Q3 2024/25.	Risk considered low as existing procedure already in place and no material changes made to revised procedure	Low confidence
F08 - Purchasing Card Procedure - V0.2.pdf	Finance	Procedure	02/02/2017	15/02/2019	Simon Weaver (BCUHB - Finance)	Financial; HR/Staff	Low	Q3 2024/25		Currently for consultation on the Draft policies page, end date of 06/10/2024, then sent to the Directors of Finance for review / sign off next week- therefore moved to Q3 2024/25.	"Awaiting Executive Director of Finance sign-off - therefore moved to Q3 2024/25. Risk considered low as existing procedure already in place and no material changes made to revised procedure"	Low confidence
F09 - Reimbursement of Travel to Hospital Costs - V3.pdf	Finance	Procedure	19/02/2020	17/02/2023	Simon Weaver (BCUHB - Finance)	Financial; Patient safety	Low	Q2 2024/25	Q4 2024/25		Risk considered low as existing procedure already in place and no material changes made to revised procedure	Medium confidence
F10 - Retention and Disposal of Property Found on Health Board Premises - V0.2.pdf	Finance	Procedure	28/03/2018	20/03/2020	Simon Weaver (BCUHB - Finance)	Health and Safety	Low		Q3 2024/25		"Draft out for consultation. Risk considered low as existing procedure already in place and no material changes expected"	Low confidence
F13 - Procedure For Use and Completion of Request To Waive SFIs - V0.1.pdf	Finance	Procedure	07/03/2018	17/01/2020	Neil Williams (BCUHB - Finance)	Financial; Legal	Low	Q3 2024/25		Awaiting Executive Director of Finance sign-off - therefore moved to Q3 2024/25.	Risk considered low as existing procedure already in place and no material changes made to revised procedure	Low confidence
F14 - Financial Procedure Salary Overpayments and Underpayments - V2.pdf	Finance	Procedure	24/02/2021	16/02/2024	Simon Weaver (BCUHB - Finance)	Financial	Low		Q4 2024/25		Risk considered low as existing procedure already in place and no material changes expected	Medium confidence
F15 - Patients Property and Monies - General Office - V0.1.pdf	Finance	Guideline	31/10/2018	16/10/2020	Simon Weaver (BCUHB - Finance)	Financial	Low		Q3 2024/25		"Draft out for consultation. Risk considered low as existing procedure already in place and no material changes expected"	Low confidence
F16 - Arranging a Hospital Funeral - V0.1.pdf	Finance	Procedure	14/12/2018	18/12/2020	Simon Weaver (BCUHB - Finance)	Financial	Low	Q4 2024/25		Review has been 'swapped' with that of F09 - 'Reimbursement of hospital travel costs', which was down to be updated later in the year. F09 was considered more pressing and has been through the various consultation stages as per the 4 procedures above and is also with the Directors of Finance for review / sign off. F16 will now be updated later in the year. Now for Q4 2024/25 review	Risk considered low as existing procedure already in place and no material changes expected	Medium confidence
F18 - Intermediaries Legislation (IR35) Procedure - V1.0.pdf	Finance	Procedure	12/02/2020	13/02/2023	Denise Roberts (BCUHB - Finance)	Financial	Low		Q3 2024/25		Risk considered low as existing procedure already in place and no material changes expected	Low confidence
AL01 - Financial Procedures - V1.11.pdf	Charities and Volunteers	Procedure	09/09/2019	09/09/2022	Neil Williams (BCUHB - Finance)	N/A	N/A	To be removed	Q2 2024/25	No longer exists - incorporated into AL02 - need Exec approval to remove from System	No longer exists - incorporated into AL02 - need Exec approval to remove from System. Update 09/12/2024 from the Interim Executive Director of Finance - confirmed that AL01 being reviewed and new versions endorsed	Low confidence
EXECUTIVE DIRECTOR OF NURSING												
BCU Criteria Led Discharge Protocol.pdf	Nursing	Protocol	14/09/2021	01/10/2022	Claire Brennan (BCUHB - Corporate Office)	Patient safety	Medium	Q4 2024/25		Policy review is the Lead for unscheduled care programme and progressing. This protocol will be within the wider work programme to develop a suite of policies. Request to move to COO oversight however delay in waiting for substantive appointment.	The Unscheduled Care Programme are reviewing this protocol in line with the wider revised hospital discharge policy and suite of documentation, to determine whether this forms an appendix to the overarching policy or remains a standalone protocol. The unscheduled care programme Group are working with National work to revise 1) Hospital Discharge policy; 2) Criteria Led Discharge and 3) Review of the use of Reluctant Discharge since its implementation. The the draft discharge policy will require a period of consultation prior to sign off by appropriate committee (PSQG or CEG). Request to move this protocol to the COO.	Low confidence

IPC16 - Food Safety in Ward Kitchens - V4.pdf	Infection Prevention and Control	Procedure	14/09/2021	01/10/2024	Andrea Ledgerton (BCUHB - Infection Control Teams)	*No update provided*	*No update provided*					*Unable to classify*
IPC29 - Animals in Healthcare Procedure - V2.pdf	Infection Prevention and Control	Procedure	14/09/2021	01/10/2024	Andrea Ledgerton (BCUHB - Infection Control Teams)	*No update provided*	*No update provided*					*Unable to classify*
ISU02 - Patient, Service User & Carer Procedure for the Production of Written Information - V4.02.pdf	Quality, Patient safety and Experience	Procedure	12/06/2020	16/06/2023	Leon Marsh (BCUHB - Nursing, Midwifery & Patient Services)	Patient safety	Low	Q3 2024/25		Due to be submitted to Patient & Carer Experience Group on 17/10/24 for approval - therefore moved to Q3 2024/25.	Final draft out for review and to be presented at the November 2024 Patient and Carers Experience Group.	Low confidence
ISUE01 - Undertaking Patient Experience Stories - V2.0.pdf	Quality, Patient safety and Experience	Other	29/04/2021	14/04/2023	Leon Marsh (BCUHB - Nursing, Midwifery & Patient Services)	Patient safety	Low	Q3 2024/25		Due to be submitted to Patient & Carer Experience Group on 17/10/24 for approval- therefore moved to Q3 2024/25.	Reviewed and revised document approved. Corporate Governance Directorate waiting confirmation on whether this is a policy. If not a policy, it can e uploaded. If a policy, it will need to go to EPOG and then ET before upload.	Low confidence
MD07 - Protocol for Using Bed Rails Safety and Effectively.pdf	Nursing	Protocol	22/06/2023	01/08/2024	Diane Read (BCUHB - Nursing, Midwifery & Patient Services)	Patient safety	Low	Q3 2024/25		Lowri reviewing the amendments prior to coming to the HB PSG with her expertise. The risk assessment has been streamlined and shared with membership with the Falls group and bed and mattress group for comment. We are expecting will be ready for the October Health Board PSG for approval - therefore moved to Q3 2024/25.	Updated protocol required further clinical specialist input therefore on the agenda for approval at the Patient Safety Group 29th October 2024. Subject to final approval and QA this will be uploaded November 2024. Request to move this protocol to clinical operational services.	Low confidence
NST03 - Parenteral Nutrition Clinical Protocol for Adults.pdf	Nursing	Protocol	13/04/2021	13/04/2024	Ruth Davies (BCUHB - Nursing, Midwifery & Patient Services); Jennifer Wykes (BCUHB - Nursing, Midwifery & Patient Services)	Patient safety	Low	Q3 2024/25		Nutrition Nurses have sent this out for stakeholders in January and have now collated their feedback, there have been some contentious feedback in relation to Out of hours provision and stock on Critical care. Jane and Ruth are planning to meet next month to update this we then send this to INCH for approval. Just to reassure there is nothing unsafe on the policy currently - therefore moved to Q3 2024/25.	Categorised as low risk as assurance gained from nutrition nurses that the current policy is safe for practice. Request to move NST03 protocol to Clinical Operational Services.	Low confidence
NU05 - Student Supervison and Assessment in Practice - V1.9.pdf	Nursing	Procedure	20/09/2021	20/09/2024	Neirian Jennings (BCUHB - Corporate Nursing)	Patient safety	Low	Q3 2024/25		Planned submission to October 2024 Policy Group for approval - therefore moved to Q3 2024/25	NU05 has been revised and updated. October 2024 Policy Group cancelled therefore NU25 submitted to 8th November meeting for approval.	Low confidence
NU10 - Urinary Catheterisation (Adults) Protocol - V0.1.pdf	Nursing	Protocol	13/01/2016	12/01/2018	Lisa Borders (BCUHB - Continence Service)	Patient safety	Low	Q3 2024/25		Now gaining the support of our Safety Matron to get this updated - therefore moved to Q3 2024/25.	Assurance gained that the existing clinical protocol is safe for clinical practice. Due the significant delay for this protocol review, the Deputy Head of Patient Safety is working with the author to review and a plan for be submission to approving group in December 2024. Request for this protocol to be moved to clinical operational services.	Low confidence
NU25 - Health Care Support Worker Development Framework - V5.pdf	Nursing	Other	20/09/2021	20/09/2024	Ade Evans (BCUHB - Corporate Nursing)	Patient safety	Low	Q3 2024/25		NU 25 going to Policy Group 18th October 2024 - therefore moved to Q3 2024/25.	NU25 Framework has been revised and updated. October 2024 Policy Group cancelled therefore NU25 submitted to 8th November meeting for approval.	Low confidence
NU26 - All Wales NHS HCA Induction Programme SOP - V1.pdf	Nursing	Procedure	20/09/2021	20/09/2024	Ade Evans (BCUHB - Corporate Nursing)	Patient safety	Low	Q3 2024/25		NU 25 going to Policy Group 18th October 2024 - therefore moved to Q3 2024/25.	NU26 SOP has been revised and updated. October 2024 Policy Group cancelled therefore NU25 submitted to 8th November meeting for approval.	Low confidence
SCH14 - Procedure for the Safeguarding Children and Young People Admitted to Adult Wards & Environments - V1.pdf	Safeguarding	Procedure	20/09/2021	20/09/2024	Lynda Collier (BCUHB - Safeguarding); Chris Walker (BCUHB - Corporate Office)	Patient safety	Low			Review not taken forward by childrens services therefore safeguarding supporting its revision.	"Transfer of sole Ownership requested to Director of Safeguarding and Public Protection on the 5th Sept 2024 from Childrens Division. procedure now aligned to Safeguarding and Public Protection. A procedure is in place, and recently out of date the risk is low. The procedure will go to the Safeguarding Governance and Performance Group Jan 2025, in line with the Safeguarding Reporting Framework."	*Unable to classify*
Stroke Thrombolysis Protocol - V4.pdf	Nursing; Office of the Medical Director	Protocol	08/09/2018	04/09/2021	Janet Michell (BCUHB - Corporate Office)	Patient safety	Low	Q3 2024/25		Revised protocol submitted for approval to the October Medical Policies and Procedures Group (submission deadline is 9th October for their meeting on 23rd October. Draft protocol to be submitted to Stroke Improvement meeting for approval on 15th October - therefore moved to Q3 2024/25	Assurance gained current protocol safe in practice.Protocol to be reviewed and approved at November 2024 Medical Policies and Procedures Group the including Patient Group Direction - Date- 20th November 24.Protocol for final approval at CEG December / January 2025. Request to move protocol to Clinical Operational Services - therefore moved to Q4 2024/25	Low confidence
EXECUTIVE DIRECTOR OF PUBLIC HEALTH												
MM40 - Influenza Pandemic Plan for Distribution of Antivirals.pdf	Pharmacy and Medicines Management; Emergency planning	Other	21/05/2019	21/05/2021	Sharon Scott (BCUHB - Corporate Office)	Patient safety; Emergency planning	Low		Q4 2024/25		In progress	Medium confidence
EXECUTIVE DIRECTOR OF WORKFORCE AND ORGANISATIONAL DEVELOPMENT												
Corporate Health & Safety Guidance on the Control of Noise in the Workplace - V7.pdf	Health and Safety	Other	01/04/2021	01/04/2024	Jason Brannan (BCUHB - Workforce & Organisational Development)	Health and Safety; Legal	Medium	Q1 2025/26			Moved to Q1 2025/26 due to capacity within H&S	High confidence
HS02 - Protecting Employees from Violence & Aggression - V2.pdf	Health and Safety	Other	01/03/2021	01/03/2024	Susan Morgan (BCUHB - Health & Safety); David Baker (BCUHB - Health & Safety)	Health and Safety; Legal	Low		Q3 2024/25		Review undertaken, on 08/11/24 Policy Group agenda	Low confidence
HS09 - Control of Noise at Work Procedure.pdf	Health and Safety	Procedure	01/01/2021	01/01/2023	Clare Jones (BCUHB - Health & Safety)	Health and Safety; Legal	Medium	Q3 2024/25	Q1 2025/26		Moved to Q1 due to capacity within H&S	High confidence
HS17 - Procedure & Guidance Document for Display Screen Equipment Use - V1.pdf	Health and Safety	Procedure	01/06/2018	01/06/2020	Clare Jones (BCUHB - Health & Safety)	Health and Safety; Legal	Medium	Q3 2024/25	Q1 2025/26		Moved to Q1 due to capacity within H&S	High confidence
OHW02 - Staff Health and Wellbeing Guidelines - V0.1.pdf	Workforce	Guideline	01/10/2017	01/10/2020	Christina Billingham (BCUHB - Child & Adolescent Health)	*No update provided*	*No update provided*		Q4 2024/25			Medium confidence
Safe Use of Step Ladders and Kick Stools - V7.pdf	Health and Safety	Other	01/04/2021	01/04/2024	Jason Brannan (BCUHB - Workforce & Organisational Development)	*No update provided*	*No update provided*		Q4 2024/25			Medium confidence
WP14a - Interim Protocol on Pay While Undertaking Jury Service and the Recovery of Loss of Earnings - V1.pdf	Workforce	Protocol	01/03/2015	01/04/2016	Jason Brannan (BCUHB - Workforce & Organisational Development)	Health and Safety; HR/Staff	Medium	Q4 2024/25	Q1 2025/26		On track for Q1 full update	High confidence
WP14c - BCU Shared Parental Leave Procedure Final v1 (Dec15).pdf	Workforce	Procedure	01/12/2015	01/12/2018	Christina Billingham (BCUHB - Child & Adolescent Health)	HR/Staff	Medium		Q4 2024/25		On track for review being completed by end of Q4 2024/25	Medium confidence
WP15 - BCUHB Partnership and Recognition Agreement - V1.pdf	Workforce	Other	01/02/2010	01/04/2011	Jason Brannan (BCUHB - Workforce & Organisational Development)	Joint working/Collaboration	Medium	Q4 2024/25	Q1 2025/26		Review will be undertaken by Policy, Process and Compliance team with AD People Director	High confidence
WP2 - Retirement Policy Procedure - V6 .pdf	Workforce	Procedure	01/11/2015	01/11/2021	Jason Brannan (BCUHB - Workforce & Organisational Development)	HR/Staff; Legal	Low		Q4 2024/25	All Wales Policy is currently in draft which will supersede this document	All Wales Policy on Pensions Flexibilities is currently in the approval process which will replace this document	Medium confidence
WP21 - Working Time Procedure.pdf	Workforce	Procedure	01/03/2015	01/03/2018	Llinos Jones (BCUHB - Workforce & Organisational Development)	HR/Staff; Legal	Low	Q4 2024/25		Awaiting update	Minor amendments made in 2023, but as these were only minor amendments, the original review date stands - overdue a review	Medium confidence
WP21a - Entitlement to Breaks for All NHS Staff covered by A4C Under review.pdf	Workforce	Procedure	01/03/2015	01/03/2018	Jason Brannan (BCUHB - Workforce & Organisational Development)	HR/Staff; Legal	Low		Q4 2024/25		Policy is currently partnership work with Workforce Optimisation and will be going through the approval route December 2024 onwards.	Medium confidence
WP22 - BCU Mufti Allowance Procedure - Final v1 (Oct14).pdf	Workforce	Procedure	01/10/2014	01/10/2017	Jason Brannan (BCUHB - Workforce & Organisational Development)	HR/Staff; Financial	Medium	Q1 2025/26		Awaiting update	Is currently in draft with MH&LD HR and managers	High confidence
WP23-BCUHB Procedure for Checking of Registrations & Qualifications V3.pdf	Workforce	Procedure	01/11/2015	01/10/2018	Jason Brannan (BCUHB - Workforce & Organisational Development)	Legal	Low		Q4 2024/25		Draft approved at Workforce Policy Group 8/11/2024, it will progress via the BCU internal approval route	Medium confidence
WP24b - BCUHB Gateway Protocol for the NHS Knowledge & Skills Framework- V1.pdf	Workforce	Protocol	12/09/2013	01/10/2014	Jason Brannan (BCUHB - Workforce & Organisational Development)	HR/Staff	Low	Q1 2025/26			On track for a review in Q1 2025/26	High confidence
WP2b - BCUHB Options for staff considering accessing their NHS pension and continuing working in the Health Board - V1 .pdf	Workforce	Other	01/11/2013	01/11/2021	Jason Brannan (BCUHB - Workforce & Organisational Development)	Legal	Medium	Q1 2025/26			Policy to be reviewed once new Pension Flexibilities has been approved	High confidence
WP41 - Recruitment and Retention Payment Protocol - V3.pdf	Workforce	Protocol	01/11/2020	01/11/2023	Jason Brannan (BCUHB - Workforce & Organisational Development)	HR/Staff; Financial	Low	Q4 2024/25			All Wales document remains extant	Medium confidence

WP42 - Guidance on Dealing with Hate Incidents_Crimes Against BCUHB Staff.pdf	Workforce	Guideline	01/08/2021	01/06/2024	Nick Such (BCUHB - Workforce & Organisational Development); David Baker (BCUHB - Health & Safety)	*No update provided*	*No update provided*		Q4 2024/25			Medium confidence
WP43 - Guidelines to Support Trans and gender diverse Staff in BCUHB .pdf	Workforce	Guideline	20/08/2021	20/08/2024	Nick Such (BCUHB - Workforce & Organisational Development)	*No update provided*	*No update provided*					*Unable to classify*
WP46 - BCU Additional Annual Leave Purchase Scheme Procedure - V4.pdf	Workforce	Procedure	01/07/2018	01/08/2021	Jason Brannan (BCUHB - Workforce & Organisational Development)	HR/Staff; Reputational	Low	Q1 2025/26			The policy has been updated , however does need a full review. The annual Leave purchase calculator (which supports the policy) but not a controlled document has been updated following the AfC pay review.	High confidence
WP47 - BCUHB Telephone Line Rental Procedure - V1.pdf	Workforce	Procedure	01/06/2015	01/04/2018	Claire Waddicor-Evans (BCUHB - Transformation & Improvement)	HR/Staff; Financial	Medium	Q1 2025/26			All Wales document/Policy due	High confidence
WP4A - Procedure for NHS Staff to Raise Concerns - V5.pdf	Workforce	Procedure	01/06/2021	01/06/2024	Jason Brannan (BCUHB - Workforce & Organisational Development)	HR/Staff	Low	Q1 2025/26			All Wales policy and remains extant until a version is approved by Welsh Partnership and BCU internal approval route	High confidence
WP54 - Study Leave Process (Applies to all staff apart from Medical & Dental) - V0.2.pdf	Workforce	Other	11/04/2016	01/01/2018	Nia Thomas (BCUHB - Workforce & Organisational Development)	HR/Staff	*No update provided*		Q4 2024/25			Medium confidence
WP56 - Procedure for the Management of the Larger Person.pdf	Workforce; Health and Safety	Procedure	01/02/2016	01/06/2020	Tracey Eccles (BCUHB - Workforce & Organisational Development)	Health and Safety	*No update provided*				Awaiting update from H&S who have in the past confirmed it's a HS policy not Workforce	*Unable to classify*
WP59 - Personal Employee Record Management Procedure - V0.1.pdf	Workforce	Procedure	01/10/2017	01/10/2020	Jason Brannan (BCUHB - Workforce & Organisational Development)	HR/Staff; Legal	Medium	Q1 2025/26			Policy in draft ready for December Policy Group	High confidence
WP60 - Exit Interview Procedure & Questionnaire V7.1 - Read only.doc	Workforce	Procedure	12/11/2018	01/10/2020	Angela Johnson (BCUHB - Workforce & Organisational Development)	HR/Staff	*No update provided*		Q4 2024/25			Medium confidence
WP62 - BCUHB Dress Code Guidelines.pdf	Workforce	Guideline	22/07/2021	22/07/2024	Anne-Marie Rowlands (BCUHB - Corporate Nursing); Jacqueline Hughes (BCUHB - Radiology)	Legal; HR/Staff	Medium				Policy is in draft, has been out to consultation and awaiting final check before progressing to approval route	*Unable to classify*
EXECUTIVE MEDICAL DIRECTOR												
HCSW SOP Administration of Enemas and Suppositories.pdf	Pharmacy and Medicines Management	Procedure	29/11/2019	29/11/2022	Lisa Morris (BCUHB - Pharmacy and Medicines Management); Suzanne Kenyon (BCUHB - Pharmacy); Jacqui Jones (BCUHB - Pharmacy and Medicines Management); Amy Reynolds (BCUHB - Pharmacy and Medicines Management)	Patient safety	Medium		Q4 2024/25		No review as yet - awaiting publication of education resources from HEIW to go alongiside up dated version	Medium confidence
HCSW SOP Administration of Eye Drops.pdf	Pharmacy and Medicines Management	Procedure	29/11/2019	29/11/2022	Lisa Morris (BCUHB - Pharmacy and Medicines Management); Suzanne Kenyon (BCUHB - Pharmacy); Jacqui Jones (BCUHB - Pharmacy and Medicines Management); Amy Reynolds (BCUHB - Pharmacy and Medicines Management)	Patient safety	Medium		Q4 2024/25		Plan to start review in November 2024	Medium confidence
HCSW SOP Administration of Oxygen.pdf	Pharmacy and Medicines Management	Procedure	29/11/2019	29/11/2022	Lisa Morris (BCUHB - Pharmacy and Medicines Management); Suzanne Kenyon (BCUHB - Pharmacy); Jacqui Jones (BCUHB - Pharmacy and Medicines Management); Amy Reynolds (BCUHB - Pharmacy and Medicines Management)	Patient safety	Medium		Q4 2024/25		No review as yet - awaiting publication of education resources from HEIW to go alongside up dated version	Medium confidence
HCSW SOP Gastrostomy Administration of Medication.pdf	Pharmacy and Medicines Management	Procedure	29/11/2019	29/11/2022	Lisa Morris (BCUHB - Pharmacy and Medicines Management); Suzanne Kenyon (BCUHB - Pharmacy); Jacqui Jones (BCUHB - Pharmacy and Medicines Management); Amy Reynolds (BCUHB - Pharmacy and Medicines Management)	Patient safety	Medium		Q4 2024/25		No review as yet - awaiting publication of education resources from HEIW to go alongside up dated version	Medium confidence
HCSW SOP Second Check of Insulin Administration.pdf	Pharmacy and Medicines Management	Procedure	29/11/2019	29/11/2022	Lisa Morris (BCUHB - Pharmacy and Medicines Management); Suzanne Kenyon (BCUHB - Pharmacy); Jacqui Jones (BCUHB - Pharmacy and Medicines Management); Amy Reynolds (BCUHB - Pharmacy and Medicines Management)	Patient safety	Medium		Q4 2024/25		No review as yet - awaiting publication of education resources from HEIW to go alongiside up dated version	Medium confidence
HCSW SOP Second Check of Oral CDs in Community Hospitals.pdf	Pharmacy and Medicines Management	Procedure	29/11/2019	29/11/2022	Lisa Morris (BCUHB - Pharmacy and Medicines Management); Suzanne Kenyon (BCUHB - Pharmacy); Jacqui Jones (BCUHB - Pharmacy and Medicines Management); Amy Reynolds (BCUHB - Pharmacy and Medicines Management)	Patient safety	Medium		Q4 2024/25		No review as yet - awaiting publication of education resources from HEIW to go alongside up dated version	Medium confidence
HCSW SOP Second Checker SC Fluids (No Additives).pdf	Pharmacy and Medicines Management	Procedure	29/11/2019	29/11/2022	Lisa Morris (BCUHB - Pharmacy and Medicines Management); Suzanne Kenyon (BCUHB - Pharmacy); Jacqui Jones (BCUHB - Pharmacy and Medicines Management); Amy Reynolds (BCUHB - Pharmacy and Medicines Management)	Patient safety	Medium		Q4 2024/25		No review as yet - awaiting publication of education resources from HEIW to go alongside up dated version	Medium confidence
MM20 - Guideline for the Administration of Subcutaneous Fluids in Adult Palliative Care Patients.pdf	Nursing; Cancer and Clinical Haematology	Guideline	14/03/2022	01/06/2023	Caroline Usborne (BCUHB - Palliative Care)	*No update provided*	Medium	Q4 2024/25		Update under review - for Q4 2024/25	With the palliative care SMT, waiting for comments	Medium confidence
MM26 - Guidelines on the Use of Antipsychotics in Children and Adolescents - V0.1.pdf	Pharmacy and Medicines Management	Guideline	01/11/2016	01/11/2018	Peter Venables (BCUHB - Pharmacy)	Patient safety	Medium	Q4 2024/25			In progress and on track. Moved to Qtr 4 due to long term staff sickness, but still being progressed by others.	Medium confidence
MM27 - Procedure for the Use of Alteplase & Urokinase via a Dysfunctional Tunnelled Haemodialysis CVC - V2.pdf	Office of the Medical Director	Procedure	01/09/2020	01/09/2022	Nick Lyons (BCUHB - Corporate Office) Stephen Stanaway (BCUHB - Diabetes & Endocrinology); Rachel Brogan (BCUHB - Renal)	Patient safety	Medium		Q4 2024/25	This policy is currently being reviewed possible completed by Q4	Circulated it to the clinical governance list for approval, deadline for comments by end of November	Medium confidence
MM71 - Warfarin Management in Adults to Enable Safe Admission & Discharge - V2.pdf	Pharmacy and Medicines Management	Procedure	21/12/2020	01/01/2023	Catherine Strong (BCUHB - Pharmacy)	Patient safety	Medium		Q3 2024/25		To be sent out for comments mid October, on track	Low confidence
MM72 - Guideline for the Use of Methoxyflurane (Penthrox) in Acute Moderate to Severe Pain in Trauma, Orthopaedics & ED - V1.pdf	Pharmacy and Medicines Management	Guideline	20/01/2021	02/12/2023	Elaine Sturman (BCUHB - Pharmacy)	Patient safety	Medium		Q4 2024/25			Medium confidence
MM75 - Hypophosphataemia Management for Adults Inpatients.pdf	Pharmacy and Medicines Management	Guideline	01/12/2021	01/12/2023	Anest Jones (BCUHB - Pharmacy)	Patient safety	Medium		Q4 2024/25		On track.	Medium confidence
B05 - Identifying Participants in Clinical Trials – Patient Medical Casenotes - Health Research - Standard Operating Procedure.pdf	Research and Development	Procedure	14/04/2022	14/04/2024	Lona Tudor Jones (BCUHB - Research & Development)	Medical Research	Low	Q3 2024/25		For November CEG meeting - therefore moved to Q3 2024/25	Await CEG meeting	Low confidence
Guidance on Intravenous Fluid Prescribing for Adults in Hospital & Community Setting - V1.pdf	Pharmacy and Medicines Management	Guideline	01/12/2019	01/12/2022	Catrin Roberts (BCUHB - Pharmacy)	Patient safety	Low		Q4 2024/25		On track for completion by end of Q4 2024/25	Medium confidence

HCSW SOP Administration of Ear Drops.pdf	Pharmacy and Medicines Management	Procedure	29/11/2019	29/11/2022	Lisa Morris (BCUHB - Pharmacy and Medicines Management); Suzanne Kenyon (BCUHB - Pharmacy); Jacqui Jones (BCUHB - Pharmacy and Medicines Management); Amy Reynolds (BCUHB - Pharmacy and Medicines Management)	Patient safety	Low		Q4 2024/25		Document updated and due to be presented at policies group Nov 2024. On track to be completed by due date	Medium confidence
HCSW SOP Administration of Inhalers.pdf	Pharmacy and Medicines Management	Procedure	29/11/2019	29/11/2022	Lisa Morris (BCUHB - Pharmacy and Medicines Management); Suzanne Kenyon (BCUHB - Pharmacy); Jacqui Jones (BCUHB - Pharmacy and Medicines Management); Amy Reynolds (BCUHB - Pharmacy and Medicines Management)	Patient safety	Low		Q4 2024/25		With CGD policies to go live on BCUHB - needs adding to MM01 doc	Medium confidence
HCSW SOP Administration of Oral Medicines.pdf	Pharmacy and Medicines Management	Procedure	29/11/2019	29/11/2022	Lisa Morris (BCUHB - Pharmacy and Medicines Management); Suzanne Kenyon (BCUHB - Pharmacy); Jacqui Jones (BCUHB - Pharmacy and Medicines Management); Amy Reynolds (BCUHB - Pharmacy and Medicines Management)	Patient safety	Low		Q4 2024/25		Due to be presented at Policies Group November 2024	Medium confidence
HCSW SOP Ordering Stock Medication.pdf	Pharmacy and Medicines Management	Procedure	29/11/2019	29/11/2022	Lisa Morris (BCUHB - Pharmacy and Medicines Management); Suzanne Kenyon (BCUHB - Pharmacy); Jacqui Jones (BCUHB - Pharmacy and Medicines Management); Amy Reynolds (BCUHB - Pharmacy and Medicines Management)	Patient safety	Low		Q4 2024/25		out to wide consultation - need to be presented at policies group ?nov 24	Medium confidence
HCSW SOP Second Checker of CD Stock Levels.pdf	Pharmacy and Medicines Management	Procedure	29/11/2019	29/11/2022	Lisa Morris (BCUHB - Pharmacy and Medicines Management); Suzanne Kenyon (BCUHB - Pharmacy); Jacqui Jones (BCUHB - Pharmacy and Medicines Management); Amy Reynolds (BCUHB - Pharmacy and Medicines Management)	Patient safety	Low		Q4 2024/25		out to wide consultation - need to be presented at policies group ?nov 24	Medium confidence
HCSW SOP Storage Meds in Automated Cupboard.pdf	Pharmacy and Medicines Management	Procedure	29/11/2019	29/11/2022	Lisa Morris (BCUHB - Pharmacy and Medicines Management); Suzanne Kenyon (BCUHB - Pharmacy); Jacqui Jones (BCUHB - Pharmacy and Medicines Management); Amy Reynolds (BCUHB - Pharmacy and Medicines Management)	Patient safety	Low		Q4 2024/25		Review done and to be presented at Nov policies meeting	Medium confidence
MM16 - Guidance on the Transcription of Medicines by Registered Nurses in Exceptional Circumstances - V0.1.pdf	Pharmacy and Medicines Management	Guideline	04/03/2015	04/03/2017	Sioned Rees (BCUHB - Pharmacy)	Patient safety	Low		Q4 2024/25		On track	Medium confidence
MM23 - Guidelines for Prescribing Steroids for Adults in Palliative Care - V1.1.pdf	Pharmacy and Medicines Management	Guideline	20/01/2022	01/02/2023	Jenny Sparks (BCUHB - Pharmacy); Jane Walker (BCUHB - Pharmacy)	Patient safety	Low		Q4 2024/25		Documents for MPPP in either November or December	Medium confidence
MM30 - Procedure for the preparation, observation, assessment & supervision of non-registered practitioners(HCSW) to undertake the administration of insulin for clinically stable named adults in community nursing.pdf	Pharmacy and Medicines Management	Procedure	01/12/2021	01/09/2024	Lisa Morris (BCUHB - Pharmacy and Medicines Management)	Patient safety	Low		Q4 2024/25		On track for completion end of Qtr 4 March 31st 2025	Medium confidence
MM44 - Guideline for Prescribing, Preparation & Administration of Single Dose Mitomycin-C Bladder Instillations - V0.1.pdf	Pharmacy and Medicines Management	Guideline	13/03/2019	01/03/2021	Haimon Chaudhry (BCUHB - Pharmacy)	Patient safety	Low		Q4 2024/25		In Progress	Medium confidence
MM48 - Acute Management of Parkinson's Disease in Patients with Compromised Swallow or Nil by Mouth - V1.0.pdf	Pharmacy and Medicines Management	Other	12/12/2019	01/11/2022	Sue Lord (BCUHB - Pharmacy)	Patient safety	Low	Q3 2024/25	Q4 2024/25	Approved at DTG 02/10/2024, will go to PSG on 29/10.2024- therefore moved to Q3 2024/25. Author off sick currently.	This policy is not able to be added to the MPPP agenda until Feb 25 therefore please could you amend the deadline date to Qtr 4.	Medium confidence
MM49 - Protocol for the Control & Administration of Depot & Long Acting Antipsychotic Injections - V0.1.pdf	Pharmacy and Medicines Management; Mental Health and Learning Disabilities	Protocol	12/02/2015	01/02/2017	Elizabeth Bond (BCUHB - Pharmacy)	Patient safety	Low		Q3 2024/25		Went to MPPPG 23/10/24, the will progress to PQSG. In progress and on track	Low confidence
MM56 - Out Patient Parental Antimicrobial Therapy (OPAT) Governance Framework Guidelines - V1.0.pdf	Pharmacy and Medicines Management	Guideline	18/03/2020	01/03/2023	Suhail Sarwar (BCUHB - Pharmacy)	Patient safety	Low		Q4 2024/25		In progress and on track	Medium confidence
MM58 - BCUHB Guideline for the Administration of Medicines via the Subcutaneous Route in Adult Palliative Care Patients - V1.0.pdf	Pharmacy and Medicines Management	Guideline	24/04/2020	01/04/2023	Jenny Sparks (BCUHB - Pharmacy); Elin Gwyn (BCUHB - Pharmacy and Medicines Management)	Patient safety	Low		Q4 2024/25		Submitted for consultation in early October. Has undergone its review and is currently being sent out for wider feedback prior to submission.	Medium confidence
MM60 - BCU Management of Acute Nausea & Vomiting in Adult Surgical Inpatients - V0.1.pdf	Pharmacy and Medicines Management	Guideline	14/07/2020	01/02/2023	Haimon Chaudhry (BCUHB - Pharmacy)	Patient safety	Low		Q4 2024/25		In Progress	Medium confidence
MM64 - Clinical Guideline for the Prescribing & Administration of Intravenous Morphine in Adults with Acute Sever Pain - V1.1.pdf	Pharmacy and Medicines Management	Guideline	01/09/2020	01/09/2023	Haimon Chaudhry (BCUHB - Pharmacy)	Patient safety	Low		Q4 2024/25		Confirmed In Progress	Medium confidence
MM64A - IV Morphine in Adults Presciption Chart - V1.1.pdf	Pharmacy and Medicines Management	Other	01/01/2021	01/07/2023	Haimon Chaudhry (BCUHB - Pharmacy)	Patient safety	Low		Q4 2024/25		Confirmed In Progress	Medium confidence
MM66 - BCUHB Iloprost Infusion for Treatment of Severe Chronic Ischaemia of Lower Limb in Adults - V1.0.pdf	Pharmacy and Medicines Management	Guideline	01/09/2020	01/08/2023	Haimon Chaudhry (BCUHB - Pharmacy)	Patient safety	Low		Q4 2024/25		Confirmed In Progress	Medium confidence
MM67 - Vitamin D Deficiency & Nutritional Rickets Supplementation & Treatment in Infants and Children - V1.pdf	Pharmacy and Medicines Management	Guideline	01/09/2020	01/09/2022	Peter Venables (BCUHB - Pharmacy)	Patient safety	Low	Q4 2024/25			In progress and on track. Moved to Qtr 4 due to long term staff sickness, but still being progressed by others.	Medium confidence
MM68 - Guidelines for the Use of Rapid Tranquillisation (RT) in Children aged 12 years to 17 years.pdf	Pharmacy and Medicines Management	Guideline	01/07/2020	01/07/2022	Peter Venables (BCUHB - Pharmacy)	Patient safety	Low	Q4 2024/25			In progress and on track. Moved to Qtr 4 due to long term staff sickness, but still being progressed by others.	Medium confidence
MM69 - Intravenous (IV) Potassium Procedure - V1.pdf	Pharmacy and Medicines Management	Procedure	13/11/2020	01/11/2023	Karen Pritchard (BCUHB - Pharmacy)	Patient safety	Low	Q3 2024/25		Moved to Qtr 3.	Been to MPPPG, on track	Low confidence
MM73 - Bone Health Management for Children at Risk of Fractures for Health Professionals working in Secondary Care - V1.pdf	Pharmacy and Medicines Management	Guideline	05/03/2021	01/12/2023	Peter Venables (BCUHB - Pharmacy)	Patient safety	Low		Q4 2024/25		On track.	Medium confidence
MM74 - BCUHB Acute Pain Guidelines for Adults in Acute Care Setting - V1.0.pdf	Pharmacy and Medicines Management	Guideline	01/07/2021	01/09/2023	Haimon Chaudhry (BCUHB - Pharmacy)	Patient safety	Low		Q4 2024/25		In progress	Medium confidence
MM85 - Vancomycin Dosing and Monitoring in Children Guideline - For Use on Children's Wards within Betsi Cadwaladr University Health Board.pdf	Children and Young People's services; Pharmacy and Medicines Management	Guideline	12/09/2022	01/07/2024	Peter Venables (BCUHB - Pharmacy)	Patient safety	Low				MM85 is Alder Hey's guideline which the Health Board has adopted for use. Alder Hey's guideline has not been updated since MM85 was introduced and so MM85 cannot be updated yet.	*Unable to classify*
NU16 - Guidance for Alcohol Detoxification in ED & Adult Inpatient Wards.pdf	Office of the Medical Director	Other	01/10/2019	01/05/2024	Akwasi Mintah (BCUHB - Pharmacy); Syed Bokhari (BCUHB - Medicine)	Patient safety	Low	Q3 2024/25		Staff member on leave at present therefore no update available - therefore moved to Q3 2024.25.	NU 16 was approved subject to the minor amendments suggested by MPPP being considered. Next step is to submit to BCU Quality Directorate to seek corporate approval. To be transferred over to the Executive Medical Director - need approval in this respect.	Low confidence

