# Bundle BCU Audit Committee 19 August 2025

1 09:30 - PRELIMINARY MATTERS

1.1 09:30 - AC25/106 Welcome and Apologies - Verbal (Chair)
*Russell Caldicott (Joanna Garrigan deputising)*
*Stuart Keen (Arwel Hughes & Gareth Griffiths deputising)*
*Denise Roberts*

1.2 09:31 - AC25/107 Declarations of Interest - Verbal (Chair)

1.3 09:32 - AC25/108 Unconfirmed Minutes of Meetings held on 08.05.25 and 24.06.25 - Attached (Chair)
- AC25.108.1 Minutes from Audit Committee 08.05.25 V0.2 Unconfirmed (Public)
- AC25.108.2 Minutes from Audit Committee 24.06.25 V0.2 Unconfirmed (Public)

1.4 09:35 - AC25/109 Matters Arising and Action Log - Attached (Chair)
*The paper attached relating to the Centre for Mental Health and Society relates to action AC24/151.1*
- AC25.109 Summary Action Log Audit Committee (Updated 12.08.25) Public
- AC25.109.1 Audit Report CfMHaS Draft

2 09:45 - GOVERNANCE

2.1 09:45 - AC25/110 Statutory Compliance Report - Paper (Director of Corporate Governance / Head of Statutory Compliance and Inquiries)
- AC25.110 Compliance report 19.08.2025 v1.00
- AC25.110.1 App 1 - IA Open Unsatisfactory v1.00
- AC25.110.2 App 2 - IA Open Limited Assurance v2.00
- AC25.110.3 App 3 IA review - summary table v1.00
- AC25.110.4 App 4 - AW open v1.00
- AC25.110.5 App 5 AW for review - summary table v1.00
- AC25.110.6 App 6 - AW recs for AW AC approval v1.00
- AC25.110.7 App 7 Returned by Audit Wales v0.01
- AC25.110.8 App 8 Overdue high risk policies v1.00

2.2 10:05 - AC25/111 Review of the Standing Orders, Scheme of Reservation and Delegation and Standing Financial Instructions - Paper (Executive Director of Finance / Director of Corporate Governance)
- AC25.111.1 Draft Review of the SORD
- AC25.111.2 Appendix 1 SoRD summary - new Table B v2

2.3 10:20 - AC25/112 Board Assurance Framework - Paper (Director of Corporate Governance)
- AC25.112 Audit Committee Board Assurance Framework August 2025 v2

2.4 10:35 - AC25/113 Fire Safety Annual Performance Report - Paper (Director of Environment and Estates)
*Arwel Hughes & Gareth Griffiths to present this item on behalf of Stuart Keen*
- AC25.113 Fire Annual Report Cover Page
- AC25.113.1 BCUHB Fire Safety - Annual Report 2024-2025

2.6 10:50 - BREAK

3 11:00 - FINANCE

3.1 11:00 - AC25/114 Conformance Report - Paper (Executive Director of Finance)
*Joanna Garrigan to present this item on behalf of Russell Caldicott*
- AC25.114.1 Audit Committee - Conformance Report - Q4 2024-25
- AC25.114.2 Audit Committee - Conformance Report - Q1 2025-26

4 11:15 - INTERNAL AUDIT

4.1 11:15 - AC25/115 Internal Audit Progress Report - Paper (Head of Internal Audit)

*Item to cover the following Internal Audit Reports:*
*Orthopaedic Surgical Hub Llandudno Hospital (Unsatisfactory) Stuart Keen / Russell Caldicott*
*Waiting List Initiative Payments – IHC Centre (Limited) Tehmeena Ajmal*
*Effective Governance - Cancer Services (Limited) Tehmeena Ajmal*
*Effective Governance - IHC East (Limited) Tehmeena Ajmal*
*Performance Management Framework and Reporting (Limited) Stephen Powell*

AC25.115 Internal Audit Progress Report Cover Sheet August 2025 (Final)
AC25.115.1 BCUHB Audit Committee progress report August 2025 (Internal Audit)
AC25.115.2 Internal Audit Report Llandudno - Final BCU-SSU-2425-17
AC25.115.3 BCU-2425-34 Final Internal Audit Report Waiting List Initiative Central IHC Management
AC25.115.4 BCU-2425-31 Final Internal Audit Report_Effective Governance-Cancer Services
AC25.115.5 BCU-2425-30 Final Internal Audit Report - Effective Governance IHC East
AC25.115.6 BCUHB 2425-25 Final Internal Audit Report Performance Management Framework and Reporting

4.2 12:30 - BREAK

5 12:45 - EXTERNAL AUDIT

5.1 12:45 - AC25/116 External Audit Progress Report - Paper (Audit Manager, Audit Wales)

AC25.116 Audit Committee Update (External Audit)

5.2 12:55 - AC25/117 Management Response to Audit Wales Planned Care Report - Paper (Executive Director of Finance)

*Joanna Garrigan to present this item on behalf of Russell Caldicott*

AC25.117 BCUHB Tackling the Planned Care Challenges
AC25.117.1 BCU Planned Care Management Response - approved

6 13:15 - COUNTER FRAUD

6.1 13:15 - AC25/118 Local Counter Fraud Service Q1 Report - Paper (Executive Director of Finance)

AC25.118 PUBLIC - Local Counter Fraud Service Q1 Report 2025-2026
AC25.118.1 PUBLIC - Appendix A – Counter Fraud Progress Dashboard Q1 2526

7 13:25 - FOR INFORMATION

7.1 13:25 - AC25/119 Summary of Business to be Reported from Private - Paper (Head of Corporate Affairs)

AC25.119 Audit Committee (Summary of Business to be Reported from Private)

7.2 13:26 - AC25/120 Corporate Governance Report - Paper (Director of Corporate Governance)

AC25.120 Corporate Governance Report (Cover paper)
AC25.120.1 Cycle of Business for the Audit Committee 2025-26 V0.1
AC25.120.2 Draft Audit Committee Annual Report - 2024-2025 V0.1
AC25.120.3 Workplan for Audit Committee (Live Version as at 12.08.25)

8 13:27 - CLOSING BUSINESS

8.1 13:27 - AC25/121 Agree Items for Referral to Board / Other Committees - Verbal (Chair)

8.2 13:28 - AC25/122 Review of Meeting Effectiveness - Verbal (Chair)

8.3 13:29 - AC25/123 Date of Next Meeting - 21.10.25

8.4 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."*

8.5 13:30 - BREAK

**Betsi Cadwaladr University Health Board (BCUHB)**
**UNCONFIRMED Minutes of the Audit Committee**
**held in Public on 8 May 2025**
**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) |
| Rhian Watcyn Jones | Independent Member |
| Dyfed Jones | Independent Member |
| **In Attendance** | |
| Sreeman Andole | Interim Executive Medical Director *(part meeting)* |
| Russell Caldicott | Executive Director of Finance |
| Nesta Collingridge | Head of Risk Management *(part meeting)* |
| Dave Harries | Head of Internal Audit |
| Fflur Jones | Performance Audit Lead, Audit Wales |
| Nicola Jones | Deputy Head of Internal Audit |
| Stuart Keen | Director of Environment and Estates *(via Teams)* |
| Michelle Phoenix | Financial Audit Manager, Audit Wales |
| Stephen Powell | Director of Performance & Commissioning *(part meeting)* |
| Carol Shillabeer | Chief Executive |
| Danielle Timmins | Head of Counter Fraud (part meeting) |
| Pam Wenger | Director of Corporate Governance |
| Angela Wood | Executive Director of Nursing and Midwifery *(part meeting)* |
| **Committee Support** | |
| Philippa Peake Jones | Head of Corporate Affairs |
| Laura Jones | Acting Corporate Governance Manager |

**PRELIMINARY MATTERS**

**AC25/56 Welcome and Apologies**

The Chair of the Committee welcomed everyone to the meeting and no apologies were received.

**AC25/57 Declarations of Interest**

No declarations of interest were raised at the meeting.

**AC25/58 Unconfirmed Minutes of Meetings held 04.03.25**

In was resolved that the Committee:

- **AGREED** that the minutes of the meeting held on 04.03.25 were a true and accurate record.

**AC25/59 Matters Arising and Action Log**

**Risk Report, Corporate Risk Register and Conformance Report**

- In relation to actions AC25/33.3 and AC25/38.2 it was agreed that these would be closed at the next meeting once the Committee Development Session has taken place on 20.5.25.

**Internal Audit Progress Report**

- There was discussion around action AC25/39.1 relating to ESR and the financial establishment, it was confirmed that the posts are in existence, there is a negative line in the ledger for whole time equivalents and the Team are working to align this to the ESR data. The reconciliation of this issue will be reported via the Conformance Report and it was agreed to close this action and open a new action to monitor progress against the reconciliation.
- There was also discussion around progress in terms of job evaluation, the Director of Corporate Governance agreed to review this and provide an update back to the Committee.
- In relation to action AC24/154.5 regarding fire safety training there was discussion around compliance against mandatory training, it was confirmed that mandatory training is being discussed by the Executive Committee and progress against this should report into the People & Culture Committee. There was also discussion around the gaps that have been identified in relation to fire warden training, the Director of Environment and Estates confirmed that a discussion is due to take place on 02.06.25 with the fire safety holder to discuss duty holders and whether the current systems are fit for purpose. The Director of Environment and Estates will be undertaking a review of the fire safety policy to ensure it is fit for purpose. It was agreed to close the action and open a new action for a paper to come back to the August meeting highlighting a baseline position and the areas that need to be addressed.

**Historical External Audit Recommendations**

- A query was raised in relation to item AC25/08 from the January meeting as to whether the historic recommendations from 2022 have been closed. It was agreed that the Director of Corporate Governance would review and circulate an update outside of the meeting.

**Revised Internal Audit Plan**

- In relation to the follow up review of Falls Management it was confirmed that on site testing continues to take place across the sites, this is due to conclude shortly to allow the review to commence and the outcome will be reported back to the Committee in due course.

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

- There was discussion around action AC25/06.3 and the bank account for the project, it was confirmed by the Director of Environment and Estates that the bank account has now been set up with Natwest and the account details are available if required.

**Actions:**

- **AC25/59.1** Executive Director of Finance to monitor progress against the reconciliation of whole-time equivalents posts and ESR data and report back to the Committee.

- **AC25/59.2** Director of Corporate Governance to assess the progress of the Job Evaluation Process and report back to the Committee.
- **AC25/59.3** Compliance and progress against mandatory training to be reported into the People & Culture Committee and a paper highlighting a baseline position in relation to fire safety including the areas that need to be addressed to be presented to the Audit Committee in August.
- **AC25/59.4** Director of Corporate Governance to review whether the historic recommendations from 2022 have been closed and provide an update outside of the meeting.

The Committee reviewed the action log and agreed to close the following actions, after consideration of the updates and papers presented to the Committee, where required: AC25/33.1, AC25/33.3, AC25/38.1, AC25/38.2, AC25/38.3, AC25/38.4, AC25/40.1, AC25/06.3, AC25/07.1, AC25/10.1, AC24/127.4 and AC24/154.5

## GOVERNANCE

### AC25/60 Update on Outstanding Audit Recommendations

The Executive Director of Nursing and Midwifery gave a presentation and highlighted:

- There are three limited assurance reports which have overdue actions and relate to Falls Management, Lessons Learnt and Deprivation of Liberty Safeguards (DoLS) 2024.
- In relation to Falls Management, the Team are awaiting sign off in one area, there are plans to increase the amount of training being provided and there has been a significant increase to 76.63% in the current mandatory training compliance figures. The Executive Director of Nursing and Midwifery is working closely with the Director of Environment and Estates in terms of addressing the Health and Safety and Manual Handling issues.
- In relation to Lessons Learnt, the majority of the actions have now been put in place, the Team have been awaiting support to complete the last outstanding action to develop the learning repository and this is now due to be completed by 31 June 2025. A range of actions have also been taken to mitigate this risk including the implementation of bi-weekly thematic learning reviews across the Health Board to discuss key themes and lessons learnt with the wider teams.
- In relation to DoLS work has taken place to improve the quality of DoLS assessments. The Executive Director of Nursing and Midwifery is the Executive Lead for Safeguarding across Wales and is working on the Care Inspectorate Wales report relating to DoLS as well as developing an action plan for the Health Board utilising best practice.

In discussing the report, the Committee:

- Queried whether the lessons learnt are recurring or whether they are being embedded to provide sustained improvements. It was confirmed that there is a corporate risk based around lessons learnt, the repository will enable more agile and consistent working in this area and provide an extra level of assurance.
- Referred to the revised DoLS form that has been developed and it was confirmed that this is being trialled as part of the All-Wales work and provides a vast improvement in the quality of information being captured.

It was resolved that the Committee:

- **NOTED** the presentation.

**AC25/61 Update on External and Internal Recommendations**

Members received the report and noted the progress made to date; the Director of Corporate Governance highlighted:

- Appendix 1 contains a summary of the recommendations with rationale for closure, these have been signed off by the Executive Committee and will now go to Internal Audit colleagues for final approval. Progress is being made in this area and Internal Audit are monitoring this closely to ensure recommendations are not being closed prematurely.
- Appendix 2 contains a summary of all open 'unsatisfactory assurance' recommendations, some of these relate to the operating model and are being aligned to the foundation for the future programme and will remain open until further progress has been made.
- Appendix 3 highlighted progress against open 'limited assurance' recommendations which include Consultant Job Planning as an additional review requested by the Chief Executive.
- Appendix 4 contains all Internal Audit recommendations for the Committee to consider closing, these have been signed off and recommended for closure by Internal Audit.
- Appendix 5 highlights External Audit recommendations for Audit Wales and the Committee to consider closing. These relate to the Structured Assessment and the Review of Board Effectiveness; some are suggested as outstanding and additional evidence has been shared with Audit Wales.