NWCRF SOP02 - Standard Operating Procedure for Volunteer Screening and Recruitment.pdf	Research and Development	Procedure	04/10/2022	01/07/2024	Lona Tudor Jones (BCUHB - Research & Development)	Medical Research	Low	Q3 2024/25		Minor changes have been made. For CRF management meeting review then SMT before submission to CEG - therefore moved to Q3 2024/25		Low confidence
NWCRF SOP03 - Standard Operating Procedure for Medical Emergencies.pdf	Research and Development	Procedure	04/10/2022	01/07/2024	Orod Osanlou (BCUHB - Acute Medicine); Lona Tudor Jones (BCUHB - Research & Development); Elizabeth Harrison (BCUHB - Research & Development)	Medical Research	Low		Q4 2024/25			Medium confidence
NWCRF SOP06 - Standard Operating Procedure for Training.pdf	Research and Development	Procedure	04/10/2022	01/07/2024	Lona Tudor Jones (BCUHB - Research & Development)	Medical Research	Low	Q3 2024/25		Minor changes have been made. For CRF management meeting review then SMT before submission to CEG - therefore moved to Q3 2024/25		Low confidence
NWCRF SOP07 - Standard Operating Procedure - Management of Volunteer Master File.pdf	Research and Development	Procedure	04/10/2022	01/08/2024	Elizabeth Harrison (BCUHB - Research & Development)	Medical Research	Low	Q3 2024/25		Minor changes have been made. For CRF management meeting review then SMT before submission to CEG - therefore moved to Q3 2024/25	SOP reviewed. Minor changes made. Will be approved at the next NWCRF meeting on the 26th November, then sent for review at the next R&D SMT scheduled for the 11th December before being sent to CEG	Low confidence
NWCRF SOP08 - Standard Operating Procedure - The Over Volunteering Prevention Scheme (TOPS).pdf	Research and Development	Procedure	04/10/2022	01/08/2024	Elizabeth Harrison (BCUHB - Research & Development)	Medical Research	Low	Q3 2024/25		Minor changes have been made. For CRF management meeting review then SMT before submission to CEG - therefore moved to Q3 2024/25	SOP reviewed. Minor changes made. Will be approved at the next NWCRF meeting on the 26th November, then sent for review at the next R&D SMT scheduled for the 11th December before being sent to CEG	Low confidence
NWCRF SOP09 - Standard Operating Procedure - Consent 4 Consent (C4C) Database.pdf	Research and Development	Procedure	04/10/2022	01/07/2024	Elizabeth Harrison (BCUHB - Research & Development)	Medical Research	Low	Q3 2024/25		Minor changes have been made. For CRF management meeting review then SMT before submission to CEG - therefore moved to Q3 2024/25	SOP reviewed. Minor changes made. Will be approved at the next NWCRF meeting on the 26th November, then sent for review at the next R&D SMT scheduled for the 11th December before being sent to CEG	Low confidence
NWCRF SOP11 - Standard Operating Procedure - For the Monika Prime Temperature Monitoring System.pdf	Research and Development	Procedure	04/10/2022	01/07/2024	Katharine Burton (Abergele - The Surgery (Abergele)) Elizabeth Harrison (BCUHB - Research & Development)	Medical Research	Low	Q3 2024/25		Minor changes have been made. For CRF management meeting review then SMT before submission to CEG - therefore moved to Q3 2024/25		Low confidence
NWCRF SOP13 - Standard Operating Procedure - for Drug and Alcohol Testing in Clinical Trials.pdf	Research and Development	Procedure	04/10/2022	01/08/2024	Katharine Burton (Abergele - The Surgery (Abergele));Elizabeth Harrison (BCUHB - Research & Development)	Medical Research	Low	Q3 2024/25		Minor changes have been made. For CRF management meeting review then SMT before submission to CEG - therefore moved to Q3 2024/25		Low confidence
NWCRF SOP15 - Standard Operating Procedure - for Requesting Access to GP Records for Trial Participants.pdf	Research and Development	Procedure	04/10/2022	01/07/2024	Elizabeth Harrison (BCUHB - Research & Development)	Medical Research	Low	Q3 2024/25		Minor changes have been made. For CRF management meeting review then SMT before submission to CEG - therefore moved to Q3 2024/25	SOP reviewed. Minor changes made. Will be approved at the next NWCRF meeting on the 26th November, then sent for review at the next R&D SMT scheduled for the 11th December before being sent to CEG	Low confidence
NWCRF SOP17 - North Wales Clinical Research Facility - Standard Operating Procedure - Laboratory Procedures.pdf	Research and Development	Procedure	17/01/2023	01/07/2024	Rhiannon Mackay (BCUHB - Research & Development);Elizabeth Harrison (BCUHB - Research & Development)	Medical Research	Low	Q3 2024/25		Minor changes have been made. For CRF management meeting review then SMT before submission to CEG - therefore moved to Q3 2024/25		Low confidence
PA04 - Pathology Standard Operating Procedure for Research & Development Studies & Clinical Trials - V7.pdf	Research and Development	Procedure	08/10/2020	01/09/2022	Bernadette Astbury (BCUHB - Pathology); Lona Tudor Jones (BCUHB - Research & Development)	Medical Research	Low		Q4 2024/25	PA04 has been reviewed and is going through the approval process	Version 10 distributed to R&D Jan 2024 for approvals - outstanding. Requested approvals from R&D 05.11.24 - no progress to date.	Medium confidence
PCT01 - SOP for Clinical Trials - Pharmacy Clinical Trials Procedure - V1.5.pdf	Pharmacy and Medicines Management; Research and Development	Procedure	01/06/2021	01/06/2024	Geraldine Mccaffrey (BCUHB - Pharmacy)	Patient safety	Low		Q4 2024/25		Updated Draft Version 1.6 circulated to pharmacy stakeholder for review 24/10/24. Feedback requested by 10/11/24. Next step is to incorporate any feedback and share with R&D for comment, then submission through the approval routes. On track	Medium confidence
PCT02 - SOP for Clinical Trials - Emergency Code Breaking Procedure - V1.1.pdf	Research and Development; Pharmacy and Medicines Management	Procedure	01/09/2020	01/08/2023	Geraldine Mccaffrey (BCUHB - Pharmacy)	Patient safety	Low		Q4 2024/25	The SOPs have been updated and reviewed by Pharmacy colleagues. I am now just awaiting a response from the R&D Senior managers meeting then submitted to the next MPPP.	Approved at September MPPG and October D&T. Submitted to November SCEG	Medium confidence
PCT03 - SOP for Clinical Trials - Writing & Testing of Emergency Unblinding Procedures - V1.1.pdf	Research and Development; Pharmacy and Medicines Management	Procedure	01/09/2020	01/08/2023	Nick Lyons (BCUHB - Corporate Office)	Patient safety	Low		Q4 2024/25	The SOPs have been updated and reviewed by Pharmacy colleagues. I am now just awaiting a response from the R&D Senior managers meeting then submitted to the next MPPP.	Approved at September MPPG and October D&T. Submitted to November SCEG	Medium confidence
PCT05 - SOP for Clinical Trials - Storage of Clinical Trials Medication Outside a Pharmacy Department - V1.0.pdf	Pharmacy and Medicines Management	Procedure	01/10/2020	01/10/2023	Geraldine Mccaffrey (BCUHB - Pharmacy)	Patient safety	Low		Q4 2024/25		Submitted to R&D 15/10/24, will be reviewed at meeting 12/11/24	Medium confidence
PCT06 - SOP for Clinical Trials - Clinical Trials Prescriptions - V1.0.pdf	Pharmacy and Medicines Management	Procedure	01/06/2021	01/03/2024	Geraldine Mccaffrey (BCUHB - Pharmacy)	Patient safety	Low		Q4 2024/25		Submitted to R&D 15/10/24, will be reviewed at meeting 12/11/24	Medium confidence
PCT08 - SOP for Clinical Trials - Pharmacy Van Transport of Investigational Medicinal Products between BCUHB Pharmacy Departments - V1.0.pdf	Pharmacy and Medicines Management	Procedure	01/06/2021	01/04/2024	Geraldine Mccaffrey (BCUHB - Pharmacy)	Patient safety	Low		Q4 2024/25		Submitted to R&D 15/10/24, will be reviewed at meeting 12/11/24	Medium confidence
PCT09 - SOP for Clinical Trials - Code Break Envelopes - V1.0.pdf	Pharmacy and Medicines Management	Procedure	01/06/2021	01/06/2024	Geraldine Mccaffrey (BCUHB - Pharmacy)	Patient safety	Low		Q4 2024/25		Submitted to R&D 15/10/24, will be reviewed at meeting 12/11/24	Medium confidence
PCT10 - SOP for Clinical Trials - Pharmacist Clinical Validation of Clinical Trials Prescriptions - V1.0.pdf	Pharmacy and Medicines Management	Procedure	01/06/2021	01/04/2024	Geraldine Mccaffrey (BCUHB - Pharmacy)	Patient safety	Low		Q4 2024/25		Submitted to R&D 15/10/24, will be reviewed at meeting 12/11/24	Medium confidence
PCT11 - SOP for Clinical Trials - Dispensing Clinical Trials Prescriptions - V1.0.pdf	Pharmacy and Medicines Management	Procedure	01/06/2021	01/06/2024	Geraldine Mccaffrey (BCUHB - Pharmacy)	Patient safety	Low		Q4 2024/25		Submitted to R&D 15/10/24, will be reviewed at meeting 12/11/24	Medium confidence
PCT12 - SOP for Clinical Trials - Accuracy Checking Clinical Trials Prescriptions - V1.0.pdf	Pharmacy and Medicines Management	Procedure	01/06/2021	01/06/2024	Geraldine Mccaffrey (BCUHB - Pharmacy)	Patient safety	Low		Q4 2024/25		Submitted to R&D 15/10/24, will be reviewed at meeting 12/11/24	Medium confidence
PCTF01 - Emergency Unbinding Form - V1.doc	Pharmacy and Medicines Management	Other	01/06/2021	01/06/2024	Geraldine Mccaffrey (BCUHB - Pharmacy)	Patient safety	Low		Q4 2024/25		Approved at September MPPG and October D&T. Submitted to November SCEG	Medium confidence
PCTF02 - Pharmacy Research CV - V1.doc	Pharmacy and Medicines Management	Other	01/09/2020	01/08/2023	Geraldine Mccaffrey (BCUHB - Pharmacy)	Patient safety	Low		Q4 2024/25		Submitted to R&D 15/10/24, will be reviewed at meeting 12/11/24	Medium confidence
PCTF03 - Remote Storage Assessment Form - V1.docx	Pharmacy and Medicines Management	Other	01/09/2020	01/08/2023	Geraldine Mccaffrey (BCUHB - Pharmacy)	Patient safety	Low		Q4 2024/25		Approved at September MPPG and October D&T. Submitted to November SCEG	Medium confidence
PCTF04 - Remote IMP Monitoring Log - V1.docx	Pharmacy and Medicines Management	Other	01/09/2020	01/08/2023	Geraldine Mccaffrey (BCUHB - Pharmacy)	Patient safety	Low		Q4 2024/25		Approved at September MPPG and October D&T. Submitted to November SCEG	Medium confidence
PCTF05 - Production of Code Break Envelopes Form - V1.doc	Pharmacy and Medicines Management	Other	01/10/2020	01/10/2023	Geraldine Mccaffrey (BCUHB - Pharmacy)	Patient safety	Low		Q4 2024/25		Submitted to R&D 15/10/24, will be reviewed at meeting 12/11/24	Medium confidence
PCTF06 - Receipt of Code Break Envelopes Form - V1.doc	Pharmacy and Medicines Management	Other	01/06/2021	01/03/2024	Geraldine Mccaffrey (BCUHB - Pharmacy)	Patient safety	Low		Q4 2024/25		Submitted to R&D 15/10/24, will be reviewed at meeting 12/11/24	Medium confidence
PCTF07 - Distribution of Code Break Envelopes Form - V1.doc	Pharmacy and Medicines Management	Other	01/04/2021	01/02/2024	Geraldine Mccaffrey (BCUHB - Pharmacy)	Patient safety	Low		Q4 2024/25		Submitted to R&D 15/10/24, will be reviewed at meeting 12/11/24	Medium confidence
PCTF08 - Investigational Medicinal Product Site to Site Transfer Form - V1.doc	Pharmacy and Medicines Management	Other	01/06/2021	01/04/2024	Geraldine Mccaffrey (BCUHB - Pharmacy)	Patient safety	Low		Q4 2024/25		Submitted to R&D 15/10/24, will be reviewed at meeting 12/11/24	Medium confidence
PCTF09 - ACT File Note - V1.doc	Pharmacy and Medicines Management	Other	01/06/2021	01/06/2024	Geraldine Mccaffrey (BCUHB - Pharmacy)	Patient safety	Low		Q4 2024/25		Submitted to R&D 15/10/24, will be reviewed at meeting 12/11/24	Medium confidence
PCTT01 - Clinical Trials Prescription Template - V1.doc	Pharmacy and Medicines Management	Other	01/06/2021	01/06/2024	Geraldine Mccaffrey (BCUHB - Pharmacy)	Patient safety	Low		Q4 2024/25		Submitted to R&D 15/10/24, will be reviewed at meeting 12/11/24	Medium confidence
R01 - SOP for Reporting of Deviations and breaches of protocol or GCP.pdf	Research and Development	Procedure	02/08/2022	02/08/2024	Lynne Grundy (BCUHB - Research & Development)	Medical Research	Low	Q3 2024/25		Undergoing departmental review - therefore moved to Q3 2024/25	Discussed at senior managers W/C 04/11/24 awaiting minutes /outcome.	Low confidence
S01 - SOP for Urgent Safety Measures in Research.pdf	Research and Development	Procedure	02/08/2022	02/08/2024	Lynne Grundy (BCUHB - Research & Development)	Medical Research	Low	Q3 2024/25		Undergoing departmental review - therefore moved to Q3 2024/25	For December senior managers meeting review	Low confidence
S02 - SOP for Safety Reporting in Research.pdf	Research and Development	Procedure	02/08/2022	02/08/2024	Lynne Grundy (BCUHB - Research & Development)	Medical Research	Low	Q3 2024/25		Undergoing departmental review - therefore moved to Q3 2024/25	Discussed at senior managers W/C 04/11/24 awaiting minutes /outcome.	Low confidence
TM14 - SOP for Study Version and Document Control.pdf	Research and Development	Procedure	02/08/2022	02/08/2024	Lynne Grundy (BCUHB - Research & Development)	Medical Research	Low	Q3 2024/25		Undergoing departmental review - therefore moved to Q3 2024/25	For December senior managers meeting review	Low confidence

MD23 - Procedure to Mitigate the Risks due to Failure to Act on Diagnostic Results - V1.pdf	Nursing; Office of the Medical Director; Radiology	Procedure	10/08/2016	15/08/2018	Conor Corr (BCUHB - Radiology)	*No update provided*	*No update provided*			Awaiting update		*Unable to classify*
MM36 - BCUHB Adult Lipid Modification Guideline.pdf	Pharmacy and Medicines Management	Guideline	14/03/2022	01/03/2024	Yee Ping Teoh (BCUHB - Pathology); Catrin Roberts (BCUHB - Pharmacy)	Patient safety	*No update provided*		Q4 2024/25		With Dr Yee Ping Teoh	Medium confidence
MM45- Pharmacist Discharge Prescription Writing Guideline - V1.0.pdf	Pharmacy and Medicines Management	Guideline	08/11/2019	01/11/2022	Kate Taylor (BCUHB - Pharmacy)	*No update provided*	*No update provided*		Q3 2024/25		To be removed as no longer used - needs Executive approval to remove	Low confidence
MM70 - Remifentanil Patient Controlledanalgesia (PCA) in Labour & Covid-19 Pandemic Guideline - V1.pdf	Pharmacy and Medicines Management; Mental Health and Learning Disabilities; Office of the Medical Director	Guideline	13/11/2020	01/11/2023	Ingrid Volikas (BCUHB - Anaesthetics)	*No update provided*	*No update provided*		Q4 2024/25		Review undertaken - in progress, awaiting finalisation.	Medium confidence
IHC DIRECTOR - CENTRE												
MP02d - Procedure for the use of Medical Devices - V1.0.pdf	Medical Devices	Procedure	24/04/2017	01/04/2020	Patrick Hill (BCUHB - North Wales Medical Physics (inc EBME))	*No update provided*	*No update provided*					*Unable to classify*
MP02f - Disposal of Medical Devices Procedure - V1.pdf	Medical Devices	Procedure	26/06/2017	01/07/2020	Patrick Hill (BCUHB - North Wales Medical Physics (inc EBME)); Mel Lewis (BCUHB - North Wales Medical Physics (inc EBME))	*No update provided*	*No update provided*	Q1 2025/26				High confidence

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

Teitl adroddiad: ***Report title:***	OBS02: Standards of Business Conduct Policy – Minor Changes
Adrodd i: ***Report to:***	Audit Committee
Dyddiad y Cyfarfod: ***Date of Meeting:***	Thursday, 16 January 2025
Crynodeb Gweithredol: ***Executive Summary:***	The Standards of Business Conduct Policy requires minor changes following a recent Internal Audit and the Director of Corporate Governance joining the Health Board.
Argymhellion: ***Recommendations:***	• **SUPPORT** the changes to the policy
Arweinydd Gweithredol: ***Executive Lead:***	Pam Wenger, Director of Corporate Governance
Awdur yr Adroddiad: ***Report Author:***	Philippa Peake-Jones, Head of Corporate Affairs

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

Lefel sicrwydd: ***Assurance level:***	Arwyddocaol *Significant* ☐ 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):***	1 Building and Effective Organisation
Goblygiadau rheoleiddio a lleol: ***Regulatory and legal implications:***	None identified
Yn unol â WP7, a oedd EqIA yn angenrheidiol ac a gafodd ei gynnal?	Not required for this change.

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

MINOR CHANGES TO THE STANDARDS OF BUSINESS CONDUCT POLICY

1. SITUATION

The purpose of this report is to seek the support of the Audit Committee to propose changes to the Standards of Business Conduct Policy. These are required following an Internal Audit and the Director of Corporate Governance joining the Health Board.

2. BACKGROUND

The Health Board is committed to ensuring that all employees and Independent Members practice the highest standards of conduct and behaviour based on the recognition that the needs of service users must come first.

The aim of this policy is to ensure that arrangements are in place to support employees to act in a manner that upholds the standards of business conduct. It also sets out specific arrangements for the appropriate declarations of interests and acceptance/refusal and record of offers of gifts, hospitality and sponsorship.

The policy aims to capture public acceptability of behaviours of those working in the public sector so that the health board can be seen to have exemplary practice in this regard. It also seeks to clarify the relative responsibilities of individuals/committees in the discharging of this policy and adhering to the standards of business conduct.

A full review of the Policy is due to take place in March 2025.

3. STANDARDS OF BUSINESS CONDUCT

The Welsh Government's Citizen-Centred Governance Principles apply to all public bodies in Wales. These principles integrate all aspects of governance and embody the values and standards of behaviour expected at all levels of public services in Wales. "Public service values and associated behaviours are, and must be at the heart of the NHS in Wales."

The Seven Principles of Public Life, also known as The Nolan Principles, form the basis of our Standards of Behaviour requirements for its Directors and staff. The Seven Principles of Public Life are:

The Nolan Principles	
Selflessness	Individuals should act solely in terms of the public interest. They should not do so, in order to gain financial or other benefits for themselves, their family or friends.
Integrity	Individuals should not place themselves under any financial or other obligation to outside individuals or organisations that might seek to influence them in the performance of their official duties.
Objectivity	In carrying out public business, including making public appointments, awarding contracts, recommending individuals for rewards and benefits, choices should be made on merit.

Accountability	Individuals are accountable for their decisions and actions to the public and must submit themselves to whatever scrutiny is appropriate for their position.
Openness	Individuals should be as open as possible about all the decisions and actions they take. They should give reasons for their decisions and restrict information only when the wider public interest clearly demands it.
Honesty	Individuals have a duty to declare any private interests relating to their duties and to take steps to resolve and conflicts arising in a way that protects the public interest.
Leadership	Individuals should promote and support these principles by leadership and example

For the purposes of this guidance, a 'conflict of interest' is defined as:
"A set of circumstances by which a reasonable person would consider that an individual's ability to apply judgement or act, in the context of delivering, commissioning, or assuring taxpayer funded health and care services is, or could be, impaired or influenced by another interest they hold."

A conflict of interest may be:

ACTUAL There is a material conflict between one or more interests	**POTENTIAL** There is the possibility of a material conflict between one or more interests in the future
Each case will be different. The general management actions, along with relevant Standards of Behaviour Framework and guidance, should complement the exercise of good judgement. It will always be appropriate to clarify circumstances with individuals involved to assess issues and risks.	

Staff may hold interests for which they cannot see a potential conflict. However, caution is always advisable because others may perceive it differently. It will be important to exercise judgement and to declare such interests where there is otherwise a risk of allegation of improper conduct. 'Interests' can arise in a number of different contexts.

A material interest is one which a reasonable person would take into account when making a decision regarding the use of taxpayers' money because the interest has relevance to that decision.

Further information is available in the attached guidance.

CONCLUSION

In order to have a compliant policy in place the minor changes highlighted in the policy are required.

4. RECOMMENDATIONS

Members are asked to:

- **SUPPORT** the changes to the Standards of Business Conduct Policy

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

Version & Reference Number: V2.1

OBS02: STANDARDS OF BUSINESS CONDUCT POLICY

Date to be reviewed:	March 2025	**No of pages:**	36
Author(s):	~~Molly Marcu~~	**Author(s) title:**	Interim Deputy Board Secretary
Responsible director:	~~Board Secretary~~ Director of Corporate Governance		
Approved by:	Audit Committee – 15th March, 2022		
Date approved:	15th March, 2022		
Date activated(live):	October 2016		
Date EQIA completed:	March 2022		
Documents to be read alongside this policy:	• The Codes of Conduct and Accountability for NHS Boards & Code of Conduct for NHS Managers • Standing Orders relating to declarations of interest and offers of gifts & hospitality • WP6 – Code of Conduct (Disciplinary Rules and • Standards of Behaviour Policy) • F03 Local Anti-Fraud, Bribery and Corruption Policy • F14 Salary Overpayments & Underpayments Local Management Procedure • MD14 - Private Practice Policy 2016 • Other codes of conduct, including those adopted by specific professional groups (GMC, NMC, HCPC etc.) • RD03 - Policy for Intellectual Property • NHS Wales SSP Procurement Services – Suppliers Policy • Documentation relating to individual's appointment as volunteers to the Health Board		
Purpose of Issue/Description of current changes: This policy has been reviewed and updated in order to incorporate All Wales provisions around the declarations of interests, particularly in relation to gifts and hospitality. The scope of the policy has also been widened to explicitly incorporate agency, locum staff and board members.			

PROPRIETARY INFORMATION

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1. Introduction and Policy Statement

Public service values are at the heart of the NHS. High standards of corporate and personal conduct in public life based on a recognition that patients come first, has been a requirement throughout the NHS since its inception.

The Health Board is committed to the NHS Codes of Conduct and the principles set out in the NHS Wales Values and Standards of Behaviour Framework. This Framework, together with standing orders and standing financial instructions, form the key elements of the governance and accountability framework for the NHS in Wales.

The Board expects all employees to abide by the core values of the Framework (throughout this document, the term 'employees' is used to refer to employees, bank , agency and locum workers, contractors, sub-contractors, students, trainees including Board and Associate Board members).
If you have any doubts about whether a declaration is needed please discuss this with your line manager or contact the Director of Corporate Governance ~~Board Secretary~~. These core values are:

- Putting quality and safety above all else: providing high value evidence based care for our patients at all times
- Integrating improvement into everyday working and eliminating harm, variation and waste
- Focusing on prevention, health improvement and inequality as key to sustainable development, wellness and wellbeing for future generations of the people of Wales
- Working in true partnerships with partners and organisations and with our staff
- Investing in our staff through training and development, enabling them to influence decisions and providing them with the tools, systems and environment to work safely and effectively.

The core values support good governance and help ensure the achievement of the highest possible standards in all that the NHS in Wales does. They are supplemented by policies and also Codes of Conduct for Board Members and NHS Managers which incorporate the Seven Principles of Public Life known as the 'Nolan Principles'.

In support of these principles, employees must be impartial and honest in the way that they go about their day to day functions. They must remain beyond suspicion at all times. They can achieve the seven Nolan Principles by:-

- Ensuring that the interests of service users remain paramount;
- Being impartial and honest in the conduct of their official business;

- Using public funds to the best advantage of the service and the service users, always seeking to ensure value for money;
- Not abusing/using their official position for personal gain or to benefit family or friends;
- Not seeking advantage or further private business or other interests in the course of their official duties;
- Not seeking or knowingly accepting preferential rates or benefits in kind for private transactions carried out with companies, with which they have had, or may have, official dealings on behalf of the Health Board.

As part of the implementation of this policy, employees and Board members attending committees, sub-committees and advisory group members, (directly or indirectly contracted with the Health Board) will apply the Nolan principles.

This policy builds upon the provisions included in Heath Board's Standing Orders. It re-emphasises the commitment of the Health Board to ensure that it operates to the highest standards, the responsibilities of those employed by the Health Board and the arrangements for ensuring that declarations are made. This policy is intended to complement the various Professional Codes of Conduct relevant to employees and board members of the Health Board.

2. Codes of Conduct

2.1 The Codes of Conduct and Accountability for NHS Boards reinforce the seven principles of public life (Nolan Principles) and focus on the crucial public service values which must underpin the work of the health service.

2.2 The Code of Conduct for NHS Managers sets out the core standards of conduct expected of NHS managers. It aims to serve two purposes: to guide NHS managers and employing health bodies in the work they do and the decisions and choices they have to make, and to reassure the public that these important decisions are being made against a background of professional standards and accountability.

The Codes of Conduct are available at the following link:
http://www.wales.nhs.uk/governance-emanual/codes-of-conduct

2.3 There are also a number of Professional Codes of Conduct, which complement this Policy, which comprise of both clinical and non-clinical staff (such as accountants, procurement staff, company secretaries, human resources professionals).
The main clinical ones are as follows:

General Medical Council

Home - GMC (gmc-uk.org)

General Pharmaceutical Council
General Pharmaceutical Council (pharmacyregulation.org)

Nursing and Midwifery Council:
https://www.nmc.org.uk/standards/code/

Health and Care Professions Council:
The Health and Care Professions Council (HCPC) | (hcpc-uk.org)

3. Purpose

The purpose of this policy is to set out the organisation's expectations in relation to the standards of conduct expected of all employees in their role.

4. Aims and Objectives

The policy is one of the mechanisms in place to enable the Health Board and its employees in maintaining ethical standards in the conduct of NHS business. It sets out the principles the Health Board expects all employees to uphold, and the steps that the Health Board as an employer will take to safeguard the organisation where conflicts of interest arise. It also describes the arrangements in place to manage declarations of interests, gifts & hospitality. All employees are required to be familiar with the content of this document, and line managers have a responsibility for bringing the policy to the attention of their staff.

The Policy also aims to reflect public acceptability of behaviours of those working in the public sector so that the Health Board can demonstrate to have exemplary practice in this regard.

5. Employee and Employer Responsibilities

5.1 It is the responsibility of all staff to ensure they are not placed in a position that risks, or appears to risk, conflict between their private interest and the NHS. This primary responsibility applies to all Health Board staff, including those who commit resources directly by ordering goods or services, and those who do so indirectly.

5.2 Appointing officers and /managers must declare any known relationship with potential applicants. If a relationship is declared the appointing officer and /managers must not be involved in any decisions relating to financial aspects of the individual's offer of employment. On an ongoing basis there should not be any involvement in any other financial decisions relating to the individual to whom the manager has declared any relationship. This shall include salaries, re-grading, authorisation of travelling expenses, overtime payments etc.

5.3 The Health Board, as an employer, will ensure that staff effectively understand and implemented the key provisions of this policy by putting in place a robust framework of awareness, training.

5.4 Staff must be impartial and honest in the conduct of business and remain beyond suspicion. It is an offence under the Bribery Act 2010 for an employee to accept a bribe in his or her official capacity, or to corruptly show favour or disfavour in the handling of contracts or other business. Staff need to be aware that a breach of the provisions of this Act may render them liable to prosecution and disciplinary action (see Section 6 for further detail).

5.5 Volunteers' Responsibilities

It is important that all volunteers adhere to Health Board policies and procedures. This policy is consistent with the Wales Council for Voluntary Action Code of Practice for organisations involving volunteers:
About us - WCVA - Who we are - Our story

6. Prevention of Fraud, Bribery and Corruption

All employees must abide by the Health Board's Anti-Fraud, Bribery and Corruption Policy. This can be accessed via the link below:
F03 - Local Counter Fraud, Bribery and Corruption Policy.pdf

The Bribery Act 2010 came into force on the 1st July 2011 and bribery is defined as the giving or taking of a reward in return for acting dishonestly and/or in breach of the law. The six possible offences are:

- Bribing another person- active bribery - the giving, promising or offering a bribe to another;
- Being bribed - passive bribery - the requesting, agreeing to receive or accepting any bribe;
- Bribing a foreign public official;
- Failure to prevent bribery;
- Also, under Section 7 of the Bribery Act - 2010 NHS Organisations are considered commercial organisations and may commit a criminal offence if they or their employees acting on their behalf fail to prevent a bribe.

Employees, agency staff and board members are therefore expected to:

- Report any issues relating to fraud, bribery or corruption to a Local Counter
- Fraud Specialist;
- Declare any interest which may result in the employee or persons known to the employee gaining direct or indirect financial advantage as a consequence of their work, which could influence any decisions made by the employee, or

which could interfere with contractual obligations to the organisation;
Submit a declaration of interest annually, either as a nil return or to confirm the existence of an interest

- Ensure the interests of patients are paramount and that use or management of any public funds ensures value for money;
- Check each payslip as soon as possible following receipt to ensure that the amount paid is correct, with any queries raised with the line manager. If the employee believes that they have been overpaid, they must declare it without delay. Where employees do not understand their payslip, they should contact the Payroll department.

Employees, contractors and board members must not:

- Abuse their official position for personal gain or in showing favouritism;
- Accept inappropriate gifts, hospitality or bribes;
- Misuse or make available confidential information;
- Misuse public funding; fraudulently use public funding for personal gain or for the offer of bribes.

This document should be read in conjunction with other related documents/policies including those that cover:

- F14 Salary Overpayments & Underpayments (Local Management Procedure);
- All Wales Code of Conduct (Business) for NHS Staff;
- F03 Local Anti - Fraud, Bribery and Corruption Policy;
- Register of Employees Interests;
- Commercial Sponsorship - Ethical
- Standard for the NHS.

7. Putting the Principles into Practice

7.1 Social Networking Sites

7.1.1 The Health Board is making increased use of social networks to engage with patients, service users, staff and other stakeholders to deliver key messages.

7.1.2 Employees must remember that expressing views or commenting on content on the Internet in relation to the Health Board cannot be divorced from their working life.

7.1.3 Unguarded comments in relation to an employee's work, working environment, colleagues, patients, carers, visitors, suppliers and contractors etc. can bring the organisation into disrepute and may invite legal action against both the employee and their employer.

7.1.4 Ultimately employees are responsible for what is published online and there can be consequences if policies are broken. If an employee is considering publishing something that makes them think twice, the guidance below applies. Where doubt remains, the employee should contact the Corporate Communications Team to discuss the matter.

7.1.5 Additional examples of situations where you are identifiable as a staff member include commenting on our official social media accounts or partner- related matters within a public forum.

7.1.6 Whilst employees are encouraged to use social media to reflect positively on and engage with the work of the Health Board and partners, it is important to maintain a coherent online presence through official social media channels.

7.1.7 Therefore, employees and board members are not permitted to communicate externally or on social media accounts, on behalf of the Health Board without having gained approval from the Corporate Communications Team, with the intention of representing official views of wards, Directorates, Divisions, Service/Hospital Sites or Departments/Specialties.

7.1.8 To set up a social media business account, a business case must be prepared, outlining how this activity will benefit the programme or business area compared to the costs in time and the resources of doing so.

7.1.9 The purpose of policies and guidelines is not just to help protect the organisation, but also to protect employees' interests, and to advise of the potential consequences of interactions online and any content that might be posted.

Guidance: NHS Wales Social Media Policy - V0.10.pdf

Facebook: Betsi Cadwaladr University Health Board

Twitter: @bcuhb

Digital Communications Manager, Communications Department (Carlton Court, St Asaph)**:** bcuhbpressdesk@wales.nhs.uk

7.2 Acceptance of Gifts or Hospitality

7.2.1 Gifts

A gift is an item of personal value, given by a third party e.g. a patient, donor or a supplier. The definition includes prizes in draws and raffles at sponsored events/conferences.

It is an offence to accept any money, gift or consideration as an inducement or reward from a person or organisation holding or seeking to hold a contract with BCUHB

Such gifts should be refused and if they have already been received, they should be returned clearly advising why they cannot be accepted.

Any acceptance of a gift needs to be justified and the context in which the offer has been made.

This Standards of Behaviour Policy excludes gifts between members of staff, for example birthday presents or leaving gifts.

7.22 Gifts from Service Users or their relatives

Gifts up to the value of £25 may be accepted from service users and relatives as a mark of their appreciation e.g. for the care that has been provided. This can include gift vouchers/ cards. A common sense approach should be applied to the valuing of gifts using an actual amount if known, or an estimate that any reasonable person would make as to its value.

There is no requirement to declare such gifts up to this value, other than where several small gifts are received to the value of £25 from the same or closely related source in a 12 month period. Where gifts are provided to a group of staff, it is the responsibility of the Line Manager to declare the gift if over the value of £25

Where a gift is offered that is likely to be over £25 in value it should be politely declined. In some cases the gift may have already been made and it may be difficult to return it, or it may be felt that the bearer may be offended by the refusal. Under such circumstances the gift can be accepted, and the bearer advised that it will be utilised for the benefit of Charitable Funds e.g. used as a prize in a raffle.

A Gifts and Hospitality Form should be completed when gifts of up to £25 are accepted.

Personal gifts of cash from service users or their relatives is not acceptable. These may only be accepted as a donation to the Awr Lys Charity and recorded as such. The Director of Corporate Governance ~~Board Secretary~~ can provide advice regarding the mechanism for appropriately receipting such items in accordance with the Institute of Fundraising Code.

7.23 Gifts from Suppliers, Contractors and Commercial Organisations

Low cost, branded or promotional gifts may be accepted where they are under the value of the common industry standard of £6 in total (selected with reference to

existing industry guidance issued by the ABPI) and do not need to be declared. Any gifts outside this definition from suppliers, contractors and other commercial organisations doing business or likely to do business with BCUHB above this value, should be politely but firmly declined.

Whilst it is not necessary to declare gifts of low intrinsic value, staff are required to declare other gifts that they are offered, but not accepted to allow BCUHB to monitor when such organisations are inappropriately offering gifts or potential inducements.

7.24 Gifts from Dignitaries/Overseas Organisations

There may be occasions when visits are made by dignitaries or overseas organisations who consider it 'culturally custom and practice' to exchange gifts. In such cases, employees should seek guidance from the Committee Secretary and declare these gifts on a Gifts, Hospitality, Honoraria and Sponsorship Form (see Appendix 2). A decision will then jointly be made as to the most appropriate way to manage the gift. This will depend on the nature of the 'gift culture' and may include decisions to 'keep and display in public', 'donate to an internal user group', 'auction for charity', etc.

7.3 Bequests/Legacies/Wills

Employees are not permitted to accept bequests left to them by a deceased patient who became known to them through providing care or treatment as part of their Health Board employment. Accepting a gift of this nature, particularly where a patient is considered vulnerable, could leave the staff member open to serious accusations of financial abuse, fraud (by abuse of position) or misconduct. If an employee is made aware that they may be a beneficiary in a patient's will, they must declare this. All cases of this nature must be escalated to the Director of Corporate Governance ~~Board Secretary~~ and subsequently reported to the Audit Committee.

7.4 Hospitality

Employees should ensure that they declare all offers of hospitality with an estimated value exceeding £25, whether accepted or declined. Hospitality is defined as the provision of beverages, meals, travel, entertainment, or entry to an event, conference or function, regardless of whether provided during or outside normal working hours. Declarations of hospitality must be made via the electronic system which can be accessed via the following link:
~~http://howis.wales.nhs.uk/sitesplus/861/page/41930. All declarations of hospitality will be reviewed by the Office of the Board Secretary.~~ Betsi Cadwaladr University Health Board (mydeclarations.co.uk)

7.5 Unacceptable Hospitality

Unacceptable hospitality includes the following examples as general guidance:

- a holiday abroad;
- hotel accommodation;
- use of a company flat;
- attendance at a function or event restricted to staff which is not for the purposes of training or organisational development.

In case of doubt, advice should be sought from the Director of Corporate Governance ~~Board Secretary~~/Local
Counter Fraud Specialist and employees should report any case where an offer of hospitality is pressed which might be open to objection.

7.6 Acceptable Hospitality

7.6.1 Hospitality must be secondary to the purpose of a meeting. The level of hospitality offered must be appropriate and not out of proportion to the occasion; and the costs involved must not exceed the level which the recipients would normally adopt when paying for themselves, or that which could be reciprocated by the NHS. It should not extend beyond those whose role makes it appropriate for them to attend the meeting. These types of hospitality must be approved by a Director/Assistant Director and recorded on the gifts and hospitality register in advance of acceptance.

7.6.2 Other hospitality may be accepted where it furthers the aims of the Health Board, provided it is normal and reasonable in the circumstances, for example lunches in the course of working visits. Where the value is estimated to be over £25, a declaration should be made.

7.6.3 Other hospitality may be accepted, for instance where:

- A member of staff is invited to a Society or Institute dinner or function;
- There is a genuine need to impart information, or represent the Health Board in stakeholder community events;
- An event is clearly part of the life of the Stakeholder community or where the organisation should be seen to be represented;
- A function or event is hosted for both Staff and Non Staff, which adds benefit and value to the Health Board or the wider NHS;
- A function or event is hosted externally for staff only for the purposes of training or organisational development.

7.7 Hospitality in the Context of Partnership Arrangements with the Pharmaceutical Industry

7.7.1 Pharmaceutical industry and allied commercial sector representatives organising meetings are permitted to provide appropriate hospitality and/or meet any reasonable actual costs, which may have been incurred. If none is required, there is no obligation or

right to provide any such hospitality, or indeed any benefit of equivalent value. See MM08: Code of Practice for BCUHB Staff with Pharmaceutical Companies MM08 - Code of Practice for BCUHB Staff with Pharmaceutical Companies - V0.3.pdf

7.7.2 The Pharmaceutical Industry is expected to adhere to the Association of the British Pharmaceutical Industry (ABPI) Code of Practice for the Pharmaceutical Industry, which clearly specifies what is and what is not acceptable. http://www.pmcpa.org.uk/thecode/Pages/default.aspx

8. Declaration of Interests

8.1 All employees should declare, to the best of their knowledge, if they, or a close relative, or associate, have a controlling or financial interest in a business, which could impact on the activities of the Health Board. All such interests should be declared on starting employment, (by way of the job application form), and then by completing a declaration form upon starting in post, annually and on acquisition of the interest. All employees shall be under a contractual obligation to declare such interests, irrespective of banding on a mandatory annual basis until the interest(s) cease to exist. Declarations should be made on the electronic declaration form via the following link: - Betsi Cadwaladr University Health Board (mydeclarations.co.uk) The declaration of interests register is reported to the Audit Committee periodically. Before publication, employees' personal identifiable information will be redacted in line with information governance requirements (apart from Board Members, for whom the information is deemed to be in the public domain). Declarations of interest are reviewed by the relevant Directorate Governance Lead, details of which are displayed on the declarations of interest intranet page. Governance Leads are responsible for escalating any concerns to the relevant line manager.

8.2 Employees must declare all private interests which could potentially result in personal gain as a consequence of their position within the Health Board.

8.3 If any employee has a financial/commercial interest in an organisation they must not refer a patient for treatment or investigation to that body.

8.4 The NHS Wales Shared Services Partnership Procurement Team will automatically issue a separate declaration of interest form with every request to waive Standing Financial Instructions.

8.5 All Health Board employees have a duty of care to establish and actively maintain clear personal relationship boundaries with patients, their families and their carers in accordance with their employment contract and/or guidance from professional regulators (e.g. GMC/NMC).

8.6 Mandatory annual declarations of interests are required from Board members, all senior employees (band 8c or equivalent and above), all Consultants and also other

employees of any pay band deemed to ~~have 'LHB Officer' status due to~~ be undertaking roles where there is potential for a conflict of interest (as determined by a Director). Annual declarations must be submitted even if a nil return (nothing to declare).

8.7 Staff should be aware that the Health Board Management Process will seek advice from the Counter Fraud Team if and when required.

9. Preferential Treatment in Private Transactions

Individual employees must not seek or accept preferential rates or benefits in kind for private transactions carried out with which they have, or may have, official dealings on behalf of the Health Board (this does not apply to concessionary agreements negotiated with companies by NHS management, or by recognised employees interests, on behalf of all employees - for example, NHS employee benefits schemes).

10. Contracts

Employees in contact with suppliers and contractors, particularly if authorised to approve purchase orders or place contracts for goods, materials or services, shall adhere to accepted professional standards, the NHS Wales Shared Services Partnership Procurement Policy and the Standing Orders and Standing Financial Instructions of the Health Board. Standing Orders and Financial Instructions - Betsi Cadwaladr University Health Board (nhs.wales)

All staff are required to comply with procurement rules and regulations in respect of systems or information which involves the collection or storage of personal data and must abide by Information Governance, Data Protection Impact Assessment and Cyber Security Requirements.

11. Favouritism in Awarding Contracts

11.1 Fair and open competition between prospective contractors or suppliers for contracts is a requirement of the Standing Orders and of European Union (EU) Directives on Public Purchasing for Works and Supplies. This means that:-

- No private, public or voluntary organisation or company which may bid for Health Board business should be given any advantage over its competitors, such as advance notice of the requirements. This applies to all potential contractors, whether or not there is a relationship between them and the Health Board, such as a long-running series of previous contracts;

- Each new contract should be awarded solely on merit, taking into account the requirements of the Health Board and the ability of the contractors to

fulfil them.

11.2 Senior managers should ensure that no special favour is shown to current or former employees or their close relatives or associates in awarding contracts to private or other businesses run by them or employing them in a senior or relevant managerial capacity.

11.3 Contracts may be awarded to such businesses where they are won in fair competition against other tenders, but scrupulous care must be taken to ensure that the selection process is conducted impartially, and that employees who are known to have a relevant interest play no part in the selection.

12. Warnings to Potential Contractors

The Health Board will ensure that all invitations to potential contractors to tender for business includes a notice warning those submitting tenders of the consequences of engaging in any corrupt practices involving employees of public bodies.

13. Outside Employment (paid, unpaid or self-employed)

13.1 Employees can undertake other employment provided this does not conflict in any way with their duties as an employee of the organisation. In particular, if employees have or are contemplating other employment, they must ensure this does not compromise their availability or physical or mental fitness to carry out their duties as an employee of the Health Board. Employees must also ensure this does not place them in a position where their judgement or actions might be influenced by considerations arising from their other employment.

13.2 Employees who engage in employment (including self-employment) outside BCUHB which may conflict with their contract of employment with the organisation must notify their Line Manager of the circumstances ~~and declare this annually via the electronic staff declaration form.~~ Betsi Cadwaladr University Health Board (mydeclarations.co.uk)

13.3 Employees have a responsibility to ensure that the line manager is made aware of any hours worked in order that the Health Board fulfils its statutory requirement of the Working Time Regulations 1998.

13.4 An employee absent because of sickness is regarded as unfit to work and should not undertake any paid or unpaid work, in any capacity, during a period of sickness absence from the organisation, unless it is deemed jointly by the manager and the Occupational Health & Well-being Department to be therapeutically beneficial to their recovery. Express written permission must be granted by the manager in advance in all such cases.

13.5 An employee found to be undertaking other work during sickness absence, without the prior written consent of the manager, may be considered in breach of contract and will be subject to disciplinary action which may result in the involvement of the Counter Fraud Department, the possibility of criminal investigation and/or dismissal. Such action will only be taken following advice from the Workforce & Organisational Development Department. WP6 – Code of Conduct (Disciplinary Rules and Standards of Behaviour) can be accessed via the Workforce Policies and Key Documents here: WP6 - BCUHB Code of Conduct (Disciplinary Rules & Standards of Behaviour -V3 .pdf

14. Private Practice for Medical Staff

14.1 This policy sets standards for all BCUHB employees and other healthcare professionals about their conduct in relation to private practice and other forms of outside employment. The scope of this policy also incorporates any form of outside employment, self-employment or consultancy for employees or Board members, and therefore requires declarations of interest to be made (with line manager oversight) as soon as the interest materialises.

14.2 This policy also:

- ensures that clear standards are in place for managing the relationship between NHS work and private practice;
- covers private work both within and outside NHS facilities;
- offers guidance to individual private practitioners concerning their responsibilities;
- offers guidance to BCUHB employees concerning their role in supporting private patients without disadvantaging NHS patients.

14.3 In particular for medical staff, the amendment to the consultant contract in Wales clarifies the relationship between NHS work, private work and fee-paying work in that it sets out that a NHS consultant's first responsibility is to the NHS. Participation in private medical services or fee-paying services should not result in detriment to NHS patients or services or diminish the public resources available for the NHS. Essentially, consultants should not schedule private work or fee-paying work at the same time as NHS activities, unless there has been a prior agreement with BCUHB. The Policy can be accessed via the link below: MD14 - Private Practice Policy - V0.1.pdf

15. Rewards for initiative

15.1 Potential intellectual property rights (IPR) should be identified, as and when they arise, in order to protect and exploit them properly, thereby ensuring that the Health Board receives any rewards or benefits (such as royalties) in respect of work commissioned from third parties, or work carried out by its employees in the course of their duties. Most intellectual property is protected by statute; e.g.

patents are protected under the Patents Act 1977 and copyright (which includes software programmes) under the Copyright Designs and Patents Act 1988. Senior managers should build appropriate specifications and provisions into the contractual arrangements which they enter into before the work is commissioned, or begins. They should always seek legal advice if in any doubt in specific cases. Advice will be provided via the Research & Development (R&D) Department.