In discussing the report, the Committee:

- Agreed that sufficient evidence has been provided for those Internal Audit recommendations proposed for closure.
- Highlighted that there has been a recent change in Internal Audit reporting where the Team are highlighting the required evidence when producing the management action to ensure Teams are aware of the requirements.
- Confirmed that the Internal Audit video has now been finalised and provides advice to staff in relation to the information required.
- Stated the need to identify the level of appropriate scrutiny by Executive Directors to ensure they are held accountable and also limit the amount of time spent following up on responses.
- Queried whether there is an escalation path in place as well as guidance to assist the production of high-quality reports. It was confirmed that the Teams do have access to the Chair and Director of Corporate Governance in terms of escalation and the Internal Audit video now provides information on 'what does good look like', this will be monitored as we move forward and evaluated as part of the wider governance hub.
- Queried the figures highlighted in the table in section 3.2.2 of the report "Limited Assurance Recommendations" and requested that this be updated to include the overall number of recommendations.
- Stated that Internal Audit are in the process of procuring software which has an escalation process and automated reminders embedded. This will allow a system for Executive Directors to use for review, will involve less manual work and will impact efficiency significantly.
- Queried whether Internal Audit reports can be shared via email, it was confirmed that these are published on the IMs Teams Channel however this process will be reviewed.

- Suggested that the External Audit recommendations remain open and come back to the next meeting, potentially in private session, for further discussion.

**Action:**

- **AC25/61.1** External Audit recommendations to remain open and come back to the next meeting, potentially in private session, for further discussion.
- **AC25/61.2** Update the limited assurance recommendations table to include the overall number of recommendations for future reports.

It was resolved that the Committee:

- **NOTED** the current position with regards to open recommendations, those proposed for closure, and 'unsatisfactory' and 'limited' assurance recommendations.
- **APPROVED** the Internal Audit recommendations outside the scope of the Internal Audit Charter put forward for Audit Committee closure approval.
- **AGREED** the External Audit recommendations would remain open and come back to the next Audit Committee.

**AC25/62 Risk Impact of Overdue Policies**

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

- The paper refers to a previous action to provide an update on the risk of overdue policies and the report has been reviewed by the Executive Committee.
- The Team are working to address the impact on clinical risk and the policy process is being reviewed and revised.

In discussing the update, the Committee:

- Stated that the request from the Committee was to review the policies with the highest risk and queried whether there are any risks in terms of compliance. It was confirmed that Executive Directors are being invited to provide updates to the Committee on their open audit recommendations which provides a review of progress.
- Confirmed that further work is required to refine the process and provide clear definitions in terms of a policy and a procedure.
- Requested a tracker is developed to monitor progress in terms of target completion dates and suggested the tracker could also be shared with other Committees.
- Stated that the IMTP refers to a governance hub and toolkit and the Internal Audit process will form part of this suite of information which is being developed.
- It was confirmed that an update on progress will come back to the next meeting.

**Action:**

- **AC25/62.1** Update on progress of the overdue policy process to come back to the next meeting with deadline / completion targets to be included.

It was resolved that the Committee:

- **NOTED** the position on all overdue policies.
- **NOTED** the risk impact of the current overdue policies.
- **NOTED** the proposals around reviewing overdue policies.
- **NOTED** the request for update information in relation to three outstanding policies. **AGREED** areas of escalation by Executive Directors.

**AC25/63 Internal Audit Explainer Video and Communication Plan**

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

- The revised Internal Audit video has been shared with the Committee along with the Internal Audit Reports via the IMs Teams Channel.
- The Communication Plan is being developed as part of a wider Plan to ensure good governance is being provided across the organisation and the progress will be evaluated by the Team.

In discussing the update, the Committee:

- Queried whether this information could form part of the induction programme for new managers, it was confirmed that the Director of Corporate Governance would discuss this further with the Director of People Services.

**Action:**

- **AC25/63.1** Director of Corporate Governance to discuss with the Director of People Services whether the Internal Audit video could be included as part of the induction programme for new managers.

It was resolved that the Committee:

- **NOTED** the Internal Audit explainer video presentation that has been developed.
- **AGREED** the communication plan detailed within this paper.

**AC25/64 Corporate Risk Register and Board Assurance Framework**

Members received the report and the Head of Risk Management highlighted:

- The Corporate Risk Register is being presented to the Committee to provide assurance.
- Updates are provided on the target date extensions that have been amended and noted by the Executive Committee.
- The target date for the Urgent and Emergency Care risk has been extended, this has been discussed with the Risk Lead and reviewed by the Risk Scrutiny Group and the Quality, Safety and Experience Committee.
- The revised target date relating to the Operational Planning for Transmittable Diseases and Outbreaks risk has been challenged by the Planning, Population Health and Partnership Committee due to the external factors that impact this risk.
- In relation to the extended target date for the Oncology Services risk, this has been requested due to the action plan recently being developed and refined.
- A new risk has been opened to focus on Neurodevelopment Waiting List, this will report into the Quality, Safety and Experience Committee and Audit Wales are supporting the Team with this risk.
- Another new risk has also been opened to focus on External Recommendations and Response plans which will sit under the remit of the Audit Committee.
- In terms of overdue actions, the rationalisation plan is progressing and the amendments have been discussed and challenged by the Committees.
- In relation to the Board Assurance Framework this has been reviewed in terms of the level of assurance for all Committees and further work is required.

- The document has been discussed by the Risk Scrutiny Group and Executive Committee and agreed that all ratings are suggested as limited assurance and this will go to the Board in May 2025.

In discussing the update, the Committee:

- Queried whether the Audit Committee are able to own a risk as the Committee are required to provide an overview of risk management. It was acknowledged that assurance is being provided against a system of internal risks and it was agreed that a paper would come back to the Committee setting out the arrangements.
- Confirmed that the Executive Committee will be reviewing the Corporate Risk Register in detail to ascertain whether the appropriate actions are being provided against the correct risks.
- Discussed the timescales, actions and further information required in relation to some of the specific risks. It was confirmed that further work is required to provide further clarity in some areas.
- Confirmed that all actions due in March have now been completed apart from the risk relating to fragmented care records.
- Stated that an update on the Corporate Risk Register will be included in the Corporate Governance Report to the Board and the Committees will review the scores in due course to align these with the IMTP.
- It was agreed that a deep dive should be undertaken in relation to risks CRR21-22 Orthodontic Services and CRR24-25 Dermatology and Plastic Surgery Services.
- It was noted that in a number of risks that the additional controls required were statements rather than controls.
- Congratulated the Team on the work completed to date and the aim to continue to make improvements in this area.

**Action:**

- **AC25/64.1** A paper to be presented to the Committee setting out the arrangements for managing the risk relating to External Recommendations and Response plans.
- **AC25/64.2** A deep dive to take place in relation to risks CRR21-22 Orthodontic Services and CRR24-25 Dermatology and Plastic Surgery Services.

It was resolved that the Committee:

- **AGREED** the new risks CRR24-27 – Neurodevelopment Waiting List and CRR24-28 External Recommendations and Response plans.
- **NOTED** the Corporate Risk Register as reported to Risk Scrutiny Group Mar 25*

**AC25/65 Breaches to the Standing Orders**

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

- The report relates to the publication and compliance in relation to any breaches of the Standing Orders.
- Progress has been made but there are some areas of challenge, improvements are required in terms of the Annual Governance Statement and the Team are working to become more transparent with the reporting arrangements.

In discussing the update, the Committee:

- Queried the reporting mechanism as the list of breaches did not appear to be comprehensive. It was confirmed that the Team will review the anomalies and noted that the organisation has been in a challenging position.
- Confirmed that an intervention order was in place which allowed a revision to the compliance and timescales which allowed papers to be published five days in advance which included weekends. It was agreed that this would be reviewed and confirmed with the Committee.
- Requested that the Executive Directors lead by example and ensure papers are available on time.

**Action:**

- **AC25/65.1** Review the anomalies in relation to the list of breaches reported and confirm the reporting arrangements in terms of publishing papers.

It was resolved that the Committee:

- **NOTED** the breaches paper.

**AC25/66 Declarations of Interest and Gifts & Hospitality Report**

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

- An Internal Audit review has previously taken place to review this area of work and provided limited assurance. A follow up review has taken place and is being finalised, progress has been made however further work is required to enhance standards of practice.
- The work due to be completed will include re-establishing levels of assurance with support from Internal Audit, amending the monitoring process and reviewing the methods used by other Health Boards.

In discussing the update, the Committee:

- Agreed the need to reinform the appropriate gifts and hospitality the Health Board is willing to accept and monitor this more closely.

It was resolved that the Committee:

- **RECEIVED** assurance on the progress in the compliance with the Standards of Business Conduct Policy noting there will be further improvements to be completed during 2025/26.
- **NOTED** the update against the Internal Audit Limited Assurance Report.
- **NOTED** that improvement has taken place over the past year that Declarations of Interests and Gifts and Hospitality are being reviewed and monitored within the Health Board and that the new monitoring system functioning
- **AGREED** the changes to the monitoring arrangements as set out in the Policy.

**AC25/67 Welsh Health Circulars and Ministerial Directions**

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

- The Welsh Health Circulars and Ministerial Directions follow a process of reporting via the Annual Accountability Report.
- There is a legal obligation to implement Ministerial Directions, this is being collated as part of the improvement plans and a compliance report will be developed.

In discussing the update, the Committee:

- Suggested further information is required around recommendations and actions to provide assurance and suggested this could form part of the system being developed to form the governance hub.
- Queried why, in relation to some WHCs requiring immediate action, the actions were only partially complete for example WHC/2024/038 and WHC/2024/040 (plus others) and requested an update at the next meeting.
- Stated that there may be a Ministerial Directions from 2022 regarding prioritising children for surgery that the Health Board are not following. Urtha Felda agreed to share the detail with the Director of Corporate Governance outside of the meeting.

**Action:**

- **AC25/67.1** Urtha Felda to share the detail of the Ministerial Directions regarding prioritising children for surgery with the Director of Corporate Governance outside of the meeting.
- **AC25/67.2** Update on incomplete WHCs requiring immediate action at the next or a future meeting.

It was resolved that the Committee:

- **NOTED** the current position regarding WHCs and MHDs received from 1st September 2024 to 31st March 2025.

**AC25/68 Audit Committee Self Assessment**

It was agreed that this would be presented to the Audit Committee Development Session being held on 20 May 2025.

**AC25/89 Response to Audit Enquiries Letter**

Members received the report and the Executive Director of Finance highlighted:

- There is a requirement for the Health Board to complete a response to a series of questions from Internal Audit, some of which relate to the accounts and commentary is required from the Chair of the Committee.
- This is a standard document that is produced on an annual basis.
- The document has been completed ahead of schedule this year and is being shared with the Committee to note and endorse.
- The Chair concurred with the management response and thanked the Team for the prompt completion.

It was resolved that the Committee:

- **NOTED** and **ENDORSED** the response to the Audit Enquiries Letter.

**INTERNAL AUDIT**

**AC25/69 Internal Audit Progress Report**

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

- There have been issues of compliance relating to policies and procedures.
- Two of the finalised reviews have been issued as reasonable assurance.
- Opportunities for improvement have been identified to provide further controls going forward.
- An additional review of 'Contract management and procurement review – Digital, Data and Technology Directorate 'has been included in the 2025/26 Internal Audit Plan.
- A follow up review of the Contracted Patient Services – Quality and Safety arrangements has been agreed due to lack of progress made in relation to the agreed actions when the initial review took place in August 2023.

In discussing the update, the Committee:

- Acknowledged the Contracted Patient Services review and the Director of Performance and Commissioning committed to action the review within Quarter 1 of the financial year.
- Confirmed that meetings have commenced with a range of external providers, supply services and internal quality teams to ensure the quality issues are addressed and confirmed that the Quality, Safety and Experience Committee will have an additional focus on quality and commissioning. It was requested that progress against this review is reported back to the August meeting.
- Referred to the approval process of contracts and highlighted the challenge involved in managing the quality aspect of contracts with partner organisations, this is an area that needs to be addressed by the operational teams.
- Noted the contract award stating that documents relating to the levels of commissioning have had full visibility through the Executive Committee.
- Highlighted that the budget has been endorsed by the Health Board, the movement has been less than 10% therefore this did not need to go back to the Board but has been to the Executive Committee for assurance.
- Stated that there has been a difference of opinion in terms of the Scheme of Reservation and Delegation and it was agreed that the Executive Director of Finance and Head of Internal Audit would discuss this further outside of the meeting to align the process and gain clarity on the narrative.
- Referred to the reports and reviews that are currently work in progress highlighting the timelines for completion and also stated that only 45% of follow up reviews have been fully closed during 2024/25. It was agreed that there have been some improvements however there is a need to focus on increasing the follow up response rates.

**Action:**

- **AC25/69.1** Director of Performance and Commissioning to report on the progress of the follow up on the Contracted Patient Services – Quality and Safety arrangements at the August meeting.
- **AC25/69.2** Executive Director of Finance and Head of Internal Audit to meet and discuss the Scheme of Reservation and Delegation further to align the process and gain clarity on the narrative.