15.2 With regard to patents and inventions, in certain defined circumstances the Patents Act gives employees a right to obtain some reward for their efforts, and an Executive Director should agree a suitable reward for individual circumstances as appropriate. Other rewards may be given voluntarily to employees who within the course of their employment have produced innovative work of outstanding benefit to the NHS. Similar rewards should be voluntarily applied to other activities such as giving lectures and publishing books and articles.

15.3 In the case of collaborative research and evaluative exercises with manufacturers, senior managers should see that the Health Board obtains a fair reward for the input its employees provide. If such an exercise involves additional work for an employee outside that paid for by the Health Board under their contract of employment, arrangements should be made for some share of any rewards or benefits to be passed on to the employee(s) concerned from the collaborating parties. Care should however be taken that involvement in this type of arrangement with a manufacturer does not influence the purchase of other supplies from that manufacturer.

16. Commercial Sponsorship for Attendance at Courses and Conferences

16.1 Some health related companies provide commercial sponsorship to the NHS, including sponsoring equipment, employees and training events. In accordance with the All Wales Code of Conduct (Business) for NHS staff, all employees must consider fully the implications of a proposed sponsorship deal before entering into any arrangement. Only very senior managers with the necessary authority can sign up to, or enter into, any advertising contract or agreement with a company or its representatives. Employees must not allow unauthorised advertising on Health Board premises or documentation.

16.2 Acceptance by employees of commercial sponsorship for attendance at relevant conferences and courses is acceptable, but only where attendance would further the aims of the Health Board and where the employee seeks permission in advance from his/her line manager in line with the Study Leave Policy. The line manager must be satisfied that acceptance will not compromise purchasing decisions in any way. In addition to completing the Study Leave form, you should also seek final approval from your relevant Director or Assistant Director

and complete the electronic hospitality declaration form.

16.3 On occasions when senior managers consider it necessary for employees advising on the purchase of equipment to inspect such equipment in operation in other parts of the country (or exceptionally, overseas), the Health Board should normally meet the costs of such a visit so as to avoid compromising the integrity of subsequent purchasing decisions. For such visits prior agreement will be sought from the Executive Director of Finance. Arrangements whereby the firm meets all/part of the cost of such a visit must be approved by the Executive Director of Finance who will consider the implications for the integrity of subsequent purchasing decisions.

17. Commercial Sponsorship · "Linked Deals"

17.1 Pharmaceutical companies, for example, may offer to sponsor, wholly or partially, a post or equipment for the Health Board. The Health Board will not enter into such arrangements, unless it has been made abundantly clear to the company concerned that the sponsorship will have no effect on purchasing decisions within the Health Board. Where such sponsorship is accepted, the Executive Director of Finance shall ensure appropriate monitoring arrangements are established to ensure that purchasing decisions are not, in fact being influenced by the sponsorship agreement.

17.2 Under no circumstances should Health Board managers agree to "linked deals", whereby sponsorship is linked to the purchase of particular products, or to supply from particular sources.

18. Postgraduate Education

Any sponsorship/hospitality related to Postgraduate Education will be coordinated and managed by the relevant Postgraduate Centre Manager.

19. Research & Development

All research sponsored by commercial companies, including those sponsored by the pharmaceutical industry, must go through the Health Board's internal Research and Development approval process and will also require an assessment by the Local Research Ethics Committee.

20. Endowment (Charitable) Funds

20.1 Monies paid into charitable funds from commercial companies must only be accepted as donations or for sponsorship. Where sponsorship is received it should only be used to fund expenditure which is in line with the terms of the fund use.

20.2 Where sponsorship is received this should be recorded on the Gifts and Hospitality Register in accordance with the approved procedure.

20.3 Funding for research from commercial companies must not be paid into endowment funds and no commercial research projects should be implemented using endowment fund monies. All such research projects should be implemented as Research and Development projects.

21. Equality

The Health Board is committed to ensuring that, as far as practicable, the way it provides services to the public and the way it treats its employees reflects their individual needs and does not discriminate against individual groups. An equality impact assessment screening exercise has been carried out to establish whether there is any possible or actual impact this policy may have on any groups in respect of gender (including maternity and pregnancy as well as marriage or civil partnership issues), race, disability, sexual orientation, Welsh language, religion or belief, transgender, age or other protected characteristics. The assessment (attached) found that there was no material impact on the protected characteristic groups mentioned above.

The Health Board is fully committed to ensuring that all employees are appraised of their obligations under the policy and that additional support and/or reasonable adjustments is available as required – for example, accessing the policy in a different format or support with completing an online declaration. This should be raised with a line manager in the first instance and escalated to the OBS as required.

Employees absent from work for a prolonged period, whether due to a disability or otherwise, are not expected to make a declaration and would not be penalised for failing to make such a declaration

22. Welsh Language

22.1 The Welsh Language (Wales) Measure 2011 has given the Welsh language official status in Wales by introducing Welsh Language Standards for organisations. The duties deriving from the standards mean that the Health Board and all of its employees should not treat the Welsh language less favourably than the English language, together with promoting and facilitating the use of the Welsh language.

22.2 In the conduct of public business, the Health Board's aim is to provide an 'active offer', meaning services should be provided in Welsh without the service user having to ask for it. Enabling our patients and the public to receive high-quality,

language appropriate care is paramount to the way we provide and plan our services, as well as encouraging other users and providers to use and promote the Welsh language in the health sector.

22.3 The Health Board has a clear vision - everyone who comes into contact with its services should be treated with dignity and respect by receiving a safe and responsive service that is accessible in their language of choice. The Health Board will ensure that equality, diversity and human rights will be mainstreamed when developing new policies through Equality Impact Assessments and will:

- Assess the impact of any new and revised policies on groups with 'protected characteristics' as defined under the Equality Act 2010;
- Facilitate and promote equity and the preservation of human rights wherever possible;
- Advance equality of opportunity and human rights wherever possible;
- Ensure that when new policies are implemented they comply with the Strategic
- Equality and Human Rights Plan.

23. Review, Audit and Monitoring

The Director of Corporate Governance ~~Board Secretary~~ will monitor the policy and formally review it every 3 years, or sooner, subject to legislative changes.
Internal Audit will conduct periodic audits of the declaration of interests and gifts & hospitality system, and report to the Audit Committee.
In addition, monitoring will be undertaken as follows:

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

24. Distribution

The Policy will be available via the Health Board's Intranet site. Where employees do not have access to the Intranet their line manager must ensure that they have access to a copy of this document and are able to complete the necessary electronic declarations where appropriate.

25. References

- Health Board Standing Orders
- Bribery Act 2010
- Commercial Sponsorship - Ethical Standards for the NHS, Department of Health
- Code of Conduct and Accountability, Welsh Assembly Government, 2003
- DGM (93)84: Standards of Business Conduct for NHS Staff
- DGM(95)5: Detailed Guidance on Implementing a Code of Conduct and Accountability Finance Guidance Note F35: Guidance on Standards of Conduct for LHB Staff
- General Medical Council Good Medical Practice guidance – financial and commercial arrangements and conflicts of interest, 2013
- NHS Code of Conduct for Boards – Welsh Government Governance e-manual
- Nursing & Midwifery Council gifts and gratuities guidance, September 2013 and The Code: Standards of conduct, performance & ethics for nurses & midwives
- WHC (2005) 016 The NHS & Sponsorship by the Pharmaceutical Industry
- Association of British Pharmaceutical Industry (ABPI) Code of Practice for the Pharmaceutical Industry 2016
- WHC(2006) 090 The Codes of Conduct and Accountability for NHS Boards and the Code of Conduct for NHS Managers Directions 2006
- WP6 BCU Code of Conduct (Disciplinary Rules & Standards of Behaviour)

Appendix 1 – Personal Checklist for Declarations of Interests, Gifts & Hospitality

1. Make sure you understand the requirements contained within the Policy. The onus of responsibility for declaring interests, gifts & hospitality is on the employee.

2. Make sure you are not in a position where your private interests and NHS duties may conflict.

3. Declare to your employer any relevant outside interests. If in doubt ask yourself:-

    a. Could my personal interests be detrimental to the Health Board or to patients' interests in any way?

    b. Do I have access to information which could influence purchasing decisions made by the Health Board?

    c. Am I or could I be in a position where I (or my family/friend) could gain from the connection between my private interests and my employment?

    d. Do I have any other reason to think I may be risking a conflict of interest?

If you remain unsure, discuss it with your manager or the ~~Board Secretary~~ Director of Corporate Governance.

4. Mandatory annual declarations of interests: These are required from Bard members, all senior employees (band 8c or equivalent and above), all Consultants and also other employees of any pay band deemed ~~to have 'LHB Officer' status due~~ to be undertaking roles where there is potential for a conflict of interest (as determined by a Director). Annual declarations must be submitted even if a nil return (nothing to declare). ~~Additionally posts within some departments at Band 7 and above will be required to submit an annual declaration of interest where is it considered that they may be in a position to influence purchasing and/or foster relationships with external organisations.~~

5. Always obtain your employer's permission before accepting any commercial sponsorship, gifts or hospitality. Permission needs to be granted as Director/Assistant Director Level.

6. Seek permission from your line manager or seek advice from the Board Secretary before accepting outside work, particularly if there is a possibility of it adversely affecting your NHS duties.

7. If your work is in any way involved with buying goods or services you must adhere to the ethical code of the Chartered Institute of Purchasing and Supply. Contact the

8. Head of Procurement if you require further details. You must not:

    a. Accept gifts, inducements or inappropriate hospitality unless of low or intrinsic estimated value (£25 or less).

    b. Use your past or present official position to obtain preferential rates for private deals.

    c. Show favouritism in awarding contracts or making grants, or in any other dealings with suppliers or potential suppliers.

    d. Make available or misuse "commercial in confidence" information.

    Employees failing to comply with the guidelines could be subject to disciplinary action under the Health Board's Disciplinary Policy and potential legal action.

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

STAFF GUIDANCE: STANDARDS OF BUSINESS CONDUCT

1. Purpose

Every year the taxpayer entrusts NHS organisations with over £110 billion to care for millions of people. This money must be spent well, free from undue influence. To deliver high quality and innovative care, organisations need to work collaboratively with each other, local authorities, industry and other public, private and voluntary bodies. Partnership working brings many benefits, but also creates the risk of conflicts of interest. Organisations, and the people who work with, for, and on behalf of them want to manage these risks in the right way.

2. Standards of Behaviour

The Welsh Government's Citizen-Centred Governance Principles apply to all public bodies in Wales. These principles integrate all aspects of governance and embody the values and standards of behaviour expected at all levels of public services in Wales. *"Public service values and associated behaviours are, and must be at the heart of the NHS in Wales."* The Seven Principles of Public Life, also known as The Nolan Principles, form the basis of our Standards of Behaviour requirements for its Directors and staff.
The Seven Principles of Public Life are:

- **Selflessness** – Individuals should act solely in terms of the public interest. They should not do so, in order to gain financial or other benefits for themselves, their family or friends.
- **Integrity** – Individuals should not place themselves under any financial or other obligation to outside individuals or organisations that might seek to influence them in the performance of their official duties.
- **Objectivity** – In carrying out public business, including making public appointments, awarding contracts, recommending individuals for rewards and benefits, choices should be made on merit.
- **Accountability** – Individuals are accountable for their decisions and actions to the public and must submit themselves to whatever scrutiny is appropriate for their position.
- **Openness** – Individuals should be as open as possible about all the decisions and actions they take. They should give reasons for their decisions and restrict information only when the wider public interest clearly demands it.
- **Honesty** – individuals have a duty to declare any private interests relating to their duties and to take steps to resolve and conflicts arising in a way that protects the public interest.
- **Leadership** – Individuals should promote and support these principles by leadership and example.

3. Declaring and Interest, Gifts, Hospitality and/or Sponsorship

Declarations of Interest need to be submitted by Board Members and all staff on pay band 8C or above (or equivalent) each financial year, normally at the commencement of the year even if this is a nil return. Additionally posts within some departments at Band 7 to 8B which may be in a position to influence purchasing and foster relationships with external organisations are required to complete an annual declaration.

Any outside employment should be declared and you can make Declarations of Interest, Gifts and hospitality using **this link** which will take you to the Civica Declare Portal. This should be done at the start of each financial year but you can make additional entries at any time.

Civica will email you directly from this email address with reminders to complete a declaration (please note - this is not a spam email address): bcuhb@mydeclarations.co.uk

The reporting system helps remove the administrative burden from the process and support the Health Board to fully comply with requirements to maintain a central register and annually publish declarations made by Directors and Independent Members. Further, the process eliminates the need for paper to be generated associated with the process, supporting the reduction in consumption of scare and finite resources, aiding the reduction of carbon footprint across Wales.

4. Actions for Staff

DO	DON'T
• Familiarise yourself with this guidance and the Standards of Behaviour Framework and follow them. • Use your common sense and judgement to consider whether the interests you have could affect the way taxpayers' money is spent. • Regularly consider what interests you have and declare these as they arise. If in doubt, declare. • Speak to your Line Manager openly about any perceived conflicts that may arise, in a timely manner. • Record these on ESR electronically, using the visual guide set out at **Appendix 1**.	• Misuse your position to further your own interests or those close to you. • Be influenced, or give the impression that you have been influenced by, outside interests. • Allow outside interests you have to inappropriately affect the decisions you make when using taxpayers' money.

5. Definitions

For the purposes of this guidance, a 'conflict of interest' is defined as:

> *"A set of circumstances by which a reasonable person would consider that an individual's ability to apply judgement or act, in the context of delivering, commissioning, or assuring taxpayer funded health and care services is, or could be, impaired or influenced by another interest they hold."*

A conflict of interest may be:

ACTUAL	**POTENTIAL**
• There is a material conflict between one or more interests	• There is the possibility of a material conflict between one or more interests in the future
Each case will be different. The general management actions, along with relevant Standards of Behaviour Framework and guidance, should complement the exercise of good judgement. It will always be appropriate to clarify circumstances with individuals involved to assess issues and risks.	

Staff may hold interests for which they cannot see a potential conflict. However, caution is always advisable because others may perceive it differently. It will be important to exercise judgement and to declare such interests where there is otherwise a risk of allegation of improper conduct.

'Interests' can arise in a number of different contexts. A material interest is one which a reasonable person would take into account when making a decision regarding the use of taxpayers' money because the interest has relevance to that decision.

Indirect interests This is where an individual has a close association with another individual who has a financial interest, a non-financial professional interest or a non-financial personal interest who would stand to benefit* from a decision they are involved in making. This would include**: • Close family members and relatives. • Close friends and associates. • Business partners.	***Example*** *Close relationships with friends/family/colleagues should be listed; if in doubt, declare.* *[Family member] works for [organisation] as [Role] since [year] – no services provided to NHS Wales*
Financial interests Where an individual may get direct financial benefits* from the consequences of a decision their organisation makes. This could include: • A director (including a non-executive director) or senior employee in another organisation which is doing, or is likely to do business with an organisation in receipt of NHS funding • A shareholder, partner or owner of an organisation which is doing, or is likely to do business with an organisation in receipt of NHS funding • Someone in outside employment • Someone in receipt of secondary income. • Someone in receipt of a grant. • Someone in receipt of other payments (e.g. honoraria, day allowances, travel or subsistence). • Someone in receipt of sponsored research – who would be referred to complete a Gifts, Hospitality, Honoraria and Sponsorship Form (Appendix 2)	***Example*** *Shareholder of 50% in [list the company], from the period [XX to XX], receiving [XX] benefits/financial gain*

Non-financial professional interests Where an individual may obtain a non-financial professional benefit* from the consequences of a decision their organisation makes, such as increasing their professional reputation or status or promoting their professional career. This could include situations where the individual is: • An advocate for a particular group of patients. • A clinician with a special interest. • An active member of a particular specialist body. • An advisor for a body such as Health Inspectorate Wales. • A research role.	***Example*** *Panel member for [specialist/regulatory body], from the period [XX to XX], receiving [XX] benefits/financial gain*
Non-financial personal interests This is where an individual may benefit* personally from a decision their organisation makes in ways which are not directly linked to their professional career and do not give rise to a direct financial benefit. This could include, for example, where the individual is: • A member of a voluntary sector board or has a position of authority within a voluntary sector organisation. • A member of a lobbying or pressure group with an interest in health and care.	***Example*** *Independent Member of [list the organisation], from the period [XX to XX], receiving [XX] benefits/financial gain* *Volunteer for [insert charity/organisation], [detail capacity of the role], from the period [XX to XX], receiving [zero] benefits/financial gain*
** A benefit may arise from the making of gain or avoiding a loss* *** These associations may arise through relationships with close family members and relatives, close friends and associates, and business partners. A common sense approach should be applied to these terms. It would be unrealistic to expect staff to know of all the interests that people in these classes might hold. However, if staff do know of material interests (or could be reasonably expected to know about these) then these should be declared.*	

There are a number of common situations, which can give rise to risk of conflicts of interest, examples are included below:

Category	What should be declared?	Example
Loyalty interests	• A description of the nature of the loyalty interest. • Relevant dates. • Any other relevant information (e.g. action taken to mitigate against a conflict, details of any approvals given to depart from this guidance).	**RELATIONSHIPS** Include details of any family members, civil partners and close friends employed by BCUHB, any NHS Wales organisation, or a known supplier to BCUHB **ANY OTHER INTEREST** Any other connection with a voluntary, statutory, charitable or private body that could create a potential opportunity for conflicting interests
Outside employment	• A description of the nature of the outside employment (e.g. who it is with, a description of duties, time commitment). • Relevant dates. • Any other relevant information (e.g. action taken to mitigate against a conflict, details of any approvals given to depart from the terms of this guidance).	**DIRECTORSHIPS** Public or private appointments, employment or consultancies. Company directorship's in private or limited companies **OTHER POSITIONS OF AUTHORITY** A position of authority (i.e. Director, Chairman. Trustee etc.) in a charity or voluntary body in the field of health and social care
Shareholdings and other ownership interests	• A description of the nature of the shareholding/other ownership interest. • Relevant dates.	**INTEREST IN COMPANIES AND SECURITIES** Substantial interest is ownership or part

	• Any other relevant information (e.g. action taken to mitigate against a conflict, details of any approvals given to depart from the terms of this guidance).	ownership, more than 1/100th (i.e. share) of private companies, businesses or consultancies
Patents	• A description of the patent or other intellectual property right and its ownership. • Relevant dates. • Any other relevant information (e.g. action taken to mitigate against a conflict, details of any approvals given to depart from the terms of this guidance).	As appropriate

Top Tips for Effective Declaring of Conflicts of Interest and Gifts, Hospitality and Sponsorship

- Remember, if in doubt, declare!
- Always include an effective date (the period from and to);
- Update at least annually, upon request or whenever circumstances change that give light to a new perceived conflict; and
- Always include the nature of the relationship, period of involvement and any financial transactions or benefits in kind associated.

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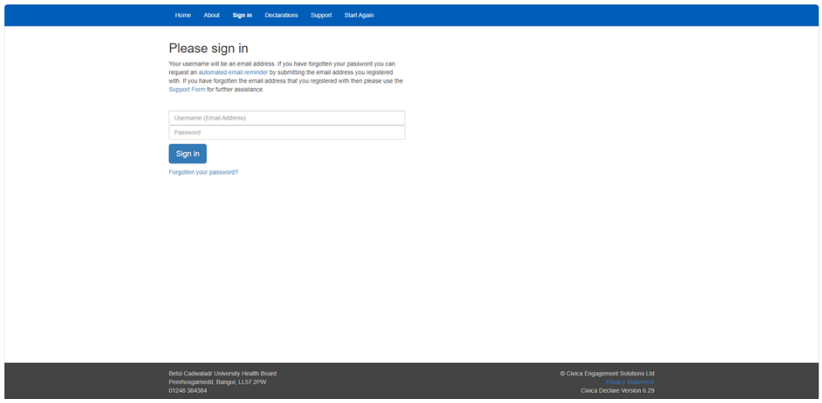
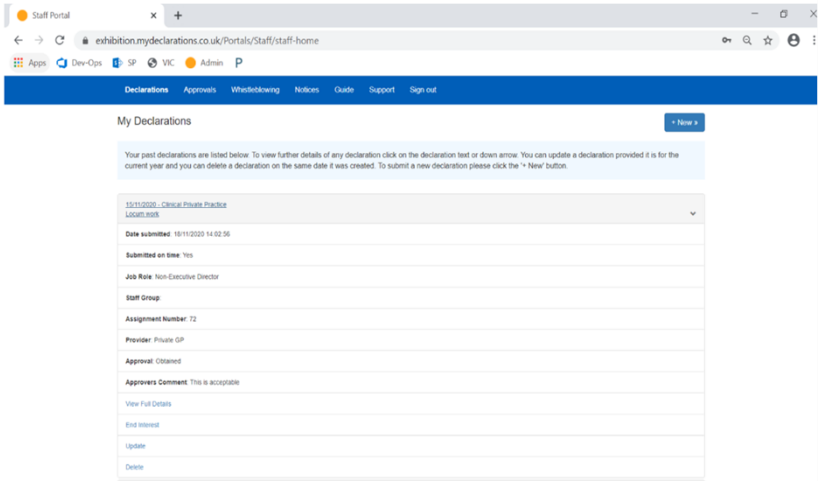
Appendix 1 – A visual guide to updating Conflicts of Interest via Declare



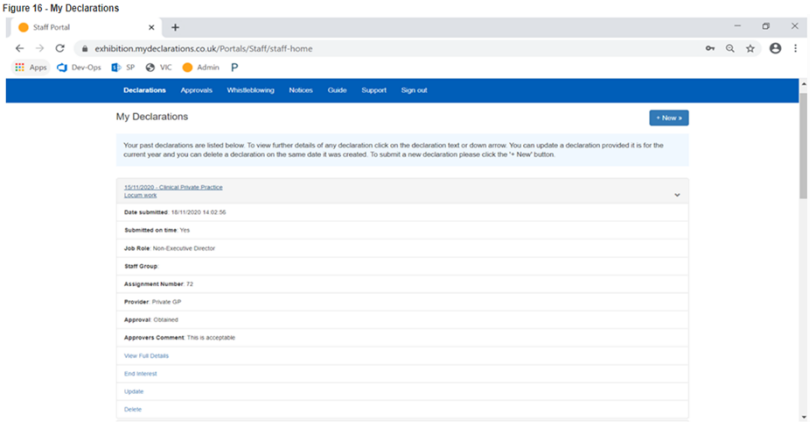
1. Sign in



2. The 'Declarations' web page lists all the past declarations of interest made by a staff member.

   By default, all records will be displayed in collapsed panel mode.

Figure 16 - My Declarations



3. At the bottom of each expanded record panel there will be 1 to 4 links displayed. These are: -

- **View Full Details** – clicking this link will display the associated detailed declaration of interest record
- **Update** – if this link is visible then clicking it will open up the detailed associated declaration of interest record in an update form so that it can be edited
- **End Interest** – if this link is visible it is because the type of declaration 'is time served' and no end date is present. Clicking this link will open a confirmation popup. Clicking OK in the popup will insert the current date as an End Date for the declaration of interest.

- **Delete** – if this link is visible then clicking it will open a Confirmation Popup to confirm that you wish to delete the record

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Declaration of Interest Flowchart

Every APRI
Email from Board Service to the Senior Leadership Tear including Medical and (inical Director and Assistant Director to complete their annual declaration of interest

ALL staff MUST declare anv interests or lodge a nil return via the declaration of Interest orm (ppendix '

In year change

I have a new intere:

need to change m declaratic

I have a new rol

You must provide details. in writing. as soon as you become aware. an no later than 28 days. to the Director of Corporate Governanc

You must declare anv interests or lodge a nil return via the declaration of interest forn

In a meetin

I have a nev intere:

Are you aware of the potential conflict before the meeting

Ye

N

Is this on the Register of Interests

Ye

N

You should declare when requested. and before the agenda ite

You need to update your declaration of interest forı

You need to declare in the meetin

Declarations ar reviewed by the Director of Corporate Governanc

Declara ion of Interests reported to Audit Committe by Director of Cor orate Governanc a yearly bas

Audit Committe reviews Register and confirms entries re appropriate for each departme

Re ster of Interests reported tc Health Boarc

The Register will be amended to the reflect th chang

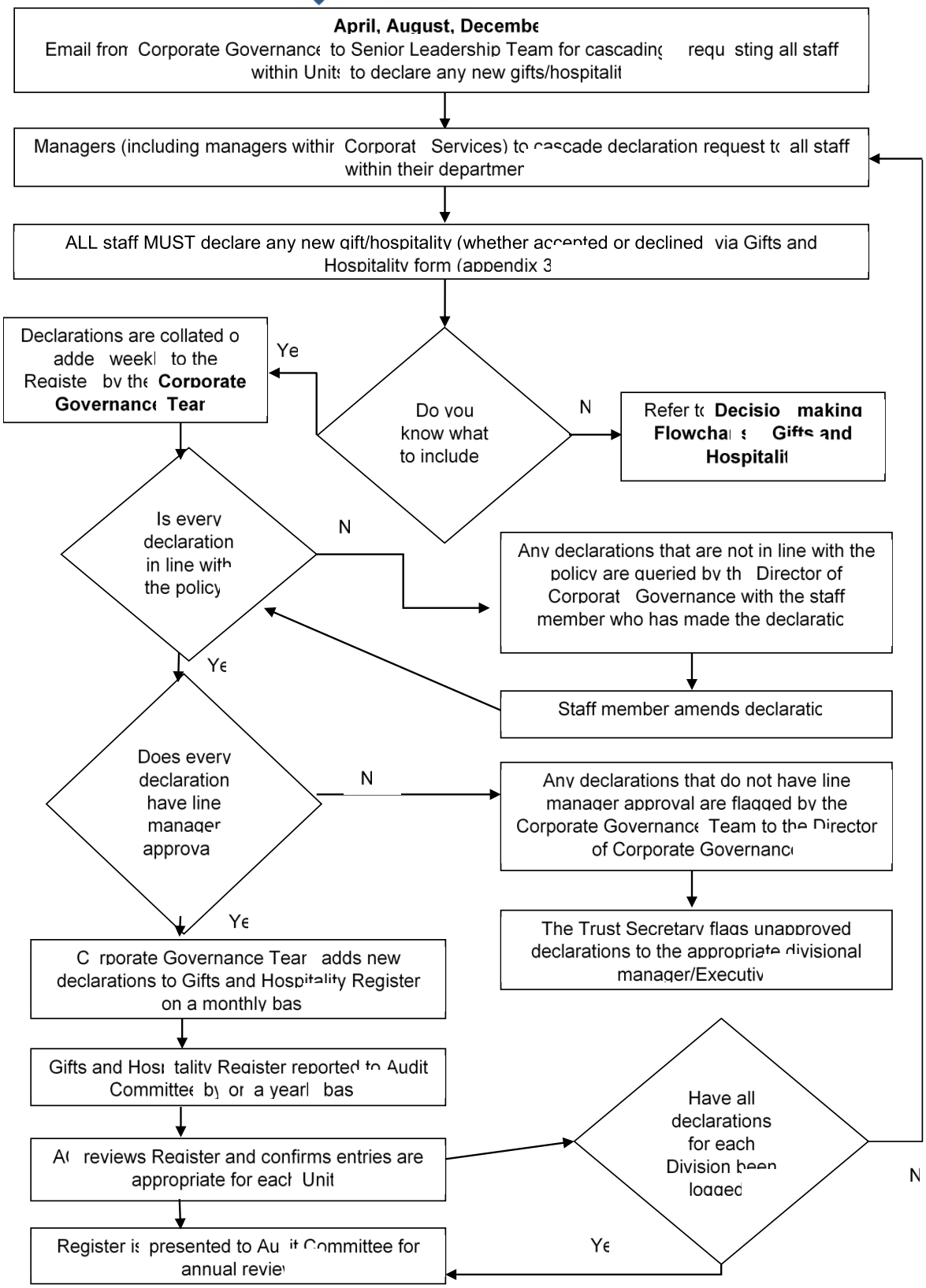
PUBLISH Register on websit via Audit Committee papers and in the Annual Report and Account

What type of Interest do you have

- Financial interest (e.g. direct financial benefit, outside income
- No -financial professional interest (e.g. increasing professional reputatio
- No -financial personal interest (e.g. personal benefit not directly linked to professional caree and that does not give rise to direct financial benefi
- Indirect interest (e.g. close association with an individual who would stand to benefit from a decision you are makin

The Chair of the meeting will determine if there is a conflict of interest and the course of action to take (YOU should advise of the arrangements already agreed for managing the conflic

The type and details of the interest and the course of action taken to be recorded in the minute


April, August, Decembe
Email from Corporate Governance to Senior Leadership Team for cascading requ sting all staff within Units to declare any new gifts/hospitalit
Managers (including managers within Corporat Services) to cascade declaration request to all staff within their departmer
ALL staff MUST declare any new gift/hospitality (whether accepted or declined via Gifts and Hospitality form (appendix 3
Do you know what to include
Ye
N
Refer to Decisio makina Flowchar s Gifts and Hospitalit
Declarations are collated o adde weekl to the Registe by the Corporate Governance Tear
Is every declaration in line with the policy
N
Any declarations that are not in line with the policy are queried by th Director of Corporat Governance with the staff member who has made the declaratic
Staff member amends declaratic
Ye
Does every declaration have line manager approva
N
Any declarations that do not have line manager approval are flagged by the Corporate Governance Team to the Director of Corporate Governanc
The Trust Secretary flags unapproved declarations to the appropriate divisional manager/Executiv
Ye
C rporate Governance Tear adds new declarations to Gifts and Hospitality Register on a monthly bas
Gifts and Hos tality Register reported to Audit Committee by or a yearl bas
A reviews Register and confirms entries are appropriate for eacl Unit
Have all declarations for each Division been logged
N
Ye
Register is presented to Au it Committee for annual revie

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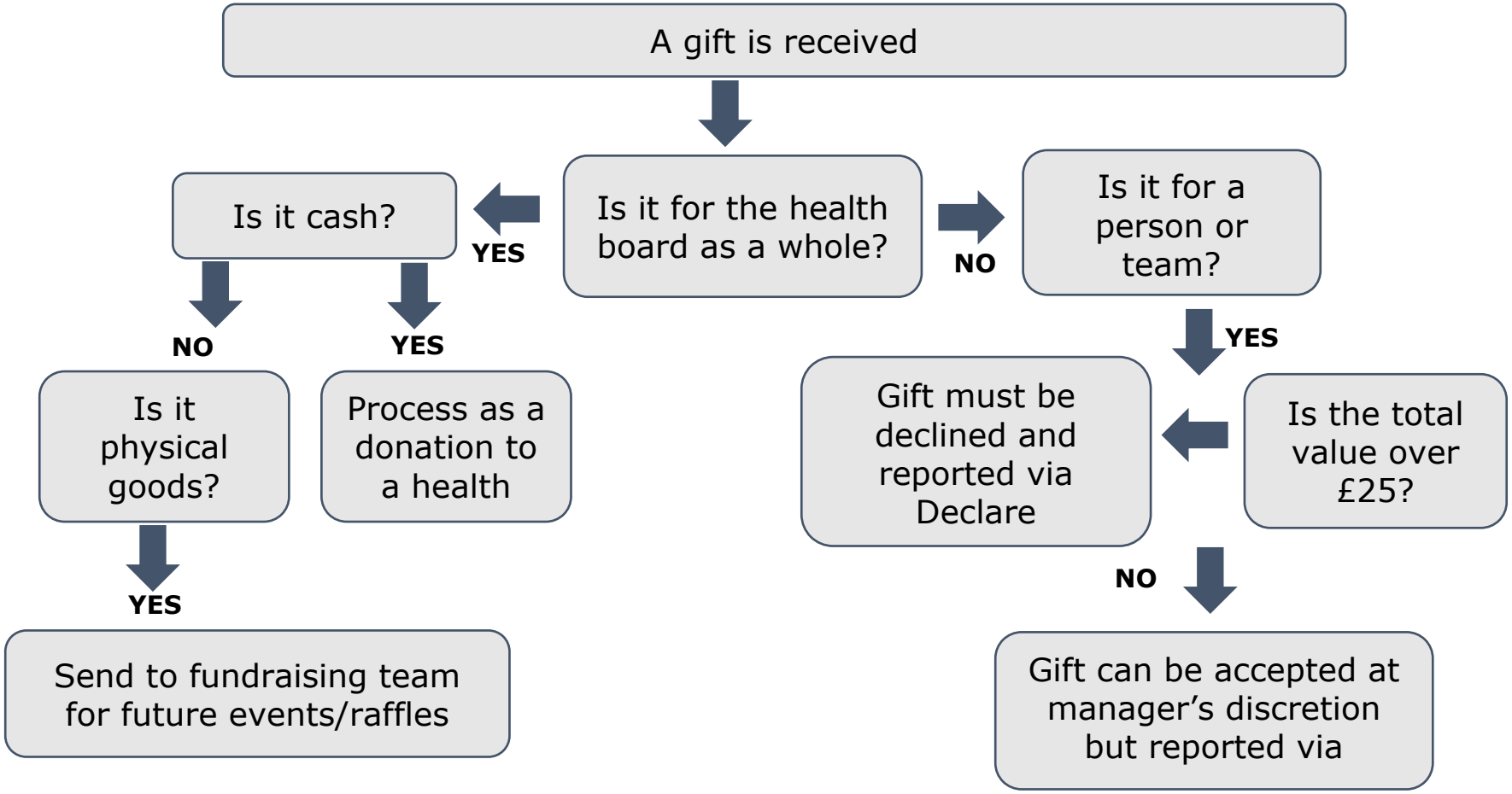
Guidance for receiving Gifts



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

Teitl adroddiad: ***Report title:***	Board Assurance Framework
Adrodd i: ***Report to:***	Audit Committee
Dyddiad y Cyfarfod: ***Date of Meeting:***	Thursday, 16 January 2025
Crynodeb Gweithredol: ***Executive Summary:***	This report provides the first 2024 iteration of the Board Assurance Framework following the approval of the Three-Year Plan and Strategic Objectives. Audit Committee is asked to consider the Board Assurance Framework presented to the January Board Meeting.
Argymhellion: ***Recommendations:***	The Committee is asked to**:** • To **receive** and **comment** the contents of the BAF prior to consideration by the Board in January 2025.
Arweinydd Gweithredol: ***Executive Lead:***	Pam Wenger, Director of Corporate Governance
Awdur yr Adroddiad: ***Report Author:***	Nesta Collingridge Head of Risk Management

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

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

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

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

Cyswllt ag Amcan/Amcanion Strategol: ***Link to Strategic Objective(s):***	Detailed in the BAF report and how the CRR aligns to the revised BAF

Goblygiadau rheoleiddio a lleol: ***Regulatory and legal implications:***	It is essential that the Board has robust arrangements in place to assess, capture and mitigate risks, as failure to do so could have legal implications for the Health Board.
Yn unol â WP7, a oedd EqIA yn angenrheidiol ac a gafodd ei gynnal? ***In accordance with WP7 has an EqIA been identified as necessary and undertaken?***	Not applicable for this report
Yn unol â WP68, a oedd SEIA yn angenrheidiol ac a gafodd ei gynnal? ***In accordance with WP68, has an SEIA identified as necessary ben undertaken?***	Not applicable for this report
Manylion am risgiau sy'n gysylltiedig â phwnc a chwmpas y papur hwn, gan gynnwys risgiau newydd (croesgyfeirio at y BAF a'r CRR) ***Details of risks associated with the subject and scope of this paper, including new risks(cross reference to the BAF and CRR)***	Board Assurance Framework paper
Goblygiadau ariannol o ganlyniad i roi'r *argymhellion ar waith* ***Financial implications as a result of implementing the recommendations***	The effective and efficient mitigation and management of risks has the potential to leverage a positive financial dividend for the Health Board through better integration of risk management into business planning, decision-making and in shaping how care is delivered to our patients thus leading to enhanced quality, less waste and no claims.
Goblygiadau gweithlu o ganlyniad i roi'r argymhellion ar waith ***Workforce implications as a result of implementing the recommendations***	Failure to capture, assess and mitigate risks can impact adversely on the workforce.
Adborth, ymateb a chrynodeb dilynol ar ôl ymgynghori ***Feedback, response, and follow up summary following consultation***	Reviewed by Equality and Human Rights corporate team. 20/11/24 Review at Risk Scrutiny Group and onward to Dec Committees private agenda for comment. 15/01/25 Executive Team final approval prior to Audit Committee 16/01/25.
Cysylltiadau â risgiau BAF: (neu gysylltiadau â'r Gofrestr Risg Gorfforaethol) ***Links to BAF risks:*** *(or links to the Corporate Risk Register)*	Board Assurance Framework risks linked to corporate risks
Rheswm dros gyflwyno adroddiad i fwrdd cyfrinachol (lle bo'n berthnasol) ***Reason for submission of report to confidential board (where relevant)***	
Camau Nesaf:	

Next Steps:

1. Presentation of the BAF to January 2025 Board meeting.
2. Following approval of risks, indicative assurance ratings to be suggested by the Executive Team for the committees to review at the next cycle of meetings.
3. Business as usual reporting and monitoring: Bi-monthly Review at Risk Scrutiny Group and Executive Team meeting, monitoring of actions within risks. Reporting to Committee quarterly and Board Bi-Annually.

Rhestr o Atodiadau:

List of Appendices:

Appendix 1 – Board Assurance Framework

Board Assurance Framework

Board Assurance Framework Report

Purpose

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

The purpose of this BAF is threefold:

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

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

Introduction

Board Assurance risks were developed by the Executive Team based on the Health Board's 5 strategic objectives. This report presents the first iteration of the BAF risks which align with the Health Board's approved Three-Year Plan and Strategic Objectives. The Risk Scrutiny Group (RSG), Individual Executives and Executive Team meeting (30 October 2024) and Audit Committee as private agenda item (5 November 2024) have reviewed the working draft BAF (prior presentation to the Board).

Next Steps

- The Board Assurance Framework is recommended for approval at the Executive Team Audit Committee prior to January Board Meeting.
- Committees will be asked to score level of assurance in relation to risks.
- The Board Assurance Framework will be maintained and reported to the Risk Scrutiny Group; Executive Team (bi-monthly) and Committees (quarterly) and Board (bi-annually) as per the Risk Management Framework on an on-going basis.

Board Assurance Framework (BAF): January 2025

Bwrdd Iechyd Prifysgol Betsi Cadwaladr University Health Board

The key elements of the BAF are:

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

Likelihood score and descriptor

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

Key to lead committee assurance ratings:

Green = Positive assurance: the Committee is satisfied that there is reliable evidence of the appropriateness of the current risk treatment strategy in addressing the threat or opportunity no gaps in assurance or control AND current exposure risk rating = target OR gaps in control and assurance are being addressed

Amber = Insufficient assurance: the Committee is not satisfied that there is sufficient evidence to be able to make a judgement as to the appropriateness of the current risk treatment strategy

Red = Negative assurance: the Committee is satisfied that there is sufficient reliable evidence that the current risk treatment strategy is not appropriate to the nature and/or scale of the threat or opportunity.

This approach informs the agenda and regular management information received by the relevant lead committees, to enable them to make informed judgements as to the level of assurance that they can take and which can then be provided to the Board in relation to each Principal Risk and to identify any further action required to improve the management of those risks.

Board Assurance Framework (BAF): January 2025

Bwrdd Iechyd Prifysgol Betsi Cadwaladr University Health Board

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

Reference	Principal risk	Lead Executive	Initial date of assessment	Last reviewed	Previous risk score (at previous review/update) C x L	Current risk score C x L	Target risk score C x L
BAF24-01	Risk of Not Fully Building an Effective and Accountable Organisation	Director of Corporate Governance and Executive Team oversight	20/10/2024		0x 0= *	4x 3= 12	2x 2= 4
BAF24-02	Risk of Ineffective Strategic Development and Digital Transformation	Executive Director of Transformation and Strategic Planning & Chief Digital & Information Officer	20/10/2024		0x 0= *	5x 4= 20	3x 3= 9
BAF24-03	Risk of Effectively Achieving Long Term Financial Sustainable	Executive Director of Finance	20/10/2024		0x 0= *	5x 4= 20	3x 3= 9
BAF24-04	Ineffectively Establishing a Compassionate Culture, Leadership, Engagement and workforce capacity and capability	Deputy Director of People Services	20/10/2024		0x 0= *	4x 4= 16	3x 3= 9
BAF24-05	Risk of Effectively Engage with Citizens, Partners and Communities	Director of Partnerships/Communications and Engagement	20/10/2024		0x 0= *	2x 3= 6	2x 2= 4
BAF24-06	Risk of ability to deliver required improvements to transform care and enhance outcomes	Executive Director of Nursing Acting Executive Director of Public Health Executive Medical Director Executive Director of Allied Health Professionals and Health Science	20/10/2024		0x 0= *	5x 4= 20	5x 2= 10
BAF24-07	Risk of effectively delivering timely access to care resulting in potential clinical harm, poor delivery of performance targets and reputational risk	Chief Operating Officer	20/10/2024		0x 0= *	4x 4= 16	4x 2= 8
BAF24-08	Inability to initiate and implement evidenced based improvement and innovation	Executive Director of Nursing & Chief Digital & Information Officer	20/10/2024		0x 0= *	4x 3= 12	3x 2= 6

Bwrdd Iechyd Prifysgol Betsi Cadwaladr University Health Board

1: Building an effective organisation

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

Principal risk (what could prevent us achieving this strategic objective)	**BAF24-01: Risk of Not Fully Building an Effective and Accountable Organisation** Ineffectively delivering interconnected governance, operational, performance, and legislative challenges that could impede the Health Board's ability to develop a high-functioning, accountable, and cohesive organisation.			**Strategic objective**	1. To Build an Effective Organisation (1A & 1B: Governance (Board Effectiveness / Risk Management) 1C Operating Model; 1D Performance and Accountability Framework;1F: Legislative Improvements)
Lead Committee	Performance, Finance and Information Governance Committee	**Risk type**	Compliance/Regulatory		
Risk Lead	Director of Corporate Governance/Executive Team Oversight	**Risk appetite**	Open 15-19		
Related Corporate Risks:	CRR24-15 Health and Safety				

Risk rating				**Review Dates**	
	Current exposure	**Tolerable**	**Target**		
Consequence	**4. Major**	2. Minor	2. Minor	**Initial date of assessment**	20/10/2024
Likelihood	**3. Possible**	2. Unlikely	2. Unlikely	**Last reviewed**	
Risk rating	**12. Moderate**	**4. Low**	**4. Low**	**Last updated**	

N.B. Tolerable and Target score lines stacked as both are 4.