It was resolved that the Committee:

- **RECEIVED** the progress report.

*Stephen Powell left the meeting*

**AC25/70 Final Internal Audit Reports**

Members received the reports and the Interim Executive Medical Director provided an update in relation to the Clinical Audit Report highlighting:

- The review focussed on areas such as services within the Health Board that are working well and are compliant, culture across the organisation and the learning gained from unsatisfactory areas of work.
- There have been three tiers of audits and there is compliance against 24 out of the 27 audits. The lack of repository resulted in limited assurance as the audits do not align and this is being addressed.
- A Clinical Audit Delivery Plan is being developed to start to deliver improvements in this area.

In discussing the reports, the Committee:

- Queried what the key barriers are, it was noted that there is no pan BCU structure in place, there is a lack of resource and difficulty in evidencing areas of good practice. There is a need to ensure a repository is in place for people to access and provide oversight.
- Discussed whether clinicians should be completing clinical audits as part of their sessional work. It was confirmed that data should be implemented at a clinical level and clinical audits should be discussed during the clinical governance meetings however this is not being documented routinely.
- Stated that the Audit also relates to clinical nurses as well as doctors and suggested a similar process and methodology is followed that has been adopted for inquests and complaints.
- Raised concerns around assurance in terms of the quality of services and suggested this is discuss in more detail with the Director of Performance and Commissioning in terms of key performance metrics.
- Agreed that this is referred to the Quality, Safety and Experience Committee to ensure a robust Clinical Audit Plan for the Health Board is in place and this comes back to the Committee in due course to approve the Clinical Audit Plan and receive assurance as we track and monitor progress going forward.

**Action:**

- **AC25/70.1** Interim Executive Medical Director to take the Clinical Audit Plan to the QSE Committee and bring this back to the Committee in due course to approve the Clinical Audit Plan and receive assurance on progress.

It was resolved that the Committee:

- **RECEIVED** the final internal audit reports.

**EXTERNAL AUDIT**

**AC25/71 External Audit Progress Report**

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

- The Audit started earlier than planned this year and the Charity Accounts have now been signed off.
- Engagement with the teams has been very positive and followed a transparent process.

- The Remuneration report has been shared with Audit colleagues, the working papers and detail relating to salaries has been to the Remuneration Committee and the formal deadline is 9 May 2025.
- In relation to the Performance audit work it was confirmed that work continues to draft the reports relating to Urgent and Emergency Care, Planned Care and Use of the Strategic Financial Assistance.
- Fieldwork relating to a deep dive into the Digital Systems as part of the Structured Assessment has commenced and a deep dive into Estates will take place later in the year.
- The publication of the Cancer Services in Wales report and Lessons from our work under the Well-being of Future Generations Act have been shared for information.

In discussing the report, the Committee:

- Queried whether the Cancer Services in Wales report is an All-Wales review. It was confirmed that it was and is being shared with the Committee to allow members to be sighted on the All Wales response. This will be reviewed at a Health Board level later in the year.

It was resolved that the Committee:

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

**AC25/72 Audit Wales Review on Cancer Services in Wales**

This item was discussed as part of item AC25/71 External Audit Progress Report

**COUNTER FRAUD**

**AC25/73 Local Counter Fraud Service Q4 Report 2024/25**

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

- There has been a positive response to the Annual Counter Fraud Staff Survey, people are aware of the standard of business conduct and the policies that are in place however the number of responses was low.
- The staff survey is published on BetsiNet however it is difficult to get staff engaged as this is in addition to the Health Board staff survey therefore further work is required to increase the numbers and potentially link in with the wider staff survey.
- The Counter Fraud Functional Standard Return and Annual Report has seen a vast improvement with the submission receiving an overall green rating. There is one outstanding red action however there is a plan in place to address this.
- A draft report has been received following the engagement visit from the NHS Counter Fraud Authority, the report was positive and only included three recommendations. This will come back to the next meeting and will be included on the action tracker.

In discussing the report, the Committee:

- Referred to the amber and red rating in the Counter Fraud Functional Standard Return and queried how these move to a green rating. It was confirmed that the document reflects an honest indication, there are areas of improvement however the Team now have a more positive approach and plan going forward.

- Stated that the Counter Fraud Functional Standard Return will be discussed as part of the private Audit Committee being held on 20 May 2025.
- Wished Graham Jones well, and thanked him for his service and the work undertaken as part of the Counter Fraud team, ahead of his retirement.

**Action:**

- **AC25/73.1** Draft report following the engagement visit from the NHS Counter Fraud Authority to come back to the next meeting.

It was resolved that the Committee:

- **CONSIDERED** and **NOTED** the contents of the update report.

**FOR INFORMATION**

**AC25/74 Summary of Business to be Reported from Private**

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

**AC25/75 Committee Forward Workplan**

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

**CLOSING BUSINESS**

**AC25/76 Agree Items for Referral to Board / Other Committees**

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

**AC25/77 Review of Meeting Effectiveness**

In discussing the item, the Committee:

- Noted the full agenda however there were many important items included that required discussion and it was felt sufficient time had been allocated accordingly
- The conversation and challenge was positive and provided assurance in most areas.
- Acknowledged that it is helpful to have wider Executive Directors present for specific items to provide assurance.

**AC25/78 Date of Next Meeting**

Tuesday 24 June 2025, 9.30-12.30pm

**Resolution to Exclude the Press and Public**

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

**Betsi Cadwaladr University Health Board (BCUHB)**
**UNCONFIRMED Minutes of the Audit Committee**
**held in Private on 24 June 2025**
**in the Boardroom, Carlton Court, St Asaph and via Team**

| **Committee Members Present** | |
|---|---|
| **Name** | **Title** |
| Karen Balmer | Independent Member (Chair of Audit Committee – via Teams) |
| Urtha Felda | Independent Member (Vice Chair of Audit Committee) |
| Dyfed Jones | Independent Member |
| Rhian Watcyn Jones | Independent Member *(via Teams)* |
| **In Attendance** | |
| Tehmeena Ajmal | Chief Operating Officer *(via Teams)* |
| Russell Caldicott | Executive Director of Finance |
| Andrew Doughton | Performance Audit Manager, Audit Wales |
| Dyfed Edwards | Chair of the Health Board |
| Dave Harries | Head of Internal Audit |
| Nicola Jones | Deputy Head of Internal Audit |
| Stuart Keen | Director of Environment & Estates *(via Teams)* |
| Michelle Phoenix | Financial Audit Manager, Audit Wales |
| Denise Roberts | Head of Capital |
| Carol Shillabeer | Chief Executive |
| Danielle Timmins | Head of Counter Fraud |
| Simon Weaver | Head of Financial Control |
| Pam Wenger | Director of Corporate Governance |
| **Committee Support** | |
| Philippa Peake Jones | Head of Corporate Affairs |
| Laura Jones | Acting Corporate Governance Manager |

**PRELIMINARY MATTERS**

**AC25/98 Welcome and Apologies**

Apologies were received for Sreeman Andole.

Urtha Felda as Vice Chair of the Audit Committee chaired the meeting on behalf of Karen Balmer.

**AC25/99 Declarations of Interest**

No declarations of interest were raised at the meeting.

The Director of Corporate Governance referred to the External Audit Report and highlighted reference to the contract related to the Director of Corporate Governance role within the report.

**ANNUAL REPORT**

**AC25/100 Annual Financial Statements 2024/2025**

Members received the report and the Executive Director of Finance highlighted:

- The accounts submitted in draft have previously been shared with the Audit Committee and have been attached as an appendix.
- The outturn for the year from the draft to the final position remains consistent however some adjustments have been made through the ISA 260.
- The Annual Accounts will receive an unqualified true and fair opinion.
- Two unadjusted statements have been identified related to capital assets in terms of the Health Board's profiled expenditure close to year end and evidence to support the receipt of capital equipment.
- A contractual payment has been identified and discussions have taken place in relation to the reporting element, it was confirmed that the Health Board will report this as an asset under construction.
- Materiality has been set as 1% of the gross expenditure and the Health Board achieved 99.9% accuracy in relation to transactions.
- Significant progress has been made in relation to the Remuneration Report and it was noted that this is a key component in the ISA 260.
- The accounts will receive a qualified regulatory opinion as the Health Board did not achieve its first financial duty to break-even over the period 2022-23 to 2024-25.
- The Health Board have set a balanced Integrated Medium Term Plan which will contribute to the aim of reaching a break-even position as we move forward.
- There has been an improved position in terms of resource allocation and the Health Board will receive recurrent conditional resource for the next two years.
- The teams were thanked for their engagement and open relationships to reach this position.

In discussing the report, the Committee:

- Queried the issue relating to goods received, it was stated that managers are either not retaining the delivery notes or the systems being used are moving towards a digital platform. It was confirmed that this is being reviewed to ensure improved processes are developed in this area.
- Highlighted the significant amount of spend during the end of the financial year and queried whether any of the spend is being apportioned into the next financial year. It was confirmed that testing has been completed and assurance was provided that the assets have been received. The team will provide the required evidence to support the receipt and accounting for capital equipment and goods in the 2024/25 financial year to Audit Wales and this process will be refined and improved going forward. It was also noted that late allocations were received and this has been highlighted with Welsh Government to provide more oversight on resource allocation in the future.
- Noted the Letter of Representation that is required to be signed by the Chair and Chief Executive highlighting that the letter contains narrative to support the issues discussed and refers to working with Audit Wales colleagues to strengthen internal procedures during 2025/26. It was agreed that the Letter of Representation would be shared with Audit Committee members for information.

- Thanked the team for the progress made and stated the importance of building on the improvement journey and taking time to reflect on the process and the wider learning attained. It was confirmed that the learning will identify areas of focus, similar sessions have previously taken place with Audit colleagues and a mapping tool will be created going forward.
- Referred to the use of pooled budgets, it was confirmed that a legal framework is in place, resources can be combined however there is a need to move away from contractual arrangements. The team are reviewing the legal framework and this is an area that requires further detailed review. It was agreed that pooled budgets and partnerships should be discussed further by the Planning, Population Health and Partnerships Committee.
- Highlighted the issue relating to the capital payment made to Scottish Power, it was confirmed that the opinion shared by Audit Wales was that the payment should have been accounted for during 2025/26. The Executive Director of Finance confirmed that as the Health Board are contracted to make the payment to Scottish Power it was deemed as an asset under construction rather than a prepayment, it has been agreed that this is noted as a non-material adjustment. The Chair of the Audit Committee agreed that this was not a finished good and has been accounted for correctly.
- Acknowledged the progress made over the past two years, the receipt of an unqualified true and fair opinion for the second year running and the approval of a balanced Integrated Medium-Term Plan. All the teams involved were thanked for their hard work in reaching this position.

**Actions:**

- **AC25/100.1** Share a copy of the Letter of Representation with Committee members.
- **AC25/100.2** It was agreed that pooled budgets and partnerships should be discussed further by the Planning, Population Health and Partnerships Committee.

It was resolved that the Committee:

- **RECOMMENDED ADOPTION** of the 2024-25 Annual Accounts to the Health Board following consideration of Audit Wales findings on their review of the Financial Statements.

**AC25/101 Annual Report 2024/2025**

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

- The report demonstrates an improvement in the level and flow of information being provided. The Remuneration Report provides an element of transparency and the Annual Report provides an accumulation of performance analysis, the Annual Governance Statement and the accounts.
- The key highlights include receiving a true and fair opinion which has been validated by Internal and External Audit including progress in terms of grip and control relating to Audit recommendations to provide assurance to the Committee.
- There has been progress in relation to the management of risks and board assurance noting that the Health Board have recently been shortlisted for the Risk Management Awards.

- An assessment has been completed against the Corporate Governance Code and self-assessments are being completed at both Board and Committee levels.
- A number of breaches relating to the Standing Orders and Standing Financial Instructions have been reported to the Audit Committee and work is taking place with the Finance team to refine the processes and strengthen governance arrangements.
- The structured assessment, although not reasonable, provides a number of positive assurances and is important for the Board and Committees to recognise the narrative in terms of the progress made.

In discussing the report, the Committee:

- Recognised that focus has been required in relation to strengthening internal controls, the Corporate Governance Directorate are able to demonstrate progress in this area and there is a need to continue to build on the foundations developed for the organisation.
- Stated that the Annual Report provides an overview to the public of the position in terms of performance, the Health Board are aware of the operational issues and the improvements required by the Health Board. It was noted that the areas of focus are set out across five strategic objectives within the Integrated Medium Term Plan which includes delivery of services to the population of North Wales. Significant progress has been made, foundations are being established and the aim going forward is to ensure the organisation becomes more effective and considerably improves performance by moving towards an efficient and sustainable model of care.
- Suggested that the narrative within the introduction of the Annual Report highlights the improvements made to date and the aims of the organisation going forward to ensure the population of North Wales are able to understand the improvement journey of the Health Board. It was agreed that this would be reviewed and the Chief Executive would provide a verbal narrative during the Board meeting.
- Queried whether a user-friendly version is being developed to share the key messages with staff, it was confirmed that the Communications team are producing a user-friendly annual review and this will be launched at the Annual General Meeting and shared with the Committee in advance.