Strategic threat (what might cause this to happen)	**Primary risk controls** (what controls/ systems & processes do we **already** have in place to assist us in managing the risk and reducing the likelihood/ impact of the threat)	**Gaps in control** (are further controls possible in order to reduce risk exposure within tolerable range?)	**Plans to improve control** (are further controls possible in order to reduce risk exposure within tolerable range?)	**Sources of assurance (and date)** (**Evidence** that the controls/ systems which we are placing reliance on are effective)	**Gaps in assurance / actions to address gaps and issues**	**Assurance rating**
Responsible: Head of Covid-19 Inquiry and Thirlwall Inquiry/Assistant Director of Occupational Health, Safety And Security/ EPRR Lead		Accountable: Executive Team				
Threat: Non-compliance with legislative requirements	• Health and Safety Policy • HS03 General Risk Assessment Procedure • HSG65 Plan, Do, Check, Act process for continuous improvement • Service Sector Health and Safety Self-Assessment and Health and Safety Reviews	• Remaining gaps in civil contingency planning post-pandemic • Incomplete integration of HSE recommendations into operational plans	• Approval and progression of the gap analysis for health and safety measures as set out in the updated Health and Safety Strategy and Plan 2024-2026 dated September 2024. • New approach for Health and Safety Management System being developed aligned to NHS Employers Health and	**Management:** Health and Safety compliance reporting to Strategic Occupational Safety and Health Group (SOSHG) and People and Culture Committee Monthly reviews of Health, Safety and Security KPIs	• Gap analysis reporting general legislative gap analysis • Limited Assurance Internal Audit report for Health and Safety & Corporate Legislative Compliance.	Committee to decide

Board Assurance Framework (BAF): January 2025

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Strategic threat (what might cause this to happen)	**Primary risk controls** (what controls/ systems & processes do we **already** have in place to assist us in managing the risk and reducing the likelihood/ impact of the threat)	**Gaps in control** (are further controls possible in order to reduce risk exposure within tolerable range?)	**Plans to improve control** (are further controls possible in order to reduce risk exposure within tolerable range?)	**Sources of assurance (and date)** (**Evidence** that the controls/ systems which we are placing reliance on are effective)	**Gaps in assurance / actions to address gaps and issues**	**Assurance rating**
	• Security Assessment of Premises • Some Civil Contingencies and Emergency Preparedness plans • Annual emergency preparedness evaluations improvement	• Incomplete integration of HSE recommendations into operational plans	Safety Standards, to include Violence Prevention and Reduction Standards Timescale: Q4 2024	**Risk and compliance:** Risk Register reporting but noted gap on the Gap analysis reporting for compliance and gaps of general legislative gap analysis **Independent assurance:** HSE audit and compliance checks • Civil Contingencies Act compliance review	Improvement action plan in place and monitored at SOSHG.	
Responsible:	Director of Performance and Commissioning		Accountable:	Director of Corporate Governance/CEO		
Threat: the Performance and Accountability Framework may not effectively establish clear lines of accountability and provide consistent, real-time performance monitoring. This could lead to poor decision-making, unaddressed performance gaps, and a lack of ownership over key outcomes, ultimately reducing the Health Board's ability to deliver its strategic goals effectively.	• Integrated Performance Framework • Integrated Performance reports aligned • Clear accountability matrix and escalation for senior and mid-level management • Performance scorecards for service delivery units	• Inconsistent application of performance tools across departments • Review Integrated Performance Framework to re-align with new strategic objectives Triangulation with risk management	• Implement full alignment of team objectives with strategic objectives • Finalise the redesign of reporting structures/timings to enhance transparency • Improved Risk triangulation with concerning trajectories	**Management:** • Reviews of performance metrics at Executive Team level • Regular reporting to Committees **Risk and compliance:** • Monthly accountability reviews if in escalation for services SLT • Performance Reviews held by the CEO • Monthly performance reviews by Welsh Government **Independent assurance**: • External NHS Wales and Health Boards performance benchmarking and NHS benchmarking network	Reports on performance at IHC Commissioning reports on out of area	Committee to decide
Responsible:	Director of Corporate Governance		Accountable:	CEO		
Threat: the Health Board's operating model may become inefficient or fragmented, leading to unclear roles, duplication of efforts, and siloed working. This could result in reduced operational effectiveness, slower decision-making, and diminished quality of care,	• Current definitions of operating model roles and structures in place • Business Partnering approach for clinical and corporate leadership • Staff co-producing a new Operating Model	• Delays in decision-making due to leadership duplication • Lack of integrated systems reducing efficiency • Service reconfiguration plans based on population health needs • Digital tools (Microsoft 365) to streamline operations	• Completion of the discovery phase reviewing of the operating model based on stakeholder feedback • Implement a streamlined decision-making protocol by Q3 and looking a re-design phase • Review of the Scheme of Delegation and establishment of a formal Executive Committee with reporting groups with clear delegations	**Management:** • Service-level performance audits **Risk and compliance:** • Assessments of operating model efficiency and insight reports **Independent assurance:** • Operating model effectiveness review by internal and external stakeholders • Internal Audit report on duplication of roles and decision-making timelines	• Limited Assurance Internal Audit report for Operating Model & Effective Governance (IHC) Central	

Board Assurance Framework (BAF): January 2025

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

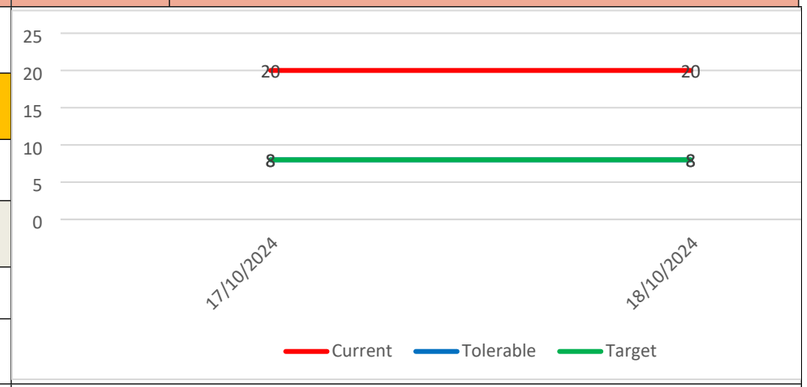
Strategic threat (what might cause this to happen)	**Primary risk controls** (what controls/ systems & processes do we **already** have in place to assist us in managing the risk and reducing the likelihood/ impact of the threat)	**Gaps in control** (are further controls possible in order to reduce risk exposure within tolerable range?)	**Plans to improve control** (are further controls possible in order to reduce risk exposure within tolerable range?)	**Sources of assurance (and date)** (**Evidence** that the controls/ systems which we are placing reliance on are effective)	**Gaps in assurance / actions to address gaps and issues**	**Assurance rating**
Responsible: Head Of Corporate Affairs/Head of Risk Management		Accountable: Director of Corporate Governance				
Threat: the Health Board's has weak Governance and Ineffective Risk Management Practices	• Risk Management Framework updated for improved escalation pathway to Risk Scrutiny Group. • Risk Appetite set 24/25 • Board Development Programme • Internal Audit Tracking of Recommendations • Board committee structure now all in place	• Gaps in risk governance maturity, with some areas requiring support and more training to integrate the Risk Framework and Procedures. • Policy Management system and overdue policies. • Self-assessment of board effectiveness • Robust Internal Audit Tracking software and systems. • Incomplete recruitment of executive roles. • Equality Impact Assessment Process integrated within Impact Assessment Impact Screening Tool to ensure compliance	• Improved Scrutiny of Corporate Risks. • Development of the BAF • Improved Data Analytics of Governance around Risk (Dashboard) and driving improvement of metrics. • Review of the current system once progress has been made on the overdue policies. • Planned assessment to take place in February/March 2025 • Reviewing current systems to have a more effective way of tracking and reporting audit recommendations • Executive Team recruitment ongoing with some progress made on appointments.	**Management:** • Risk reporting at local level and strategic level. **Risk and compliance:** • Risk reporting to the Executive Team and Committees Key Performance Indicators (KPIs) on risk management performance to Audit Committee • Internal Audit Reporting to Audit Committee **Independent assurance:** • Audit Wales Structured Assessment Report and other Audit Wales Reports	• Limited Assurance Internal Audit reports for: Review of Board Effectiveness & Standards of Business Conduct - Declarations of Interest, Gifts and Hospitality & Risk Management • Audit Wales governance recommendations	

Bwrdd Iechyd Prifysgol Betsi Cadwaladr University Health Board

2: Developing strategy and long-lasting change

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

Principal risk (what could prevent us achieving this strategic objective)	**BAF24-02: Risk of Ineffective Strategic Development and Digital Transformation** Ineffective strategy development, robust planning processes, and a forward-looking approach to digital technology to ensure long-lasting organisational change.			**Strategic objective**	2. Developing strategy and long-lasting change (2A 10-year Strategy & 2H Strengthening Planning; 2E Digital, Data, and Technology;)
Lead Committee	Planning, Population Health & Partnership Committee	**Risk type**	Quality		
Risk Lead	Executive Director of Strategy and Transformation/ Chief Digital & Information Officer	**Risk appetite**	Open 15-19		
Related Corporate Risks:	CRR24-07 Fragmented Patient Care Record/CRR24-17 ICT Failure and Cyber				
Risk rating				**Review Dates**	
	Current exposure	**Tolerable**	**Target**		
Consequence	**5. Catastrophic**	4. Major	4. Major	**Initial date of assessment**	20/10/2024
Likelihood	**4. Somewhat likely**	2. Unlikely	2. Unlikely	**Last reviewed**	
Risk rating	**20. High**	**8. Medium**	**8. Medium**	**Last updated**	



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

Board Assurance Framework (BAF): January 2025

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Strategic threat (what might cause this to happen)	**Primary risk controls** (what controls/ systems & processes do we **already** have in place to assist us in managing the risk and reducing the likelihood/ impact of the threat)	**Gaps in control** (are further controls possible in order to reduce risk exposure within tolerable range?)	**Plans to improve control** (are further controls possible in order to reduce risk exposure within tolerable range?)	**Sources of assurance (and date)** (**Evidence** that the controls/ systems which we are placing reliance on are effective)	**Gaps in assurance / actions to address gaps and issues**	**Assurance rating**
Responsible:	Assistant Director of Compliance and Business Management	Accountable:	Chief Digital & Information Officer			
Threat: threat that the organisation may struggle to keep pace with the rapid evolution of digital, data, and technology innovations and have outdated systems, inefficiencies, and an inability to fully harness data for informed decision-making and personalised patient care by lack of investment in DDaT infrastructure due to competing priorities	• Digital strategy and roadmap • Information Standards aligned with NHS Wales' standards • Some investment in digital tools to improve service delivery and data analytics • Internal Audit Report substantial cyber process • Electronic Health Record Board including Corporate Risk and Action Plan • Reasonable Internal Audit report for Digital Operating Model Fragmented Care Records	• Delays in digital transformation due to lack of reoccurring investment • Gaps in the integration of data systems across different service areas • Insufficient data on service reconfiguration effectiveness • Effectiveness of Clinical Coding and target review	• Senior Posts for reviewing Digital architecture and EHR. • Roll-out of key priority digital transformation projects. • System integration • Transformation of the DDaT Operating Model. **Timescale: Q4 2024**	**Management:** • Quarterly reviews of digital objectives including projects at service level to Senior Leadership Team • Performance and accountability meetings for Annual Plan objectives **Risk and compliance:** • Annual audit of data governance and cyber security measures **Independent assurance**: • Internal and external audits of data governance and technology • Information Commissioners office • Audit Committee Reporting and Corporate Risk in place		Committee to decide
Strategic threat (what might cause this to happen)	**Primary risk controls** (what controls/ systems & processes do we **already** have in place to assist us in managing the risk and reducing the likelihood/ impact of the threat)	**Gaps in control** (are further controls possible in order to reduce risk exposure within tolerable range?)	**Plans to improve control** (are further controls possible in order to reduce risk exposure within tolerable range?)	**Sources of assurance (and date)** (**Evidence** that the controls/ systems which we are placing reliance on are effective)	**Gaps in assurance / actions to address gaps and issues**	**Assurance rating**
Responsible:	Assistant Director of Health Strategy & Planning	Accountable:	Executive Director of Strategy and Transformation			
Threat: Lack of Long-Term Strategic Alignment amd development and implementation of the 10-year strategy undermining align short-term actions with long-term objectives the strategy's goals and long-term impact.	• Strategic alignment with population needs assessments • Comprehensive stakeholder engagement framework • Integrated planning framework with multi-year objectives • Regular planning reviews aligned with financial and performance data • Collaboration and coproduction with external stakeholders to inform planning decisions	• Limited public consultation and stakeholder input at early stages. • Unclear prioritisation of strategic initiatives. • Delayed integration of planning with performance data. • Gaps in external stakeholder engagement in the planning process also includes diverse and inclusive stakeholders	• Establish a systematic approach to developing the 10-year strategy • Inclusive engagement with stakeholders for 'what matters' discussions • Quarterly performance reviews of planning outcomes • Annual audit of planning and resource alignment • Strengthen planning integration with performance and financial data • Meaningful and more frequent engagement with external stakeholders for planning insights **Timescale: Q4 2024**	**Management:** • Quarterly strategic planning reviews • Progress reports on strategy development milestones • Quarterly planning reviews by the Executive Team **Risk and compliance:** • External benchmarking of planning effectiveness **Independent assurance**: • Annual external audit of strategic alignment with population needs • External validation of strategic priorities by key stakeholders	• Public consultation and external engagement	Committee to decide

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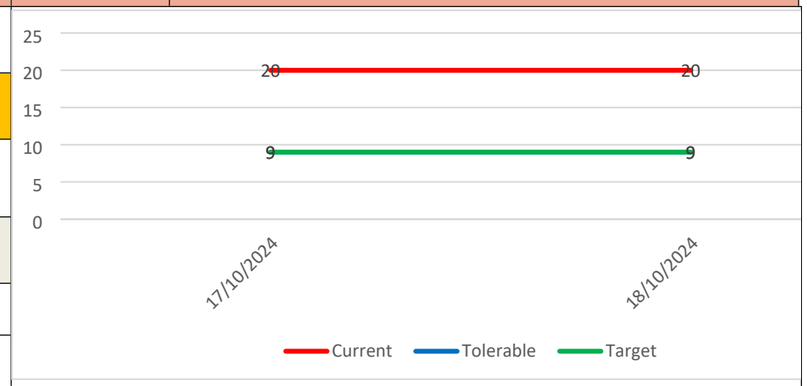
Principal risk (what could prevent us achieving this strategic objective)	**BAF24-03: Risk of Effectively Achieving Long Term Financial Sustainable**			**Strategic objective**	2. Developing strategy and long-lasting change (2I Finance Governance Environment; 2D Capital Priorities: Supporting Change)
Lead Committee	Performance, Finance and Information Governance Committee	**Risk type**	Finance		
Risk Lead	Executive Director of Finance	**Risk appetite**	Open 15-19		
Related Corporate Risks:	CRR24-05 Financial Sustainability /CRR24-06 Suitability and Safety of Sites				

Risk rating				**Review Dates**	
	Current exposure	**Tolerable**	**Target**		
Consequence	**5. Catastrophic**	3. Moderate	3. Moderate	**Initial date of assessment**	20/10/2024
Likelihood	**4. Somewhat likely**	3. Possible	3. Possible	**Last reviewed**	
Risk rating	**20. High**	**9. Medium**	**9. Medium**	**Last updated**	



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

Strategic threat (what might cause this to happen)	**Primary risk controls** (what controls/ systems & processes do we **already** have in place to assist us in managing the risk and reducing the likelihood/ impact of the threat)	**Gaps in control** (are further controls possible in order to reduce risk exposure within tolerable range?)	**Plans to improve control**	**Sources of assurance (and date)** (**Evidence** that the controls/ systems which we are placing reliance on are effective)	**Gaps in assurance / actions to address gaps**	**Assurance rating**
Responsible:		Interim Director of Finance	Accountable:	Executive Director of Finance		
Threat: Health Board key financial duty is to attain a break-even financial position**.** Failure to achieve the key duty results in cash depletion and a lack of ability to pay employees and suppliers of goods and services. A reduction in funding or change in financial trajectory or unexpected event resulting in an increased Financial Improvement Plan (FIP) requirement to reduce the scale of the financial deficit, without having an adverse impact on quality and safety	• Annual Plan details requirements for further controls and required controls detailed in 'Gaps in controls' • Monthly reporting of financial performance, articulating risk to delivery, drivers of any financial risk and suggested actions in place to mitigate risk • Monthly reporting to Welsh Government financial performance each month, again articulating drivers of risk to delivery and mitigating actions • Corporate risk for shorter term sustainability in place	• Financial governance framework aligned with the organisation's strategic priorities. • An endorsed Clinical Strategy that articulates demand and capacity modelling by speciality. • Financial capital resource availability • Integration of financial planning with performance and risk management processes • Deficit in year balancing financial allocations with spending • Inconsistent alignment between financial planning and strategic service goals	• Implementation of Value Based Healthcare and a Value and Sustainability approach to savings development • Strengthen financial forecasting and integrate financial risks into operational planning. • Develop further the control environment for addressing planned position and implementation of any corrective actions. • Enhanced Accountability & Performance framework to hold officers to account for delivery	**Management:** • Monthly financial reporting and budgetary controls **Risk and compliance:** • Oversight by Audit Committee • Annual audit of financial governance effectiveness • Regular financial performance reviews **Independent assurance**: • Internal and external audit reports on financial controls • Annual review of compliance with Welsh Government financial guidelines • Monthly oversight of financial performance by Welsh Government	• Limited Assurance Internal Audit report for Delivery of Health Board Transformational Savings & Budgetary Control • Limited assurance report on budgetary control environment • Head of Internal Control Opinion articulating limited assurance over systems of internal control • Qualification of accounts 2022/23 and Qualification for regulatory breach 2024/25 All containing actions to address gaps	Committee to decide
Responsible:		Head Of Capital Development	Accountable:	Executive Director of Finance		

Board Assurance Framework (BAF): January 2025

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Threat: Inadequate Capital Investment to Support Organisational Change	• Estates Strategy • Capital prioritisation programme aligned with strategic objectives that involves operational and clinical teams in prioritisation of limited resources • Project management for capital investments, the Health Board having substantial material schemes in train • Prioritisation of investments in infrastructure to support clinical services and statutory requirements • Capital Manual • Capital prioritisation for urgent projects • Six facet survey being completed for all provider infrastructure	• Delays in capital project approvals and implementation. • End of year wrap up report on overheads and programme progress. • Implement stronger project management controls to track capital investments. • Discretionary capital use in prioritisation between medical equipment, IM&T and Estates works (relative prioritisation between asset classes not undertaken) • Prioritisation of substantial business cases within the plans of the Health Board that aligns to Clinical Strategy	• Decarbonisation Board reporting of key objectives through to Committee (PPHP), articulating goals and objectives through to Health Board • Ongoing development of Estates strategy to be informed by completion of six facet survey • Monthly reporting of this year's expenditure verse plans in order to ensure delivery of this year's capital programme • Prioritisation of major capital works within the strategy for the Health Board in completion of the three-year IMTP. **Timescale: Q4 2024**	**Management:** • Monthly financial reporting of plan verse actual expenditure and budgetary controls **Risk and compliance:** • Oversight by Audit Committee • Some reviews to assess the alignment of capital investments with strategic goals Board **Independent assurance:** • Internal Governance of capital project progress and expenditure and reporting up to Committee and Welsh Government. • Welsh Government monthly reviews of plans for expenditure in year verse allocated resources.	• Reports on alignment of capital investments with strategic goals Board • Prioritisation plans being endorsed through Executive for inclusion within the IMTP endorsed through Health Board and Committees. • External support secured to service major capital developments. • Capital Investment Group formed, reporting into Executive on Capital works.	

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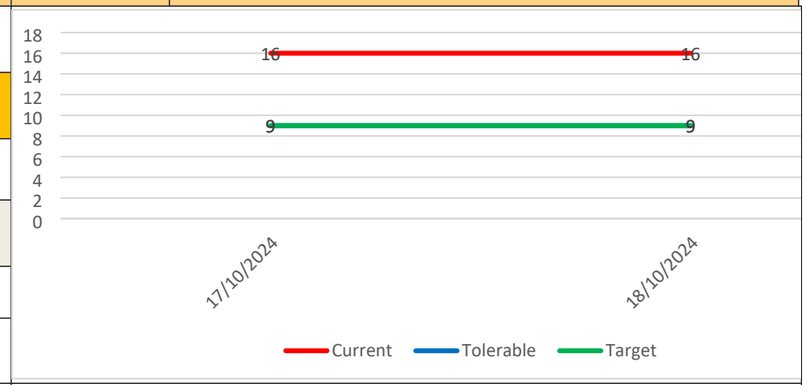
3: Creating compassionate culture, leadership and engagement

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

Principal risk (what could prevent us achieving this strategic objective)	**BAF24-04: Ineffectively Establishing a Compassionate Culture, Leadership, Engagement and workforce capacity and capability** A risk that the Health Board may inadequately foster a compassionate culture and strong leadership, resulting in disengaged staff, low morale, and high turnover.	**Strategic objective**	3: To have a compassionate culture, leadership & engagement (3A Compassionate Leadership and Organisational Development & 1G Workforce Planning)
Lead Committee	People & Culture Committee	**Risk type**	Quality
Risk Lead	Deputy Director of People's Services	**Risk appetite**	Seek 15-19
Related Corporate Risks:	CRR24-01 People, Culture and Wellbeing /CRR24-16 Leadership/Special Measures		

Risk rating				**Review Dates**	
	Current exposure	**Tolerable**	**Target**		
Consequence	**4. Major**	3. Moderate	3. Moderate	**Initial date of assessment**	20/10/2024
Likelihood	**4. Somewhat likely**	3. Possible	3. Possible	**Last reviewed**	
Risk rating	**16. High**	**9. Medium**	**9. Medium**	**Last updated**	



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

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Strategic threat (what might cause this to happen)	**Primary risk controls** (what controls/ systems & processes do we **already** have in place to assist us in managing the risk and reducing the likelihood/ impact of the threat)	**Gaps in control** (Specific areas / issues where further work is required to manage the risk to accepted appetite/ tolerance level)	**Plans to improve control** (are further controls possible in order to reduce risk exposure within tolerable range?)	**Sources of assurance (and date)** (**Evidence** that the controls/ systems which we are placing reliance on are effective)	**Gaps in assurance / actions to address gaps and issues**	**Assurance rating**
Responsible:	Head Of Policy, Practice & Compliance-WOD	Accountable:	Deputy Director of People's Services			
Threat: that the Health Board may inadequately foster a compassionate culture and strong leadership, resulting in disengaged staff, low morale, and high turnover.	• Workforce Planning Framework in collaboration with HEIW • Skill-mix review and capacity-building programmes • Strategic partnership with Bangor University • Integrated Leadership Development Framework • Staff Engagement Plan • Continuous feedback loops for leadership performance • All Wales International Recruitment programme for nurses and doctors. • Improved Internal Audit Assurance with recruitment of senior and interim staff • Staff counselling / Occupational Health support • Strategic Equality Plan key driver in the culture change required for a compassionate and inclusive culture.	• Critical vacancies, particularly in clinical and leadership roles • Underdeveloped retention and progression pathways • Further embedding of Integrated Leadership Development Framework • Further leadership development initiatives • Current Equality governance arrangements require strengthening	• Prioritise workforce plans for 'challenged services' • Continue reducing agency usage and improve value and sustainability of workforce • Digital Enablers for workforce skill-mix, recruitment and retention • Further development of develop local training opportunities **Timescale:** Q4	**Management:** • Service Led skill-mix efficiency and commissioning requirements • Annual staff engagement surveys and reports to Committee and Board • People & Culture Dashboard to Committee **Risk and compliance:** • Corporate risks CRR24-01 People, Culture and Wellbeing CRR24-16 Leadership/Special Measures reported to committee. • Review of all Organisational Development risks reported. Local Workforce and Organisational Development risk meeting. • Quarterly performance reviews to CEO of Directorates/ Divisions • Freedom to Speak Up Guardian report **Independent assurance**: • Annual workforce plan reviews with HEIW • Internal Audit reports	• Limited Assurance Internal Audit report for Review of Workforce Planning Arrangements	Committee to decide

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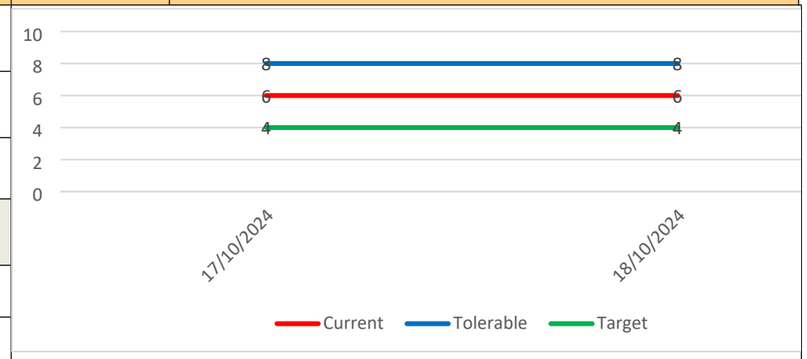
Principal risk (what could prevent us achieving this strategic objective)	**BAF24-05: Risk of Effectively Engage with Citizens, Partners and Communities** Risk of ineffective engagement with citizens, partners and communities may result in a lack of public trust, poor service user experience, and a disconnect between the Health Board's services and the needs of the population.	**Strategic objective**	3: To have a compassionate culture, leadership & engagement encompassing 3B: Citizen Engagement & 3C: Being a Good Partner
Lead Committee	Planning, Population Health & Partnership Committee	**Risk type**	Reputation
Risk Lead	Director of Partnerships/Communications and Engagement	**Risk appetite**	Seek 20-25
Related Corporate Risks:			

Risk rating				**Review Dates**	
	Current exposure	**Tolerable**	**Target**		
Consequence	**2. Minor**	2. Minor	2. Minor	**Initial date of assessment**	20/10/2024
Likelihood	**3. Possible**	4. Possible	2. Unlikely	**Last reviewed**	
Risk rating	**6. Low**	**8. Medium**	**4. Low**	**Last updated**	



Strategic threat (what might cause this to happen)	**Primary risk controls** (what controls/ systems & processes do we **already** have in place to assist us in managing the risk and reducing the likelihood/ impact of the threat)	**Gaps in control** (are further controls possible in order to reduce risk exposure within tolerable range?)	**Plans to improve control** (are further controls possible in order to reduce risk exposure within tolerable range?)	**Sources of assurance (and date)** (**Evidence** that the controls/ systems which we are placing reliance on are effective)	**Gaps in assurance / actions to address gaps and issues**	**Assurance rating**
Responsible:	Director Of Partnerships/communications And Engagement	Accountable:	Director Of Partnerships/communications And Engagement			
Threat: of ineffective engagement with citizens and communities may result in a lack of public trust, poor service user experience, and a disconnect between the Health Board's services and the needs of the population.	• Collaboration with key stakeholders • Strategic partnerships with local authorities and community organisations • Partnership governance frameworks • Comprehensive inclusive and diverse citizen engagement strategy • Accessible feedback mechanisms such as surveys and public engagement activity • Regular updates to the public on strategic priorities • Survey of engagement across the Health Board • Collaboration on complaint's process	Communication back to the public on their influence from feedback Lack of structured feedback from key partners Limited cross-sector collaboration in specific service areas Anchor Institute Framework	Perception Survey Timescale: Q4 2024 Developing Anchor Institute Framework **Timescale: Q4 2024** Citizen Engagement Plan being reviewed **Timescale: Q4 2024** Improve the feedback loop to ensure timely action on public input **Timescale: Q4 2024**	**Management:** • Citizen experience reports to Board • Feedback from engagement and where required public consultations. **Risk and compliance:** • Partnership feedback sessions • Forward Plan and oversight of Regional Partnership Board by the Planning, Population Health & Partnership Committee **Independent assurance**: • Perception survey with partners • Independent Advisor for external perspective on engagement approach	Risk Register for Partnerships/Communications and Engagement.	Committee to decide

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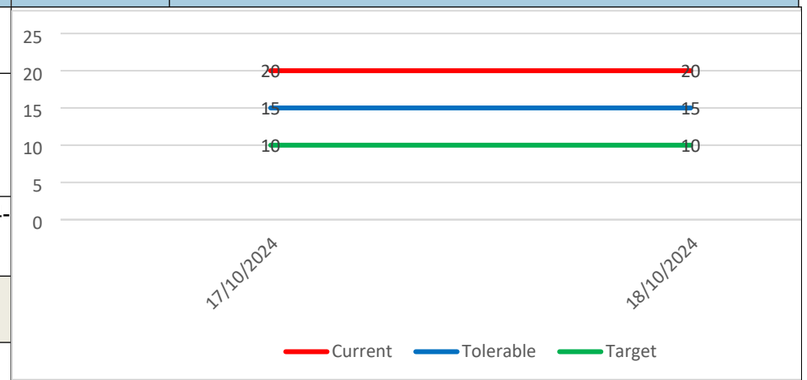
4: Improving quality, outcomes and experience

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

Principal risk (what could prevent us achieving this strategic objective)	**BAF24-06: Risk of ability to deliver required improvements to transform care and enhance outcomes** Risk of ineffectively delivering consistent high quality of patient care across the HB resulting in incidents of avoidable harm and poor clinical unmet patient needs, regulatory non-compliance, and reputational harm.			**Strategic objective**	4. To Improve Quality, Outcomes and Experience (4A Patient Experience; 4B Prevention; 4I Adult Mental Health, Learning Disability)
Lead Committee	Quality, Safety and Experience Committee / Planning, Population Health & Partnership Committee	**Risk type**	Quality		
Risk Lead	Executive Director of Nursing Acting Executive Director of Public Health Executive Medical Director Executive Director of Allied Health Professionals and Health Science	**Risk appetite**	Open 15-19		
Related Corporate Risks:	**CRR24-02** Patient Safety /**CRR24-04** Failure to Embed Learning/ **CRR24-08** Delivering a population health approach to health and wellbeing/ CRR24-18 Managing Outbreaks				

Risk rating				**Review Dates**	
	Current exposure	**Tolerable**	**Target**		
Consequence	5. Catastrophic	5. Catastrophic	5. Catastrophic	**Initial date of assessment**	20/10/2024
Likelihood	4. Somewhat likely	3. Possible	2. Unlikely	**Last reviewed**	
Risk rating	20. High	15. High	10. Medium	**Last updated**	



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Strategic threat (what might cause this to happen)	**Primary risk controls** (what controls/ systems & processes do we **already** have in place to assist us in managing the risk and reducing the likelihood/ impact of the threat)	**Gaps in control** (Specific areas / issues where further work is required to manage the risk to accepted appetite/tolerance level)	**Plans to improve control** (are further controls possible in order to reduce risk exposure within tolerable range?)	**Sources of assurance (and date)** (**Evidence** that the controls/ systems which we are placing reliance on are effective)	**Gaps in assurance / actions to address gaps and issues** (Insufficient evidence as to effectiveness of the controls or negative assurance)	**Assurance rating**
Responsible:	Deputy Executive Director of Nursing	Accountable:	Executive Director of Nursing	Responsible Committee	Quality, Safety and Experience Committee	
A loss of organisational focus on patient safety and quality of care leading to increased incidence of avoidable harm, exposure to 'Never Events', higher than expected mortality, and significant reduction in patient satisfaction	• Patient incident/feedback systems and policies • Data analysis and learning at service level • Datix Reporting • Staff training - falls, HAPU, etc • Quality governance arrangements at Health Board, IHC/division & service levels including: ○ Local and Exec PSE Groups ○ Local and Exec Quality Delivery Groups ○ Clinical audit programme & monitoring arrangements ○ Ward accreditation/ metrics and programme • Integrated Concerns Policy and Toolkit • Concerns Hub • 72 hr incident reviews • Sign-off process for incidents and Nationally Reported Incidents • Executive Led Oversight Group • Quality assurance visits • Internal Reviews against External National Reports • Getting it Right First Time (GIRFT) • Localised deep dives, reports and action plans • Operational grip on workforce gaps • Patient Advice and Liaison Service Activity • Comprehensive Cultural Competence training and awareness	• Inconsistent collection of real-time patient feedback • Delays in addressing patient concerns or complaints. • Operational oversight of sustainable change, evidence of learning and improvement measures	• Civica mapping of services to improve consistency of levels of feedback **Timescale: Q4 2024** • Expand real-time feedback systems across all services (SMS texting for priority areas e.g. ED) **Timescale: Q3 2024** • QMS in development. – pilots in urology and vascular • Reduced response times for addressing patient complaints. **Timescale: Q4 2024** • Learning Repository Development **Timescale: Q3 2024**	**Management:** • Learning from deaths Report to QC and Board • Quarterly Strategic Priority Report to Board; • Divisional risk reports to SRG bi-annually; • Guardian of Safe Working report to Board • Quality and Governance Reporting Pathway; Quality Safety and Experience Committee reports include: ○ Safeguarding Annual Report to QSE ○ Infection Control Annual Report ○ Health and Safety Annual Report ○ Bi monthly Quality Report ○ Deep dive Reports ○ Risk Management Report ○ Integrated Performance Report **Risk and compliance:** • Quality Dashboard • Annual Quality Report & Duty of Candour • Corporate Risks • Ombudsman Annual Letter **Independent assurance**: • Health Inspectorate Wales Reports • Care Inspectorate Wales Reports • Coroners reports: • Internal Audit reports. • Royal College Reports • Llais Reports Screening Quality Assurance Services assessments and reports of: • Antenatal and New-born screening • Breast Cancer Screening Services	Limited Assurance Internal Audit report for Limited Assurance: Lessons Learnt, Falls, Deprivation of Liberty Ombudsman recommendations to be managed. Services maintaining a proactive for complaint management and strategic oversight. • Nursing & Midwifery Vision • Allied Health Professional Strategy • Clinical services plan	Committee to decide

				• Bowel Cancer Screening Services • Cervical Screening Services External Accreditation/Regulation annual assessments and reports of; • Pathology (UKAS) • Endoscopy Services (JAG) • Medical Equipment and Medical Devices (BSI) • Blood Transfusion Annual Compliance Report (MHRA) • Ionising Radiation (Medical Exposure) Regulations		

Strategic threat (what might cause this to happen)	**Primary risk controls** (what controls/ systems & processes do we **already** have in place to assist us in managing the risk and reducing the likelihood/ impact of the threat)	**Gaps in control** (Specific areas / issues where further work is required to manage the risk to accepted appetite/tolerance level)	**Plans to improve control** (are further controls possible in order to reduce risk exposure within tolerable range?)	**Sources of assurance (and date)** (**Evidence** that the controls/ systems which we are placing reliance on are effective)	**Gaps in assurance / actions to address gaps and issues** (Insufficient evidence as to effectiveness of the controls or negative assurance)	**Assurance rating**
Responsible:	Head Of Public Health Assurance & Development	Accountable:	Acting Executive Director of Public Health	Responsible Committee	Population Health & Partnership Committee	
Threat: A widespread loss of organisational focus on investment and support to improve integrated prevention to better population health and wellbeing	• Public Health team and other teams across the HB, working on evidenced based programmes of work which link to National and local priorities • Integrated prevention strategies focused on population health and wellbeing to reduce health inequalities	• Limited access to timely integrated data supporting prevention activity. • Insufficient integration between prevention and clinical services • Services fail to prioritise prevention as part of the delivery of effective services and outcomes. • Large proportion of budget is non-recurrent grant funding	• Increase collaboration with community partners • Strengthen the integration of prevention into service and Health Board planning. **Timescale: Q4 2024**	**Management:** • Regular reports against a range of outcomes from the public health outcomes framework to Planning, Population Health & Partnership Committee **Risk and compliance:** • CRR24-08 Delivering a population health approach to health and wellbeing and CRR24-18 Outbreak Management reported to Planning, Population Health & Partnership Committee. • Operational Risk Register maintained. **Independent assurance:** • Regular reports against a range of outcomes from the public health outcomes framework to Regional Partnership Board Public Service Boards & Welsh Government	• Limited assurance of effective models - based on availability of data, intelligence, evidence and evaluation of impact of current prevention approaches within the Health Board and wider partner networks.	Committee to decide

Board Assurance Framework (BAF): January 2025

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

Strategic threat (what might cause this to happen)	**Primary risk controls** (what controls/ systems & processes do we **already** have in place to assist us in managing the risk and reducing the likelihood/ impact of the threat)	**Gaps in control** (Specific areas / issues where further work is required to manage the risk to accepted appetite/tolerance level)	**Plans to improve control** (are further controls possible in order to reduce risk exposure within tolerable range?)	**Sources of assurance (and date)** (**Evidence** that the controls/ systems which we are placing reliance on are effective)	**Gaps in assurance / actions to address gaps and issues** (Insufficient evidence as to effectiveness of the controls or negative assurance)	**Assurance rating**
Responsible:	Director of Mental Health & Learning Disabilities	Accountable:	Executive Director of Allied Health Professionals and Health Science	Responsible Committee	Quality, Safety and Experience Committee	
Threat: Risk of insufficient focus on Mental Health, wellbeing and Learning Disabilities in the Health Board strategy, planning and operations leading to sub optimal patient outcomes, lack of an holistic approach, regulatory non-compliance and reputational harm.	• Alignment with Welsh Government National strategies for Mental Health and wellbeing, Learning Disabilities and Substance Misuse • Adherence to Royal College and Clinical standards • National NHS Executive Mental Health and Learning Disabilities (MHLD) Strategic Improvement Programme • Established Royal College Psychiatry Improvement programme with Health Board wide reporting and governance • Established reporting through existing HB Governance Frameworks, Oversight committees and routine audits to ensure compliance and monitor progress. • Inclusion in Health Board Annual Plan and monitoring mechanisms • Inclusion in organisational Major change programme, oversight and reporting • Clinically led Physical health work stream in MHLD • Primary care pathways • Crisis Care Concordat in place	• Recruitment and Retention challenges impacting on workforce including interim posts • Engagement and collaboration with physical health services • 'Foundations for the Future' programme maturity • Insufficient focus on health inequalities • Lack of integrated Electronic Health Record and other digital systems • Limited visibility of Mental health and Learning disabilities data at Board level • Current risk to balanced financial position • Greater focus on community and earlier intervention services	• Recruitment plans for substantive workforce • Increased pathways with Primary care • Active engagement with the Foundations for the future programme • Electronic Health Record programme with MHLD as early adopter • Increased prominence of MH in governance and reporting frameworks (integrated performance dashboard) • Enhanced Savings plans • Responsive annual plan • Implementation of Communication strategy • Alignment with Learning Disabilities national programme- Improving Care Improving lives review	**Management:** • External reviews in 2023-24, undertaken as part of Special Measures all recommendations completed and managed. • Performance Management and reporting • Civica and patient reporting metrics **Risk and compliance:** • Compliance with Royal College Standards • Audit Reports • Committee reports e.g. QSE **Independent assurance:** • Development of co-produced Patient Carer engagement work • Expert advisory group • External reviews • National and Local performance reporting • Together 4 Mental Health Partnership Board in place	• Lack of integrated patient care records impacting on care, planning and reporting • Increasing the scope of performance reviews focusing on patient pathways. • Improving our real time patient data • Visibility of community mental health activity	Committee to decide

Board Assurance Framework (BAF): January 2025

Bwrdd Iechyd Prifysgol Betsi Cadwaladr University Health Board

Principal risk (what could prevent us achieving this strategic objective)	**BAF24-07: Ineffectively delivering timely access** Risk of ineffectively delivering timely access to care resulting in potential clinical harm, poor delivery of performance targets and reputational risk	**Strategic objective**	4. To Improve Quality, Outcomes and Experience 4E: Planned Care; 4F: Cancer Care; 4G: Urgent and Emergency Care; 4H: Diagnostics; 4ICAMHS and Neurodevelopment)
Lead Committee	Performance, Finance and Information Governance Committee	**Risk type**	Quality
Risk Lead	Interim Chief Operating Officer	**Risk appetite**	Open 15-19
Related Corporate Risks:	CRR24-10 Urgent Emergency Care/ CRR24-11 Planned Care/ CRR24-12 Areas of Clinical Concern /CRR24-13 Timely Diagnostics		

Risk rating				**Review Dates**	
	Current exposure	**Tolerable**	**Target**		
Consequence	**4. Major**	4. Major	4. Major	**Initial date of assessment**	20/10/2024
Likelihood	**4. Somewhat likely**	2. Unlikely	2. Unlikely	**Last reviewed**	
Risk rating	**16. High**	**8. Medium**	**8. Medium**	**Last updated**	