It was resolved that the Committee:

- **RECEIVED** and **CONSIDERED** the Annual Report 2024-25, Part 1 and 2 and the Annual Governance Statement.
- **RECOMMENDED** to Board at its meeting on 26 June 2025 the approval and signature of the Annual Report and Financial Accounts for year ended 31st March 2025.
- **NOTED** that the components parts of the annual report will be merged together and a further page reference and proof check completed prior to submission.

**INTERNAL AUDIT**

**AC25/102 Head of Internal Audit Opinion & Annual Report 2024/2025**

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

- This will be the last report issued under the Public Sector Internal Audit Standards as there will be a move to the new standards from 1 April 2025.
- Twenty-Eight reports have been issued during 2024/25 with fifteen receiving reasonable assurance and seven receiving limited assurance. There were two reports that received unsatisfactory assurance and these were related to Consultant Job Planning and the Orthopaedic Surgical Hub Llandudno Hospital.
- Four follow up reviews were undertaken however an opinion does not get issued in relation to follow ups and these are listed as advisory. It was noted that one report had been issued without an opinion as there had been an issue in relation to receiving the required evidence and the planned review on the Civil Contingencies Act had been deferred.
- The key points taken into consideration when developing the Opinion were highlighted and included evidenced improvement in the system of internal control and risk management. It was noted that there is a need to ensure these improvements are embedded and sustained within the relevant areas.
- In relation to the unsatisfactory assurance assigned to the Llandudno Hospital Orthopaedic Hub, it was noted that critical matters within the gateway review had not been addressed and some significant issues had been identified.
- As part of the follow up reviews, one hundred and forty-five executive approved recommendations and actions were reviewed for closure however 55% were returned due to insufficient evidence provided.
- A penalty was incurred by the Health Board in relation to the Health and Safety at work Act and a Public Services Ombudsman for Wales report was published relating to the findings linked to the 2022/23 review on Contracted Patient Services: Quality and Safety arrangements.
- It was concluded that the Health Board is progressing well however challenges remain in embedding systems of internal control.

In discussing the report, the Committee:

- Queried how the organisation can improve and maintain the need to embed actions, it was confirmed that sustaining improvement is a key marker for the Health Board to ensure progress and performance are maintained.
- Discussed the review based on commissioning, it was confirmed that the follow up review on Contracted Patient Services: Quality and Safety was received by the Committee and the outputs from the review will be dealt with by the Quality, Safety & Experience Committee. Work is also taking place to collate a baseline position in terms of commissioning and incorporate this within the Integrated Performance Framework.
- Referred to the issue raised in relation to providing evidence, this issue has been addressed and it was confirmed that relevant information will be shared in future.
- Thanked the Internal Audit team for all the hard work and levels of engagement, this was reciprocated to the teams within the Health Board.

It was resolved that the Committee:

- **NOTED** and **RECEIVED** the Head of Internal Audit opinion and annual report for 2024/25 and associated Briefing Paper detailing the rationale for the 2024/25 Opinion.

## EXTERNAL AUDIT

**AC25/103 ISA 260 Audit of Financial Statements**

Members received the update and the Financial Audit Manager, Audit Wales highlighted:

- The outcome provides an unqualified true and fair opinion on the accounts with an adjustment agreed.
- There have been notable improvements in governance arrangements however an issue had been identified with the contract of employment for the Director of Governance, this has now been rectified.
- The declarations of interest process has been identified as an area of inconsistency in the way Board Members submit declarations, this issue has been discussed and it has been agreed that there is a need to review the current process.
- An issue was highlighted in relation to evidence to support the receipt of capital equipment, this has been discussed by the Committee and will be addressed.
- As part of the review of pharmacy expenditure, the pharmacy journals caused concern in terms of the complexity and time required to audit this area of work. The Finance team are aware of the issue and will work to streamline the process.
- Thanks were extended to all the teams for working well together and providing a more efficient process than in previous years.

In discussing the report, the Committee:

- Acknowledged the issue relating to the declarations of interest process stating this is a priority area going forward.
- Thanked the teams for all the work completed in this area.

It was resolved that the Committee:

- **NOTED** and **RECEIVED** the Audit Wales findings on the review of the Financial Statements.

Following discussion of items AC25/100 through to AC25/103 the Audit Committee accepted the recommendations and noted that the final comments would be reflected in the Annual Accounts.

Subject to the above, the Audit Committee approved the Annual Report and Accounts for 2024/25 for onward approval by the Board.

## COUNTER FRAUD

**AC25/104 Local Counter Fraud Annual Report 2024/2025**

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

- The appendices to the report are determined by the Local Counter Fraud Standards.
- There has been a lack of proactive work conducted during the financial year due to staffing shortages, moving forward the team aim to meet the duty to undertaken proactive work.
- In relation to reactive work, there have been issues with governance and management of investigations, improvements have been made however further work is required in this area.

- A full review of staffing levels within the team is being conducted to ensure there are no risks related to resource.
- The Local Counter Fraud, Bribery and Corruption Policy was approved in March 2025 which includes the forthcoming legislation relating to "Failure to Prevent Fraud" which is due to be operational by September 2025.
- An Audit Committee Development Session was held in February 2025 providing information to the Committee on areas including duty and legislation.
- The Counter Fraud Functional Standards Return for 2024/25 received an overall 'Green' rating and going forward the team will focus on areas including prevention and culture.

In discussing the report, the Committee:

- Queried how the resource within the team compares to other Health Boards. It was confirmed that, in terms of budget the figures are low and the staffing review being completed will potentially highlight that additional resource is required.
- Referred to the nine risks listed on the Corporate Risk Register relating to Counter Fraud and the need to identify appropriate risk owners. It was confirmed that work is taking place to score the risks and assess appropriate risk owners.
- Confirmed that Counter Fraud links to the systems of internal control, there is a need to prioritise key areas, ensure staff throughout the organisation have an understanding of bribery and corruption and identify areas of Counter Fraud that require action.
- Suggested the need to be proactive in raising awareness of Counter Fraud and ensuring new employees are educated around processes and policies.
- Thanked the team for all the hard work completed.

It was resolved that the Committee:

- **NOTED** the need to track progress of the annual workplan through progress reports by the Head of Local Counter Fraud.
- **NOTED** that an action plan will be created by the Head of Local Counter Fraud for the implementation of recommendations made in the NHSCFA Engagement Visit report and the action plan will be monitored by the Committee until implemented.
- **NOTED** that the Head of Local Counter Fraud will review the Counter Fraud resource alongside the Executive Director of Finance as per Audit Wales recommendation from September 2020.

**CLOSING BUSINESS**

**AC25/105 Date of Next Meeting**

Tuesday 19 August 2025, 9.30-2pm

# Audit Committee Action Log (Public)

**Updated 12.08.25**

| Open Actions | | | | | | |
|---|---|---|---|---|---|---|
| **Action No.** | **Minute Ref.** | **Date** | **Agreed Action** | **Lead** | **Timescale** | **Status** |
| | | | **REMAIN OPEN** | | | |
| **1** | **AC25/64.1** | 08.05.25 | **Corporate Risk Register and Board Assurance Framework**<br>A paper to be presented to the Committee setting out the arrangements for managing the risks relating to External Recommendations and Response plans. | Pam Wenger<br>Nesta Collingridge | October 25 | **Remain Open**<br>**07.07.25** Risk Appetite Session with the Board is scheduled for August 25. The Corporate Governance Directorate and the Executive Team have reviewed the risk relating to this and it is being de-escalated from the Corporate Risk Register due to plans in place to monitor external recommendations from various Committees. The Committee is asked to confirm if any further assurances are required at this stage. |
| **2** | **AC25/64.2** | 08.05.25 | **Corporate Risk Register and Board Assurance Framework**<br>A deep dive to take place in relation to risks CRR21-22 Orthodontic Services and CRR24-25 Dermatology and Plastic Surgery Services. | Pam Wenger<br>Nesta Collingridge | October 25 | **Remain Open**<br>**07.07.25** This has been scheduled for the QSE Committee in September 25 and will be reported back to the Audit Committee. |
| **3** | **AC25/67.2** | 08.05.25 | **Welsh Health Circulars and Ministerial Directions**<br>Update on incomplete WHCs | Pam Wenger<br>Glesni Driver | October 25 | **Remain Open**<br>**01.07.25** Work is taking place and this will be presented to a future |

| | | | | | | |
|---|---|---|---|---|---|---|
| | | | requiring immediate action at the next or a future meeting. | | | meeting of the Committee. WHCs now form part of the Compliance Report which is included on the agenda for the August 25 meeting. |
| **4** | **AC25/70.1** | 08.05.25 | **Final Internal Audit Reports (Clinical Audit Report)**<br>Interim Executive Medical Director to take the Clinical Audit Plan to the QSE Committee and bring this back to the Committee in due course to approve the Clinical Audit Plan and receive assurance on progress. | Sree Andole<br>Angela Wood | October 25 | **Remain Open**<br>**07.07.25** The Clinical Audit Plan was received by the QSE Committee in July, further work is required and this will be received by the Audit Committee in October 25. |
| **5** | **AC25/32.1** | 04.03.25 | **Information Governance and Records Management Position**<br>The Executive Committee to take some time to consider the matter, identify best practice, clarify that the risk is logged and bring the item back to the Committee. | Pam Wenger<br>Dylan Roberts | October 25 | **Remain Open**<br>**29.07.25** A session on records management to take place with the Executive Committee and this will be included on the agenda for a more substantive item at the next meeting.<br>**19.03.25** Dylan Roberts to discuss with Carol Shillabeer and agree how the corporate records management function will be resourced. A paper will be presented to the Executive Committee and come back to a future meeting of the Audit Committee. |
| **6** | **AC25/04.1** | 16.01.25 | **Matters Arising and Action Log (Trusted Assessor)**<br>Board Development Session focussing on the role of the Trusted Assessor to be arranged. | Pam Wenger | ~~March 25~~<br><br>Revised timescale October 25 | **Remain Open**<br>**29.07.25** This is being discussed with the Chief Operating Officer to arrange a session for Independent Members.<br>**10.02.25** The session will be added to the Board Development Programme |

| | | | | | | |
|---|---|---|---|---|---|---|
| | | | | | | and a suitable date arranged for 2025/26. This will not be before March 25 but will be planned before September 2025 as it would be helpful for the new COO to co-ordinate this session. |
| **7** | **AC24/151.1** | 05.11.24 | **Centre for Mental Health and Society (CfMHaS)**<br>(Title changed from Response to Freedom of Information Request)<br>A full evaluation report to be presented at the next Audit Committee. | Pam Wenger<br>Russell Caldicott | ~~March 25~~<br>~~May 25~~<br><br>Revised timescale October 25 | **Remain Open**<br>**27.07.25** An extended deadline of 10 July 2025 was provided and the Health Board has received two expressions of interest. The Corporate Governance Directorate will now progress this in partnership with the Procurement Team with work estimated to commence during August 2025 with an update to Audit Committee planned for October 2025.<br>**09.05.25** An independent reviewer has been sought on the procurement portal (since 14.03.25). Currently awaiting expressions of interest to complete the work. A report is due to go to the Committee in June 25 dependant on securing an independent reviewer.<br>**04.03.25** In relation to the Centre for Mental Health it has been agreed to commission a review and this will come back to Committee.<br>**03.02.25** ToR have now been drafted |

| | | | | | | |
|---|---|---|---|---|---|---|
| | | | | | | and awaiting final review before procurement in February 2025. A full evaluation report is due to be presented to the Committee in April 25 (subject to procurement)<br>**08.01.25** An evaluation of the CfMHaS Agreement will be commissioned and the final report will be brought to the Committee once received. The terms of reference for the review are currently being finalised in order that procurement for the review can be commissioned. |
| **8** | **AC24.60.1.10** | 07.05.24 | **Internal Audit Progress Report**<br>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<br>Pam Wenger<br>Philippa Peake-Jones | ~~June 25~~<br><br>Revised timescale October 25 | **Remain Open**<br>**29.07.25** Verbal update by Vice Chair to be provided during the meeting.<br>**10.04.25** This has been included on the agenda for the next Chairs Advisory Group which is due to take place on 24.04.25.<br>**08.01.25** The Head of Corporate Affairs has included this on the agenda for the next Chairs Advisory Group for discussion which is due to take place on 26.02.25. This meeting has subsequently been stood down and this item will roll over to the next meeting.<br>**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.<br>**12.09.24** This will be discussed at the next Committee Chair's Meeting.<br>**02.09.24** Update to be provided during the meeting.<br>**18.07.24** To be raised at the next meeting in August 2024 as part of feedback from the Audit Committee Chair. |
| **9** | **AC24/121.2** | 12.09.24 | **Speak Up Safely**<br>Future update to consider the compliance against the policy/protocol and particularly in the context of raising concerns and Whistleblowing arrangements. | Internal Audit<br>Jason Brannan<br>Tracey Eccles<br>Rebecca Testa<br>~~Gareth Evans~~ | ~~Nov 24~~<br>~~Jan 25~~<br>~~March 25~~<br>~~May 25~~<br><br>Revised timescale October 25 | **Remain Open**<br>**04.07.25** Process review underway to align current SUS process to All Wales SUS Framework. This is due for completion by end of Q2.<br>**17.04.25** An SBAR has been submitted via Jason Brannan for a review of the referral process of submitting a concern and aligning the reporting data to allow comparison against other Health Boards / Trusts.<br>**04.03.25** The Audit Committee approved the Internal Audit Plan for 2025/26 which includes Speaking up Safely as review reference 25. It is planned for Q4 but Internal Audit have agreed with management's request to bring the review forward |

| | | | | | | |
|---|---|---|---|---|---|---|
| | | | | | | earlier in the year.<br>**19.02.25** An SBAR is being prepared to share with the Executive Team to gain approval to begin a process of review of the SuS framework and arrangements to include reviewing compliance and factors related to this included in the action tracker. Part of this review will include involving other stakeholders in the process to identify what the SuS Team currently provide from the perspective of a number of interested parties e.g. Trade Unions, Board Champions, Staff Networks, People Services, Information Governance, and if appropriate, Internal Audit. This will provide a more comprehensive review of the framework and approach and offer a greater level of assurance too. Speaking Up Safety is also included in the draft BCU Internal Audit Plan for 2025-26, which is being presented for approval at the March 25 meeting.<br>**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)<br>**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. |
| **10** | **AC24/124.3** | 12.09.24 | **Update on Health Board Policies and Written Control Documents**<br>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<br>Glesni Driver | ~~Nov 24~~<br>~~Jan 25~~<br><br>Revised timescale October 25 | **Remain Open**<br>**07.07.25** A revised policy is being developed and will be presented to the Committee in October 25.<br>**01.07.25** Work on the new process is ongoing with the approval routes for these documents still requiring further work to align to operational and strategic meetings / Committees.<br>**12.03.25** An update on progress around a revised policy process will be provided to the June 25 meeting.<br>**03.02.25** Work on the Health Board policy review and approval processes has commenced, which will include a full consultation process, as well as a refresh of the 'Policy on Policies'. An update will be provided at the meeting in June 25. |

| | | | | | | |
|---|---|---|---|---|---|---|
| | | | | | | **10.12.24** A paper has been included on the agenda for the January meeting. Further work is required on policies once progress has been made against the current policies. **24.10.24** The immediate focus is reviewing the work in terms of the governance and overdue policies. There is opportunity to review the current processes going forward but given the focus on dealing with overdue policies this will be the immediate priority. This has been included on the forward workplan in terms of the long term review of the processes. |
| **ACTIONS PROPOSED FOR CLOSURE** | | | | | | |
| **1** | **AC25/73.1** | 08.05.25 | **Local Counter Fraud Service Q4 Report 2024/25** Draft report following the engagement visit from the NHS Counter Fraud Authority to come back to the next meeting. | Danielle Timmins | August 25 | **Action proposed for closure** **01.07.25** The full engagement visit report was presented as part of the appendices to the Annual Report which was presented to the Committee on 24.06.25 |
| **2** | **AC25/69.2** | 08.05.25 | **Internal Audit Progress Report** Executive Director of Finance and Head of Internal Audit to meet and discuss the Scheme of Reservation and Delegation further to align the process and gain clarity on the narrative. | Russell Caldicott Dave Harries | August 25 | **Action proposed for closure** **08.07.25** Discussions have concluded, the report is compliant with SFIs which would have satisfied the requirement to approve contracts however the Executive Director of Finance was on leave and the report was not taken by Committee. This will |

| | | | | | | |
|---|---|---|---|---|---|---|
| | | | | | | be corrected moving forward. The report as produced, requires presentation to the Committee and subsequent recommendations for approval to Health Board to ensure Compliance and delegation to Officers for 2025/26. |
| **3** | **AC25/69.1** | 08.05.25 | **Internal Audit Progress Report** Director of Performance and Commissioning to report on the progress of the follow up on the Contracted Patient Services – Quality and Safety arrangements at the August meeting. | Stephen Powell | August 25 | **Action proposed for closure** **29.07.25** This is included on the agenda for the August 25 meeting. |
| **4** | **AC25/67.1** | 08.05.25 | **Welsh Health Circulars and Ministerial Directions** Urtha Felda to share the detail of the Ministerial Directions regarding prioritising children for surgery with the Director of Corporate Governance outside of the meeting. | Pam Wenger<br>Glesni Driver<br>Urtha Felda | August 25 | **Action proposed for closure** **01.07.25** This information has been shared by Urtha Felda. |
| **5** | **AC25/63.1** | 08.05.25 | **Internal Audit Explainer Video and Communication Plan** Director of Corporate Governance to discuss with the Director of People Services whether the Internal Audit video could be included as part of the induction programme for new managers. | Pam Wenger<br>Georgina Roberts<br>~~Jason Brannan~~ | August 25 | **Action proposed for closure** **07.07.25** Internal Audit video to be added to the scoping evidence being collected as part of the exercise for the Managers Induction and Handbook within Q2. Development of new Mangers Induction and Handbook to be undertaken in Q3 with Implementation and socialisation in Q4 25/26. |

| | | | | | | |
|---|---|---|---|---|---|---|
| **6** | **AC25/65.1** | 08.05.25 | **Breaches to the Standing Orders**<br>Review the anomalies in relation to the list of breaches reported and confirm the reporting arrangements in terms of publishing papers. | Pam Wenger<br>Philippa Peake-Jones | August 25 | **Action proposed for closure**<br>**07.07.25** The Board approved the Annual Report at the meeting in June 25. |
| **7** | **AC25/62.1** | 08.05.25 | **Risk Impact of Overdue Policies**<br>Update on progress of the overdue policy process to come back to the next meeting with deadline / completion targets to be included. | Pam Wenger<br>Glesni Driver | August 25 | **Action proposed for closure**<br>**01.07.25** This will be included in the Statutory Compliance report being presented to the next meeting in August 25. |
| **8** | **AC25/61.1** | 08.05.25 | **Update on External and Internal Recommendations**<br>External Audit recommendations to remain open and come back to the next meeting, potentially in private session, for further discussion. | Pam Wenger<br>Glesni Driver | August 25 | **Action proposed for closure**<br>**01.07.25** This will be included in the Statutory Compliance report being presented to the next meeting in August 25. |
| **9** | **AC25/61.2** | 08.05.25 | **Update on External and Internal Recommendations**<br>Update the limited assurance recommendations table to include the overall number of recommendations for future reports. | Pam Wenger<br>Glesni Driver | August 25 | **Action proposed for closure**<br>**01.07.25** This will be included in the Statutory Compliance report being presented to the next meeting in August 25. |
| **10** | **AC25/59.1** | 08.05.25 | **Matters Arising and Action Log**<br>Executive Director of Finance to monitor progress against the reconciliation of whole-time equivalents posts and ESR data and report back to the Committee. | Russell Caldicott | August 25 | **Action proposed for closure**<br>**05.08.25** Discrepancy largely relates to budgeted whole-time equivalents reduced as non-recurrent savings are released, as the posts are still being recruited to. For month 4 reporting these negative budgets have been reversed with only recurrent reduction in pay budget having a whole-time |

| | | | | | | |
|---|---|---|---|---|---|---|
| | | | | | | equivalent movement and any discrepancy remaining relates to minor housekeeping matters. At the time of the Audit Committee relating to the action point, the negative budgets were 535.71 relating to savings non-delivery and they are now confirmed to be zero as they have been reversed. The remaining discrepancy remaining is now 4.67 whole time equivalents which as stated are minor housekeeping matters which are monitored and amended as appropriate. |
| **11** | **AC25/59.2** | 08.05.25 | **Matters Arising and Action Log** Director of Corporate Governance to assess the progress of the Job Evaluation Process and report back to the Committee. | Pam Wenger | August 25 | **Action proposed for closure** **07.07.25** The Audit Committee received an update from the Chief Executive at the meeting held in June 25 confirming that the issue had been discussed and resolved with the Trade Unions. |
| **12** | **AC25/59.3** | 08.05.25 | **Matters Arising and Action Log** Compliance and progress against mandatory training to be reported into the People & Culture Committee and a paper highlighting a baseline position in relation to fire safety including the areas that need to be addressed to be presented to the Audit Committee in August. | Stuart Keen | August 25 | **Action proposed for closure** **07.07.25** The presentation that was considered by the People & Culture Committee has been shared with Audit Committee for information and to provide assurance. A paper on Fire Safety Baseline Position has been included on the agenda for the August 25 meeting. |
| **13** | **AC25/59.4** | 08.05.25 | **Matters Arising and Action Log** | Pam Wenger | August 25 | **Action proposed for closure** |

| | | | | | | |
|---|---|---|---|---|---|---|
| | | | Director of Corporate Governance to review whether the historic recommendations from 2022 have been closed and provide an update outside of the meeting. | | | **29.07.25** There are no outstanding recommendations relating to 2022 as these have all now been removed / closed in accordance with the approach agreed at Audit Committee. |
| **14** | **AC25/39.1** | 04.03.25 | **Internal Audit Progress Report** Review ESR and the financial establishment as soon as possible to understand why they are not aligning and bring an update back to the May meeting and alert the People & Culture Committee of this anomaly. | Russell Caldicott | May 25 | **Action proposed for closure** **08.05.25** It was confirmed during the meeting that the posts are in existence, there is a negative line in the ledger for whole time equivalents and the Team are working to align this to the ESR data. The reconciliation of this issue will be reported via the Conformance Report and it was agreed to close this action and open a new action, (see action AC25/59.1). **30.04.25** Funded establishment contains a reduction for vacancy factor (to reflect posts held vacant). The ESR system doesn't reflect these negative whole time equivalents results in a difference in reporting of vacancies within the two systems. The IHC's are working to allocate the negative whole time equivalents to roles, which will then enable alignment to the ESR data, as these posts are removed from this system. Propose this action is closed. |
| **15** | **AC25/33.2** | 04.03.25 | **Risk Report and Corporate Risk** | Nesta Collingridge | Aug 25 | **Action proposed for closure** |

| | | | | | | |
|---|---|---|---|---|---|---|
| | | | **Register**<br>Share an update on Civil Contingencies with the Audit Committee. | | | **29.07.25** The PPHP Committee reviewed the latest version of the EPRR at its meeting on 03.07.25 and received assurance that work is progressing positively though there is still more to do. A report is being presented at the July Board meeting.<br>**30.04.25** An item relating to EPRR will be discussed at the PPHP Committee on 03.07.25 and an update will come back to the Audit Committee at the meeting on 19.08.25.<br>**12.03.25** All corporate risks have now been reviewed by the Emergency Preparedness, Resilience and Response (EPRR) Lead. This item is on the agenda for a full update to PPHP when operational risks have been developed. The EPRR Lead has only recently recruited support for the development of risks and they have explained to PPHP that updates will be provided in the next meeting as to the position. |
| **16** | **AC25/32.2** | 04.03.25 | **Information Governance and Records Management Position**<br>Access Control Policy and Record Management Code of Practice to be uploaded to the Audit Committee IMs area on the Teams Channel. | Carol Johnson<br>Laura Jones | June 25 | **Action proposed for closure**<br>**01.08.25** A copy of the Access Control Standard has been circulated to the Audit Committee for information.<br>**04.03.25** A copy of the Records |

| | | | | | | |
|---|---|---|---|---|---|---|
| | | | | | | Management Code of Practice and the Information Governance & Records Management Review which includes the recommendations and actions have been circulated via email. The Access Control Policy is being finalised and a copy will be shared once this has been approved. |
| **17** | **AC25/06.2** | 16.01.25 | **Update on Open Audit Recommendations – Final Audit Report on Llandudno Hospital Orthopaedic Surgical Hub**<br>Review introducing virtual sign off for capital programmes under the SFIs as part of the review of the SORD. | Russell Caldicott<br>Pam Wenger | June 25 | **Action proposed for closure**<br>**08.07.25** A paper on Standing Orders, SFIs and Scheme of Reservation and Delegation has been included on the agenda for August 25 meeting.<br>**30.04.25** The SORD is being reviewed and scheduled to be considered at the Audit Committee in June 25, the review will incorporate this action.<br>**10.02.25** The review of the Scheme of Delegation has commenced; further work is required to align to the Foundations for the Future Programme and therefore suggest this will be finalised by end of May 2025. |
| **18** | **AC24/151.2** | 05.11.24 | **Centre for Mental Health and Society (CfMHaS)**<br>(Title changed from Response to Freedom of Information Request)<br>Gain the opinion of the Information | Pam Wenger<br>Phil Meakin | ~~Jan 25~~<br>~~March 25~~<br>~~May 25~~<br><br>Revised | **Action proposed for closure**<br>**27.07.25** There is no further update on this action therefore it is recommended for closure.<br>**16.04.25** A communication has been |

| | | | | | | |
|---|---|---|---|---|---|---|
| | | | Commissioner on the FOI. | | timescale June 25 | received from the ICO (letter dated 31.01.25). The letter confirmed that there has been a complaint made to the ICO and provided the Health Board with guidance and advice on how to resolve and revisit the complaint and clarify a response in accordance with the relevant rules/laws for FOI Requests. The letter from the ICO also requested a copy of the final letter to the complainant which was duly sent on 09.04.25.<br>**03.02.25** The Information Commissioner has received a copy of the FOI response. As of the 04.02.25 no response has been received from ICO to the Health Board. Monitoring of an anticipated response will continue from the Freedom of Information Team and communicated to Director of Corporate Governance when it is received.<br>**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). |