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

Strategic threat (what might cause this to happen)	**Primary risk controls** (what controls/ systems & processes do we **already** have in place to assist us in managing the risk and reducing the likelihood/ impact of the threat)	**Gaps in control** (Specific areas / issues where further work is required to manage the risk to accepted appetite/tolerance level)	**Plans to improve control** (are further controls possible in order to reduce risk exposure within tolerable range?)	**Sources of assurance (and date)** (**Evidence** that the controls/ systems which we are placing reliance on are effective)	**Gaps in assurance / actions to address gaps and issues** (Insufficient evidence as to effectiveness of the controls or negative assurance)	**Assurance rating**
Responsible:	Interim Associate Director for Emergency Care/ Associate Director of Planned Care/ Professional Service Manager Radiography/ Assistant Area Director – Children	Accountable:	Interim Chief Operating Officer	Responsible Committee	Performance, Finance and Information Governance Committee	
Threat: The Health Board faces significant risks related to the ability to meet national and local performance targets related to access to timely care. The increased patient acuity, backlog of long waiting times, lack of standardised processes and robust demand and capacity planning at service level may negatively impact the delivery of consistent quality of care. Without strategic planning and robust controls, these risks could lead to reduced public confidence, increased colleague fatigue, ineffective use of resources and failure to achieve regulatory compliance or national standards.	• Initiation of demand capacity plans at specialty/service level • Improved planning including the Winter Resilience Plan with clear principles to protect urgent and planned care pathways • Major change programmes for Urgent and Emergency Care (UEC) and Planned Care • Strengthening preventative support through integrating services such as SICAT and GP out of hours with active community pathways • Strengthening capability and capacity to lead and deliver services with clear executive Senior Responsible Officers (SRO) in place supported by clinical and operational leads • Cancer recovery plan • Planned care delivery plan against the agreed trajectories supported with resource allocations • Diagnostics delivery plan against the agreed trajectories supported with resource allocations	• Clinical variations and lack of standardised operational processes across the Health Board • Limited integration of pathways and care processes between primary, community and secondary care • Insufficient capacity in challenged services and Neurodevelopment • Strategic approach for equipment replacement scheme to ensure service efficiency and sustainability • Estates strategy to address service needs • Challenges in workforce retention and gaps in critical roles affecting service delivery • Need for enhanced digital infrastructure to support predictive analytics and proactive planning	• Major change programmes for UEC and planned care aligned to the Six Goals for Urgent and Emergency Care (UEC) framework and national objectives (such as timely access to care and building community capacity) • Quality Management System (QMS) for supporting challenged services • Regional approach for services such as Child and Adolescent Mental Health (CAMHS) • Workforce planning to include targeted recruitment efforts for clinical posts Technology and Data-Driven Approaches: • Deployment of live dashboards for real-time monitoring of performance and governance metrics • Use of data analytics to identify high-risk populations and optimise resource allocation	**Management:** Integrated Quality Performance Delivery Tracking referrals and waiting times Performance tracking on ambulance handovers Monthly Performance monitoring Strategic Improvement Development Groups. Reviewing consistency in triage processes **Risk and compliance:** Performance reports to Integrated Performance Executive Delivery Group & Board Corporate Risk reporting to Performance and finance committee Patient-reported outcome measures (PROMs) and Patient-reported experience measures (PREMs) data **Independent assurance:** Internal Audit findings demonstrating substantial assurance Welsh Government Targets Joint Executive Team WG	• Independent reviews (focused on areas of concern) • Daily Health Board wide oversight grip in control for UEC performance and reporting • Health Board resource plan for seven-day UEC care model • Health Board workforce plan to align demand and capacity on a seven-day basis • Clear structure and delivery for pathways of care delays for North Wales as a system • Ensuring compliance with Joint Advisory Group on Gastrointestinal Endoscopy (JAG) accreditation.	Committee to decide

	• Governance framework for accountability including weekly executive led progress reviews for UEC and Planned Care • Chief Operating Officer and Director of Performance and commissioning collective leadership oversight for operational performance with support from the executive team • Clear workstreams (4) for UEC incorporated into operational planning and delivery as a framework aligned to the national 6 goals for UEC • Optimised hospital flow through SAFER programmes and discharge protocols ensuring resilience to protect planned care pathways • Access to care based on clinical urgency and then chronological wait across all programmes of care • Developing close partnership working with the 6 Local Authorities, Welsh Ambulance Service Trust (WAST), third sector and other providers to maximise care outcomes • Effective utilisation through planning and robust governance for use of nationally allocated resources for planned care and UEC • Regional approach in strategic planning through the Regional Partnership Board ensuring a North Wales approach for delivering services for our citizens		• Telehealth care to strengthen out of hospital care including home systems and video facilitated care • Re-enforce specialty level planning cycle through service line demand and capacity plan across the Health Board • Standardising care pathways across the Health Board • Revised Access policy to ensure standardised practice across the Health Board • Continued efforts to further strengthen collaboration with local authorities and voluntary sectors for integrated care delivery models • Incorporate public health needs analysis to service planning (such as deprivation links to access for UEC, Planned Care, CAMHS and Womens services) • Strengthened workforce planning for key areas linked to challenged services • Strengthen digital capabilities to support service teams (such as e-triage, further roll out of home adaptations particularly rural areas, single patient tracking lists) • Standardise data collection and reporting processes to reduce variability in decision-making. • Winter Resilience Plan milestones and adherence to ministerial requirements for capacity building	UEC Programme Board with WG attendance NHS Executive touch points Significant guidance and steer with National Imaging Programme CAMHS & Neurodevelopment National Programme links established. National Specification being worked towards. Regional ND, CAMHs meetings for improvement. CAMHS & Neurodevelopment Enhanced Monthly NHS Exec meeting with performance leads.	• Lack of consistent and reliable performance data at daily and weekly level. • Health Board workforce plan at modality level. • Specific diagnostics assurance process to delivery national patient standard for wait levels. • CAMHS & Neurodevelopment Improvement programme reporting to be defined and governance structure	

5: Establishing an effective environment for Learning

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

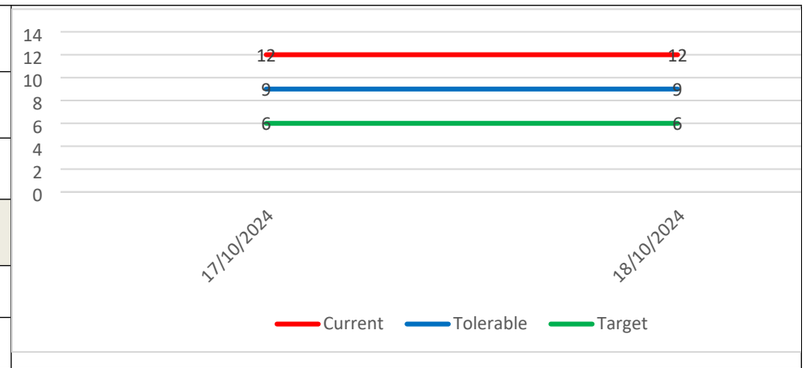
Principal risk (what could prevent us achieving this strategic objective)	**BAF24-08: Inability to initiate and implement evidence-based improvement and innovation** Lack of support, capability and agility to optimise strategic and operational opportunities to improve patient care	**Strategic objective**	5: Effective Environment for Learning 5A: University Partnership; 5B: Research, Development and Innovation & 5C: Academic Careers)

Board Assurance Framework (BAF): January 2025

Bwrdd Iechyd Prifysgol Betsi Cadwaladr University Health Board

Lead Committee	Planning, Population Health & Partnership Committee	**Risk type**	Quality
Risk Lead	Executive Director of Nursing /Chief Digital & Information Officer	**Risk appetite**	Open 15-19
Related Corporate Risks:	CRR24-04 Failure to Embed Learning		

Risk rating				**Review Dates**	
	Current exposure	**Tolerable**	**Target**		
Consequence	**4. Major**	3. Moderate	3. Moderate	**Initial date of assessment**	20/10/2024
Likelihood	**3. Possible**	3. Possible	2. Unlikely	**Last reviewed**	
Risk rating	**12. Medium**	**9. Medium**	**6. Low**	**Last updated**	



Strategic threat (what might cause this to happen)	**Primary risk controls** (what controls/ systems & processes do we **already** have in place to assist us in managing the risk and reducing the likelihood/ impact of the threat)	**Gaps in control** (are further controls possible in order to reduce risk exposure within tolerable range?)	**Plans to improve control** (are further controls possible in order to reduce risk exposure within tolerable range?)	**Sources of assurance (and date)** (**Evidence** that the controls/ systems which we are placing reliance on are effective)	**Gaps in assurance / actions to address gaps and issues**	**Assurance rating**
Responsible:	Assistant Director Data, Intelligence & Insight		Accountable:	Chief Digital & Information Officer		
Threat: Lack of understanding and agility resulting in reduced efficiency and effectiveness around how we provide care for patients	• Data collated and available through various systems and software (IRIS/RTT Hub) • Information account Managers to ensure data is interpreted correctly • Some Integrated data analytics and reporting in place • Integrated Leadership Framework & Performance Appraisal and Development Review (PADR) policy, staff development toolkit. • Continuous professional development opportunities for staff	• Regular data analytics reviews and intelligence reports for further assurances • More Assurance on evidence of being intelligence-led • Insufficient integration of data analytics consistently across all service areas • Data driven decision-making framework for services • Limited use of real-time data in clinical decision-making • Inconsistent access to learning opportunities across different service areas • Limited evaluation of the impact of training on service delivery • Limited collaboration on research projects	• Develop BCU's data warehouse, broadening the range of datasets available • Improve integration of data analytics into operational processes • Standardise access to leadership, apprenticeship and learning opportunities • Quality Management System redesign **Timescale: Q4 2024**	**Management:** • Monthly data governance reviews • Progress against annual plan to committees **Risk and compliance:** • Annual reviews of the effectiveness of learning initiatives **Independent assurance:** • Clinical body reporting on external evaluations of learning and development programmes		Committee to decide
Responsible:	Associate Director Research & Development		Accountable:	Executive Director Nursing		
Threat: Ineffective university partnerships, inadequate joint investment in research, and supporting academic career development to sustain a joint effective environment for learning.	• Some strategic partnerships with academic institutions • Memorandum of Understanding in place with Bangor University • Dedicated governance structure for North Wales Medical School and related projects • Research governance structure	• Inconsistent engagement with academic partners across all healthcare services • Lack of investment in healthcare innovation projects • Limited career progression opportunities in academia for clinical and non-clinical staff • No Memorandum of Understanding in place with Wrexham University at present	• Strengthen collaborative research projects with university partners • Strengthen academic career pathways with universities • Increase student placements and healthcare training initiatives through partnerships • Increase R&D collaboration with industry and academic institutions • Secure additional funding for healthcare innovation projects	**Management:** • Clinical Effectiveness Group reporting **Risk and compliance:** • Regular joint project reviews and risk register for projects maintained **Independent assurance:** • External evaluations of projects	• Strategic partnership with Wrexham University to be established with a supporting Memorandum of Understanding • Internal governance arrangements and reporting to Clinical Effectiveness Group to be strengthened. • Reporting and monitoring of academic career pathways,	

Board Assurance Framework (BAF): January 2025

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

Strategic threat (what might cause this to happen)	**Primary risk controls** (what controls/ systems & processes do we **already** have in place to assist us in managing the risk and reducing the likelihood/ impact of the threat)	**Gaps in control** (are further controls possible in order to reduce risk exposure within tolerable range?)	**Plans to improve control** (are further controls possible in order to reduce risk exposure within tolerable range?)	**Sources of assurance (and date)** (**Evidence** that the controls/ systems which we are placing reliance on are effective)	**Gaps in assurance / actions to address gaps and issues**	**Assurance rating**
	• Collaboration with external research bodies and innovation hubs • All Wales Innovation Pathway deployed		• Increase the number of joint appointments between the Health Board and academic institutions **Timescale: 2025/26** (next update provided will be quarterly milestones based off annual plan)	• Welsh Government Annual review of university designation criteria	assessments of joint academic roles and impact on healthcare delivery • Commitment to joint investment in research and innovation • Partnership reviews with universities. • Further review of independent assurance requirements	

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

Teitl adroddiad: ***Report title:***	Annual Report 2024/25 Arrangements		
Adrodd i: ***Report to:***	Audit Committee		
Dyddiad y Cyfarfod: ***Date of Meeting:***	Thursday, 16 January 2025		
Crynodeb Gweithredol: ***Executive Summary:***	The purpose of this report is to provide Audit Committee with the arrangements for the production of the 2024/25 Annual Report and Accounts. The Corporate Governance and Finance Directorates have been working with Health Board, Audit Wales and Internal Audit colleagues to achieve early and clear arrangements in place for the production of the Annual Report and its constituent parts. This report is seeking to give Assurance to the Audit Committee that robust arrangements are in place including: • Timescales for the development of the Annual Report and Accounts • Clear roles and responsibilities for the production of the Annual Report and Accounts • Proposed dates of future Audit Committee and Board meetings where the Annual Reports and Accounts are to be considered. This outline timetable has now been shared with Audit Wales colleagues and Internal Audit colleagues.		
Argymhellion: ***Recommendations:***	The Audit Committee is asked to: • **Consider** the arrangements that have been developed for the production of the Annual Report for 2024/25. • **Receive assurance** on the arrangements for the production of the Annual Report for 2024/25.		
Arweinydd Gweithredol: ***Executive Lead:***	Pam Wenger – Director of Corporate Governance		
Awdur yr Adroddiad: ***Report Author:***	Phil Meakin – Associate Director of 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:***	
Cyswllt ag Amcan/Amcanion Strategol: ***Link to Strategic Objective(s):***	This paper aligns to the strategic goal of *being an effective organisation*
Goblygiadau rheoleiddio a lleol: ***Regulatory and legal implications:***	Statutory requirements for the Health Board to produce an Annual Report and a set of Audited Annual Accounts for the Auditor General for Wales for the Welsh Government and for laying at the Senedd.
Yn unol â WP7, a oedd EqIA yn angenrheidiol ac a gafodd ei gynnal? ***In accordance with WP7 has an EqIA been identified as necessary and undertaken?***	The Equality duty is not applicable. This report is purely administrative in nature and submitted for information only. The associated public sector duties are not engaged, and there are no associated impacts on any of the protected groups
Yn unol â WP68, a oedd SEIA yn angenrheidiol ac a gafodd ei gynnal? ***In accordance with WP68, has an SEIA identified as necessary been undertaken?***	The Socio-Economic duty is not applicable. This report is purely administrative in nature and submitted for information only. The associated public sector duties are not engaged, and the report does not relate to a decision, strategic or otherwise.
Manylion am risgiau sy'n gysylltiedig â phwnc a chwmpas y papur hwn, gan	BAF24-01 Risk of Not Fully Building an Effective and Accountable Organisation

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)***	
Goblygiadau ariannol o ganlyniad i roi'r argymhellion ar waith ***Financial implications as a result of implementing the recommendations***	Not applicable at this point
Goblygiadau gweithlu o ganlyniad i roi'r argymhellion ar waith ***Workforce implications as a result of implementing the recommendations***	Not applicable at this point
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)*	CRR 24-16 – Leadership Not having effective governance arrangements could have a negative impact on the sustainability of staffing and subsequently patient care and safety and service delivery
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:*** • Commence the fortnightly programme meetings • Ensure the Corporate Calendar reflects the dates reflected in this report • Review of Compliance with the Corporate Governance Code to be reported to Audit Committee	
Rhestr o Atodiadau: **Appendices:**	

ANNUAL REPORT 2024/25 ARRANGEMENTS

1. INTRODUCTION

The purpose of this report is to provide Audit Committee with the arrangements for the production of the 2024/25 Annual Report and Accounts**.**

The Corporate Governance and Finance Directorates have been working with Health Board, Audit Wales and Internal Audit colleagues to establish clear arrangements in place for the production of the Annual Report for 2024/25 and its constituent parts.

This report is seeking to give Assurance to the Audit Committee that robust arrangements are in place including:

- Timescales for the development of the Annual Report and Accounts
- Clear roles and responsibilities for the production of the Annual Report and Accounts
- Proposed dates of future Audit Committee and Board meetings where the Annual Reports and Accounts are to be considered.

2. BACKGROUND

The Annual Report and Accounts are part of the Health Board's public annual reporting and set out the Health Board service delivery, environmental and financial performance for the year and describe management and governance arrangements.

Audit Wales identified that the level of engagement with Health Board colleagues from Finance and Corporate in the 2023/24 production of the Annual Reports and Accounts was encouraging and effective so these plans will build on this and this Programme approach that includes regular engagement with Audit Wales colleagues will continue and be developed further. Fortnightly programme meetings will include invites to Audit Wales colleagues.

3. OUTLINE OF ARRANGEMENTS FOR THE DEVELOPMENT OF THE 2024/25 ANNUAL REPORT

3.1 Clear Roles and Responsibilities

The Corporate Governance Directorate and Finance Directorate have worked with Audit Wales between October 2024 and December 2024 to identify and communicate clear roles and responsibilities to colleagues who will be involved with the production of the Annual Report and Accounts.

This will be underpinned by a Programme approach that enables the milestones in the plan to be monitored. The Associate Director of Governance will Chair a fortnightly core Programme Team that meets fortnightly from January 2025. Reflecting the points made above colleagues from Audit Wales will be invited and attend these meetings wherever appropriate. This will enable timely escalation of concerns and a transparent way of working.

The Associate Director of Governance will be the Programme Lead and the first line of escalation for matters raised by Audit Wales and/or Welsh Governement. The Director of Corporate Governance will be the Senior Responsible Officer and the second line escalation of enquiries from Audit Wales and/or Welsh Government.

This approach has also been taken in the development of corporate governance information that is to be reported in the Annual Governance Statement (AGS). The Head of Corporate Affairs will lead this work and the first draft will be completed by the end March 2025. This will enable an extended quality assurance period with the intention that the draft submitted on 9th May 2025 will be the final draft subject to audit queries and finalisation.

3.2 **Key Timescales Identified**

The plan has been developed with members of the Health Board teams plus Audit Wales and Internal Audit colleagues. The plan reflects the inter-dependencies of key information from Welsh Government, including the Manual for Accounts which is the key technical document that sets the content requirement for the Reports. The draft Manual for Accounts has now been received and is currently being considered by the Health Board's finance team for feedback by 18 January 2025.

Last year the Audit Committee received a self-assessment of compliance with the Corporate Governance Code and this will be reported to the Audit Committee on the 4 March 2025.

The submission dates as set down in the Draft Manual for Accounts are as follows:

NHS Wales 12-month Audited accounts submission	**Health Board Governance**	**Submission Date**
Unaudited Accounts	**30 April 2025** Audit Committee	2nd May 2025
Draft Accountability Report	**30 April 2025** Audit Committee	9th May 2025
Draft Remuneration Report	**30 April 2025** Audit Committee	9th May 2025
Audited Accounts and Annual Report	**20 May 2025** Audit Committee **25 June 2025** Audit Committee **26 June 2025** Board	30th June 2025

The Audit Committee will meet as follows to ensure the sign off of the annual report and accounts:

30th April 2025 (Private)

20th May 2025 (Private) – the whole Board will be invited to this session

25th June 2025 – Chair and Chief Executive will be invited to this meeting

4. **SUMMARY AND NEXT STEPS**

This report reflects the ambition the Health Board has for producing a high quality and accurate Annual Report and Accounts for 2024/25, reflecting what went well last year and what could be improved upon.

The immediate next steps include;

- Commence the fortnightly programme meetings
- Ensuring oversight of these arrangements by the Executive Team
- Ensure the Corporate Calendars reflects the dates reflected in this report
- Review of Compliance with the Corporate Governance Code to be reported to Audit Committee

5. RECOMMENDATIONS

The Audit Committee is asked to**:**

- **Consider** the arrangements that have been developed for the production of the Annual Report for 2024/25.
- **Receive assurance** on the arrangements for the production of the Annual Report for 2024/25.

6. BUDGETARY/FINANCIAL IMPLICATIONS

There are no budgetary implications associated with this paper.

7. EQUALITY AND DIVERSITY IMPLICATIONS

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

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

Teitl adroddiad: ***Report title:***	Internal Audit Progress Report (17 October 2024 – 7 January 2025)
Adrodd i: ***Report to:***	Audit Committee
Dyddiad y Cyfarfod: ***Date of Meeting:***	16 January 2025
Crynodeb Gweithredol: ***Executive Summary:***	<u>Progress report</u> The progress report is produced in accordance with: • the requirements as set out within the Public Sector Internal Audit Standards: Standard 2060 – Reporting to Senior Management. • the Welsh Government NHS Wales Audit Committee Handbook – Section 4.5 Reviewing internal audit assignment reports. The progress report summarises four assurance reviews finalised since the last Committee meeting in November 2024, with the recorded assurance as follows: • Reasonable assurance – three • Unsatisfactory assurance – one The report also includes information on draft reports issued and work in progress.
Argymhellion: ***Recommendations:***	The Committee is asked to: • Receive the progress report. • Approve changes to the plan for the Waiting List Initiative Payments (IHC Centre) review and the Integrated Assurance and Approval Plans (IAAP) for Wrexham Maelor Business Continuity.
Arweinydd Gweithredol: ***Executive Lead:***	Director of Corporate Governance
Awdur yr Adroddiad: ***Report Author:***	Dave Harries, Head of Internal Audit, CMIIA, QiCA Nicola Jones, Deputy Head of Internal Audit, CMIIA

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

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

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

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

(or links to the Corporate Risk Register)	
Rheswm dros gyflwyno adroddiad i fwrdd cyfrinachol (lle bo'n berthnasol) ***Reason for submission of report to confidential board (where relevant)***	N/A
Camau Nesaf: **Gweithredu argymhellion** ***Next Steps:*** ***Implementation of recommendations*** The progress report is presented according to the Committee's cycle of business and in line with the requirements of the NHS Wales Audit Committee Handbook.	
Rhestr o Atodiadau: ***List of Appendices:*** • Appendix 1: Progress report	

Betsi Cadwaladr University Local Health Board

Audit Committee
Internal Audit Progress Report

17 October 2024 to 7 January 2025

NWSSP Audit and Assurance Services

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

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

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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) Plans for 2024/25.

Access to information and provision of evidence by the Health Board

2. To fulfil our responsibility in evaluating the effectiveness of internal controls, risk management, and governance processes we are required to have unrestricted access to all relevant information. Without complete and accurate information, we cannot provide a reliable assessment of the Health Board's risk management, control, and governance processes.

3. Where we have limited access to certain data or are only provided with selective information, our ability to conduct an unbiased and comprehensive review is compromised. Such selective access can lead to incomplete findings and identification of matters arising which may not address the root cause of issues. Full access ensures we can perform our role without any undue influence or restriction.

4. The Internal Audit Charter sets out the requirements of access to information in paragraph *10 – Access and Confidentiality* (which is considered and approved annually by the Audit Committee), paragraph 10.1 refers specifically:

   '10.1 Internal Audit shall have the authority to access all the organisation's information, documents, records, assets, personnel and premises that it considers necessary to fulfil its role. This shall extend to the resources of the third parties that provide services on behalf of the organisation.

   10.2 All information obtained during the course of a review will be regarded as strictly confidential to the organisation and shall not be divulged to any third party without the prior permission of the Accountable Officer.'

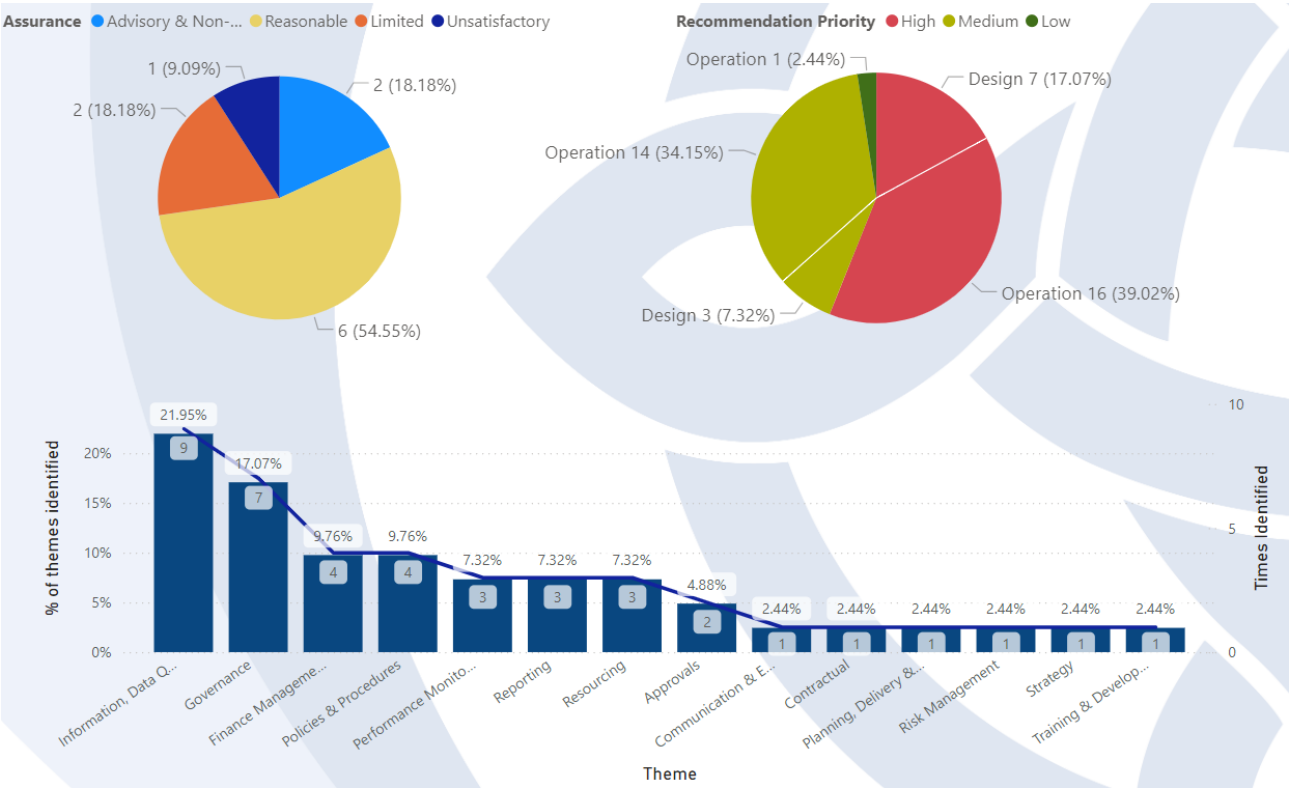
5. We must advise the Committee that some restrictions have been placed on us receiving/accessing Health Board information required to support two reviews which will impact our review and assurance.

Reports Issued

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

7. The image below details draft and final report ratings to date, recommendations by priority and themes identified. This shows the key themes of recommendations to date relate to information, data quality and data accuracy; governance; finance management and control; policies & procedures and performance management.

Image 1: Extract from the NHS Wales tracker for Betsi Cadwaladr University Health Board as at 7 January 2025 – 2024/25 overview



- Theme definition is included at Table 6.

Executive Summaries

Charitable Funds BCU-2425-06 13 November 2024

Report opinion: Reasonable

Purpose: To review whether there are robust processes and controls in place within the Health Board to support the management and administration of BCU Charitable Funds.

Overview

The following was observed at the time of the current review:

- Lack of formal controls to ensure procedural compliance - monitoring and administration of Fund Advisor list, Accountability Agreements, and registered fundraising events.
- The Charitable Support Operational Plan has not been finalised, reviewed, or recommended for approval by the Charitable Funds Committee or Board of Trustees.
- The Charitable Funds Committee is not fulfilling its expenditure approval responsibilities per the Committee Terms of Reference and Scheme of Reservation and Delegation.
- The expenditure approval requirements specified in the Charitable Funds Standing Financial Instructions are not consistent with other written control documents.

	Objectives	Assurance
1	Charitable Funds are subject to robust governance, oversight, and escalation arrangements facilitated by the Charitable Funds Committee	Reasonable
2	There are effective policies, procedures, and training provision in place to support the management and administration of Charitable Funds	Reasonable
3	All Charitable Funds income received is appropriate and accounted for correctly, including gift aid	Reasonable
4	All charitable funds expenditure is appropriate, authorised and within the terms of the relevant fund	Limited

	Key Matters Arising	Objective	Control Design or Operation	Recommendation Priority
1	There were some issues identified relating to governance of the Charity, including no review/update of the Charity Declaration of Trust, and no routine review of the Charity risk register by the Charitable Funds Committee.	1	Operation	Medium
2	The Fund Advisor list is not monitored to ensure compliance with Your Charity Procedures. Also, Accountability Agreements have not been used for some time.	2	Operation	Medium

3	The Charitable Support Operational Plan which details how the approved Strategy will be delivered has not been finalised, reviewed, or recommended for approval by the Charitable Funds Committee.	2	Design	High
4	Registered fundraising events are recorded however the document is not routinely monitored, reviewed, or updated to ensure all expected income has been received.	3	Operation	Medium
5	The Charitable Funds Committee has delegated expenditure approval to the Grants Decision Group, therefore is not fulfilling its responsibilities per the Committee Terms of Reference and Scheme of Reservation and Delegation. The expenditure approval requirements specified in the Charitable Funds Standing Financial Instructions are not consistent with other written control documents.	4	Operation	High

Intelligence led organisation BCU-2425-11 11 November 2024

Report opinion: Reasonable

Purpose: To review the capabilities in place, from a people, process and technology perspectives, for the Health Board to manage and transform its data to deliver the appropriate and accurate intelligence to inform better decisions.

Overview

The aim of being an intelligence lead organisation is with the digital strategy and within the 3-year plan. This is underpinned by a Digital & Intelligence roadmap which contains key actions to improve the position. There is a good structure in place to engage with stakeholders to identify information needs and the resources and skills required are generally understood, however they are not currently sufficient to provide the full information needs. The roadmap considers both the tools needed and the need for data governance and the organisation has recognised concerns with data quality and is taking action to improve.

The matters requiring management attention are:

- Ensuring that skills and resources for information provision are sufficient.
- Fully defining the actions to include modern intelligence tools.
- Defining a data quality policy.
- Defining a process for correction of data quality errors.
- Ensuring that data literacy is improved across the organisation.

Objectives		Assurance
1	Strategy	Substantial
2	Resources	Limited
3	Tools and Technology	Reasonable
4	Engagement	Substantial
5	Data Quality	Limited
6	Data Governance	Substantial
7	Decision Making	Reasonable

Key Matters Arising		Objective	Control Design or Operation	Recommendation Priority
1	Skills	2	Operational	Medium
2	Tools	3	Operational	Medium
3	Data Quality Policy	5	Design	High
4	Data Quality Resolution	5	Design	High
5	Data Literacy	7	Operational	High

Consultant Job Planning BCU-2425-20 7 January 2025

Report opinion: Unsatisfactory

Purpose: To review arrangements across the health board for management of the systems and controls in place for consultant job planning.

Overview

This review was identified as a high risk area by the Chief Executive for rapid review.

A job plan is a professional and contractual obligation for consultants and employers and sets out the duties, responsibilities and outcomes and the support and resources provided by the employer for the coming year. Job plans record the work that a consultant will undertake for the Betsi Cadwaladr University Health Board (the health board), split by Direct Clinical Care (DCC) and Supporting Professional Activities (SPA).

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

- The is no agreed Health Board policy in place for job planning. The Health Board must agree and publish its draft policy *Job Planning for Consultants, Speciality and Specialist Doctors: Betsi Cadwaladr University Health Board* as a matter of urgency to ensure standardisation and equity across all its services.

- Overall, the Health Board is not compliant with the requirements set out in the *Amendment to the National Consultant Contract in Wales* where annual job plans are required. Compliance is generally poor, at the time of this report thirty-four percent (34%) of job plans had expired.
- There were limited personal and service/team objectives evident throughout our sample and it is unclear why operational management are approving job plans without a key element of the national contract included. The recording of the Health Board's strategic goals was evident throughout our sample; however, these are outdated and do not reflect the strategic objectives detailed in the 2024-2027 Three-Year Plan.
- The Health Board pays Consultants for whole sessions and do not include part sessions (where agreed in the job plan). This may adversely impact the delivery of clinical sessions and impact the timely delivery of services to patients.
- It is unclear how the delivery and outcomes of sessions agreed in job plans are measured to ensure that clinical capacity is utilised effectively. For example, the number of patients to be seen in clinics/session time and theatre time and whether this is being achieved.
- Generally, there is inadequate reporting of job plan performance and scrutiny at operational management level, with limited use advised of the job plan dashboard. The Medical Workforce Group has not been meeting in accordance with its Terms of Reference, however its assurance reporting to the executive has not happened due to the People & Culture Executive Delivery Group also not meeting. There is little focus on medical and dental workforce matters reported to the People & Culture Committee.

	Objectives	Assurance
1	There is relevant and up to date procedures in place that are available to staff and align to the All-Wales guidance.	**Unsatisfactory**
2	Job plans accurately reflect both the individual and organisation activity requirements and are completed in a timely manner.	**Limited**
3	Job plans include outcomes that are linked to the health board's organisational objectives, and the level of achievement is subject to appropriate assessment.	**Unsatisfactory**
4	Completed job plans reconcile to system records and session payments are correct.	**Limited**
5	The completion rates of job plans are monitored and reported to an appropriate forum, with further escalation if there is low compliance.	**Unsatisfactory**

	Key Matters Arising	Objective	Control Design or Operation	Recommendation Priority
1	The Health Board has no Policy or Procedure detailing the expectations of both management and Consultant in discussing and agreeing the Job Plan in line with the nationally agreed Consultant Contract.	1	Design	High
2	Through discussion with all clinical directorates/divisions, each advised on the limited support available to them in relation to Medical and Dental Contract matters, following the removal of a dedicated medical staffing resource. We have confirmed this was	1	Operation	Medium

	Key Matters Arising	Objective	Control Design or Operation	Recommendation Priority
	absorbed into the operating model change instigated in People & OD.			
3	Through a review of first and second sign off details in the Ejob plan system, and verification with the seven clinical directorates / divisions, there were gaps in second approvers, officers no longer in post, and inconsistency with operational management included as either first or second sign off.	1	Design	High
4	The EJob Plan system is a hosted platform on the cloud and is wholly reliant on an internet connection. We have confirmed there is no documented business continuity plan in place centrally but are unsighted whether there are arrangements in place locally.	1	Design	Medium
5	Annual job plan reviews are not undertaken every twelve months.	2	Operation	High
6	There is no clear service objectives included in job plans and yet management are approving job plans without expected service objectives.	2	Operation	High
7	Strategic goals detailed in the Board Outcomes section of the job plan are not current with no measurable outcomes agreed.	3	Operation	High
8	Regular review of salary payments to agreed job plan commitments are not being undertaken to ensure under/overpayments are identified in a timely manner.	4	Design	High
9	Some Consultants are undertaking additional sessional work for the Health Board, but these are not fully reflected/declared within their substantive job plan	4	Operation	Medium
10	There is inadequate reporting of medical and dental job plan performance, across the Health Board	5	Operation	High
11	Routine scrutiny via the Medical Workforce Group & People & Culture Executive Delivery Group (EDG) is not happening.	5	Operation	High

Special Measures	BCU-2425-02	20 December 2024
Report opinion:	Reasonable	

Purpose: To review progress and delivery against the five stated Outcomes and, where relevant, corroborate whether the actions have resulted in improvement. We have reviewed the work undertaken by the Programme Management Office and relevant divisions / directorates / service areas across the Health Board.

Overview

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

- Whilst a significant number of deliverables / milestones were achieved, these were not always completed within the specified timescales.
- The quality of evidence submitted to the PMO to support delivery of milestones was inconsistent.
- Evidence is focused on action delivery rather than the benefit, impact, and outcome of implementation.

	Objectives	Assurance
1	Progress against delivery of the five stated Outcomes is in line with plans agreed by the Health Board.	**Reasonable**
2	There is evidence to support deliverables that have been achieved, and where improvements have been stated, this is available from the relevant services / areas. We will confirm that deliverables outstanding are being progressed, and, where appropriate, included in future plans.	**Reasonable**
3	The Health Board and relevant Committees are provided with sufficient information to be assured on the process and achievements of the special measures plan.	**Substantial**
4	There is evidence that completed deliverables are embedded through business-as-usual processes.	**Limited**
5	The independent reviews commissioned as part of Special Measures have been reviewed and recommendations are being implemented.	**Reasonable**

	Key Matters Arising	Objective	Control Design or Operation	Recommendation Priority
1	Whilst significant progress was made during the stabilisation phase of Special Measures, milestones were not consistently completed within the specified timescales.	1	Operation	Medium
2	The robustness and quality of submitted evidence was not consistent across the completed milestones reviewed and / or did not demonstrate impact of implementation (where reported).	2	Operation	Medium

	Key Matters Arising	Objective	Control Design or Operation	Recommendation Priority
3	The established controls and procedures in place focus on supporting the delivery and implementation of agreed actions / milestones / deliverables. It is not clear how the Health Board will monitor and evidence the impact and outcomes of implemented changes moving forward into the standardisation and sustain phases of Special Measures.	4	Design	High
4	We noted minor inconsistencies in the reporting of completion rates – specifically the inclusion of "Complete Pending Evidence" as complete for some Independent Reviews but not for others.	5	Operation	Medium

Work in Progress Summary

8. The following draft reports have been issued:

Table 1: Draft Reports issued

Review	Status	Date draft report issued	Management response due
Transformation & Improvement	Draft report issued – awaiting management response.	5 December 2024	14 January 2025
Job evaluation	Draft report issued – awaiting management response.	17 December 2024	21 January 2025
Establishment Control	Draft report issued – awaiting management response.	19 December 2024	23 January 2025
Network & Disaster Recovery	Draft report issued – awaiting management response	6 January 2025	3 February 2025

9. The following 2024/25 reviews are currently in progress:

Table 2: Reviews in progress

Review	Draft report due:
Discretionary Capital Funding Allocation (previously Capital Business Cases)	January 2025
Standing Financial Instructions - Procurement	January 2025
Clinical Audit	February 2025
Grievance Management	February 2025

Review	Draft report due:
Effective Governance – Cancer Services	February 2025
Effective Governance – IHC East	February 2025
Waiting List Initiative Payments – IHC Centre	February 2025

Follow Up

10. The Corporate Governance Directorate provide Internal Audit with details of actions agreed as closed by Executives and provide relevant evidence to support closure.
11. No requests to undertake follow-up reviews have been received in this period.

Contingency/Organisational Support/Advice

12. Internal Audit supports the Health Board through providing advice and guidance on areas of control, new systems, and processes.
13. We meet regularly with Audit Wales to discuss recent issues and areas of emerging risks to the Health Board.

Delivering the Plan

14. The additional support provided to the Health Board with focused reviews is channelled through contingency. As new risks are identified in year, the Director of Corporate Governance and internal audit will consider the planned reviews against the emerging high-level risks.
15. During the period, we have identified the following changes to the plan which require Committee approval:

    - Waiting List Initiative Payments – IHC Central

      During our review into Consultant Job Planning, we were made aware of a risk surrounding the payment of Waiting List Initiative within IHC Centre where additional activity may have been paid during already contracted sessions per the job plan. We discussed and agreed with the Accountable Officer that this review be undertaken, subject to Committee approval, noting the performance and financial risks the Health Board faces.

      It is **recommended** the Committee approve the addition of this review to the 2024/25 plan.

    - Integrated Assurance and Approval Plans (IAAP) Wrexham Maelor Business Continuity

      Through discussions with our Specialist Services Unit who undertake reviews on the all-Wales funded capital schemes, through IAAP provision in the business case, they have advised that through the current plans to address the backlog at the hospital, funding is being allocated on a risk basis and therefore is not being progressed under an IAAP. Should assurance on the progress at the Wrexham Maelor be required, this will need to be charged directly to the Health Board.

It is **recommended** the Committee approve the removal of this review from the 2024/25 plan.

16. 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).

17. Table 4 is reporting a positive status across two of three indicators. Figures are based on seven reports issued as final for 2024/25. We have seen a reduction in management response turnaround times, and this has reduced compliance to amber.

Table 4: Performance Indicators

Indicator	Status	Actual	Target	Red	Amber	Green
Report turnaround: time from fieldwork completion to draft reporting [10 days]	Green	100%	80%	v>20%	10%<v <20%	v<10%
Report turnaround: time taken for management response to draft report [20 days per Internal Audit Charter and Service Level Agreement]	Green	71%	80%	v>20%	10%<v <20%	v<10%
Report turnaround: time from management response to issue of final report [10 days]	Green	100%	80%	v>20%	10%<v <20%	v<10%

Table 5: Core Plan 2024-25

Planned output	Outline timing	Status	Assurance (including draft report assurance opinions)
Special Measures	June / July 2024	Final report issued.	Reasonable
Follow-Up of Internal Audit recommendations	April to September 2024	Completed – reported through progress report.	Not applicable
Transformation & Improvement	August / September 2024	Draft report issued.	Limited, however further evidence has been provided, and is being reviewed.
Charitable Funds (Deferred from 2023/24)	June / July 2024	Final report issued.	Reasonable
Value Based Healthcare	June / July 2024	Final report issued.	Reasonable
Discretionary Capital Funding Allocation (previously Capital Business Cases)	July / August 2024	Review in progress.	

Planned output	Outline timing	Status	Assurance (including draft report assurance opinions)
Corporate Legislative Compliance: Health and Social Care (Quality and Engagement) (Wales) Act 2020 (Duty of Candour and Duty of Quality)	March / April 2025	Planning.	
Intelligence led organisation	July 2024	Final report issued.	Reasonable
Network and Disaster Recovery	September 2024	Review in progress.	Reasonable
Recruitment of substantive and interim executive and senior posts (Deferred from 2023/24)	June / July 2024	Final report issued.	Reasonable
Establishment Control and Recruitment	July / August 2024	Draft report issued.	Reasonable
Integrated Assurance and Approval Plans (IAAP) • Llandudno Hospital Orthopaedic Hub • Ysbyty Glan Clwyd - Adult and Older Persons Mental Health Unit • Ysbyty Maelor Wrecsam - Infrastructure/ Continuity Works	April to September 2024	Planning.	
Corporate Legislative Compliance: Fire Safety	May 2024	Final report issued.	Limited
Board Assurance Framework & Risk Management	January / February 2025	Planning.	
Standards of Business Conduct - Declarations of interest, gifts, and hospitality	February / March 2025	Planning.	
Contracted Patient Services: Quality and Safety arrangements - Follow up (Deferred from 2023/24)	February 2025	Planning.	
Performance management framework & Reporting	January / February 2025	Brief issued.	
Partnerships, Engagement and Communications	January / February 2025	Brief approved.	
Budgetary Control & Financial reporting	February / March 2025	Planning.	
Standing Financial Instructions – Procurement	December 2024 / January 2025	Review in progress.	

Planned output	Outline timing	Status	Assurance (including draft report assurance opinions)
Clinical Audit	December 2024 / January 2025	Review in progress.	
Effective Governance: Integrated Health Community – East	January / February 2025	Review in progress.	
Effective Governance: Cancer Services	December 2024 / January 2025	Review in progress.	
Consultant Job Planning	October / November 2024	Final report issued.	Unsatisfactory
Job evaluation	November / December 2024	Draft report issued.	Not applicable
Waste Management	February / March 2025	Planning.	
Waiting List Initiative – IHC Centre	December 2024 / January 2025	Review in progress.	
People & OD Strategy: Operational implementation (Deferred from 2022/23 & 2023/24)	June / July 2024	Deferred.	
Quality Governance: Concerns and Complaints	July / September 2024	Deferred.	
Corporate Legislative Compliance: Civil Contingencies Act 2004	June / July 2024	Deferred.	
Contracted Patient Services: Quality and Safety arrangements - Follow up (Deferred from 2023/24)	October 2024 to March 2025	Deferred.	

Audit Assurance Ratings

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

	Substantial	Few matters require attention and are compliance or advisory in nature. **Low impact** on residual risk exposure.
	Reasonable	Some matters require management attention in control design or compliance. **Low to moderate impact** on residual risk exposure until resolved.