| | | | | | | |
|---|---|---|---|---|---|---|
| **19** | **AC24/154.5** | 05.11.24 | **Internal Audit Progress Report**<br>Review the option to include Fire Safety Training within Mandatory Training rather than it being at staff discretion and also review the policy. | Stuart Keen<br>Russell Caldicott | ~~Jan 25~~<br>~~May 25~~<br><br>Revised timescale June 25 | **Action proposed for closure**<br>**08.05.25** It was agreed during the meeting that compliance and progress against mandatory training should be reported into the People & Culture Committee. It was agreed to close this action and open a new action for a paper highlighting a baseline position and the areas that need to be addressed in terms of fire safety to come back to the August meeting (see action AC25/59.3).<br>**30.04.25** Contact made with Workforce to confirm whether Fire Safety Training is already part of the Mandatory Training programme.<br>**25.02.25** The Director of Environment & Estates is taking this forward to build this into the training modules.<br>**09.01.25** Update from RC to follow. |
| **20** | **AC24/121.1** | 12.09.24 | **Speak Up Safely**<br>Share benchmarking information from other Health Boards in relation to the number of concerns being raised. | Jason Brannan<br>Tracey Eccles<br>Rebecca Testa<br>~~Gareth Evans~~ | ~~Nov 24~~<br>~~Jan 25~~<br>~~March 25~~<br>~~May 25~~<br><br>Revised timescale June 25 | **Action proposed for closure**<br>**08.07.25** Both BCUHB and WAST are in the process of implementing alignment of the reporting data. Other Health Boards currently working on data capture / implementation of SUS. Review of Internal process to capture data ongoing in BCUHB - to be completed by September 25. Ongoing collaboration of data sharing across Wales. |

| | | | | | | |
|---|---|---|---|---|---|---|
| | | | | | | **17.04.25** Currently work continues across Wales to implement Guardians in line with the WG framework, currently not all Health Boards have Guardian representation. The current All Wales Group are working in collaboration to align the reporting data through the working in confidence platform using categories already used by the National Guardians Office for Speaking up Safely and this will be implemented once the SBAR cited in AC24/121.2 is approved.<br>**19.02.25** Tracey Eccles, SuS Guardian is working with colleagues across Wales to collate comparative data, this piece of work is ongoing and will be shared once finalised. This work aligns to the proposed review process noted in action AC24/121.1.<br>**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. |
| **21** | **AC24.60.1.8** | 07.05.24 | **Internal Audit Progress Report** Quality, safety and commissioned services. The Committee agreed to a 6-month deferral requesting that the review take place before the end of the current financial year - it was agreed to inform the QSE of this decision and for the QSE Committee to drive progress on recommendations from the May 23 report. | Philippa Peake Jones to inform the Quality, Safety and Experience Committee (QSE) | ~~May 24~~ ~~Nov 24~~ ~~Jan 25~~ Revised timescale June 25 | **Action proposed for closure** **07.07.25** This is being proposed for closure on the basis that Internal Audit have now undertaken a follow up Audit and an update is due to be presented to the Committee at the August 25 meeting. **10.04.25** A follow up review is being undertaken and the findings will be shared as soon as possible. **04.03.25** A follow up Audit has been commissioned. **12.02.25** As the Director of Performance & Commissioning is now post, this will be considered at the QSE Committee in May 25. **08.01.25** An update on the progress against the Quality, Safety and Commissioned Services Report has been included on the forward plan for the QSE Committee. **24.10.24** Action to remain open and to be taken forward with the new Director of Planning & Commissioning. **02.09.24** PPJ confirmed that this has |

| | | | | | | |
|---|---|---|---|---|---|---|
| | | | | | | been referred to QSE Committee however the issue has not yet been resolved therefore the action remains open.<br>**04.03.25** It was noted in Committee that this is being taken forward as part of this years Internal Audit and will be led by the Director of Performance & Commissioning |
| **Closed Actions (as agreed at meeting on 08.05.25)** | | | | | | |
| **Action** | **Minute Ref.** | **Date** | **Agreed Action** | **Lead** | **Timescale** | **Status** |
| **1** | **AC25/33.1** | 04.03.25 | **Risk Report and Corporate Risk Register**<br>Revise the dates included in the report where dates are extended. | Nesta Collingridge | May 25 | **12.03.25** Revised target dates are presented to the Committee as business as usual, going forward we will ensure the rationale is clear and includes details of prior scrutiny and will monitor this closely to ensure target dates are appropriate. |
| **2** | **AC25/33.3** | 04.03.25 | **Risk Report and Corporate Risk Register**<br>Share information relating to the legal services plan and learning from legal cases at a future Committee Development Session. | Pam Wenger<br>Matt Joyes | May 25 | **11.03.25** This will be included on the agenda for the next Audit Committee Development Session taking place on 20.05.25. Propose this action will be closed after the session has taken place. |
| **3** | **AC25/38.1** | 04.03.25 | **Conformance Report**<br>Add page numbers to the Conformance Report and ensure a movement arrow is included in relation to LFERs to show where numbers have changed. | Russell Caldicott<br>Denise Roberts | May 25 | **19.03.25** The Team are addressing the issues highlighted and these will be implemented ahead of submission of the next Conformance Report. |

| | | | | | | |
|---|---|---|---|---|---|---|
| **4** | **AC25/38.2** | 04.03.25 | **Conformance Report**<br>Share a briefing on LFERs with Independent Members. | Pam Wenger<br>Matt Joyes | May 25 | **14.04.25** This will be included on the agenda for the next Audit Committee Development Session taking place on 20.05.25. Propose this action will be closed after the session has taken place. |
| **5** | **AC25/38.3** | 04.03.25 | **Conformance Report**<br>Share a briefing on the 5 payments for loss/damage of patient's property, 1 payment for ex-gratia payments and 6 ombudsman payments for delayed and unsatisfactory treatment. | Russell Caldicott<br>Denise Roberts | May 25 | **30.04.25** This information has been circulated to the Committee. |
| **6** | **AC25/38.4** | 04.03.25 | **Conformance Report**<br>RATS to be amended to Remuneration Committee on the losses and special payments section. | Russell Caldicott<br>Denise Roberts | May 25 | **16.04.25** This reference will be corrected in the Conformance Report ahead of being issued for the next meeting. |
| **7** | **AC25/40.1** | 04.03.25 | **Revised Internal Audit Plan**<br>Include a follow up review of Falls Management in the Internal Audit Plan. | Dave Harris | May 25 | **07.03.25** The plan for 2025/26 has been updated to include Falls Management Follow Up as review reference 36. The Internal Audit Team plan to undertake this review in the period April to June 2025 (Quarter 1). The revised plan has been circulated and uploaded to the IMs Teams Channel. |
| **8** | **AC25/06.3** | 16.01.25 | **Update on Open Audit Recommendations – Final Audit Report on Llandudno Hospital Orthopaedic Surgical Hub**<br>Follow up the governance element of the lack of a project bank account, if it | Russell Caldicott | ~~March 25~~<br><br>Revised timescale May 25 | **30.04.25** Bank account now opened and to be used moving forwards for transactions in regards to this development.<br>**25.02.25** Further request instructed 23 December 2024 – Health Board |

| | | | | | | |
|---|---|---|---|---|---|---|
| | | | is considered to have been a breach of SFI's then report back to the Committee. | | | representatives seeking clarification as to why this remains outstanding. Escalated to Director of Environment |
| **9** | **AC25/07.1** | 16.01.25 | **Update Report on Internal and External Audit Recommendations** Invite the Executive Director of Nursing or Executive Director of Public Health to provide an update on their Internal and External Audit Recommendations at the next meeting. | Pam Wenger<br>Angela Wood<br>Jane Moore | ~~March 25~~<br><br>Revised timescale May 25 | **09.04.25** The Executive Director of Nursing is joining the next meeting in May 25 to provide an update against her Audit Recommendation.<br>**10.02.25** The Executive Director of Nursing and Executive Director of Public Health are on leave on 4th March and will therefore be asked to join the next meeting in April 25. The Director of Performance & Commissioning has been invited to join the March 25 to provide a presentation. |
| **10** | **AC25/10.1** | 16.01.25 | **Update on Health Board Policies and Written Control Documents** Summarise the policies that carry the biggest risk and provide a paper to the Committee in April 2025. | Pam Wenger<br>Glesni Driver | May 25 | **12.03.25** A paper will be presented to the April 25 meeting.<br>**04.02.25** A paper focussing on overdue policies will be presented to the meeting in April 25. |
| **11** | **AC24/127.4** | 12.09.24 | **Internal Audit Progress Report** Consider options for raising awareness and understanding of internal audit. | Pam Wenger<br>Dave Harries | ~~Nov 24~~<br>~~Jan 25~~<br>~~March 25~~<br><br>Revised timescale May 25 | **12.03.25** Work is ongoing between the Corporate Governance Directorate and Internal Audit to revise the training material, and a revised version and communication plan will be presented to the May 25 meeting.<br>**16.01.25** It was agreed during the meeting to keep this action open. The video will be shared at the Audit |

| | | | | | | |
|---|---|---|---|---|---|---|
| | | | | | | Committee Development Session on 20.02.25. A communication plan is being development across the organisation to understand how the Audit Plan is set up. An update on the Internal Audit video and the communication plan will be shared at the meeting in April 25.<br>**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.<br>**03.10.24** PW to discuss options including developing video resource, an update will be provided in Jan 25. |
| **12** | **AC24/154.5** | 05.11.24 | **Internal Audit Progress Report**<br>Review the option to include Fire Safety Training within Mandatory Training rather than it being at staff discretion and also review the policy. | Stuart Keen<br>Russell Caldicott | ~~Jan 25~~<br>~~May 25~~<br><br>Revised timescale June 25 | **30.04.25** It has been confirmed that Fire Training is mandatory for all BCU staff, and included in the WP30 Statutory Mandatory Training Policy.<br>**25.02.25** The Director of Environment & Estates is taking this forward to build this into the training modules.<br>**09.01.25** Update from RC to follow. |

| | | | | |
|---|---|---|---|---|
| **Teitl adroddiad:**<br><br>***Report title:*** | Centre for Mental Health and Society – Independent Review | | | |
| **Adrodd i:**<br><br>***Report to:*** | Audit Committee | | | |
| **Dyddiad y Cyfarfod:**<br><br>***Date of Meeting:*** | Tuesday, 19 August 2025 | | | |
| **Crynodeb Gweithredol:**<br><br>***Executive Summary:*** | The purpose of this report is to provide Audit Committee with a briefing related to the procurement of an Independent Review into the Health Board arrangements for the Centre for Mental Health and Society (CfMHaS). This is the briefing that the Executive Committee received on 6 August 2025 and it endorsed the onward reporting to the Audit Committee and the next steps that are set out in this report.<br><br>The report provides an update on the procurement for the independent review and outcome that has resulted in a successful bidder. It also sets out the timescales for the review and the need to secure Health Board colleagues time for the Independent Reviewer to complete their work. The report sets out next steps in this respect.<br><br>Work on the report is anticipated to conclude during September 2025 with a further report being made to Executive Committee and Audit Committee in October 2025. | | | |
| **Argymhellion:**<br><br>***Recommendations:*** | The Audit Committee is asked to**:**<br><br>• Note the progress on the Procurement of an Independent Review of the arrangements for the Centre for Mental Health and Society.<br>• Note the support required to commence the Independent Review from August 2025. | | | |
| **Arweinydd Gweithredol:**<br><br>***Executive Lead:*** | Pam Wenger – Director of Corporate Governance | | | |
| **Awdur yr Adroddiad:**<br><br>***Report Author:*** | Phil Meakin – Associate Director of Governance | | | |
| **Pwrpas yr adroddiad:**<br><br>***Purpose of report:*** | I'w Nodi<br>*For Noting*<br>☒ | I Benderfynu arno<br>*For Decision*<br>☐ | Am sicrwydd<br>*For Assurance*<br>☒ | |
| **Lefel sicrwydd:**<br><br>***Assurance level:*** | Arwyddocaol<br>*Significant*<br>☐<br>Lefel uchel o hyder/tystiolaeth o ran darparu'r mecanweithiau / amcanion presennol<br><br>*High level of confidence/evidence in* | Derbyniol<br>*Acceptable*<br>☒<br>Lefel gyffredinol o hyder/tystiolaeth o ran darparu'r mecanweithiau / amcanion presennol<br><br>*General confidence / evidence in delivery of* | Rhannol<br>*Partial*<br>☐<br>Rhywfaint o hyder/tystiolaeth o ran darparu'r mecanweithiau / amcanion presennol<br><br>*Some confidence / evidence in delivery of* | Dim Sicrwydd<br>*No Assurance*<br>☐<br>Dim hyder/tystiolaeth o ran y ddarpariaeth<br><br>*No confidence / evidence in delivery* |

| | | | | |
|---|---|---|---|---|
| | *delivery of existing mechanisms/objectives* | *existing mechanisms / objectives* | *existing mechanisms / objectives* | |