	Limited	More significant matters require management attention. **Moderate impact** on residual risk exposure until resolved.
	Unsatisfactory	Action is required to address the whole control framework in this area. **High impact** on residual risk exposure until resolved.
	Advisory	Given to reviews and support provided to management which form part of the internal audit plan, to which the assurance definitions are not appropriate. These reviews are still relevant to the evidence base upon which the overall opinion is formed.

Table 6: Themes and definitions relating to Image 1

Ref.	Theme	Definition / Examples
1	Approvals	The internal control framework for securing approvals is ineffective. Appropriate approvals have not been sought/ obtained prior to key decisions.
2	Communication & Engagement	There is no clear communication strategy and/ or stakeholder identification arrangements. Information is not communicated clearly internally within teams, or externally with partners, for a or wider stakeholders. Lack of engagement with staff, partners and wider stakeholders. Engagement with external providers is not consistent, resulting in contracts or agreements not being monitored.
3	Contractual	The form of contract is not appropriate and does not adequately protect the interests of the organisation. Contractual documentation has not been executed in a timely manner. The contract is not being applied as intended.
4	Cyber Security	There is no strategy for maintaining cyber security and/ or it is deficient. The strategy/ plans are not implemented as intended and are therefore ineffective.
5	Financial Management & Control	Financial controls and management information requirements have not been properly considered. The financial controls or management arrangements are inadequate and/ or poorly applied, impacting the exposure to risk.
6	Governance	Inadequate / ineffective governance and oversight structures in place, which may include: • Absence of key roles and associated responsibilities to provide good governance.

Ref.	Theme	Definition / Examples
		• Ineffective accountability and reporting structures with the absence of key scrutiny groups/ committees. General weaknesses in the internal control framework that are sufficient to impact the overall governance of the area audited.
7	Information & Data Quality / Accuracy	Systems, processes and procedures that support data accuracy/ quality are poorly designed or are not operating as intended, resulting in poor data quality. There is limited/ no guidance on the expected arrangements for data and information management. Insufficient records are maintained and/ or there are key gaps that would impact decision making. Information and/ or data is of an insufficient quality for monitoring, reporting and decision making.
8	Lessons Learnt	There are inadequate or no systems and processes in place to capture lessons learnt. Lessons learnt are not regularly shared/ reviewed within the organisation. There is clear evidence that the organisation has not learnt from prior experiences.
9	Performance Monitoring	There are no/ limited systems in place to capture performance information. The systems are ineffective in capturing the required information to manage performance. Performance information is not monitored and/ or shared. Corrective action to address performance issues is not determined or is ineffective.
10	Physical Security	There is no strategy/ plan to maintain physical security. There is a lack of consideration of physical security needs (either current and/or future)
11	Planning, Delivery & Deadline Management	A lack of timescales or deadlines being set. Unmonitored scope creep results in missed deadlines, non-delivery of projects and/or tasks, overspends or negative impacts on the quality of the final output.
12	Policies & Procedures	There are no policies or procedures in place, or they are inadequate to manage the risk. Policies or procedures are overdue for review or do not reflect current operational and/or best practice.
13	Reporting	Reporting and escalation requirements not clearly defined, including what gets reported where and when. Defined reporting does not provide adequate information to support robust assurance, escalation and risk management.

Ref.	Theme	Definition / Examples
		Reporting does not take place at the agreed frequency to the agreed fora in the agreed format, or there is a lack of evidence that reporting is taking place.
14	Resourcing	Organisational planning and management approaches do not incorporate consideration of demand and capacity. Demand and capacity inadequately considered. Lack of proactive review of resource to deliver plans or business-as-usual activities.
15	Risk Management	Inadequate/ ineffective risk strategy, appetite and/or management arrangements. The approach to risk management and/ or arrangements applied are not operating as intended.
16	Strategy	An appropriate strategy has not been developed to outline the vision of the organisation. The strategy is not an effective tool in achieving organisational objectives.
17	Training & Development	There is no defined strategy for training and development. Training needs have not been identified. There is no plan in place to address identified training needs.

Archwilio Cymru
Audit Wales

Audit Committee Update – Betsi Cadwaladr University Health Board

Date issued: January 2025

Document reference: 4651A2024

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About this document

1 This document provides the Audit Committee with an update on our current and planned accounts and performance audit work at Betsi Cadwaladr University Health Board. We presented our most recent Audit Plan to the committee on 7 May 2024.

2 We also provide additional information on:

- Other relevant examinations and studies published by the Audit General.
- Relevant corporate documents published by Audit Wales (e.g. fee schemes, annual plans, annual reports), as well as details of any consultations underway.

3 Details of future and past Good Practice Exchange (GPX) events are available on our website.

Accounts audit update

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

Exhibit 1 – Accounts audit work

Area of work	Executive Lead	Focus of the work	Current status	Planned date for consideration
Audit of the Awyr Las charity Accounts 2023-24: • **Planning** • **Audit of the draft Financial Statements**	Russell Caldicott, Interim Executive Director of Finance	This work involves undertaking risk assessment procedures to identify risks of material misstatement within the Charitable Fund's financial statements. The subsequent design and performance of our audit approach will be responsive to each assessed risk. We will follow the audit approach designed as part of our planning work and undertake appropriate audit testing to enable the Auditor General to provide an opinion on the 2023-24 Awyr Las financial statements..	Fieldwork is underway	Early 2025 (reporting to the Health Board's Charitable Funds Committee)
Audit of Accounts:	Russell Caldicott, Interim	Ongoing dialogue and meetings held to follow up on matters identified in our joint post project	Ongoing	Not applicable

Area of work	Executive Lead	Focus of the work	Current status	Planned date for consideration
planning for 2024-25	Executive Director of Finance	learning in preparation of the 2024-25 draft accounts and subsequent audit.		

Performance audit update

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

Exhibit 2 – Performance audit work

Area of work	Executive Lead	Focus of the work	Current status	Planned date for consideration
All Wales thematic work on Urgent and Emergency Care	Director of Therapies	This work examines different aspects of the urgent and emergency care system in three parts: • Part One: Flow out of hospital. • Part Two: accessing urgent and emergency care. • Part Three: national arrangements and leadership structures.	Part One: Completed Part Two: Report drafting Part Three: Planning	July 2024 March 2025 To be confirmed
Structured Assessment - core	Director of Corporate Governance / Board Secretary	This work will review the following core areas: • Board and committee effectiveness, cohesion, and transparency. • Corporate systems of assurance. • Corporate planning arrangements. • Corporate financial planning arrangements.	Complete.	January 2025

Area of work	Executive Lead	Focus of the work	Current status	Planned date for consideration
		This work will also seek to provide an update on the Health Board's progress in addressing audit recommendations made in previous structured assessment reports.		
Planned Care	Executive Medical Director	This work will follow on from the national report on tackling the planned care backlog. Whilst the exact focus of this work is still to be determined, it is likely to consider: • The extent that health boards have achieved Welsh Government targets for recovering planned care services; • The efficacy of local plans and activity to recover waiting lists; and • Use of the additional Welsh Government financial allocations to improve waiting lists.	Fieldwork	March 2025
Use of the strategic financial assistance provided by the Welsh	Executive Director of Finance and Corporate Resources	This audit will encompass a high-level examination of the Health Board's use of the additional £297m financial assistance provided by the Welsh Government as part of the targeted intervention package announced in October 2020.	Fieldwork	March 2025

Area of work	Executive Lead	Focus of the work	Current status	Planned date for consideration
Government for the 3.5-year period October 2020 to March 2024				
Structured Assessment - deep dive review of investment in digital systems to support service resilience and transformation	Director of Digital Services	This audit will examine digital arrangements, with a particular focus on how NHS bodies are investing in digital technologies, solutions, and capabilities to support the workforce, transform patient care, meet demand, and improve productivity and efficiency.	Scoping	To be confirmed
Follow on review of quality governance arrangements	Executive Director of Nursing	This audit will examine progress in addressing issues identified in previous audit work. The scope of the work will be determined during the audit planning process.	Not yet started	To be confirmed

Other relevant publications

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

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

Title	Publication Date
National Fraud Initiative Self appraisal checklist	December 2024
The National Fraud Initiative in Wales 2022-23	October 2024
Active Travel (and Data Tool)	September 2024
Affordable Housing	September 2024
NHS Wales Finance Data Tool	August 2024

Additional information

7 Exhibit 4 provides information on corporate documents published by Audit Wales since the last committee update. Links to the documents on our website are provided.

Exhibit 4 – Audit Wales corporate documents

Title	Publication Date
Equality Report 2023-24	November 2024

Title	Publication Date
Estimate of Income and Expenses for Audit Wales for the year ended 31 March 2026	October 2024
Interim Report 2024-25	October 2024
Annual Report and Accounts 2023/24	August 2024

8 **Exhibit 5** provides information on relevant Audit Wales consultations currently underway

Title	Publication Date
Consultation on revision of the Code of Audit Practice of the Auditor General for Wales	November 2024

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

Archwilio Cymru
Audit Wales

Review of Cost Savings Arrangements – Betsi Cadwaladr University Health Board

Audit year: 2023

Date issued: November 2024

Document reference: 4539A2024

This document has been prepared as part of work performed in accordance with statutory functions.

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

We welcome correspondence and telephone calls in Welsh and English. Corresponding in Welsh will not lead to delay. Rydym yn croesawu gohebiaeth a galwadau ffôn yn Gymraeg a Saesneg. Ni fydd gohebu yn Gymraeg yn arwain at oedi.

Mae’r ddogfen hon hefyd ar gael yn Gymraeg. This document is also available in Welsh.

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Detailed report

Introduction

1 NHS Wales is facing unprecedented financial challenges. The legacy of the COVID-19 pandemic on service demand, the rising costs associated with staffing, energy, medicines, maintaining an ageing estate; and tackling the increasingly complex health conditions associated with an ageing population all contribute to the worsening financial situation across the NHS.

2 Despite the Welsh Government making an additional £425 million available to the NHS in October 2023, the 2023-24 year-end audited position for NHS Wales was a collective deficit of £183 million. Whilst some NHS bodies were able to achieve year-end financial balance, the position for others - particularly some Health Boards - was challenging with several not being able to deliver the control total[1] deficit expected by Welsh Government.

3 The position for 2024-25 is equally, if not more challenging. Health bodies will need to ensure that they have robust approaches in place to identify and deliver in year cost improvement opportunities and to also take a longer-term approach to achieving financial sustainability that moves away from short-term approaches to ones where savings are achieved by transforming service models and ways of working.

Objectives and scope of our work

4 Given the challenges outlined above, the objective of our review has been to examine whether the Health Board has an effective approach to identifying, delivering, and monitoring sustainable cost savings opportunities. The detailed audit criteria are set out in **Appendix 1**.

5 The work has been undertaken to discharge the Auditor General's statutory duty under Section 61 of the Public Audit (Wales) Act 2004 to be satisfied that the Health Board has proper arrangements in place to secure economy, efficiency, and effectiveness in its use of resources.

6 We undertook our work between December 2023 and March 2024. The methods we used to deliver our work are summarised in **Appendix 2**. Our work comments on the approach within the Health Board to identifying, delivering, and overseeing cost saving opportunities. It considers the impact these arrangements had on the 2023-24 year-end position and highlights where arrangements may need to be strengthened for 2024-25 and beyond.

[1] Revised deficit positions for 2023-24, known as 'control totals', were allocated to Health Boards by Welsh Government in November 2023 following the provision of additional funding to support their financial positions.

Key findings

7 Overall, we found that **whilst the Health Board exceeded its savings target and almost met its control deficit target for 2023-24, it has a varied track record of delivering recurrent savings. Given the Health Board's challenging current financial position, it urgently needs to accelerate work on rolling out and embedding its new cost savings arrangements across the organisation.**

8 The findings that support our overall conclusion are summarised below under the following headings:

- Identifying cost savings opportunities.
- Delivering cost savings plans.
- Monitoring and oversight of savings plans.

Identifying cost savings opportunities

9 We considered whether the Health Board:

- has a clear understanding of the factors that are driving its costs;
- routinely uses a range of data and intelligence to help identify cost savings opportunities; and
- has an effective approach to selecting cost savings opportunities.

10 We found that **the Health Board has a good understanding of its cost drivers and has also developed a new approach for identifying transformational savings opportunities. However, opportunities remain to strengthen this approach further to ensure the Health Board can meet its financial challenges in both the short- and longer-term.**

Understanding the drivers of cost

11 The Health Board has a good understanding of its cost drivers. Independent Members and Executive Directors routinely receive progress updates on these cost drivers as part of the Health Board's ongoing financial reporting and analysis. Reports highlight areas of high cost such as pay and non-pay costs (including nursing and medical agency costs), continuing health care, and medicines management. Whilst the Health Board has a good understanding of its cost drivers and made progress towards achieving its 2023-24 control total deficit of £20 million with a final year end position of £24 million deficit, these high-cost areas continue to be the key contributors to its challenging financial position and significant underlying deficit of £253 million.

12 The Health Board maintained a short-term focus on reducing its cost drivers in 2023-24 by introducing several specific financial control measures, including:

- a Vacancy Control Review process for particular grades and roles;

- a Recurrent Investment Group Assurance (RIGA) initiative to review previously committed investments and current year use of Performance and Transformation Budgets;
- additional non-pay checks and challenge process for over seventy areas of spend; and
- the introduction of additional in-year Divisional Expenditure Control Targets.

Whilst not all of these controls have generated budget releasing savings, they have resulted in the Health Board improving its financial position. However, whilst introducing these controls was necessary to prevent the Health Board's financial position from deteriorating further, some Directorates and Integrated Health Communities (IHCs) felt that the approach to their implementation was not as collaborative as it could have been.

13 For 2024-25, the Health Board has proposed a new approach to identifying and delivering savings based around the national Value and Sustainability Board[2] (VSB) workstreams. Some of these, particularly those around workforce and clinical variation, have the potential to deliver significant transformational efficiencies for the Health Board. However, sound budget management and ownership of financial targets and requirements at the operational level will also continue to be of central importance in identifying and addressing the factors that are driving costs within the organisation. During our review, concerns were raised from some operational areas about the accuracy of their base budgets. The Health Board, therefore, should seek to address this by demonstrating that base budgets have been informed by a clear understanding of the costs of services that are to be delivered. (**Recommendation 1.1**)

14 The Health Board is still in the process of developing a clearer longer term Strategic Plan and Clinical Services Strategy. These are of fundamental importance in driving the service transformation that is needed in order to establish a service model that is clinically and financially sustainable, as highlighted in our 2023 Structured Assessment report and the Internal Audit report on savings[3] (noting also that there is still an outstanding recommendation from our 2022 Structured Assessment report relating to the development of a Clinical Services Plan).

[2] The national Value and Sustainability Board (VSB) was set up by Welsh Government and is chaired by NHS Executive to focus on specific themes to deliver possible pan Wales efficiencies. The workstreams include Continuing Health Care, Medicines Management, Workforce, Non-Pay, and Clinical Variation..

[3] Internal Audit completed a follow-up review of the 'Delivery of the Health Board's Savings'. Whilst the original report gave a 'No Assurance' rating, the follow-up has seen a very slight improvement to 'Limited Assurance'. The report was presented to the Audit Committee in March 2024.

Using data and intelligence to identify cost savings opportunities

15 The Health Board's use of benchmarking data such as that from the VSB, VAULT[4], and GIRFT[5] to support its cost efficiency and savings programme has been variable. This is mainly due to the historical resource and capacity challenges within the Finance Team to undertake this type of analysis work. In addition, the Health Board has confirmed that outputs from its GIRFT reviews do not necessarily always identify savings opportunities. Furthermore, when they highlight potential efficiency gains, they are not always progressed as they usually require a level of initial investment which the organisation is unable to provide due to its challenging financial position. The Health Board's new approach to savings identification through its VSB workstreams should provide a framework for making more systematic use of data and intelligence to support the identification of savings schemes. This approach will be supported by a new project team that will provide additional capacity to undertake this type of analysis work, which we discuss further in **paragraph 30**.

16 The Health Board has developed a proactive initiative to engage staff in identifying cost savings. The 'Small Change Big Difference' initiative enables engagement with staff on improvement and cost savings ideas. The Health Board has promoted this initiative through its management structures, team meetings, and regular Chief Executive staff briefings. At the time of our review, the initiative had generated sixty-one suggestions for further assessment. The Health Board intends to further embed this new approach during 2024-25. Notwithstanding the positive engagement of staff, our review identified limited evidence of the Health Board canvassing and using the views of service users and other stakeholders in the generation of savings ideas. As we discuss in **paragraph 17**, the Health Board intends to streamline and improve its savings guidance. This presents an opportunity to provide greater clarity around how and when the views of service users and stakeholders should be canvassed in the process of generating savings ideas. (**Recommendation 3.1**)

Selecting cost savings opportunities

17 The Health Board is continuing to improve its processes for savings selection as defined within its guidance and proformas on the submission of Savings Schemes and Savings Plans for 2024-25. The Health Board also intends to streamline and improve its savings guidance to ensure that all budget holders clearly understand

[4] The Value, Allocation, Utilisation and Learning Toolkit (VAULT) is managed by the NHS Executive to support and improve resource utilisation across the Welsh NHS.

[5] Getting it right first time (GIRFT) are programmes designed to improve the treatment and care of patients through in-depth review of services, benchmarking, and presenting a data-driven evidence base to support change.

its savings arrangements. When updating its guidance, the Health Board should take the opportunity to ensure that it also reflects its new savings approach based around its VSB workstreams. (**Recommendation 3.2**)

18 There is variability in the use of impact assessments for savings schemes, with some schemes not identifying the need for a quality impact assessment despite their potential clinical implications. We also heard concerns from some senior staff over the maturity of the Health Board's consideration of quality and patient safety in its savings arrangements. These arrangements will need to be strengthened through the VSB workstreams, particularly if the Health Board hopes to achieve greater levels of savings through more complex and challenging transformational change programmes. (**Recommendation 3.3**)

19 For 2024-25, the Health Board's financial plan reflects the challenges experienced in 2023-24 with a planned deficit position of £19.8 million and a savings requirement of £48 million. However, despite the scale of this challenge, the Health Board has been slow in selecting viable savings schemes for 2024-25. Independent Members have expressed concerns over the delays in both financial planning and developing viable savings schemes for 2024-25 and the potential impact this might have on the achievement and effective scrutiny of 2024-25 financial / savings plans. These concerns echo comments in our 2023 Structured Assessment report around the slow identification of savings schemes and converting schemes to 'green' within the Health Board's RAG classification of savings. (**Recommendation 2.1**)

20 The finance update to the Board in July 2024 indicates that the organisation continues to hold significant risks in respect of the savings it needs to deliver in order to achieve its 2024-25 control total deficit of £19.8 million. The Month 3 position showed a £21.5 million shortfall in the forecast savings position with £26.5 million of savings identified against a target of £48 million. Significant action over the remainder of the year is therefore needed in the identification and delivery of savings if the forecast year end position is to be achieved.

Delivery of cost savings opportunities

21 We considered whether the Health Board has:

- a good track record of delivering savings plans and cost improvements
- clear plans in place to deliver cost savings opportunities it identifies; and
- the necessary skills and capacity to deliver its agreed cost savings opportunities.

22 We found that **whilst the Health Board's delivery of recurrent savings improved in 2023-24, savings performance was variable across its Integrated Health Communities and Directorates. As a result, it will need to identify and deliver significantly more recurrent savings at pace as well as strengthen financial competencies across the organisation if it is to achieve its challenging 2024-25 savings target.**

Track record of delivery savings plans and cost improvements

23 Although the Health Board exceeded its savings target for 2023-24, it failed to do so in the previous five years (see **Exhibit 1**). Whilst there has been some challenge[6] over the accuracy of the 2023-24 savings target, its overall savings performance for 2023-24 is a significant improvement on prior years. However, this positive overall savings performance masks the significant variation in savings performance within the IHCs. For example, the Centre IHC achieved only 58% of its target savings, with less than 50% of these being recurrent in nature. Given that the IHCs account for most of the Health Board's budget, continued underperformance of savings in these areas will significantly undermine its ability to achieve its challenging savings target for 2024-25. (**Recommendation 2.2**) The Health Board also has a variable track record of delivering recurrent savings. Whilst it delivered significantly more recurrent savings in 2023-24 than in the prior three years, they only represented 63% of the total savings delivered. However, apart from 2020-21 and 2022-23, between 2018-19, and 2023-24 the percentage of recurrent savings delivered against the Health Board's overall savings target has exceeded 50%. (**Recommendation 2.3**)

24 The Health Board's track record of delivering savings in 2023-24 would have been worse than reported if it had reflected the additional 10% savings requirement of £13.4 million in its overall savings target and subsequent savings plans. The Welsh Government savings requirement of an additional 10% was set to deliver the Health Board's 2023-24 control total deficit of £20 million. Whilst the Health Board reported the need to deliver the additional 10% requirement in overall terms, its original savings target of £31 million was not updated to reflect this additional element and, therefore, was not part of its routine reporting on savings to the Board and the Performance, Finance, and Information Governance Committee. Whilst the Health Board exceeded its original 2023-24 savings target and almost achieved its 2023-24 control total, incorporating the additional savings target would have provided a more accurate picture of the overall savings required for 2023-24. This addition would have resulted in a savings target of £44 million and a reduction in the percentage of delivered recurrent savings from 63% to 50%. (**Recommendation 4**)

[6] Internal Audit's January 2024 follow-up report on the Delivery of Savings contains a management response highlighting some internal errors in the classification of stretch savings target with the correct savings target being £30.9 million. However, we note that the Health Board has continued to report its high-level performance against a savings target of £25.2 million, with a sub note that the additional £5 million were stretch targets.

Exhibit 1 – Health Board's savings track-record between 2018 and 2024

Year	Overall Savings Target £(M)	Actual overall savings delivered (£M)	Recurrent savings as a % of the higher of overall savings target or delivered	Delivered non-recurrent savings (£M)	Delivered recurrent savings (£M)
2018-19	45	37	78%	2	35
2019-20	45	34	53%	10	24
2020-21	45	9.4	18%	1.2	8.2
2021-22	17	16.6	65%	5.5	11.1
2022-23	35	23	14%	18.1	4.9
2023-24	31	35	63%	14	22

Source: Welsh Government Monthly Monitoring Returns and Health Board Finance Reports.

Approach to delivery of savings plans

25 The Health Board has developed a targeted approach to delivering savings as part of wider efforts to strengthen its grip and control over its finances. As part of this approach, the Health Board allocated a savings target of 2.5% to all Directorates and IHCs in 2023-24 which has increased to 2.8% in 2024-25. As part of this, Directorates and IHCs are required to identify savings and produce an annual savings plan which outlines how they will achieve this target. However, our review highlighted concerns from Directorates and IHCs about the extent to which having a pan-Health Board savings target recognises their specific and unique context. (**Recommendation 1.2**)

26 The Health Board aligns its planning for cost savings with the development of its Integrated Medium-Term Plan (IMTP) and annual planning cycle. In our 2023

Structured Assessment report, we noted that the approach for financial planning for 2023-24 was affected by significant disruption at senior levels in the Finance Team and the high level of turnover of other senior staff. Notwithstanding this, the Health Board has made progress in developing its savings delivery plans. The master savings tracker captures individual savings schemes and includes key saving scheme data[7].

27 The Health Board's new 2024-25 VSB workstreams were being finalised at the time of our review. Some initial observations indicate that the proposed governance structure for the individual workstreams should result in better engagement across the Health Board and increase the success of delivering savings schemes benefits. However, the outline framework could benefit from being clearer not only on the arrangements for considering the quality and patient safety impacts but also the extent to which savings schemes underpin the strategic direction of travel and consider the impact that they may have on other services as well as how Value Based Health Care (VBHC) initiatives would be integrated into the overall savings programme (see **Recommendation 3.3**).

28 The Health Board had drafted accountability letters for 2023-24, but these were not issued to IHCs and Directorates due to internal personnel changes within the Finance Team. Instead, the IHCs and Directorates were allocated individual control totals for 2023-24 in November 2023. The Health Board has confirmed that it was issuing new updated accountability letters for 2024-25. The accountability letters are an important component in the Health Board's overall approach to financial recovery and need to be used to provide clarity around roles, responsibilities, and financial targets. As such, they can help address some of the potential gaps in understanding / communications between the corporate Finance Team and the IHCs in relation to financial accountability and responsibility for initiating financial improvement plans. (**Recommendation 1.3**)

Skills and capacity to deliver savings opportunities

29 The Health Board has taken some steps to develop financial competencies by issuing guidance through its Budget Holders Handbook and delivering training on procurement for budget holders. However, we were made aware of some financial competency gaps across areas of organisation which are impacting its ability to effectively manage its financial and savings planning. (**Recommendation 5.1**) Significant disruption at senior levels in the corporate Finance Team during 2023-24, and senior staff turnover, have also contributed to these challenges. The challenges around financial competencies also extend to Independent Members.

30 The Health Board indicated its intention to bolster its capacity for savings delivery in 2024-25 through its new centralised savings Value and Sustainability Project

[7] The master savings tracker data includes - savings classification, delivery milestones, and responsible officers. Saving scheme owners are required to identify other information, such as key risks and wider impacts during the initial saving planning stages.

Team. This team will comprise of staff from the Transformational Support Team, Corporate Finance Officer and Service Area Leads focussing on both central and locally identified savings opportunities. The Health Board proposes that the new team will link into national groups and other stakeholders on a regular basis to ensure that the opportunities to build upon national savings initiatives, data and learning are maximised within the Health Board. At the time of our work, this team was in the process of forming. However, once fully embedded, it should enable the Health Board to make greater use of data and intelligence to identify cost savings opportunities provide greater capacity to deliver its challenging 2024-25 savings target.

31 The Health Board's engagement with clinicians around savings is variable. The current Directorate Triumvirate Management structures within the IHCs and Directorates include senior clinical representatives and therefore provide a framework for clinical engagement around savings. However, the Health Board recognises that it needs to improve how clinicians are engaged in identifying and delivering financial efficiencies and savings. For 2024-25, the Health Board's new governance around its VSB workstreams will include clinical leads which should, when fully embedded, start to address this concern. However, it will be important that this positive clinical engagement approach also extends to the savings identified and delivered within the IHCs and Directorates where engagement with clinicians was considered to be variable. (**Recommendation 2.4**)

Monitoring and oversight of cost savings delivery

32 We considered whether the Health Board:

- has an effective approach to monitoring and reporting the delivery of its cost savings plans;
- identifies risks to the delivery of savings plans and actions to mitigate those risks; and
- applies learning where cost savings plans previously haven't been achieved.

33 We found that **whilst the Health Board's arrangements for scrutinising, monitoring, tracking, and reporting on cost savings are improving, they have not resulted in improved financial performance across the organisation. As a result, it needs to better hold the Integrated Health Communities and Directorates to account for poor delivery of savings and strengthen its approach to sharing best practice and the lessons learnt from ineffective savings schemes.**

Monitoring and reporting the delivery of savings plans

34 The Board has a clear understanding of the Health Board's financial challenges through its regular finance and savings reports. The Performance, Finance, and Information Governance Committee (PFIG) and Executive Finance and Information Delivery Group (EFIDG) also receive these detailed financial reports which

incorporate progress updates on savings. These reports are sufficiently detailed and granular to facilitate progress monitoring at the IHC and Directorate level. The Board has also taken part in several Board Development Sessions which have focused on finance, savings, and financial planning. Independent Members consider the quality of the financial information has improved over the last year and our observations at PFIG and Board meetings in February 2024 confirmed that there is a good level of challenge and debate around finance. However, as part of this review, we observed that some Independent Members ability to discharge their role would benefit from having a more detailed understanding of the Health Board's finances. (**Recommendation 5.2**)

35 In our 2023 Structured Assessment report, we commented that the Health Board is strengthening its oversight of savings plans through the Executive, the Executive Delivery Group for Performance and Finance, and routine review of major programmes and monthly review with service leads. The Finance Team has also undertaken several 'check and challenge' meetings with IHCs and Directorates to provide a focus on delivering financial targets, including savings. However, the Health Board has recognised it will need to continue to make improvements in key areas, such as clarifying the roles and accountability of senior management and continuing to improve its financial control environment in areas such as business case approval. Whilst these improvements will be crystalised in the Health Board's refreshed governance arrangements to support its new VSB workstreams, there is opportunity to strengthen these arrangements further by introducing a more structured escalation process for when IHCs and Directorates are not meeting their savings targets. (**Recommendation 2.5**)

Identification of risks to savings plans delivery

36 The Health Board's Corporate Risk Register clearly identifies financial sustainability as a key corporate risk. The Executive Team, Risk Management Group, PFIG and Audit Committee regularly review this risk and have kept its status unchanged due to the Health Board's ongoing challenging financial position. Whilst the controls and assurances outlined for the Health Board's key financial sustainability risk appear to be reasonable, its financial position continues to remain challenging. Therefore, it will be important for the Board and its committees to continue to scrutinise the effectiveness of these controls to ensure that they remain fit for purpose.

37 The Health Board's savings guidance outlines the risk assessment of savings schemes, which follows the RAG savings risk classifications set out by Welsh Government. The master savings tracker reflects this RAG classification and forms the basis for savings classification in the savings tracker and internal and external reporting on savings. As we discussed in **paragraph 20**, as at Month 3 2024-25 the Health Board had identified £26.5 million of savings, which were classified as 'green'. This equates to 55% of the Health Board's overall savings target for 2024-25. The Health Board, therefore, continues to carry a significant risk to achieving its

overall savings target for 2024-25 unless it converts the remaining 'amber' and 'red' schemes to recurrent 'green' schemes at pace.

Applying learning

38 The Health Board does not have a well-developed approach to learning lessons from underperforming savings schemes. There were some limited examples of informal sharing of ideas and learning between IHCs and Directorates and some parts of the Health Board have been working with the NHSE F&DT[8] to access learning from across Wales to support the development of savings opportunities. However, in overall terms the Health Board needs to embed a more systematic approach to learning lessons from others, and to understand why saving schemes it has identified have failed or underperformed. The Health Board has told us that its recently established VSB workstreams should, when embedded, provide greater opportunity to adapt its approach to savings based on learning. (**Recommendation 6**)

Recommendations

39 **Exhibit 2** details the recommendations arising from this audit.

Recommendations
R1 The Health Board should seek to obtain better ownership of financial targets and savings requirements by Directorates and the Integrated Health Communities (IHCs) through: R1.1 Demonstrating that base budgets have been informed by a clear understanding of the costs of services that are to be delivered. **(Paragraph 13)** R1.2 Ensuring that savings targets are based on an analysis of the actual opportunities that exist within Directorates and IHCs as opposed to a pan Health Board savings target. **(Paragraph 25)** R1.3 Ensuring that accountability letters are issued in a timely manner and clearly set out the roles, responsibilities, and accountabilities of the Directorates, Integrated Health Communities, and the corporate centre. **(Paragraph 28)**

[8] National Health Service Executive Wales – Financial Delivery Team (NHSE FDT)

Recommendations

R2 The Health Board should strengthen its approach to the identification and delivery of savings by:

- R2.1 Identifying viable savings schemes to meet the Health Board's overall savings target earlier in the financial planning cycle. **(Paragraph 19)**
- R2.2 Taking earlier remedial action to bring under-performing saving schemes back on track. **(Paragraph 23)**
- R2.3 Maintaining a focus on the identification of saving schemes that deliver recurrent savings. **(Paragraph 23)**
- R2.4 Securing greater engagement from clinicians in the development and delivery of savings schemes. **(Paragraph 31)**
- R2.5 Introducing a more formalised escalation process where Directorates and IHCs are not delivering against their savings targets. **(Paragraph 35)**

R3 When updating its savings guidance, the Health Board should ensure:

- R3.1 That the guidance provides greater clarity around how and when the views of service users and stakeholders should be canvassed in the process of generating savings ideas. **(Paragraph 16)**
- R3.2 That the guidance reflects the new savings approach based around its Value and Sustainability Board framework. **(Paragraph 17)**
- R3.3 That the guidance clearly articulates the arrangements for assessing the impact of savings schemes on quality and patient safety, how they support the Health Board's strategic priorities, and impact on other services, as well as the integration with other initiatives (such as Value Based Health Care). **(Paragraphs 18 & 27)**

R4 The Health Board should ensure that future savings reports clearly articulate all the savings it needs to deliver in a given year to meet its Welsh Government control total. **(Paragraph 24)**

R5.1 The Health Board should ensure that it has a clear programme in place to address the financial capability gaps across the organisation to ensure operational managers have the necessary skills to support financial planning and savings delivery arrangements. **(Paragraph 28)**

R5.2 The Health Board should put arrangements in place to support Independent Members to gain a better understanding of the organisation's finances. **(Paragraph 34)**

Recommendations	
R6	The Health Board should adopt a more systematic approach to the identification and sharing of learning on the delivery of savings schemes. This should include lessons learnt from Health Board savings schemes which have failed or underperformed and the sharing of good practice from the approach to savings schemes in other organisations. **(Paragraph 38)**

Appendix 1

Audit methods

Exhibit 3 below sets out the methods we used to deliver this work. Our evidence is limited to the information drawn from the methods below.

Element of audit approach	Description
Self-assessment	The Health Board completed a self-assessment structured around the audit criteria.
Documents	We reviewed a range of documents, many of which were provided in support of the self-assessment, including: • Board and Committees agenda's, papers, and minutes • Key organisational strategies and plans • Savings benchmarking data • Key risk management documents, including the Board Assurance Framework and Corporate Risk Register • Key reports and plans relation to organisational finances and savings • Reports prepared by the Internal Audit service.

Element of audit approach	Description
Interviews	We interviewed the following senior officers and Independent Members: • Chief Executive Officer • Interim Executive Director of Finance • Executive Medical Director • Director of East Integrated Health Community • Chair of Performance Finance and Information Governance Committee • Director of Centre Integrated Health Community • Director of West Integrated Health Community • Director of Midwifery and Women's Services • Director of Mental Health and Learning Disabilities • Finance Director Commissioning and Financial Planning • Interim Finance Director: Operational Finance
Observations	We observed Board meetings as well as meetings of the following committee: • Performance Finance and Information Governance Committee (PFIGC)

Appendix 2

Management response to audit recommendations

Exhibit 4: Betsi Cadwaladr University Health Board management response to our audit recommendations.

Ref	Recommendation	Management response Please set out here relevant commentary on the planned actions in response to the recommendations	Completion date Please set out by when the planned actions will be complete	Responsible officer (title)
R1	The Health Board should seek to obtain better ownership of financial targets and savings requirements by Directorates and the Integrated Health Communities (IHCs) through: R1.1 Demonstrating that base budgets have been informed by a clear understanding of the costs of	R1.1 The base budgets have been developed from determination of the underlying position, unavoidable cost pressures and additional developments supported through a process of allocation by the Executive and then wider Health Board. This will be enhanced for 2025/26 through use of Value Based Healthcare (Value & sustainability) work that will include articulation productivity and efficiency by speciality.	October 2025	Executive Director of Finance

Ref	Recommendation	Management response Please set out here relevant commentary on the planned actions in response to the recommendations	Completion date Please set out by when the planned actions will be complete	Responsible officer (title)
	services that are to be delivered. **(Paragraph 13)** R1.2 Ensuring that savings targets are based on an analysis of the actual opportunities that exist within Directorates and IHCs as opposed to a pan Health Board savings target. **(Paragraph 25)** R1.3 Ensuring that accountability letters are issued in a timely manner and clearly set out the roles, responsibilities, and accountabilities of the Directorates, Integrated Health Communities, and the corporate centre. **(Paragraph 28)**	R1.2 The articulation of demand and capacity by speciality and comparison to national metrics will enable allocative efficiency models to be endorsed. This will depend largely upon formation of the above speciality plans and Corporate benchmarking that will occur prior to and during 2025/26. R1.3 The Accountability Letters have been fully refreshed in 2024/25 and clearly set out the Accountable Officer's expectations for deliver by each of the Budget Holders. Over 464 electronic letters have been issued to Managers with over 400 returned signed.	October 2025 Complete	Chief Operating Officer Executive Director of Finance
R2	The Health Board should strengthen its approach to the identification and delivery of savings by: R2.1 Identifying viable savings schemes to meet the Health	R2.1 The Health Board identified the 2024/25 full year ask of £48m by month 7. This gives greater opportunity to identify opportunities and turn those into savings green rated schemes prior to commencement of the 2025/26 financial year.	Complete	Executive Director of Finance

Appendix 2

Ref	Recommendation	Management response Please set out here relevant commentary on the planned actions in response to the recommendations	Completion date Please set out by when the planned actions will be complete	Responsible officer (title)
	Board's overall savings target earlier in the financial planning cycle. **(Paragraph 19)** R2.2 Taking earlier remedial action to bring under-performing saving schemes back on track. **(Paragraph 23)** R2.3 Maintaining a focus on the identification of saving schemes that deliver recurrent savings. **(Paragraph 23)** R2.4 Securing greater engagement from clinicians in the development and delivery	To support identification and delivery of savings, a Director of Value and Sustainability will co-ordinate identification of opportunities through to delivery of savings, an Executive lead identified for each of the five V&S national themes. The all-Wales Vault, Informatics data, costing data, all Wales V&S Group Reports support the Executive officers in identification of opportunities. Each Executive held accountable at the Monthly Integrated Performance – Executive Delivery Group for progress, which is chaired by Chief Executive. The Divisional	Complete July 2025	Executive Director of Finance Executive Director of Finance

Ref	Recommendation	Management response Please set out here relevant commentary on the planned actions in response to the recommendations	Completion date Please set out by when the planned actions will be complete	Responsible officer (title)
	of savings schemes. **(Paragraph 31)** R2.5 Introducing a more formalised escalation process where Directorates and IHCs are not delivering against their savings targets. **(Paragraph 35)**	Directors also held accountable within this forum for delegated savings target performance. R2.2 The guidance will be amended to include the reporting of underperforming schemes to the Integrated Performance – Executive Delivery Group. The report will include the supporting explanations and the action to be taken to either recover or mitigate the performance. R2.3 The Annual Plan (endorsed by the Board) sets out the expectation to deliver the annual savings requirement on a recurrent basis. The 2023/24 Full Year Effect (FYE) outturn was £26.3m which was in excess of the required target £25.2m. The 2024/25 current recurrent FYE forecast against the £48m Savings Target stands at £39.2m (at Month 6). R2.4 The formation of a model that mirrors Welsh Government's approach to securing 'Value and Sustainability' will result in greater engagement from	March 2025 March 2025 Complete	Executive Director of Finance Executive Director of Finance Executive Director of Finance

Appendix 2

Ref	Recommendation	Management response Please set out here relevant commentary on the planned actions in response to the recommendations	Completion date Please set out by when the planned actions will be complete	Responsible officer (title)
		Clinicians (the Clinical Variation component led by the Medical Director). R2.5 The Monthly Finance Report which includes the delivery against target by each Division is discussed at the Monthly Integrated Performance – Executive Delivery Group chaired by the Chief Executive. Individual performance reviews with areas and directorates will also include performance against savings targets, where teams will further be held to account for delivery.	Complete	Executive Director of Finance

Ref	Recommendation	Management response Please set out here relevant commentary on the planned actions in response to the recommendations	Completion date Please set out by when the planned actions will be complete	Responsible officer (title)
R3	When updating its savings guidance, the Health Board should ensure: R3.1 That the guidance provides greater clarity around how and when the views of service users and stakeholders should be canvassed in the process of generating savings ideas. **(Paragraph 16)** R3.2 That the guidance reflects the new savings approach based around its Value and Sustainability Board framework. **(Paragraph 17)** R3.3 That the guidance clearly articulates the arrangements for assessing the impact of savings schemes on quality and patient safety, how they support the Health Board's strategic priorities, and impact on other services, as well as	R3.1 The Health Board launched Small Change Big Difference in 2023, which sought ideas from all staff. We will continue to progress and follow up on these initiatives to secure enhanced savings delivery. R3.2 The guidance refers to the Value and Sustainability categories. However, this will be expanded to include references to the newly developed Value and Sustainability Framework. R3.3 The guidance and scheme templates require the Divisions to have indicated whether a scheme requires an impact assessment. It is the responsibility of the Director approving the scheme submission to be satisfied on the robustness of the assessment and maintain the document within Division.	Ongoing 2025 March 2025 Complete	Executive Director of Finance Executive Director of Finance Executive Director of Finance

Appendix 2

Ref	Recommendation	Management response Please set out here relevant commentary on the planned actions in response to the recommendations	Completion date Please set out by when the planned actions will be complete	Responsible officer (title)
	the integration with other initiatives (such as Value Based Health Care). **(Paragraphs 18 & 27)**			
R4	The Health Board should ensure that future savings reports clearly articulate all the savings it needs to deliver in a given year to meet its Welsh Government control total. **(Paragraph 24)**	The Health Board ensures that the Finance Reports and Monthly Financial Monitoring Return Submission clearly articulate the required savings to meet the Board endorsed Financial Outturn, including the requirement for further mitigations in year to manage the impact of emerging unplanned cost pressures.	Complete	Executive Director of Finance

Ref	Recommendation	Management response Please set out here relevant commentary on the planned actions in response to the recommendations	Completion date Please set out by when the planned actions will be complete	Responsible officer (title)
R5	R5.1 The Health Board should ensure that it has a clear programme in place to address the financial capability gaps across the organisation to ensure operational managers have the necessary skills to support financial planning and savings delivery arrangements. **(Paragraph 28)**	R5.1 The Health Board has developed a budget managers guide that is readily available and signposted to officers within the intranet, published with hyper links to supporting policies and procedures. In addition, training sessions are held with all budget managers to emphasise the skills required to deliver within budget the services for which funds are allocated out to officers.	Complete	Executive Director of Finance
	R5.2 The Health Board should put arrangements in place to support Independent Members to gain a better understanding of the organisation's finances. **(Paragraph 34)**	R5.2 Development sessions have been held in regards to financial plans, development of the plans (that articulate a reconciliation to the outturn for the year in addition to underlying deficit. In addition, sessions have been held as a group and for individual new Independent Members to update on financial planning, performance and relevant actions required to mitigate risks to attainment of plan.	Complete (and continuing)	Executive Director of Finance
R6	The Health Board should adopt a more systematic approach to the identification and sharing of learning on the delivery of	The criteria for assessing schemes as Green ensures that delivery expectation is robust. A small number of schemes show immaterial non delivery; however, these	Complete	Executive Director of Finance

Appendix 2

Ref	Recommendation	Management response Please set out here relevant commentary on the planned actions in response to the recommendations	Completion date Please set out by when the planned actions will be complete	Responsible officer (title)
	savings schemes. This should include lessons learnt from Health Board savings schemes which have failed or underperformed and the sharing of good practice from the approach to savings schemes in other organisations. **(Paragraph 38)**	relate to transactional schemes where there can be some movement in actual delivery. The Health Board recognises that the relevance of this recommendation would certainly be key for larger Transformational schemes and it is important to create a culture that seeks innovation, accepting this will not always deliver and importantly there is a vehicle to learn from these experiences. The Value and Sustainability Board will give a vehicle for this to develop moving forwards.		

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Archwilio Cymru
Audit Wales

Structured Assessment 2024 – Betsi Cadwaladr University Health Board

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Summary report

About this report

1 This report sets out the findings from the Auditor General's 2024 structured assessment work at Betsi Cadwaladr University Health Board (the Health Board) Our structured assessment work is designed to help discharge the Auditor General's statutory requirement under section 61 of the Public Audit (Wales) Act 2004 to be satisfied that NHS bodies have made proper arrangements to secure economy, efficiency, and effectiveness in their use of resources.

2 Our 2024 Structured Assessment work took place at a time when NHS bodies were continuing to respond to a broader set of challenges associated with the cost-of-living crisis, the climate emergency, inflationary pressures on public finances, workforce shortages, and an ageing estate. In addition, NHS bodies are still dealing with the legacy of the COVID-19 pandemic. More than ever, therefore, NHS bodies and their Boards need to have sound corporate governance arrangements that can provide assurance to themselves, the public, and key stakeholders that the necessary action is being taken to deliver high-quality, safe and responsive services, and that public money is being spent wisely.

3 The key focus of the work has been on the Health Board's corporate arrangements for ensuring that resources are used efficiently, effectively, and economically, with a specific focus on:

- Board transparency, cohesion, and effectiveness;
- Corporate systems of assurance;
- Corporate approach to planning; and
- Corporate approach to financial management.

We have not reviewed the Health Board's operational arrangements as part of this work.

4 Our work has been informed by our previous structured assessment work, which has been developed and refined over a number of years. It has also been informed by:

- Model Standing Orders, Reservation and Delegation of Powers
- Model Standing Financial Instructions
- Relevant Welsh Government health circulars and guidance
- The Good Governance Guide for NHS Wales Boards (Second Edition)
- Other relevant good practice guides

We undertook our work between September and November 2024. The methods we used to deliver our work are summarised in **Appendix 1**. Our work was conducted in accordance with the auditing standards set by the International Organization of Supreme Audit Institutions (INTOSAI).

5 We also provide an update in this report on the Health Board's progress in addressing outstanding recommendations identified in previous structured assessment reports in **Appendix 2**.

Background context

6 In February 2023, the Auditor General published a report in the public interest on Board effectiveness at the Health Board which described a worrying degree of dysfunctionality within the Board and wider senior leadership of the organisation at that time. One week after the publication of the report, the Health Board was escalated into special measures[1], and the Board's Independent Members all resigned. During 2023, several changes were made within the Health Board, with appointments to key roles on the Board.

7 Our follow-up review, published in February 2024, concluded that after a period of significant disruption during 2023, the Board was in a more stable position and working relationships amongst senior leaders were more positive overall. However, the report indicated that there were still fundamental challenges to address, including building a high performing Executive Team, recruiting substantively to remaining posts on the Board, and ensuring the new Board demonstrates the unified and effective leadership that is needed to tackle the challenges the organisation faces. We have used our 2024 Structured Assessment work to assess the Health Board's progress in addressing those challenges.

8 Our 2024 Structured Assessment was undertaken at a point in time when the Health Board is still subject to significant levels of oversight from Welsh Government associated with the escalation to special measures in 2023. This report, therefore, should be read alongside the Welsh Government's latest special measures progress report covering the period July to September 2024.

Key findings

9 Overall, we found that **since last year's structured assessment and our follow up work on board effectiveness, there have been positive developments in some of the Health Board's key corporate governance arrangements and progress in recruiting to some business-critical senior roles. However, there remains much to do especially in respect of establishing a stable, cohesive and high performing Executive Team, developing a longer-term strategy and supporting Clinical Services Plan, and ensuring the Health Board's organisational structure and operating model is fit for purpose.**

- We considered whether the Health Board's Board conducts its business appropriately, effectively, and transparently. We also considered leadership

[1] Special Measures are the highest level of escalation on the NHS Wales escalation framework

capacity within the Health Board as well as its organisational model. **We found that there is now a full cadre of substantive independent members on the Board and that board and committee meetings are conducted appropriately and transparently. However, ongoing instability within the Executive Team, gaps in wider senior leadership structures, and ongoing challenges with the operating model are compromising the Health Board's ability to tackle the significant challenges it faces.**

- We considered whether the Health Board has a sound corporate approach to managing risks, performance, and the quality and safety of services. **We found that whilst the Health Board is making reasonable progress in strengthening its systems of assurance, there is more to do in relation to the Board Assurance Framework and ensuring systems of assurance are fully owned and utilised to drive improvements across the organisation.**
- We considered whether the Health Board has a sound corporate approach to producing strategies and corporate plans and overseeing their delivery. **We found that the Health Board is planning to develop sustainable long-term organisational and clinical plans; however, to support this work, it will need to strengthen its approach to planning and ensure that plans are achievable.**
- We considered whether the Health Board has a sound corporate approach to managing its financial resources. **We found that whilst there are improvements in the Health Board's approach to financial management and delivery of savings, significant challenges remain in terms of spending within budget. The Health Board was not able to meet its statutory financial duties for 2023-24 despite significant financial assistance from Welsh Government. Whilst the Health Board is predicting it will achieve its financial targets for 2024-25, this will be challenging and is also reliant on an element of one-off savings.**

Recommendations

10 **Exhibit 1** details the recommendations arising from our work. The Health Board's response to our recommendations is summarised in **Appendix 3**.

Exhibit 1: 2024 recommendations

Recommendations	
R1	The Health Board should progress its plans to introduce arrangements for an Executive Committee and its related operating arrangements by April 2025. **(Paragraph 23)**
R2	In the context of ongoing work in relation to the Foundations of the Future programme and strengthening its operational governance the Health Board should develop a Terms of Reference for its Senior Leadership Team meetings to clarify the purpose of meetings and to ensure that the frequency of meetings is sufficient to effectively discharge its role. **(paragraph 24)(paragraph 24)**
R3	When the Board reports against decisions taken in private session or via Chair's Actions, it should ensure that, where relevant, the cost implications of decisions are clearly reported. **(Paragraph 29)**
R4	The Health Board should ensure review of minutes is a standing item on the agenda of each Remuneration Committee meeting (including additional meetings) to ensure there is an accurate and timely record of the decisions taken. **(Paragraph 40)**
R5	The Health Board should develop a structured programme of Board member visits, to include a mechanism to provide feedback to the Board. **(Paragraph 46)**
R6	As part of the development of a meaningful Board Assurance Framework, the Health Board should provide Board members with further supporting detail on its strategic objectives to clarify what the objectives are seeking to achieve. **(Paragraph 57)**

Recommendations	
R7	The Health Board should ensure that audit reports that are relevant to the remit of other Board committees are received and discussed by those committees, including periodic updates against any associated recommendations. **(Paragraph 78)**
R8	The Health Board should ensure that it appropriately engages with Board members and Regional Partnership Board partners in the process of developing future Integrated Medium-Term Plans or Annual Plans. **(Paragraph 87)**
R9	Where the Health Board needs to carry forward actions from one Annual Plan to the next, it should ensure that progress reports are clear on which actions have been retired or carried forward and provide clear and realistic milestones for those actions. **(Paragraph 95)**

Detailed report

Board effectiveness, leadership capacity, and the organisational model

11 We considered whether the Health Board's Board conducts its business appropriately, effectively, and transparently. We also considered leadership capacity within the Health Board as well as its organisational model.

12 We found that **whilst there is now a full cadre of substantive independent members on the board, ongoing instability within the Executive Team, gaps in wider senior leadership structures, and ongoing challenges with the operating model are compromising the Health Board's ability to tackle the significant challenges it faces.**

Board and senior leadership stability and cohesiveness

13 We considered whether the Board is stable and cohesive. We were specifically looking for evidence of a stable and cohesive Board and a cadre of senior leaders who have the appropriate capacity, skills, and experience.

14 We found that **whilst there is now a full cadre of substantive independent members on the Board there remains instability within the Executive Team and gaps in some of the wider senior leadership structures.**

15 Our follow-up report on Board effectiveness in 2024 highlighted an immediate need for the Health Board to continue and conclude work to stabilise the Board and wider senior leadership of the organisation. The Health Board now has a full complement of substantive Independent Members, having appointed a further two during 2024.

16 The Health Board has made several substantive appointments to the Executive Team since our last structured assessment report[2]. However, during the last twelve months, there has been on-going instability within the Executive Team caused by vacancies, absences, and interim cover arrangements. The Chief Operating Officer role was vacant for five months during 2024 before an interim was appointed. There was an absence in the Executive Medical Director role for a similar length of time due to sickness, and the Executive Director of People and Organisational Development role remains vacant following several unsuccessful attempts at recruitment.

17 These gaps have meant that some senior leaders have needed to pick up additional responsibilities and workloads, which is contributing to delays in progressing key programmes of work, such as the development of strategic plans.

[2] These include the Director of Corporate Governance, Executive Director of Allied Health Professionals and Health Science, Executive Director of Public Health, Director of Performance and Commissioning, Director of Environment and Estates and the Chief Operating Officer, though the last of these is not contracted to begin until April 2025.

It has also resulted in temporary leadership arrangements being put in place in challenging areas, such as planned care. These arrangements are not sustainable and demonstrate that the Health Board still has some way to go in establishing a substantively appointed and high performing Executive Team. There have also been gaps and a reliance on interim arrangements across the broader senior leadership structures, particularly within the Integrated Health Communities. The Health Board is reviewing its operational structures, as described later, and therefore it is understandable that it is delaying f decisions to appoint to some roles on a substantive basis until further clarity on those structures is achieved. However, these gaps are contributing to the wider pressures on senior leaders that was clearly evident across many of the interviews we conducted for this year's structured assessment.

18 There is some evidence that the Health Board will be able to address some of the concerns identified above as it moves into 2025, at least in respect of the Executive Team. A substantive Chief Operating Officer will take up post in April 2025, an interim Medical Director has been appointed ahead of advertising for a substantive replacement, and recruitment is also underway for a substantive Executive Director of Finance. We also note that the Health Board is taking steps to respond to the independent review of Executive Portfolios, completed in 2023 as part of the special measures framework. The findings have led to some specific functions transferring between Executive Portfolios during 2024[3].

Operational structures

19 We considered whether the operational structures are supporting the business of the Board. We were specifically looking for evidence of:

- well-considered operational structures which enable the achievement of the Health Board's strategic vision and objectives; and
- effective arrangements for communicating decisions by senior leaders throughout the organisation.

20 We found that **there is a general consensus that Health Board's operating model introduced in 2022 is not fit for purpose and that action is needed to provide greater clarity on roles and responsibilities within the model and improve the cascading of information within the organisation. Action is also needed to improve arrangements for capturing discussions and decisions at Executive Team meetings.**

21 The Health Board is undertaking a review of its operating model (operational structures) as part of its wider 'Foundations for the Future' programme. The

[3] Including legal services transferring from People and Workforce Development to the Office of the Director of Corporate Governance. Changes have also been enacted to some portfolios, for example, legal services, charitable funds, performance and commissioning.

previous model, introduced in August 2022, was based on a matrix management arrangement and the creation of three Integrated Health Communities. However, at the point at which the previous Chief Executive left the organisation in Autumn 2022 the model had not been fully implemented. The operating model in its current format creates several challenges for the organisation, including in relation to clarity of responsibilities and accountabilities and enacting strategic change.[4]

22 The 'discovery' stage of the 'Foundations for the Future' programme, which included engaging with staff and included drawing insights from Independent Reviews relating to Special Measures and feedback from external partners ended in October 2024. The current 'design' stage is due to be completed by April 2025 when any potential changes to the operating model will be announced and actioned. A key part of the 'Foundations for the Future' work is the new Values and Behaviours Framework, approved by the Board in November 2024, ahead of its launch across the organisation in December 2024. The Health Board undertook extensive engagement in developing this new framework, which is intended to support culture change across the organisation.

23 We also heard during our interviews that the current arrangements don't always support the effective communication and cascading of decisions taken by the Executive Team. The Health Board no longer produces minutes to record discussions at its Executive Team meetings. Instead, an action log is used to record and track decisions taken during its fortnightly meetings. However, our review of the action log found it was not sufficiently clear and comprehensive, with important information sometimes missing. Furthermore, the action log is not accessible until the next Executive Team meeting. The Health Board is planning to introduce an Executive Committee which will further formalise the reporting of key discussions and decisions to the Board. (Recommendation 1) As the Health Board progresses its plans, there will be a need to ensure the action notes for its executive committee is completed consistently to ensure effective coverage of key points of discussion, including any risks raised, action owners and timescales, and that it is shared as appropriate with those who need the information for their roles.

24 Our follow-up of board effectiveness review commented on tensions at that time that were resulting from the Integrated Health Community Directors feeling marginalised following changes to operational governance arrangements and decision-making processes. The report highlighted the need for the Executive Team to be appropriately connected to the leadership structures that sit below it, supported by ensuring the Health Board's operational model is fit for purpose. Interviews this year indicated that these tensions have continued, which was exacerbated by the absence of a Chief Operating Officer for five months during 2024. The Health Board has established Executive Delivery Group meetings which

[4] A report produced by the Health Board identifies seven themes for the weaknesses experienced with the current operating model structure: organisational structures rather than operating model; accountability, responsibility, autonomy; equity; multi-professional team working; resources; how change happens; and strategic change.

provide opportunities for senior leaders to meet regularly to discuss specific areas of the business, including integrated performance. However, interviews indicate that some senior leaders continue to feel they are not sufficiently engaged on the breadth of the business as under previous arrangements. Regular meetings between the Executive Team and the broader senior leadership team used to take the form of Health Board Leadership Team meetings but these were dissolved in 2023. More recently the Health Board has established Senior Leadership Team meetings in their place, however, these meetings would benefit from a terms of reference to clarify their purpose and to ensure the meetings are sufficiently frequent.

25 Recognising some of the strains caused by absences and vacancies within the current operational leadership structure, as well as the inevitable level of unease caused during periods of organisational change, it is important that the Health Board progresses its 'Foundations for the Future' programme in a timely fashion. However, it is having to do so in the absence of a clear plan for the future shape of its clinical services (discussed later in **paragraph 83).** This creates a risk of committing to operational structures that may not align to future service changes the organisation would like to make. A further challenge is the gap in senior leadership capacity for organisational change caused by challenges in recruiting an Executive Director of People and Organisational Development.

Public transparency of Board business

26 We considered whether the Board promotes and demonstrates a commitment to public transparency of board and committee business. We were specifically looking for evidence of:

- Board and committee meetings that are accessible to the public;
- Board and committee papers being made publicly available in advance of meetings; and
- Board and committee business and decision-making being conducted transparently.

27 We found that **whilst the Health Board takes a number of actions to promote public transparency of Board and committee business, it needs to clarify internal time standards for publishing committee papers, and upload minutes of committee meetings to its website in a timelier fashion.**

28 The Board continues to meet in-person, primarily in the central region of north Wales. Board members are free to contribute to meetings in English or Welsh with simultaneous translation available from Welsh into English during each meeting. Members of the public can observe Board meetings either in person or via the live broadcast on YouTube. Recordings of meetings are also made available shortly after the meeting. Committee meetings are also in-person but are not currently live-streamed or recorded for the public to view. The Health Board's website offers information on how the public can request to observe committees. However, we

have notified the Health Board of information on its website which indicates that some committees are not open to public observation. The Health Board has stated it will resolve this issue urgently. The Health Board is also exploring options for further increasing the transparency of committee meetings, such as by extending its practice of live-streaming.

29 Positively, the Health Board is proactively minimising the use of private meetings, reserving these for confidential and sensitive matters only. When the Board takes decisions in private, it reports those in the following public session alongside details of any Chair's Actions taken since the previous meeting. It is positive to note that very few Chair's Actions have been taken over the past 12 months. However, where these are reported, arrangements could be strengthened further to include information on any cost implications associated with the Chair's Actions. **(Recommendation 3)**

30 In our 2023 structured assessment report, we commented that there was confusion around the deadline for publishing papers ahead of committee meetings, and this year's work has indicated that these arrangements still require some rationalisation. The Health Board's current practice is to aim to publish papers seven days in advance of a meeting. Whilst this is an agreed expectation within the Health Board, it is not the standard against which the Health Board monitors and records breaches, which is the five-day target set within the Intervention Order 2023[5]. Furthermore, this does not align with the ten-day standard articulated within its Standing Orders. We note that the Intervention Order 2023 was revoked in November 2024. Therefore, it is timely for the Health Board to communicate and record a consistent standard for the publication of papers (see **Appendix 2, Recommendation 1, 2023**). There also continues to be delays in uploading minutes for committees following meetings. At the time of our review, we found that minutes were not consistently uploaded to the website in a timely way after being confirmed at the following committee meeting (see **Appendix 2, Recommendation 2, 2023**).

Arrangements to support the conduct of Board business

31 We considered whether there are proper and transparent arrangements in place to support the effective conduct of Board and committee business. We were specifically looking for evidence of:

- a formal, up-to-date, and publicly available Reservation and Delegation of Powers and Scheme of Delegation in place, which clearly sets out accountabilities;

[5] The Betsi Cadwaladr University Local Health Board Intervention Order 2023 modified parts of the 2009 regulation and the National Health Service (Wales) Act 2006, including amending the rule relating to how many days prior to a public meeting an agenda should be published from ten days to five days.

- formal, up-to-date, and publicly available Standing Orders (SOs) and Standing Financial Instructions (SFIs) in place, along with evidence of compliance; and
- formal, up-to-date, and publicly available policies and procedures in place to promote and ensure probity and propriety.

32 We found that **the Health Board's Standing Orders are up to date; however, more work is needed to address weaknesses in its arrangements for registering declarations, gifts and hospitality and to address the significant backlog of policies which are overdue for review.**

33 The Board, supported by the Audit Committee, regularly and appropriately reviews its Standing Orders, the Scheme of Reservation and Delegation, and Standing Financial Instructions. The Standing Orders were adopted by the Board in September 2023, following minor amendments agreed at the Board in March 2024 to reflect the creation of the Joint Commissioning Committee, and in November 2024 to adjust the Scheme of Reservation and Delegation. The current Standing Orders are available on the Health Board's website.

34 The Health Board launched a new system for recording declarations of interests, gifts and hospitality in August 2023. However, issues with its implementation led to several weaknesses being highlighted by Internal Audit in its report on standards of business conduct received by the Audit Committee in July 2024. These included the policy not reflecting working practices and insufficient reporting to the Audit Committee. The Health Board has taken some steps in response, including increasing the oversight by the Audit Committee, updating its Standards of Business Conduct Policy and clearly documenting the processes for staff to follow to declare interests and gifts, which it will communicate with staff across the organisation. This work is a recognised priority for the Corporate Governance directorate and further work is scheduled into 2025-26 with progress to be overseen by the Audit Committee.

35 During our 2023 structured assessment, we reported that a significant proportion of the Health Board's policies were overdue for review. Whilst the Health Board has since developed a new policy review process and has updated its Policy on Policies, progress in clearing the backlog of overdue policies has been slow. In September 2024, the Audit Committee received a detailed report on the Health Board's position, which stated that 46% of policies were overdue with 82 more due to become overdue in 2024-25. Positively, the report outlined steps to strengthen senior ownership of the policy review process going forward, including the establishment of an Executive Policy Oversight Group in September 2024. The Health Board also appointed a Policy Lead in October 2024 to increase capacity and skills, which should accelerate the pace of progress in this area. However, the Health Board has yet to undertake a risk assessment for overdue policies to ensure it addresses the highest-risk policies first (see **Appendix 2, Recommendation 4, 2022**).

Effectiveness of Board and committee meetings

36 We considered whether Board and committee meetings are conducted appropriately and effectively and whether the Board and committees receive timely, high-quality information that supports effective scrutiny, assurance, and decision making. We were specifically looking for evidence of:

- an appropriate, integrated, and well-functioning committee structure in place, which is aligned to key strategic priorities and risks, reflects relevant guidance, and helps discharge statutory requirements;
- Board and committee agendas and work programmes covering all aspects of their respective Terms of Reference as well being shaped on an ongoing basis by the Board Assurance Framework;
- well-chaired Board and committee meetings that follow agreed processes, with members observing meeting etiquette and providing a good balance of scrutiny, support, and challenge;
- clear and timely Board and committee papers that contain the necessary / appropriate level of information needed for effective decision making, scrutiny, and assurance; and
- committees receiving and acting on required assurances and providing timely and appropriate assurances to the Board.

37 We found that **Board and committee meetings are conducted appropriately and effectively, but there is scope to further improve the quality of papers and for the Board to place more reliance on the work of its committees.**

38 The Health Board has had a full committee structure in place since January 2024. The structure is comprised of eight committees which meet statutory requirements. Committees are supported by effective arrangements, including recently reviewed terms of reference, cycles of business, and forward work plans to ensure they align to the strategic objectives in the Annual Plan 2024-25. As discussed in **paragraph 55**, the organisation's Board Assurance Framework was being redeveloped at the time of writing.

39 Our observations throughout the year indicate that the Board and committees are currently functioning well. We found that meetings are well-chaired and that, over the year, as committees have become established and met frequently, members (both independent and executive) are demonstrating increasing confidence to contribute equally to discussion and provide constructive challenge. The Health Board has also established a bi-monthly committee chairs meeting which provides opportunities for committees to cross-refer issues and ensure effective collective oversight of key risks.

40 For Board meetings, we found that discussions on items for noting, such as reports from committees, were sometimes lengthy and impacting on the time available to focus on more strategic issues. This indicates that the Board needs to place more reliance on the assurance it receives from the work of committees. The Health Board is exploring opportunities to achieve this through mechanisms such as

Assure, Alert, and Advise Highlight Reports, and requesting chairs to introduce reports at the Board by summarising previous discussions from the committee. Whilst the Remuneration Committee as standard practice reviews the minutes from its previous meetings, a number of additional meetings were held during 2024, and we found that the review of minutes for each of these additional meetings was not timely. The Health Board, therefore, should ensure a review of the minutes of a previous meeting is a standing item on any Remuneration Committee meeting agenda, including additional meetings, to ensure there is an accurate and timely record of decisions taken at previous meetings. **(Recommendation 4)**

41 Our 2023 structured assessment report highlighted scope to improve quality of information provided to committees and the Board, particularly a need to present clearer and more concise analysis of performance and assurance on actions being taken to manage risks and secure improvement. The Director of Corporate Governance has since developed a new template to support improvements in the clarity of reports and many of those we spoke to felt that this is having a positive impact. However, this work will take time to embed, and we continue to see some papers that contain insufficient information or clarity to adequately inform decisions or provide assurance.

Board commitment to hearing from patients/service users and staff

42 We considered whether the Board promotes and demonstrates a commitment to hearing from patients/service users and staff. We were specifically looking for evidence of the Board using a range of suitable approaches to hear from a diversity of patients/service users, the public and staff.

43 We found that **whilst the Health Board demonstrates a clear commitment to hearing from patients via reports and patient and staff stories, there is a need to formalise its approach to Board visits to services.**

44 The Board and its committees regularly hear the perspective of patients and staff to inform its business. The Quality, Safety, and Experience Committee receives patient stories at each meeting. Whilst there has been a delay in the People and Culture Committee receiving staff stories, this practice began in October 2024. The Board alternates between receiving patient and staff stories at each public meeting. Our observations and review of minutes found that these stories are actively used to inform business during meetings. The Health Board consistently summarises key themes of stories and tracks what actions have been taken in response to the stories they have heard.

45 The Board also receives a citizen experience report at every other meeting. These reports are comprehensive, detailing how the Health Board has engaged with and responded to communication from members of the public in relation to its services, including planned improvement actions. We found that these reports also generate good and open discussion on the quality of services from a patent's perspective.

46 The Health Board does not currently have structured arrangements for Board visits to services. Over the past twelve months, visits by Board members have been arranged on an ad hoc basis without a process for recording visits or feeding back significant observations. Our interviews indicate that the number of visits conducted in the past twelve months varies significantly between Board members. The current arrangements need to be strengthened to ensure Board visits become an established method of engaging with staff and patients, and a means of triangulating the information it gathers from the visits with that provided from other sources. **(Recommendation 5)**

Commitment to continuous improvement at Board and committee level

47 We considered whether the Board demonstrates a commitment to continuous improvement in the way it works. We were specifically looking for evidence of:

- the Board and its committees regularly reviewing their effectiveness and using the findings to inform and support continuous improvement; and
- a relevant programme of Board development, support, and training in place.

48 We found that **the Health Board has established a formal board development programme and has plans to establish formal self-review processes in early 2025.**

49 The Board and its committees regularly reflect on the effectiveness of meetings, as feedback sessions are standing items on the agenda. The recently established Chairs Advisory Group has begun to collate and reflect on feedback themes raised during meetings. The Health Board informs us that this approach enables them to make small iterative changes. Whilst helpful, this practice does not negate the need for a fuller reflection exercise. Welsh Government has included progressing self-effectiveness reviews as a special measures objective for the Health Board. The Health Board informs us that the Board will be undertaking its self-review process in February 2025 which will enable it to feed into its priorities for 2025-26 as well as its annual reporting arrangements.

50 The Health Board has a formal Board development programme in place, which was presented to the Board in July 2024. The bi-monthly development sessions were developed by members of the Board. For 2024-25, the programme includes three sessions on building effectiveness and capability, led by external facilitators Silvermaple, with positive feedback following the first session. The Health Board also holds bi-monthly board briefings on topical issues which aim to raise understanding of members on specific areas, such on the operating model. As the Board continues to see changes in its composition, it will need to ensure that attention is also given to integrate newer members in due course.

Corporate systems of assurance

51 We considered whether the Health Board has a sound corporate approach to managing risks, performance, and the quality and safety of services.

52 We found that **whilst the Health Board is making reasonable progress in strengthening its systems of assurance, there is more to do in relation to the Board Assurance Framework and ensuring systems of assurance are fully owned and utilised to drive improvements across the organisation.**

Corporate approach to overseeing strategic risks

53 We considered whether the Health Board has a sound corporate approach to identifying, overseeing, and scrutinising strategic risks to the delivery of strategic priorities / objectives as well as corporate risks. We were specifically looking for evidence of:

- an up-to-date and publicly available Board Assurance Framework (BAF) in place, which brings together all of the relevant information on the risks to achieving the organisation's strategic priorities / objectives; and
- the Board actively owning, reviewing, updating, and using the BAF to oversee, scrutinise, and address strategic risks;
- an appropriate and up-to-date risk management framework in place, which is underpinned by clear policies, procedures, and roles and responsibilities; and
- the Board providing effective oversight and scrutiny of the effectiveness of the risk management system and corporate risks.

54 We found that **whilst the Health Board is developing a new Board Assurance Framework, the high-level nature of its current strategic objectives and risks is making this task more challenging.**

55 The Health Board was in the process of developing a new Board Assurance Framework (BAF) at the time of our work. Work is due to be completed by the end of March 2025 with progress overseen regularly by the Audit Committee.

56 In our 2023 structured assessment report, we commented that the previous BAF was aligned to the strategic priorities of its previous Annual Plan, as opposed to long-term strategic objectives, which limited its effectiveness. The Health Board has since set five strategic objectives within its Annual Plan 2024-25, which are:

- Building an effective organisation;
- Developing strategy and long-lasting change;
- Creating compassionate culture, leadership and engagement;
- Improving quality, outcomes and experience; and
- Establishing an effective environment for learning.

57 Whilst the Health Board has now linked its strategic risks to its strategic objectives, in our view, the strategic objectives are too high-level and are not SMART[6]. This is

[6] specific, measurable, achievable, relevant and time-bound

compromising the fundamental purpose of the BAF which is to provide the Board with assurance that it is identifying and mitigating the risks to achieving the organisation's strategic objectives. **(Recommendation 6)**

58 The Health Board has also held a board development session to discuss the BAF and develop accompanying strategic risks. The initial set of strategic risks were approved by the Board in July 2024, with sub-sections for each being developed by the Risk Scrutiny Group at the time of writing.

59 The Board revised its Risk Management Framework in July 2024. Changes include lower frequency of reporting the BAF and Corporate Risk Register, improved clarity for lines of assurance, and the replacement of the previous Risk Management Group with a smaller Risk Scrutiny Group. Feedback suggests the group provides effective and constructive challenge to new and existing risks on the register and that the Corporate Governance Team provides helpful support to services in reporting on risk. The Framework is supported by a range of policies, procedures, and sets out clear roles and responsibilities for each area of the organisation.

60 The Corporate Risk Register continues to contain a high number of high-scoring risks, with the Health Board facing challenges in reducing the score of some key risks in line with their target scores. Whilst this remains a challenge for the Health Board, our observations of Board and committee meetings during the year provided assurance that there is constructive challenge to ensure risks are clearly articulated and that actions to mitigate risks are linked to the Health Board's Annual Plan and are progressing in line with set timescales.

Corporate approach to overseeing organisational performance

61 We considered whether the Health Board has a sound corporate approach to identifying, overseeing, and scrutinising organisational performance. We were specifically looking for evidence of:

- an appropriate, comprehensive, and up-to-date performance management framework in place, underpinned by clear roles and responsibilities; and
- the Board and committees providing effective oversight and scrutiny of organisational performance.

62 We found that **the Health Board's performance reporting continues to evolve, but there is need to establish a consistent reporting format to support effective monitoring and oversight.**

63 The Health Board continues to embed its Integrated Performance Framework, approved in September 2023. The Framework outlines roles and responsibilities across the organisation and internal escalation arrangements. Future steps to further embed the framework include developing formal and informal integrated accountability review structures and internal escalation and de-escalation measures.

64 The Health Board has continued work during 2024 to review and refine its Integrated Performance Report to committees and the Board. During 2024 this work has led to some useful improvements, including the inclusion of Statistical Process Control[7] charts for several performance metrics and a dashboard of escalated metrics to highlight the challenges facing a high number of Health Board services. However, less positive changes have also been made, such as significantly reducing the narrative accompanying metrics to describe actions in place to support improvement. Reports show that performance is particularly challenged in areas including mental health, cancer waiting times and standards, planned care waiting times, ambulance handover delays and patient flow through Emergency Departments and delayed discharge.

65 The Integrated Performance Reports are regularly reported to the Performance, Finance and Information Governance Committee, the Quality, Safety and Experience Committee, and the Board. During the year, Board members have provided continued challenge to areas of underperformance. Members have also continued to raise concerns about the level of analysis and coverage of reports during meetings. A new Director of Performance and Commissioning had been appointed to the Health Board which may lead to further changes to performance reporting in the coming months. However, whilst the Health Board is continually seeking to strengthen its performance reporting, the frequency and level of changes to the format of reports are likely to make it more challenging for Board members to effectively monitor and track performance over time (see **Appendix 2, Recommendation 2, 2022**).

Corporate approach to overseeing the quality and safety of services

66 We considered whether the Health Board has a sound corporate approach to overseeing and scrutinising the quality and safety of services. We were specifically looking for evidence of:

- the Board providing effective oversight and scrutiny of the effectiveness of the quality governance framework
- clear organisational structures and lines of accountability in place for clinical/quality governance; and
- the Board and relevant committee providing effective oversight and scrutiny of the quality and safety of services.

67 We found that **the Health Board is developing new systems which have the potential to improve quality arrangements, and there is evidence of it making positive progress in responding to complaints in a timely way.**

[7] Statistical Process Control charts are used to measure changes in data over time by using statistics to identify patterns and anomalies.

68 The Quality, Safety, and Experience Committee provides good oversight of the arrangements for ensuring the quality and safety of services. Meetings have been extended from three to four hours to ensure sufficient time for discussion and assurance. Quality reporting to the committee was revised in April 2024, with it now receiving a standing integrated quality report. This replaces the previous patient safety report. The integrated quality report covers several aspects of quality governance, including patient safety, clinical audit, and relevant regulatory and legal issues.

69 Following the decision not to replace its Quality Strategy 2017-20, the Health Board has since incorporated its quality ambitions within its Annual Plan 2024-25. A key commitment within the Annual Plan 2024-25 relates to the design and development of a Quality Management System (QMS). An outline of the QMS was presented to the Quality, Safety, and Experience Committee and the Board in May 2024 with its development informed by engagement with representatives from across the organisation. the approved QMS has initially been applied to two selected 'challenged services': vascular and urology services, to support their improvement by integrating quality-related metrics to help identify improvement opportunities. The QMS is supported by a new Quality Management Framework, also approved in May 2024. The Framework is aligned to the Health Board's strategic objectives as outlined in the Annual Plan 2024-25 and describes the four domains of the QMS model: Planning, Control, Improvement, and Assurance.

70 The Health Board continues to receive a significant amount of complaints. However, the number of complaints is reducing and performance for responding within 30 days, while challenging, is improving, with performance reaching the 75% target for October 2024. The Health Board reports that the number of overdue complaints (i.e. beyond the 30-day target) has reduced by 88.3% between April 2024 and October 2024. Despite our recommendation in 2023, the Health Board has not reported any identified reasons for the unexplained drop in the number of complaints received for the first six months of 2023-24 compared to the previous year, stating that it is confident the new QMS will provide strengthened oversight to complaint trends in the future (see **Appendix 2, Recommendation 3, 2023**). We note from the September Audit Committee papers that this recommendation was going through a closure approval process; however, this recommendation should, in our view, remain open and be marked as 'in progress'.

71 The Auditor General plans to review the Health Board's quality governance arrangements in more detail in early 2025.

Corporate approach to tracking recommendations

72 We considered whether the Health Board has a sound corporate approach to overseeing and scrutinising systems for tracking progress to address audit and review recommendations and findings. We were specifically looking for evidence of appropriate and effective systems in place for tracking responses to audit and other review recommendations and findings in a timely manner.

73 We found that **the Health Board is strengthening its arrangements for audit tracking, however, there is scope for Executive Leads to better evidence the actions taken in response to the recommendations they are responsible for implementing.**

74 The Audit Committee continues to receive audit tracker reports at each meeting, with reports providing comprehensive detail for open recommendations and recommendations proposed for closure. The Health Board is intending to move its audit tracker to an electronic platform and was exploring options to achieve this at the time of writing.

75 In response to our 2023 structured assessment recommendation on missing audit recommendations, the Health Board conducted a thorough and comprehensive review of published Internal Audit and Audit Wales reports. The Audit Committee received a detailed report showing the status of audit recommendations going back several years in September 2024 (see **Appendix 2, Recommendation 4, 2023**). The Health Board has reviewed each recommendation to identify those that are no longer relevant. For those that remain open, the Health Board has agreed revised and realistic implementation dates and matched the recommendations to new owners where there has been a change in leadership.

76 More broadly, since July 2024 a new recommendation closure process is in place which requires Executive Officers to provide individual and collective sign-off to the proposals to close audit recommendations. For external audit recommendations, the Audit Committee is asked to consider and approve the proposals. In contrast, proposals to close Internal Audit recommendations are firstly submitted to Internal Audit for quality assurance. Reports by Internal Audit show that they send a significant proportion of the proposals back to the Executive Team to request that further evidence is provided to support the closure of the recommendation.[8] In addition to the need for better responses to recommendations from Executives, this also indicates a need for more robust quality assurance of that information when it is reviewed by the Directorate of Corporate Governance prior to being sent to Internal Audit.

77 Our review of progress against previous Structured Assessment recommendations indicates that several recommendations which have been closed or are in the process of being closed by the Health Board appear to require further action. We have indicated where we believe recommendations to be ongoing in **Appendix 2** and would expect the Health Board to review its progress to ensure evidence fully supports the closure of these recommendations.

78 Opportunities remain to strengthen oversight of both audit and non-audit recommendations amongst other committees. Our review of papers found only a small number of audit reports are cross referred from the Audit Committee to other committees, despite being relevant to the remits of those committees.

[8] 19 actions were returned by internal audit to the Health Board in June and 50 actions were returned in November 2024.

(Recommendation 7) In addition, the Health Board has yet to progress actions to track the implementation of recommendations from other external / independent reviews (see **Appendix 2, Recommendation 5, 2023**).

Corporate approach to planning

79 We considered whether the Health Board has a sound corporate approach to producing strategies and corporate plans and overseeing their delivery.

80 We found that **the Health Board is planning to develop sustainable long-term organisational and clinical plans; however, to support this work, it will need to strengthen its approach to planning and ensure that plans are achievable.**

Corporate approach to producing strategies and plans

81 We considered whether the Health Board has a sound corporate approach to producing, overseeing, and scrutinising the development of strategies and corporate plans. We were specifically looking for evidence of:

- a clear Board approved vision, appropriate objectives and a long-term strategy in place which are future-focussed, rooted in population health, and informed by a detailed and comprehensive analysis of needs, opportunities, challenges, and risks;
- the long-term strategy underpinned by an appropriate Board approved long-term clinical strategy;
- appropriate and effective corporate arrangements in place for developing and producing the Integrated Medium-Term Plan (IMTP), and other corporate plans; and
- the Board appropriately scrutinising the IMTP and other corporate plans prior to their approval.

82 We found that **although the Health Board is revising its long-term strategy, it still lacks a clear Clinical Services Plan and the resources needed to take forward these key strategic planning tasks. It also needs to strengthen its arrangements for ensuring sufficient internal and external engagement in the development of key corporate strategies and plans.**

83 The Health Board is replacing its 10-year strategy - 'Living Healthier, Staying Well' 2018-28 - due to the significant external and internal changes that have occurred since its development in 2018, including the impact of COVID-19, considerable Board turnover, and changing workforce challenges. The Health Board has started work to develop a new ten-year strategy, as well as a long-term Clinical Services Strategy, aiming to have them in place by the end of September 2025. Plans indicate that both strategies will be informed by significant research, including a population needs assessment.

84 Our previous structured assessment reports have repeatedly highlighted the need for a Clinical Services Plan which sets out how the organisation will provide sustainable services for the future. Whilst it is positive that the Health Board is looking to articulate its vision for future services and the organisation more generally, it faces challenges in advancing this work at the intended pace. Whilst there is transformation capacity in place within the Health Board, some of those we spoke to during our review raised concerns about insufficient dedicated capacity and resources availableto progress these key strategies and there is already significant pressure on senior leadership capacity as discussed in **paragraph 17**. Of particular concern has been the gap at Executive Medical Director level, given the importance of clinical leadership in taking forward the Clinical Services Plan. The Health Board will also likely find it challenging to undertake the required work to develop these plans at a time when it continues to face significant operational challenges and the need to progress other key programmes, such as revising its operating model.

85 The Health Board was unable to produce an approvable and financially balanced Integrated Medium-Term Plan (IMTP) for 2024-27. The Health Board therefore developed an Annual Plan for 2024-25 which is set within a three-year context to 2027.

86 The Health Board has reflected on its approach to annual planning following the challenges it experienced in developing the Annual Plan 2024-25. During late 2023, the Health Board sought and collated service plans from across the organisation. Whilst this approach involved a range of services, it culminated in the receipt of a variety of different ideas and approaches, which had to be brought together into a cohesive organisational plan. This process took significant time to complete and resulted in insufficient time to effectively engage the Board or Local Authority partners (via the Regional Partnership Board) in the development of the plan prior to its submission to Welsh Government to meet the deadline.

87 The Board scrutinised a draft version of the Annual Plan 2024-25 at an additional meeting of the Performance, Finance, and Information Governance Committee in March 2024 which was made open to all Board members. Despite expressing its disappointment at the lack of Board involvement in its development, the committee provided helpful challenge on the draft plan. Given that timescales were so short, officers were not able to fully consider and respond to some comments ahead of submission of the plan to the Board. The Board subsequently approved the plan for submission to Welsh Government on 28 March 2024. Whilst the Health Board met the required timeframe for submission, going forward it needs to ensure that its processes for producing key plans include sufficient and timely engagement with the Board and relevant committees. **(Recommendation 8)**

88 The Health Board is aiming to streamline its annual planning process for 2025. In September 2024, it issued high-level guidance to planning leads to provide them with clearer expectations against which to form their service plans. This has the potential to strengthen the process and should allow greater time to provide Board members with a draft to scrutinise.

89 In addition to the Annual Plan 2024-25, the Health Board approved its Strategic Equality Plan 2024-28 on 28 March 2024, therefore meeting the statutory deadline. Several other plans are also due for review over the next twelve months, including the Digital Plan and Estates Plan. Progress in developing these plans will be monitored by the Planning, Population Health, and Partnerships Committee. The Health Board has recently appointed a new Director of Environment and Estates. Given that the Health Board's 2023-24 Annual Report stated that it faces total backlog maintenance costs of £348m for its estate, reviewing the Estates Plan will be a key priority for the new appointee.

90 The Health Board committed to reviewing and refreshing its well-being objectives[9] by October 2024. However, whilst the Health Board has undertaken some work in relation to the 'fair pay' well-being objective in response to a Ministerial letter in 2023, its broader review of well-being objectives has not progressed. This work has since been re-programmed to form part of developing the ten-year strategy, which offers opportunities to align the organisation's strategic objectives and well-being objectives. The Auditor General will undertake a review of the Health Board's progress in reviewing and refreshing its well-being objectives at the appropriate time.

Corporate approach to overseeing the delivery of strategies and plans

91 We considered whether the Health Board has a sound corporate approach to overseeing and scrutinising the implementation and delivery of corporate plans. We were specifically looking for evidence of:

- corporate plans, including the IMTP, containing clear strategic priorities/objectives and SMART[10] milestones, targets, and outcomes that aid monitoring and reporting; and
- the Board appropriately monitoring the implementation and delivery of corporate plans, including the IMTP.

92 We found that **the actions in the Health Board's Annual Plan for 2024-25 do not contain sufficiently clear milestones to help monitor delivery. Furthermore, given the amount of actions carried forward into the 2024-25 Annual Plan, there is a risk that delivery will become further off-track.**

93 Recognising the Health Board's status under Special Measures, the Annual Plan 2024-25 was developed along the five strategic objectives listed in **paragraph 53**.