| | |
|---|---|
| **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:**<br><br>***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:**<br><br>***Link to Strategic Objective(s):*** | • Building an Effective Organisation<br>• Creating compassionate culture, leadership and engagement<br>• Improving quality, outcomes and experience |
| **Goblygiadau rheoleiddio a lleol:**<br><br>***Regulatory and legal implications:*** | This paper relates to an FOI request that was received in relation to the Centre for Mental Health and Society. This report relates to how effectively Health Board regulations are enacted in the oversight of these arrangements. |
| **Yn unol â WP7, a oedd EqIA yn angenrheidiol ac a gafodd ei gynnal?**<br><br>***In accordance with WP7 has an EqIA been identified as necessary and undertaken?*** | Not applicable to this report |
| **Yn unol â WP68, a oedd SEIA yn angenrheidiol ac a gafodd ei gynnal?**<br><br>***In accordance with WP68, has a SEIA identified as necessary been undertaken?*** | Not applicable to 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)**<br><br>***Details of risks associated with the subject and scope of this paper, including new risks (cross reference to the BAF and CRR)*** | CRR 24-04 – Learning |
| **Goblygiadau ariannol o ganlyniad i roi'r *argymhellion ar waith***<br><br>***Financial implications as a result of implementing the recommendations*** | The report contains details of a procurement to secure an Independent Review of the arrangements for the CfMHaS which has a cost attached of £19,500. |
| **Goblygiadau gweithlu o ganlyniad i roi'r argymhellion ar waith**<br><br>***Workforce implications as a result of implementing the recommendations*** | Not applicable to this report |
| **Adborth, ymateb a chrynodeb dilynol ar ôl ymgynghori**<br><br>***Feedback, response, and follow up summary following consultation*** | This paper has been prepared following a report to the Audit Committee on 5 November 2024 where an update on the response to FOI was provided. Since then it was agreed to undertake an Independent Review of the arrangements that the Health Board has with the CfMHaS. This has been through a |

| | |
|---|---|
| | procurement process and this report dets out the outcome of that procurement.<br><br>The Executive Committee received this report on 6 August 2025, noted and endorsed the contents of this report and its onward reporting to Audit Committee on 19 August 2025.<br><br>The Mental Health and Learning Disability leadership team has also been made aware of the Terms of Reference. |

| | |
|---|---|
| **Cysylltiadau â risgiau BAF:**<br>(neu gysylltiadau â'r Gofrestr Risg Gorfforaethol)<br><br>***Links to BAF risks:***<br>*(or links to the Corporate Risk Register)* | BAF 24-01 Not Fully Building an Effective and Accountable Organisation |
| **Rheswm dros gyflwyno adroddiad i fwrdd cyfrinachol (lle bo'n berthnasol)**<br><br>***Reason for submission of report to confidential board (where relevant)*** | Not applicable |
| **Camau Nesaf:**<br>***Next Steps:***<br><br>1. Commence the Independent Review with the successful bidder under the Terms of Reference agreed<br>2. Communicate the final report through Executive Committee and Audit Committee on 21 October 2025 | |
| **Rhestr o Atodiadau:**<br>***List of Appendices:***<br>***Appendix 1***<br>*Terms of Reference for the Procurement* | |

# CENTRE FOR MENTAL HEALTH AND SOCIETY
# INDEPENDENT REVIEW
# EXECUTIVE COMMITTEE BRIEFING

## 1. INTRODUCTION

The purpose of this report is to provide Audit Committee with a briefing related to the procurement of an Independent Review into the Health Board arrangements for the Centre for Mental Health and Society (CfMHaS). This is the briefing that the Executive Committee received on 6 August 2025 and the Executive Committee endorsed the onward reporting to the Audit Committee. Audit Committee is asked to:

a. Note progress on the Procurement of an Independent Review of the arrangements for the Centre for Mental Health and Society.
b. Note the support required to commence the Independent Review from August 2025.

The Health Board has had an agreement with Bangor University since July 2012 and provides grant funding to support the work of the CfMHaS. Freedom of Information (FOI) Request 1552066 was received into the Health Board on 21 March 2024. The Health Board responded to the FOI Request on 17 September 2024 to the requestor and Llais. In addition to this a meeting was held with the individual who made the request on the 24th September 2024. In broad terms the matters in the response to the FOI Request related to payments to BCUHB members of staff, the arrangements between BCUHB and Bangor University and the activity of the CfMHaS. An internal review of the current use of resources was undertaken to inform the response provided to the requestor.

Audit Committee received a report on this matter on 5 November 2024 that set out:

- The governance processes that were followed in checking the information contained in the response.
- Outcome of counter fraud investigations
- Adherence to the Health Board scheme of delegation

Following Audit Committee on 5 November 2025, it was agreed that it would be important to reach a conclusion with the request and the matters raised 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. To this end a procurement to initiate an Independent Review was commissioned.

## 2. OUTCOME OF THE PROCUREMENT

A Terms of Reference was developed in consultation with the Director of Corporate Governance, Executive Director or Finance and Executive Director of Allied Health Professionals and Health Science. The Terms of Reference are attached in **Appendix 1.**

The procurement notice was arranged through NWSSP Procurement Team under the *Consultancy and Advisory Services for Health Specification*. Bidders were invited to participate in the quotation opportunity via Multiquote on the 14th March 2025 with a closing date of 20th March 2025 which was repeatedly extended. Bidders were asked to review the outlined requirements and provide a total cost for completion and delivery of the service.

No bids were received through this method. However, the Corporate Governance Directorate sourced their own quotation from 2 suppliers and this was forwarded on to the NWSSP Procurement team who evaluated the quotation and specification. The procurement period was then extended to 13 July 2025.

After the evaluation process, it is the recommendation of the evaluation panel that this quotation is awarded to Heidi Smoult Coaching and Consulting (HSCC). The cost of this bid was £19,500.

In choosing the successful bidder there was a need to consider the quality impact and experience of the person in selecting a preferred bid, rather than just cost. The panel reviewed the two proposals and from a deliverability and understanding perspective and assessed that HSCC would deliver the remit noting the high-profile nature of the work. A procurement ratification document was produced, signed by Associate Director of Governance, Director of Corporate Governance and Executive Director of Finance and returned to the Procurement Team to process on 23 July 2025 who will now communicate with the successful bidder.

Declarations of Interest forms have been completed by the Director of Corporate Governance and Associate Director of Governance and returned to the Procurement Team.

The cost of the work is £19,500 and this has been communicated as an upper limit to the bidder.

## 3. KEY POINTS

The bidder has stated in their response that they will commence work during August 2025 and anticipate completing it during September 2025. The final review will then be reported through to Executive Committee and Audit Committee on 21 October 2025.

Audit Committee are asked to note that the Independent Reviewer will need to meet with a number of Health Board colleagues and stakeholders during August and September 2025. This will include, but not limited to Finance, MHLD, Corporate Governance colleagues, Bangor University, and other external stakeholders. The Associate Director of Governance will coordinate this work. Executive Committee colleagues were asked to support this urgent work and support in the communication of requirements. This was noted at the meeting of Executive Committee on 6 August 2025.

## 4. NEXT STEPS

1. Commence the Independent Review with the successful bidder under the Terms of Reference agreed
2. Communicate the final Independent Review report through Executive Committee and Audit Committee on 21 October 2025

## 5. RECOMMENDATIONS

For Audit Committee to:

- Note the progress on the Procurement of an Independent Review of the arrangements for the Centre for Mental Health and Society.
- Note the support required to commence the Independent Review from August 2025.

**APPENDIX 1 - Terms of Reference for the Independent Review of the arrangements for CfMHaS.**

**TERMS OF REFERENCE**
**An Independent Review of the Current and Future Arrangements in Relation to the Centre for Mental Health and Society (CfMHaS)**

## 1.Introduction

Betsi Cadwaladr University Health Board (BCUHB) wishes to undertake an independent review of the current and future arrangements in relation to the CfMHaS. The Health Board has an historic agreement with Bangor University that has been in place since July 2012 and provides grant funding to support the work of the CfMHaS.

An information report can be made available to bidders on this work from the contacts below.

## 2. Scope of Work

The review is asked to undertake the following;

**2.1** The review is asked to undertake a historical assessment of contribution and resultant benefits from entering into this collaboration.

**2.2** To consider the current and future arrangements in place between the Health Board and Bangor University in relation to the Centre for Mental Health and Society. (this should include a review of the clarity in terms of the services provided, the roles and responsibilities, the performance management arrangements and adherence to quality standards)

**2.3** Assess and determine the value for money of these arrangements including the benefits of arrangements for the Health Board and the wider population. (in accordance with the documentation in place between the two parties)

**2.4** Assess and evaluate the proposal for future arrangements with the CfMHaS that are referenced in the "SBAR" that the Medical Director of Mental Health and Learning Disabilities has developed and make any suggestions thereafter.

**2.5** Make recommendations on the legal requirements for the constitutional arrangements for the Centre for Mental Health and Society, assess how these are currently being met and any subsequent recommendations for improvement.

## 3. Approach and methodology

**3.1** Bidders are asked to set out their approach and methodology for the work.

**3.2** Also to set out details of their proposed team to develop a report containing the above scope.

**3.3** The report will be made to the Director of Corporate Governance and will be reported at the Health Board Audit Committee.

**3.4** The proposal for future arrangements and proposals identified in 2.3 above will be made available to bidders if successful.

## 4.Timeline

**4.1** We would aim to commence the review as soon as practicable following acceptance of this proposal and appropriate approval has been received. We would then schedule a set up or kick off meeting where will consider and agree the approach, communications and the 1:1 discussions.

**4.2** We would anticipate concluding the review by the end of February 2025.

## 5. Health Board Contacts

**5.1** Joanna Garrigan - Finance Director - Joanna.Garrigan@wales.nhs.uk/Phil Meakin Associate Director of Governance – phil.meakin@wales.nhs.uk

| | | | | |
|---|---|---|---|---|
| **Teitl adroddiad:**<br><br>***Report title:*** | Statutory Compliance Report | | | |
| **Adrodd i:**<br><br>***Report to:*** | Audit Committee | | | |
| **Dyddiad y Cyfarfod:**<br><br>***Date of Meeting:*** | Tuesday, 19 August 2025 | | | |
| **Crynodeb Gweithredol:**<br><br>***Executive Summary:*** | The purpose of this report is to provide the Committee with:<br><br>• an update on compliance activities, including:<br>➢ internal and external audits<br>➢ regulatory body reviews<br>➢ policy management<br>➢ UK Covid-19 Inquiry and Thirlwall Inquiry<br>• recommendations for further action in relation to the different compliance-related activities included within this report. | | | |
| **Argymhellion:**<br><br>***Recommendations:*** | The Committee is asked to:<br><br>• **NOTE** the content of the report<br>• **AGREE** the recommendations included in Section 8 of this report. | | | |
| **Arweinydd Gweithredol:**<br><br>***Executive Lead:*** | Pam Wenger, Director of Corporate Governance | | | |
| **Awdur yr Adroddiad:**<br><br>***Report Author:*** | Glesni Driver, Head of Statutory Compliance and Inquiries | | | |
| **Pwrpas yr adroddiad:**<br>***Purpose of report:*** | I'w Nodi<br>*For Noting*<br>☒ | I Benderfynu arno<br>*For Decision*<br>☒ | Am sicrwydd<br>*For Assurance*<br>☒ | |
| **Lefel sicrwydd:**<br><br>***Assurance level:*** | Arwyddocaol<br>*Significant*<br>☐<br>Lefel uchel o hyder/tystiolaeth o ran darparu'r mecanweithiau / amcanion presennol<br><br>*High level of confidence/evidence in delivery of existing mechanisms/objectives* | Derbyniol<br>*Acceptable*<br>☐<br>Lefel gyffredinol o hyder/tystiolaeth o ran darparu'r mecanweithiau / amcanion presennol<br><br>*General confidence / evidence in delivery of existing mechanisms / objectives* | Rhannol<br>*Partial*<br>☒<br>Rhywfaint o hyder/tystiolaeth o ran darparu'r mecanweithiau / amcanion presennol<br><br>*Some confidence / evidence in delivery of existing mechanisms / objectives* | Dim Sicrwydd<br>*No Assurance*<br>☐<br>Dim hyder/tystiolaeth o ran y ddarpariaeth<br><br>*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:**<br><br>***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 Statutory Compliance arm of the Corporate Governance Directorate ensures compliance to duties relating to laws, regulations, and statutory requirements set by the government and regulatory bodies, audit and non-audit bodies, and statutory inquiries. | | | | |

| | |
|---|---|
| **Cyswllt ag Amcan/Amcanion Strategol:**<br><br>***Link to Strategic Objective(s):*** | Building an Effective Organisation |
| **Goblygiadau rheoleiddio a lleol:**<br><br>***Regulatory and legal implications:*** | Compliance with statutory compliance requirements |
| **Yn unol â WP7, a oedd EqIA yn angenrheidiol ac a gafodd ei gynnal?**<br><br>***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?**<br><br>***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)**<br><br>***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 regulatory body reviews and audit reports |
| **Goblygiadau ariannol o ganlyniad i roi'r *argymhellion ar waith***<br><br>***Financial implications as a result of implementing the recommendations*** | Not applicable, other than those relating to individual regulatory body reviews and audit reports |
| **Goblygiadau gweithlu o ganlyniad i roi'r argymhellion ar waith**<br><br>***Workforce implications as a result of implementing the recommendations*** | Not applicable, other than those relating to individual regulatory body reviews and audit reports |
| **Adborth, ymateb a chrynodeb dilynol ar ôl ymgynghori**<br><br>***Feedback, response, and follow up summary following consultation*** | The report has been prepared as an amalgamated report of all compliance-related requirements |
| **Cysylltiadau â risgiau BAF:**<br>(neu gysylltiadau â'r Gofrestr Risg Gorfforaethol)<br><br>***Links to BAF risks:***<br>*(or links to the Corporate Risk Register)* | Not applicable, other than those relating to individual regulatory body reviews and audit reports |
| **Rheswm dros gyflwyno adroddiad i fwrdd cyfrinachol (lle bo'n berthnasol)**<br><br>***Reason for submission of report to confidential board (where relevant)*** | Not applicable |

**Camau Nesaf:**
**Gweithredu argymhellion**

***Next Steps:***
***Implementation of recommendations***

Regular updates on audit, regulatory body reviews, policy management and legislation will be submitted to the Audit Committee.