[9] The Well-being of Future Generations (Wales) Act 2015 places a duty on bodies named under the legislation to set and publish well-being objectives that are designed to maximise its contribution to achieving each of the well-being goals and take all reasonable steps (in exercising its functions) to meet those objectives.

[10] Specific, measurable, achievable, relevant, and time-bound

This approach was used to provide the Health Board with a single, unitary plan which incorporates both annual plan ambitions and special measures expectations.

94 The Annual Plan 2024-25 contains a significant number of improvement actions. However, many actions do not contain clear delivery milestones or measures which limits effective oversight of progress. For example, several of the actions are aimed at developing further plans or continuing to embed practices.

95 A significant number of actions from the Annual Plan 2023-24 and Special Measures Plan 2023-24 have yet to be delivered and have been carried forward into the Annual Plan 2024-25. However, the report to Board in July 2024 that describe these changes lacked sufficient detail on which actions had been retired and which had been added to the existing objectives within the Annual Plan 2024-25. This creates the risk that some actions will be 'lost' in the carry forward from one year to the next. There is also a need to ensure that the carried forward actions have clear and realistic milestones. **(Recommendation 9)**

96 The Health Board has recently altered its arrangements for overseeing delivery of the Annual Plan. Whilst the Board scrutinised a Quarter One 2024-25 report in July 2024, according to the Health Board there were issues related to the proximity of the end of the cycle to the Board meeting. As a result, the Health Board will split this oversight role for the remainder of 2024-25 and future cycles. The Board will receive updates for quarters two and four and the Performance, Finance, and Information Governance Committee will receive updates for quarters one and three.

97 Positively, the Quarter One Annual Plan 2024-25 update report demonstrated greater transparency and detail than the 2023-24 closure report. In addition, the Health Board has started to cross-refer actions within its Annual Plan 2024-25 to its performance reporting to identify where the outcome of an action should be evident within operational performance, such as in relation to the design of its Quality Management System. However, the volume of actions now in the existing Annual Plan 2024-25 is a cause for concern given that the Quarter One update report showed that 13 (33%) of the 38 actions programmed for that quarter had not been completed within the planned timeframe. Whilst seven of the remaining actions were expected to be completed within four weeks, six were rated as off-track with no remedial plan. The report also notes that the volume of deliverables from Quarter Two onwards would increase significantly. There is, therefore, a significant risk that delivery of the Annual Plan 2024-25 will become further off-track.

Corporate approach to managing financial resources

98 We considered whether the Health Board has a sound corporate approach to managing its financial resources.

99 We found that **whilst there are improvements in the Health Board's approach to financial management, significant challenges remain in terms of spending**

within budget. The Health Board was not able to meet its statutory financial duties for 2023-24 despite significant financial assistance from Welsh Government. Whilst the Health Board is predicting it will achieve its financial targets for 2024-25, this will be challenging and is also reliant on a significant element of one-off savings.

Financial objectives

100 We considered whether the Health Board has a sound corporate approach to meeting its key financial objectives. We were specifically looking for evidence of:

- the organisation meeting its financial objectives and duties for 2023-24, and the rolling three-year period of 2021-22 to 2023-24; and
- the organisation being on course to meet its objectives and duties in 2024-25.

101 We found that **the Health Board was unable to meet its statutory financial duties for 2023-24 and the rolling three-period of 2021-24. Whilst it is on track to deliver its savings target for 2024-25, its year-to-date deficit position indicates that delivery of its financial plan will be very challenging.**

102 The Health Board did not meet its financial objectives and duties for 2023-24 as it reported a year-end deficit of £24.3million. This is despite the Health Board receiving £82million[11] strategic assistance funding to support sustainable improvements in key services and £27million cash-only support from Welsh Government during 2023-24 to assist the Health Board with making payments to staff and suppliers. However, within the year the Health Board made positive progress in reducing its cost-drivers and introducing several financial control measures which supported it towards achieving the 2023-24 control total deficit of £20million. Despite small underspends in the two prior years, the 2023-24 deficit also negatively impacted on its ability to meet its financial duty to breakeven over a three-year rolling period, as it had an overall 2021-24 deficit of £23.7million. As previously stated, the Health Board was unable to produce a financially balanced three-year plan for 2024-27. Positively, the Health Board met its financial duty to break even against its Capital Resource Limit over three years between 2021-24.

103 As of month 6 2024-25, the Health Board was reporting a year-to-date deficit position of £18.7million, which represented an in-year adverse variation of £8.9million against the planned full-year control deficit target of £19.8 million set by Welsh Government. Whilst the Health Board's capital resource limit was forecast to be spent in full, spend as of Month 6 was £5.8million against a year-to-date expectation of £10.3million.

104 The Health Board's 2024-25 Financial Plan sets a savings target of £48million to be delivered to the meet the planned £19.8million deficit position. As of Month 6,

[11] The £82million was an annual allocation provided to the Health Board by Welsh Government between 2021-22 and 2023-24.

the Health Board had delivered £27.1million savings, a positive year-to-date variance of some £3.1million, with a forecast that it will deliver £48.4million savings by year end.

105 The Finance Report presented to the Performance, Finance and Information Governance Committee in October 2024 indicated that the Health Board is still forecasting it will achieve the year-end control total deficit of £19.8million despite the Month 6 position already showing a £18.7million deficit. The Finance Report articulated the need for action to mitigate cost over-runs and securing the planned savings. The report indicated that this was resulting in the Health Board managing a risk of circa £25.9million in respect of delivery of the planned year-end position. Much is riding on the Health Board's ability to deliver its planned year-end position given the Welsh Government has confirmed that the annual strategic support funding of £82million that is currently non-recurrent will be received on recurrent basis if the Annual Plan deficit of £19.8million is achieved.

Corporate approach to financial planning

106 We considered whether the Health Board has a sound corporate approach to overseeing and scrutinising financial planning. We were specifically looking for evidence of:

- clear and robust corporate financial planning arrangements in place;
- the Board appropriately scrutinising financial plans prior to their approval;
- sustainable, realistic, and accurately costed savings and cost improvement plans in place which are designed to support financial sustainability and service transformation; and
- the Board appropriately scrutinising savings and cost improvement plans prior to their approval.

107 We found that **whilst the Health Board demonstrates good awareness of its financial risks, it is still relying heavily on non-recurrent savings to meet year- end financial targets with the ability to adopt a more transformational approach to cost improvement being limited by the absence of a long-term plan for services.**

108 The Board and the Performance, Finance, and Information Governance Committee scrutinised the Health Board's Financial Plan as part of the Annual Plan 2024-25 ahead of its formal submission to Welsh Government in March 2024. However, as with the development of the 2024-25 Annual Plan, Board members had limited engagement with the development of the Financial Plan ahead of providing formal scrutiny and approval.

109 The Financial Plan 2024-25 sets out key financial risks, three of which had materialised into issues by Month 6. These included continuing healthcare, out of area mental health placements, and prescribing. These spends are being mitigated to an extent through increased scrutiny and escalation, cost avoidance and the use

of contingency funds. The Finance Team is closely monitoring these risks and escalating matters to committees as appropriate.

110 The Health Board has adopted a new approach to identifying and delivering savings for the year, based around the national Value and Sustainability Board (VSB) workstreams which have identified savings with the potential to deliver significant transformational efficiencies. In our separate Review of Cost Savings Arrangements, we indicated that the Health Board was slow in selecting viable savings schemes for 2024-25. Despite this, at Month 6, the Health Board was reporting a positive year-to-date variance on delivery of planned savings as noted in the previous section. However, it is worth noting that of the £48.4million of savings the Health Board is forecasting it will achieve this year, £19.8million are non-recurrent. Furthermore, the figure also includes £6.9million of accountancy gains, which are fortuitous one-off reductions in spending resulting from reviews of accruals from the previous year.

111 The Health Board's 2024-25 Annual Plan signals a commitment to embed the principles of Value-Based Healthcare into decision making throughout the organisation. However, it is not clear how this will be achieved and as of Quarter One, the Health Board was off-track for delivery of this objective. It has stated that additional central resource was now being applied to support its achievement (see **Appendix 2 – 2022, Recommendation 8**).

112 As noted in **paragraph 83**, the Health Board is in the process of developing a long-term organisational strategy and Clinical Services Plan. The latter in particular is fundamentally important to drive the service transformation that is needed to establish a service model that is clinically and financially sustainable for the future (see **Appendix 2 – 2023, Recommendation 7**).

Corporate approach to financial management

113 We considered whether the Health Board has a sound corporate approach to overseeing and scrutinising financial management. We were specifically looking for evidence of:

- effective controls in place that ensure compliance with Standing Financial Instructions and Schemes of Reservation and Delegation;
- the Board maintaining appropriate oversight of arrangements and performance relating to single tender actions, special payments, losses, and counter-fraud;
- effective financial management arrangements in place which enable the Board to understand cost drivers and how they impact on the delivery of strategic objectives; and
- the organisation's financial statements for 2023-24 were submitted on time, contained no material misstatements, and received a clean audit opinion.

114 We found that **strengthened financial controls are leading to fewer single tender actions and special payments. Whilst the quality of the draft financial**

statements significantly improved in 2023-24, there is scope to improve the accuracy of the associated Remuneration Report.

115 The Health Board has taken steps to establish tighter financial controls and strengthen the culture of financial scrutiny and accountability in response to the challenging financial situation, and the findings of independent reviews which highlighted significant weaknesses.

116 An Internal Audit review on contract and procurement management, conducted between September and October 2023, highlighted several areas of concern on non-compliance with the Standing Financial Instructions (SFIs) in relation to contracting and procurement within the Health Board. The review raised 24 actions for the Health Board to consider. Officers responded by launching a detailed programme of work with 50 smaller actions. Good progress was reported to the Audit Committee in May 2024, including joint-working between the Health Board and NHS Wales Shared Services Partnership to increase the capture and reporting of information when breaches occur.

117 The Health Board is also responding to an Internal Audit review of budgetary control, published in July 2024. Whilst the report recognised positive progress in financial management and control during 2023-24, it also highlighted areas that required further improvement, including lack of detailed budgetary control procedures in place and a failure to issue Accountability Letters to budget holders during 2023-24. We are aware that Accountability Letters have been issued to budget holders in 2024-25. Although a significant majority have been signed and returned, this did not happen in all cases until well into the financial year. Internal Audit also identified a need to develop and deliver a training plan on finance and procurement to relevant staff, which the Health Board reports as being in progress.

118 The Audit Committee continues to provide oversight of compliance of SFIs and the Scheme of Reservation and Delegation. It also oversees and scrutinises information on losses and special payments, counter-fraud activity, procurement controls, and single tender actions. As a result of increased financial controls, the Health Board has seen a significant reduction in the volume and value of purchase orders in breach of its Standing Financial Instructions, and single tender action waivers in 2024-25 compared to 2023-24.

119 The Health Board has also been monitoring actions to address the range of issues identified in our 2021-22 and 2022-23 audit of accounts, as well as issues identified by an independent EY review through a finance special measures action plan (see **Appendix 2, - 2023, Recommendation 8**). Progress was last reported to the Performance, Finance, and Information Governance Committee in February 2024 and showed mixed success in meeting milestones, with incomplete actions taken forward into the Annual Plan 2024-25. However, the way in which this information was presented makes it difficult to identify the transferred actions and consequently to know whether they have been adequately addressed.

120 The Health Board submitted draft financial statements for 2023-24 for audit within the required Welsh Government timeframe. The Auditor General issued an

unqualified 'true and fair' opinion on the accounts. However, the Auditor General issued a qualified regularity opinion due to the Health Board not meeting its financial duty to break-even over the rolling three-year period 2021-22 to 2023-24, as well as incurring irregular expenditure and breaching its standing financial instructions in making payments to a former interim executive member of the Board. Our audit report noted that there was a significant improvement in the quality of the 2023-24 draft financial statements compared to the previous year. However, we also reported some concerns with the content of the draft Remuneration Report, including errors in the appointment dates or incorrect salary calculations.

121 The Auditor General is currently undertaking a high-level examination of the Health Board's use of the additional £297million financial assistance provided by the Welsh Government as part of the targeted intervention package announced in October 2020. This review is due to be reported through the Audit Committee in 2025.

Board oversight of financial performance

122 We considered whether the Board appropriately oversees and scrutinises financial performance. We were specifically looking for evidence of:

- the Board receiving accurate, transparent, and timely reports on financial performance, as well as the key financial challenges, risks, and mitigating actions; and
- the Board appropriately scrutinising the ongoing assessments of the organisation's financial position.

123 We found that **the Board and Performance, Finance and Information Governance Committee regularly oversees and scrutinises financial performance information that is accurate, timely, and transparent. However, these discussions need to acknowledge the severity of the risks to achieving the year-end financial targets.**

124 Financial reports to the Performance, Finance, and Information Governance Committee and the Board are timely, comprehensive, and transparent that support scrutiny and oversight. They provide good analysis on areas of spending, overspending, and financial expenditure trends. The reports set out the short-term financial challenges and identify where there are specific financial concerns.

125 The Board and the Performance, Finance, and Information Governance Committee are keenly aware that the Health Board's approach to financial planning is not sustainable in the longer term. However, the committee maintains a confidence that the year-end financial targets will be achieved despite the risks the Health Board holding.

Appendix 1

Audit methods

Exhibit 2 below sets out the methods we used to deliver this work. Our evidence is limited to the information drawn from the methods below.

Element of audit approach	Description
Observations	We observed Board meetings as well as meetings of the following committees: • Audit Committee; • Planning, Population Health and Partnership Committee; • Quality, Safety and Experience Committee; and • Performance, Finance and Information Governance Committee.

Element of audit approach	Description
Documents	We reviewed a range of documents, including: • Board and Committee Terms of Reference, work programmes, agendas, papers, and minutes; • key governance documents, including Schemes of Delegation, Standing Orders, Standing Financial Instructions, Registers of Interest, and Registers of Gifts and Hospitality; • key organisational strategies and plans, including the IMTP; • key risk management documents, including the Board Assurance Framework and Corporate Risk Register; • key reports relating to organisational performance and finances; • Annual Report, including the Annual Governance Statement; • relevant policies and procedures; and • reports prepared by the Internal Audit Service, Health Inspectorate Wales, Local Counter-Fraud Service, and other relevant external bodies.

Interviews	We interviewed the following Senior Officers and Independent Members: • Chair; • Vice-Chair and Chair of Performance, Finance and Information Governance; • Chair of Planning, Population Health and Partnerships Committee; • Chair of Quality, Safety and Experience Committee; • Chair of Audit Committee; • Chief Executive Officer; • Executive Director of Transformation, Strategic Planning and Commissioning; • Executive Director of Nursing and Midwifery; • Executive Director of Public Health; • Executive Director of Allied Health Professionals and Health Science • Interim Executive Director of Finance; • Deputy Director of People and Organisational Development; • Director of Corporate Governance; • Director of Midwifery and Women's Services • Director of Mental Health; • IHC Director, East; • IHC Director, Central; • IHC Director, West.

Appendix 2

Progress made on previous-year recommendations

Exhibit 3 below sets out the progress made by the Health Board in implementing recommendations from previous structure assessment reports.

Recommendation	Health Board assessment of progress	Audit Wales assessment of progress
Transparency of board and committee business, 2023: R1 Currently, there is confusion about how many days in advance of meetings papers for Board and committee papers should be made publicly available. The Health Board should agree and communicate a consistent target date for publishing agendas ahead of Board and committee meetings.	Going through closure approval process	**In progress**. See paragraph 30
Transparency of board and committee business, 2023: R2 The minutes for some committee meetings are missing from the website many months after the meeting date. This affects timely public access to committee	Ongoing and in progress	**No progress.** See paragraph 30

Recommendation	Health Board assessment of progress	Audit Wales assessment of progress
discussions. The Health Board should introduce arrangements to ensure the public have timelier access to records of committee meetings as part of its wider efforts to enhance transparency of Board business.		
Changing trends in complaint numbers 2023-24, 2023: R3 There has also been a significant unexplained drop in the number of complaints received for the first six months of 2023-24 compared to the previous year. The Health Board should urgently work to discover the reason to ensure complaints are not being missed or mis-reported.	Going through closure approval process	**No progress.** See paragraph 70
Recommendation tracking, 2023: R4 Our work identified that not all Audit Wales recommendations made in 2023 were added to the audit tracker. The Health Board should ensure there is a process to add all recommendations made by Audit Wales to the audit tracker in a timely fashion.	Going through closure approval process	**Complete.** See paragraph 75
Recommendation tracking, 2023: R5 Currently, there is insufficient committee oversight to monitor progress made against recommendations made by non-audit bodies. The Health Board should introduce effective committee oversight for monitoring progress made	Ongoing and in progress	**No progress.** See paragraph 78

Recommendation	Health Board assessment of progress	Audit Wales assessment of progress
against recommendations of regulators, including, but not limited to, Healthcare Inspectorate Wales, the Coroner, the Welsh Language Commissioner, the Health and Safety Executive, and the Public Services Ombudsman for Wales.		
Clinical engagement plan, 2023: R6 More needs to be done to reconfigure services to ensure they sustainably meet current and future population healthcare needs. To accompany its clinical strategy, the Health Board should undertake key stakeholder engagement plan to help it shape sustainable service models designed to meet current and future demand.	Ongoing and in progress	**Superseded.** See paragraph 83
Financial strategy, 2023: R7 It is difficult to see the extent to which the Health Board's improvement initiatives and aims set out in the 2023-24 Annual Plan were financially affordable. The Health Board should develop a financial strategy, supported by a medium-term financial plan with the aim of supporting good quality and sustainable service models and reducing the Health Board's deficit and underlying deficit.	Going through closure approval process	**No progress.** See paragraph 112

Recommendation	Health Board assessment of progress	Audit Wales assessment of progress
Monitoring progress against accounting issues R8 Ensure that the Audit Committee receives assurance on the progress that the Health Board is making to address the complete range of issues identified in the Audit Wales 2021-22 and 2022-23 audit of accounts, and the subsequent EY review has been slower than intended.	Going through closure approval process	**In progress**. See paragraph 119
Review and where needed, strengthen risk mitigating actions, 2022 R1 Despite recent changes to the Health Board's strategic and corporate risk arrangements, risk scores in some key areas are not decreasing. The Health Board should review the mitigating actions on the corporate risk register and Board Assurance Framework to ensure they are having the intended impact.	Going through closure approval process	**Superseded.** See paragraph 60
Review of performance management assurance reporting, 2022 R2 The Health Board is continuing to refine performance reporting into board and committees. However, there remain concerns around the quality of the performance report and the extent that stated actions will lead to the intended improvements. The Health Board should improve its performance assurance reporting, focussing more on the impact of performance improvement actions.	Going through closure approval process	**In progress**. See paragraph 65

Recommendation	Health Board assessment of progress	Audit Wales assessment of progress
Review Health Board policies, 2022 R4 The Health Board has a significant number of policies overdue for renewal, which exposes the organisation to service and administrative risks. The Health Board should review and update Health Board policies, prioritising high importance policies first, including the policy on policies.	Going through closure approval process	**In progress**. See paragraph 35
Review audit recommendation tracker, 2022 R5 The audit recommendation tracker and report in their current format provide limited detail, particularly around actions considered complete. The Health Board should work with Audit Committee members to review the format of the audit tracker and report to ensure it provides sufficient information to provide assurance.	Ongoing and in progress	**Superseded.** See paragraph 75
Implementation of the new operating model, 2022 R6 The Health Board should complete the implementation of the new operating model as a matter of urgency, particularly in respect of recruiting substantial post holders and reducing reliance on interim appointments.	Approved for closure	**Superseded.** See paragraph 21

Recommendation	Health Board assessment of progress	Audit Wales assessment of progress
Develop a supporting clinical delivery plan, 2022 R7 The Health Board has developed a clinical strategy for its services, however, there is lack of detail on how it will be implemented. The Health Board should develop supporting clinical delivery plan/plans and delivery structures to shape and implement sustainable service models. Clinical plans should inform workforce, estate, financial resource, and digital services planning.	Ongoing and in progress	**Superseded.** See paragraph 83
Reporting on the impact of value-based healthcare initiatives, 2022 R8 We found limited evidence of how the Health Board is implementing value-based healthcare operationally to its services to maximise value and efficiency. The Health Board should ensure reporting on its value-based healthcare programme focusses on the outcomes achieved.	Going through closure approval process	**In progress**. See paragraph 111
Urgently implement financial recovery approaches to strengthen the financial position, 2022 R9 As of January 2023 the Health Board is off-track with its current savings plan and is slow to progress the savings plan for 2023-24. The Health Board should: • prepare appropriate financial recovery programmes as a matter of urgency for both the remainder of this, and the next financial year; • review options for estate and service disinvestment (ie where services are not demonstrating sufficient patient impact and outcomes);	Going through closure approval process	**Superseded.** See paragraph 102

Recommendation	Health Board assessment of progress	Audit Wales assessment of progress
• introduce stronger reporting and oversight of the medium-term financial position, financial strategy and recovery approaches; and • target digital investments on areas of clear business benefits, ie where digital can be used to release service efficiency and/or quality gains elsewhere.		
Ensure effectiveness of staff well-being services, 2022 R11 The Health Board has introduced a programme of services to support staff wellbeing. However, it is not currently undertaking sufficient evaluation to ensure these are meeting the needs of staff. The Health Board should evaluate the impact of its staff wellbeing services to inform future investment decisions.	Closed	Complete. The Health Board informs us it has completed a review of staff health and wellbeing health needs assessment, as well as a new data reporting dashboard for counselling services.

Recommendation	Health Board assessment of progress	Audit Wales assessment of progress
Improve performance and financial oversight for digital and estates, 2022 R12 There is a need to put in place arrangements to understand the impact of digital and estates strategies, as well as the financial feasibility of the strategy. The Health Board should: • review any funding gaps in the digital and estates strategies to determine if they are financially feasible. Update the relevant committee on the findings of the financial feasibility review and how any associated risks will be managed. • introduce periodic committee reports that not only focus on actions completed but the impact its digital and estates strategies are having on the organisation.	Ongoing and in progress	**In progress**. The Health Board states that its digital roadmap plan, once developed will be fully costed and will articulate anticipated benefits. The Health Board has recently appointed a new Director of Environment who will lead the development of a new, robust estates strategy. Progress in developing these plans will be monitored via the Planning, Population Health and Partnerships Committee.

Appendix 3

Management response to audit recommendations

Exhibit 4: Betsi Cadwaladr University Health Board response to our audit recommendations

Ref	Recommendation	Management response Please set out here relevant commentary on the planned actions in response to the recommendations	Completion date Please set out by when the planned actions will be complete	Responsible officer (title)
R1	The Health Board should progress its plans to introduce arrangements for an Executive Committee and its related operating arrangements by April 2025. **(Paragraph 23)**	The Health Board will be establishing a formal Committee of the Board which will form part of the wider approach aligned to Foundations for the Future Programme. Immediate Actions will include: 1. Terms of Reference approved by the Board 2. Agreed operating and reporting arrangements	April 2025	Director of Corporate Governance

Ref	Recommendation	Management response Please set out here relevant commentary on the planned actions in response to the recommendations	Completion date Please set out by when the planned actions will be complete	Responsible officer (title)
		3. Reporting at each meeting of the Board items considered by the Executive Committee		
R2	In the context of ongoing work in relation to the Foundations of the Future programme and strengthening its operational governance the Health Board should develop a Terms of Reference for its Senior Leadership Team meetings to clarify the purpose of meetings and to ensure that the frequency of meetings is sufficient to effectively discharge its role. **(paragraph 24)**	Currently there is no accountability or responsibility for the Senior Leadership Team in terms of operational governance, it is a mechanism by which the Members of the Executive Team can engage to support the delivery of the Health Board plans. As part of the Foundations for the Future Programme, clarity on roles and responsibilities for groups will be confirmed alongside the role of the Senior Leadership Team and the Operational Leadership Team.		

Ref	Recommendation	Management response Please set out here relevant commentary on the planned actions in response to the recommendations	Completion date Please set out by when the planned actions will be complete	Responsible officer (title)
		Key actions include: • Review of the operational governance arrangements including the role of the Senior Leadership Team (July 2025)	July 2025	Director of Corporate Governance
R3	When the Board reports against decisions taken in private session or via Chair's Actions, it should ensure that, where relevant, the cost implications of decisions are clearly reported. **(Paragraph 29)**	The Health Board has strengthened the reporting of the decisions made in private during 2024/24 as previously this was a verbal update. **Key actions include:** Reporting of financial implications as part of the decision-making process, unless of course, in matters relating to individuals and therefore an exemption would apply.	January 2025	Director of Corporate Governance

Ref	Recommendation	Management response Please set out here relevant commentary on the planned actions in response to the recommendations	Completion date Please set out by when the planned actions will be complete	Responsible officer (title)
R4	The Health Board should ensure review of minutes is a standing item on the agenda of each Remuneration Committee meeting (including additional meetings) to ensure the Board has access to an accurate and timely description of the decisions taken. **(Paragraph 40)**	The Health Board has held a number of additional Remuneration Committee's during 2024 to progress the appointment of Executive Director posts. **Key actions include:** Ensuring that where minutes are available then these will be brought to the next available meeting as per the cycle of business	January 2025	Director of Corporate Governance
R5	The Health Board should develop a structured programme of Board member visits, to include a mechanism to provide feedback to the Board. **(Paragraph 46)**	The Health Board is considering the most appropriate way to engage the wider Board in terms of visiting services. Individual Board Members visit sites on a regular basis. **Key actions include:** • Agree how the Board can engage with services, which	June 2025	Director of Corporate Governance

Ref	Recommendation	Management response Please set out here relevant commentary on the planned actions in response to the recommendations	Completion date Please set out by when the planned actions will be complete	Responsible officer (title)
		will include plans in terms of service reviews; and • Establish a reporting mechanism to the Board in terms of service visits		(with Chair and Chief Executive Officer)
R6	As part of the development of a meaningful Board Assurance Framework, the Health Board should provide Board members with further supporting detail on its strategic objectives to clarify what the objectives are seeking to achieve. **(Paragraph 57)**	The Health Board has reviewed the Board Assurance Framework during 2024/25 which will be aligned to the Strategic Objectives for the 2025/26 Plan once agreed by the Board. **Action:** To provide additional detail as part of the development of the IMTP for 2025/26	January 2025	Director of Corporate Governance
R7	The Health Board should ensure that audit reports that are relevant to the remit of other Board committees are	The Health Board is considering the approach to dealing with reports from external regulatory bodies as part of		

Ref	Recommendation	Management response Please set out here relevant commentary on the planned actions in response to the recommendations	Completion date Please set out by when the planned actions will be complete	Responsible officer (title)
	received and discussed by those committees, including periodic updates against any associated recommendations. **(Paragraph 78)**	the IMTP for 2025/26. However, there has been progress during 2024/25 which has included progress against external audits at committees, and it recognises there is more to do in this area. **Action:** The governance process on reviewing of audit reports will be developed further to ensure that audit reports are considered at the relevant committees as well as Audit Committee.	April 2025	Director of Corporate Governance
R8	The Health Board should ensure that it appropriately engages with Board members and Regional Partnership Board partners in the process of developing future Integrated Medium-Term Plans or Annual Plans. **(Paragraph 87)**	The Health Board has reviewed the approach and membership at the RPB during 2024/25. **Action:** • The Health Board will ensure that it engages with the RPB	April 2025	Director of Strategy and Transformation

Ref	Recommendation	Management response Please set out here relevant commentary on the planned actions in response to the recommendations	Completion date Please set out by when the planned actions will be complete	Responsible officer (title)
		as part of the development of the IMTP and other corporate plans such as the development of the Organisational Strategy.		
R9	Where the Health Board needs to carry forward actions from one Annual Plan to the next, it should ensure that progress reports are clear on which actions have been retired or carried forward and provide clear and realistic milestones for those actions. **(Paragraph 95)**	The Health Board has made progress during 2024/25 in the reporting of the progress against the Annual Plan, further work will be continued into 2025/26. **Actions:** The monitoring report will be strengthen to address the recommendation including clear milestones and actions.	April 2025	Director of Strategy and Transformation

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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.

Teitl adroddiad: ***Report title:***	Local Counter Fraud Service Progress Report - **PUBLIC**
Adrodd i: ***Report to:***	Audit Committee
Dyddiad y Cyfarfod: ***Date of Meeting:***	Thursday, 16 January 2025
Crynodeb Gweithredol: ***Executive Summary:***	The purpose of this paper is to provide assurance to the Audit Committee around the progress of the Local Counter Fraud Service for the Health Board ahead of the Quarter 3 2024/2025 report, which will be presented at the next Audit Committee. The paper includes an update on training, staffing, areas of concern and areas of progress.
Argymhellion: ***Recommendations:***	The Audit Committee is asked to consider and note the contents of the report.
Arweinydd Gweithredol: ***Executive Lead:***	Mr. Russell Caldicott – Interim Executive Director of Finance
Awdur yr Adroddiad: ***Report Author:***	Ms Danielle Kerr-Timmins – Head of Local Counter Fraud Service

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

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

Cyfiawnhad dros y gyfradd sicrwydd uchod. Lle bo sicrwydd 'Rhannol' neu 'Dim Sicrwydd' wedi'i nodi uchod, nodwch gamau i gyflawni sicrwydd 'Derbyniol' uchod, a'r terfyn amser ar gyfer cyflawni hyn: ***Justification for the above assurance rating. Where 'Partial' or 'No' assurance has been indicated above, please indicate steps to achieve 'Acceptable' assurance or above, and the timeframe for achieving this:***	
Cyswllt ag Amcan/Amcanion Strategol: ***Link to Strategic Objective(s):***	The Local Counter Fraud Service Workplan for 2024/25 was approved by the Audit Committee on 7 May 2024
Goblygiadau rheoleiddio a lleol:	The progress against the Local Counter Fraud

Regulatory and legal implications:	Service Workplan for 2024/25 will be reported to the Audit Committee and also to Welsh Government in the Counter Fraud Annual Report for 2024/25.
Yn unol â WP7, a oedd EqIA yn angenrheidiol ac a gafodd ei gynnal? ***In accordance with WP7 has an EqIA been identified as necessary and undertaken?***	No Equality Assessment is not required to be carried out, as this report is administrative in nature and reports the quarterly progress relating to Fraud, Bribery and Corruption. Gweithdrefn ar gyfer Asesu Effaith ar Gydraddoldeb WP7 *WP7 Procedure for Equality Impact Assessments*
Yn unol â WP68, a oedd SEIA yn angenrheidiol ac a gafodd ei gynnal? ***In accordance with WP68, has an SEIA identified as necessary been undertaken?***	No Socio-economic Impact Assessment is not required to be carried out, as this report does not deal with Health Board's strategic decisions. Gweithdrefn WP68 ar gyfer Asesu Effaith Economaidd-Gymdeithasol. *WP68 Procedure for Socio-economic Impact Assessment.*
Manylion am risgiau sy'n gysylltiedig â phwnc a chwmpas y papur hwn, gan gynnwys risgiau newydd (croesgyfeirio at y BAF a'r CRR) ***Details of risks associated with the subject and scope of this paper, including new risks(cross reference to the BAF and CRR)***	This paper is intended to draw to the Audit Committee's attention, the progress of work which has been undertaken in accordance with the Welsh Government Directions to protect NHS financial resources from Fraud, Bribery and Corruption.
Goblygiadau ariannol o ganlyniad i roi'r *argymhellion ar waith* ***Financial implications as a result of implementing the recommendations***	No recommendations
Goblygiadau gweithlu o ganlyniad i roi'r argymhellion ar waith ***Workforce implications as a result of implementing the recommendations***	No recommendations
Adborth, ymateb a chrynodeb dilynol ar ôl ymgynghori ***Feedback, response, and follow up summary following consultation***	The paper has been subject to Executive review and sign off.

Cysylltiadau â risgiau BAF: (neu gysylltiadau â'r Gofrestr Risg Gorfforaethol) ***Links to BAF risks:*** *(or links to the Corporate Risk Register)*	1. Risk of significant financial loss due to Salary Overpayments (Risk Register 2601) 2. Potential Loss of income to Overseas Visitor Patients (Risk Register 3058) 3. General Medical Services - Capitation /Patient Registration Fees (Risk register 3061) 4. Pharmaceutical Fraud (Risk Register 3064) 5. Private Patients (Risk Register 3060) 6. Cyber Enabled Salary Diversion (Risk Register 4165) 7. Continence Services (Risk Register 4170) 8. Payroll Fraud – Misrepresentation of Qualifications, Skills and Experience (Risk Register 4171) 9. Hospital Mortality Services (Risk Register 4172)
Rheswm dros gyflwyno adroddiad i fwrdd cyfrinachol (lle bo'n berthnasol) ***Reason for submission of report to confidential board (where relevant)***	
Next Steps: The Committee is required to note the contents of this Local Counter Fraud Service – Progress Report. This information forms part of all Wales Counter Fraud Wales Reports which are shared with Welsh Government.	
List of Appendices: *None*	

AUDIT COMMITTEE,16TH JANUARY 2025

Local Counter Fraud Service Progress Report

1. Introduction/Background

This report is intended to provide the Audit Committee with assurance regarding the progress of the Local Counter Fraud Service. As this is an assurance-focused report, it has not been presented to any other forums for consultation prior to submission.

The purpose of this report is to inform the Audit Committee of key updates and progress in the following areas: compliance with NHS Counter Fraud Authority Standards, delivery of the Annual Workplan, ongoing and concluded investigations, training initiatives, risk management, and any other relevant developments. The Committee is invited to review and note the contents of this report.

2. Updates

2.1 UK Government Functional Standard GovS 013: Counter Fraud

The Counter Fraud Functional Standard Return (CFFSR) for financial year 2023/24 was submitted in May 2024 with an overall rating of 'Green' for the Health Board. A copy of the return was submitted to the Audit Committee on the 9th July 2024 as part of the Local Counter Fraud Service Annual Report 2023/24.

NHS Requirement 12: Policies and registers for gifts and hospitality, and conflicts of interest was the only requirement which did not achieve a green rating and was scored as an amber rating. Work remains ongoing between the Corporate Governance Team and Local Counter Fraud Service to identify areas of improvement.

2.2 Annual Workplan

In alignment with the submitted Counter Fraud Functional Standard Return (CFFSR) and its individual components, an annual workplan was presented to the Audit Committee in May 2024. The team has since been diligently progressing with the objectives outlined in the plan, though there have been some challenges due to resourcing. At this stage, we remain confident that the majority of the planned actions will be completed within the current financial year.

2.3 Cases

At the time of writing, there are currently 37 open cases. 15 cases have been closed in this year to date.
Work is ongoing between the Head of Local Counter Fraud Services, the Executive Director of Finance and NHS Counter Fraud Services Wales to ensure that long standing cases are resolved and closed.

2.4 Training

Training continues to be delivered predominantly through e-learning modules, with workbooks provided as an alternative for staff unable to access a computer. The training remains mandatory for all staff and requires updates every three years. Compliance remains high at 89.03%.

BCUHB remains the leading Health Board in Wales for Counter Fraud Training. Face-to-face orientation sessions have also been conducted, incorporating Counter Fraud presentations; however, attendance has been notably poor. Efforts are ongoing in collaboration with the Mandatory Training team to review and improve attendance strategies.

2.5 Policy

The Counter Fraud, Bribery, and Corruption Policy (F03) was originally scheduled for review in August 2024. However, the review has been delayed due to the retirement of the previous Head of Local Counter Fraud Service end of June 2024 and sickness absence within the team.

Guidance from the Home Office on the new corporate criminal offence of 'failure to prevent fraud' was also delayed due to the General Election held in July.

The review is now underway, and a draft of the updated policy has been shared for consultation. The policy is scheduled to be presented to the Executive Policy Oversight Group in January 2025, with final approval anticipated at the Audit Committee meeting in March 2025.

2.6 Other matters of note

- Pam Wenger has been nominated as Counter Fraud Champion for BCUHB.
- Danielle Kerr-Timmins is now in post as Head of Local Counter Fraud Service

3. Budgetary / Financial Implications

There are no budgetary implications associated with this paper.

4. Risk Management

There are 9 risks recorded on Datix linked to Counter Fraud which are:

1. Risk of significant financial loss due to Salary Overpayments (Risk Register 2601)
2. Potential Loss of income to Overseas Visitor Patients (Risk Register 3058)
3. General Medical Services- Capitation /Patient Registration Fees (Risk Register 3061)
4. Pharmaceutical Fraud (Risk Register 3064)
5. Private Patients (Risk Register 3060)
6. Cyber Enabled Salary Diversion (Risk Register 4165)
7. Continence Services (Risk Register 4170)
8. Payroll Fraud – Misrepresentation of Qualifications, Skills and Experience (Risk Register 4171)
9. Hospital Mortality Services (Risk Register 4172)

There are no significant updates relating to risk management at this time. The team will meet on a bi-weekly basis to discuss and update risks.

5. Equality and Diversity Implications

Equality Assessment is not required to be carried out, as this report is administrative in nature and reports the quarterly progress relating to Fraud, Bribery and Corruption.

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

Cyfarfod a dyddiad: **Meeting and date:**	Audit Committee
Cyhoeddus neu Breifat: **Public or Private:**	Public
Teitl yr Adroddiad **Report Title:**	Summary of business considered in private session to be reported in public
Cyfarwyddwr Cyfrifol: **Responsible Director:**	Pam Wenger, Director of Corporate Governance
Awdur yr Adroddiad **Report Author:**	Philippa Peake-Jones, Head of Corporate Affairs
Craffu blaenorol: **Prior Scrutiny:**	None
Atodiadau **Appendices:**	None

Y/N to indicate whether the Equality/SED duty is applicable **N**

Argymhelliad / Recommendation:

The Committee is asked to note the report.

Ar gyfer penderfyniad /cymeradwyaeth For Decision/ Approval		**Ar gyfer Trafodaeth For Discussion**		**Ar gyfer sicrwydd For Assurance**		**Er gwybodaeth For Information**	✓

Sefyllfa / Situation:

To report in public session on matters previously considered in private session.

Cefndir / Background:

Standing Order 6.5.3 requires the Board to formally report any decisions taken in private session to the next meeting of the Board in public session. This principle is also applied to Committee meetings.

Asesiad / Assessment

The Committee considered the following matters in private session:

5 November 2024

- Section 117 Mental Health Placements
- Board Assurance Framework

Audit Committee – Non-Routine Committee Business Workplan

(1 April 2024 – 31 March 2025)

This forward plan is only to be used for one-off Adhoc items that do not require inclusion as routine business on the Annual Committee Cycle of Business.

Date of Request	Origin of Request	Requestor	Item Summary / Title	Nature of Request	Lead Officer	Executive Lead	Intended Meeting Date	Status
24.10.24	Action AC24/124.3 from Audit Committee	Audit Committee / Pam Wenger	Health Board Policies	• Establish a long term review of the process for reviewing policies and procedures. • A paper has been included on the agenda for the January meeting. • Further work is required on policies once progress has been made against the current policies.	Glesni Driver	Pam Wenger	04.03.25	On Track
24.08.24	Email from Andrea Hughes on 24.08.24	Andrea Hughes	Counter Fraud Policy – was due to Sept meeting but not ready, also not ready for Nov meeting, needs to go to consultation (see email from AH 24.10.24) Latest update from AH 21.11.24 policy won't be ready to go in Jan 25 so put forward for March 25.	• Counter Fraud Policy to go to Committee • Draft Policy in development and being progressed by Head of Counter Fraud.	Danielle Timmins	Russell Caldicott	04.03.25	On Track
08.01.25	Action AC24/151.1 from Audit Committee	Pam Wenger	Review of Centre for Mental Health and Society (CfMHaS) / Report on FOI Request	A full evaluation report to be presented at Audit Committee – this was due to go to Jan meeting but put forward for March meeting as the review will be commissioned externally.	Phil Meakin	Pam Wenger	04.03.25	On Track
05.11.24	Action AC24/167.1	Audit Committee	Section 117 Mental Health Placements (Private agenda)	Present an update paper to the Committee.	Russell Caldicott	Russell Caldicott	04.03.25	On Track
12.09.24	Action from Audit Committee 12.09.24	Audit Committee	Audit Wales Community Pharmacy Data Matching Pilot	Lois Lloyd to provide an update to the Committee	Lois Lloyd	Pam Wenger	16.01.25	**CLOSED** Went to Comm in Jan 25
16.09.24	Action AC24.94.9 from Audit Committee	Audit Committee	Effective Governance – (IHC) Central - Final Internal Audit Report	Update on the impact of the actions being taken to reduce the number of outstanding complaint responses (see email sent to Di Platt 01.10.24) PW suggested adding to agenda under an item – Update on Internal Audit Actions (see email from PW 08.10.24)	Gareth Evans / Di Platt	Gareth Evans	16.01.25	**CLOSED** Went to Comm in Jan 25
24.10.24	Action AC24/124.2 from Audit Committee	Audit Committee / Pam Wenger	Health Board Policies	A summary as to which policies carry the biggest risks (financial, legal compliance, safety etc) and progress being made against them.	Glesni Driver	Pam Wenger	16.01.25	**CLOSED** Went to Comm in Jan 25
29.10.24	Email from Pam re: Action AC24.43.6 from Audit Committee	Pam Wenger	Welsh Risk Pool	Level of exposure costs in terms of WRP payments	Matt Joyes	Pam Wenger	16.01.25	**CLOSED** Went to Comm in Jan 25

05.11.24	Action AC24.154.4 from Audit Committee	Audit Committee	Internal Audit Progress Report	Due to the lack of regular oversight of the Llandudno Hospital Orthopaedic Surgical Hub invite Chris Stockport to join the January 25 meeting (this is also being noted via PFIG)	Pam Wenger	Pam Wenger	16.01.25	**CLOSED** Went to Comm in Jan 25
02.09.24	Action from Audit Committee 18.07.24 Action AC24.95.7	Audit Committee	Session with Board Members to discuss the role and operations of Shared Services	This has been included on the Audit Committee Development Plan	Pam Wenger	Pam Wenger	05.11.24	**CLOSED** This is included on the AC Development Plan
02.09.24	Action from private Audit Committee 21.05.24	Audit Committee	Development session with Board Members on Counter Fraud	This has been included on the Audit Committee Development Plan	Pam Wenger	Pam Wenger	05.11.24	**CLOSED** This is included on the AC Development Plan