**Rhestr o Atodiadau:**

***List of Appendices:***

- Appendix 1 – Internal Audit – open 'unsatisfactory' assurance recommendations
- Appendix 2 – Internal Audit – open 'limited' assurance recommendations
- Appendix 3 – Internal Audit – summary of audit recommendations for Internal Audit review
- Appendix 4 – Audit Wales – open recommendations
- Appendix 5 – Audit Wales – summary of audit recommendations for Audit Wales review
- Appendix 6 – Audit Wales – for Audit Wales and Audit Committee closure consideration
- Appendix 7 – Audit Wales – recommendations returned for re-work following AW review
- Appendix 8 – Policy Management – High-risk policies that remain overdue a review

# Contents

# BETSI CADWALADR UNIVERSITY HEALTH BOARD
# STATUTORY COMPLIANCE REPORT

## 1. INTRODUCTION

This report provides an update on governance activities, including internal and external audits, compliance with regulatory body reviews, legislative changes impacting the Health Board, and updates on policy management.

## 2. INTERNAL AUDIT

### 2.1 Internal Audit – new audit reports

Table 1 below shows a list of all the Internal Audit reports received since the last update, up to 29th July 2025:

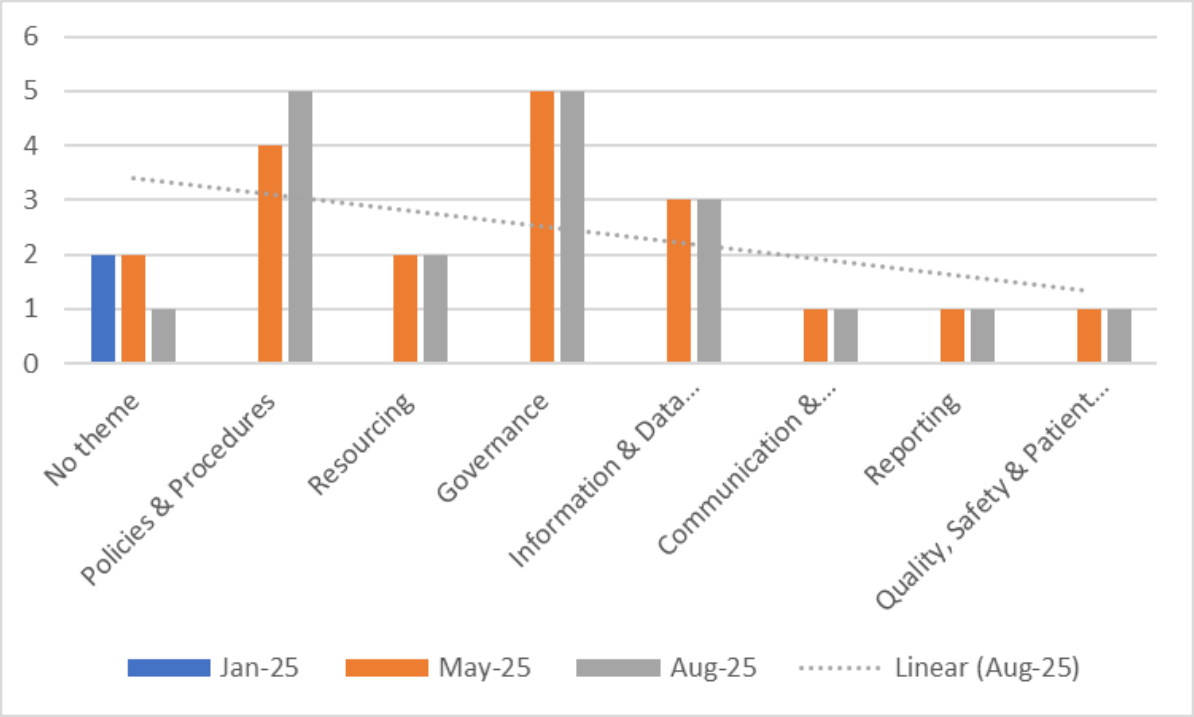
| | |
|---|---|
| **Reasonable assurance** | Board Assurance Framework and Risk Management |
| | Discretionary Capital Funding Allocation |
| | Standing Financial Instructions - Procurement |
| | Grievance Management |
| | Budgetary Control |
| | Duty of Quality |
| | Waste Management |
| **Limited assurance** | Clinical Audit - 2025 |
| | Contracted Patient Services: Quality and Safety Arrangements - Follow-up |
| | Waiting List Initiative payments – IHC Centre |
| | Partnerships, Engagement and Communication |
| | Effective Governance - Cancer Services |
| | Standards of Business Conduct – Declarations of Interest, Gifts and Hospitality - follow-up |
| | Effective Governance – Integrated Health Community - East |
| | Performance Management Framework and Reporting |
| **Not rated** | Falls Management - Follow up |
| **Advisory review** | Contract management and procurement review – Digital, Data and Technology Directorate - *Commercial in Confidence* |

## 2.2 Internal Audit – open 'Unsatisfactory' assurance recommendations

Table 2 below shows a summary, by Executive, of all open 'unsatisfactory' assurance recommendations, the number of these open recommendations overdue their original implementation date, and number put forward for closure. The table also includes the total number of high priority recommendations overdue their original implementation date by 6 months or more (as at end of June 2025):

| Audit report | Executive Lead | 'Unsatisfactory' assurance recs - open | Open 'Unsatisfactory' assurance recs overdue original implementation date | High priority recommendation overdue original implementation date by 6 months or more | Total 'Unsatisfactory' assurance recs put forward for closure |
|---|---|---|---|---|---|
| Operating Model | Chief Executive | 1 | 1 | 1 | 0 |
| Consultant Job Planning | Interim Executive Medical Director; Deputy Director of People | 16 | 14 | 0 | 0 |
| Waiting List Initiative payments – IHC | Chief Operating Officer | 1 | 0 | 0 | 0 |
| Effective Governance - Cancer Services | Chief Operating Officer | 1 | 0 | 0 | 0 |
| | **Total** | **19** | **15** | **1** | **0** |

Graph 1 below shows the trend of open unsatisfactory recommendations per theme in 2025.




A copy of the live tracker, which includes all open 'unsatisfactory' assurance reports is included in Appendix 1.

### 2.2.1 High priority unsatisfactory recommendations

The one high priority unsatisfactory assurance recommendation listed above is overdue its original implementation date of 30/06/2024. The latest update is that the Executive Committee is established, and work being undertaken to review reporting groups. As previously reported, the Operational Governance Accountability Framework is being reviewed as part of Foundations for the Future, and therefore it is proposed that the Health Board consider formally confirming the current framework is not in operation and should be archived pending new governance arrangements.

## 2.3 Internal Audit – open 'Limited' assurance recommendations

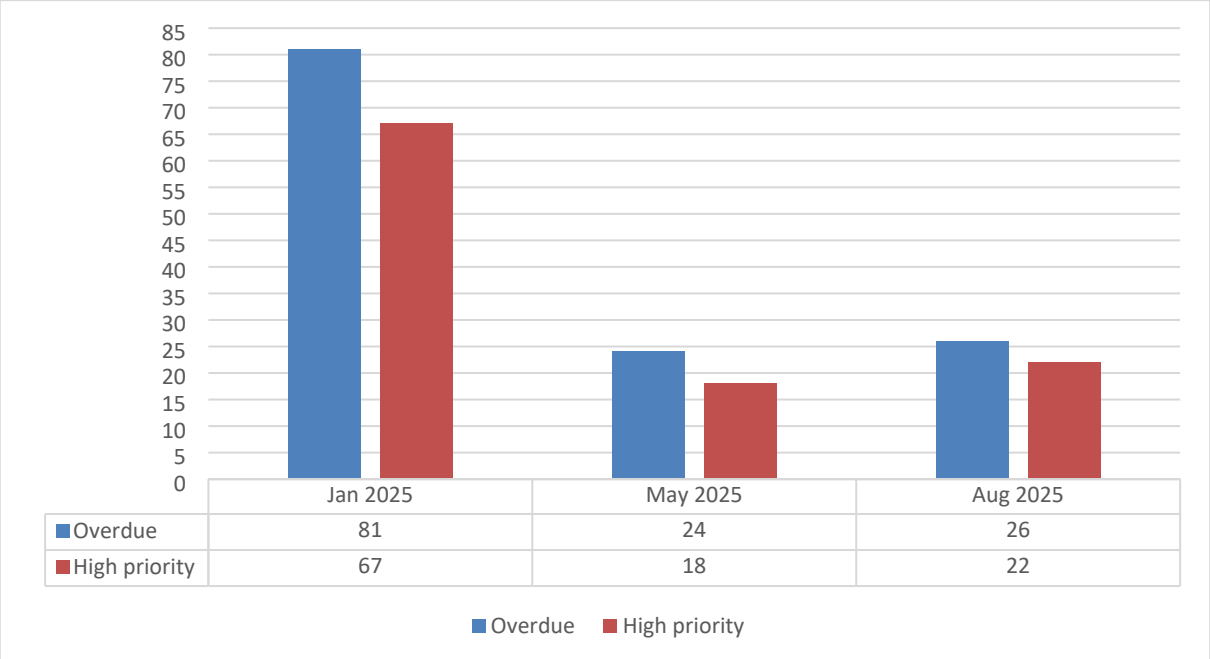
Table 3 below shows a summary, by Executive, of all open 'limited' assurance recommendations, the number of these open recommendations overdue their original implementation date, and number put forward for closure. The table also includes the total number of high priority recommendations overdue their original implementation date by 6 months or more (as at end of June 2025):

| Executive Lead | Total 'Limited' Assurance recs - Open | Open 'Limited' assurance recs overdue original implementation date *(as at 31/05/2025)* | High priority recommendation overdue original implementation date by 6 months or more | 'Limited' Assurance recs put forward for closure |
|---|---|---|---|---|
| Executive Director of Nursing | 1 | 1 | 1 | 3 |
| Interim Executive Director of Transformation and Strategic | 1 | 1 | | - |
| Chief Executive | | | | 2 |
| Chief Operating Officer | 9 | 2 | | 6 |
| Deputy Director of People | 2 | | | 1 |
| Director of Corporate Governance | 11 | | | 2 |
| Chief Digital and Information Officer | | | | |
| Executive Director of Finance | 2 | 2 | | |
| Interim Executive Medical Director | 4 | 4 | | |
| Interim Executive Medical Director; Deputy Director of People | 7 | 6 | | |
| Executive Director of Allied Health Professionals and Health Science | | | | |
| Director of Performance and Commissioning | 5 | | | 3 |
| Director of Partnerships, Engagement and Communications | 11 | | | |
| Director of Environment and Estates | 10 | 10 | 4 | |
| | **63** | **26** | **5** | **17** |

A copy of the live tracker, which includes all open 'limited' assurance recommendations is included in Appendix 2.

### 2.3.1 High priority limited recommendations

Graph 2 below shows all overdue limited assurance recommendations as reported to the January and May 2025 Audit Committee, and of those overdue, the total that are 'high priority'.




### 2.4 Internal Audit – approved recommendations for Internal Audit review

Table 4 below provides a summary of all recommendations approved for closure by the respective Executive and the Executive Committee – these will now be shared with Internal Audit for review.

| Executive Lead | Approved for closure |
|---|---|
| Chief Digital and Information Officer | 10 |
| Chief Executive | 4 |
| Chief Operating Officer | 6 |
| Executive Director of Nursing | 3 |
| Interim Executive Director of Transformation and Strategic Planning | 2 |
| Deputy Director of People | 1 |
| Interim Executive Medical Director | 4 |
| Director of Corporate Governance | 2 |
| Director of Environment and Estates | 3 |
| Executive Director of Finance | 8 |
| **Total** | **43** |

A summary of the closure narrative for each of the recommendations is included in Appendix 3.

## 2.5 Internal Audit – recommendations returned for further evidence

A total of 59 audit recommendations were submitted to Internal Audit for review on 18th June 2025 – these included 24 for 1st review, 33 for 2nd review, and 2 for 3rd review. The ones for 2nd review have already been reviewed by Internal Audit, but required further information/evidence, and those submitted for 3rd review, have already been reviewed by Internal Audit on two other occasions, and returned both times for further evidence.

These have now been reviewed, and the results are as follows:

| | **Number of recommendations** | **Closed** | **Partially closed** | **Outstanding** |
|---|---|---|---|---|
| For 1st review | 24 | 17 (71%) | 5 (21%) | 2 (8%) |
| For 2nd review | 33 | 20 (61%) | 9 (27%) | 4 (12%) |
| For 3rd review | 2 | 2 (100%) | 0 | 0 |
| **TOTAL** | **59** | **39 (66%)** | **14 (24%)** | **6 (10%)** |

The information relating to the recommendations marked as partially closed or outstanding has been shared with the Executive Director to progress the updates required, and once this information is received, it will be shared with Internal Audit for further review.

A copy of the feedback received on all recommendations reviewed and proposed for closure by Internal Audit has also been shared with the Executive Directors to assist with understanding the level and type of evidence and information required by Internal Audit to support closure going forward.

# 3. AUDIT WALES

## 3.1 Audit Wales – new audit reports

No new Audit Wales reports have been published since the last update.

## 3.2 Audit Wales – open recommendations

A total of 22 Audit Wales recommendations remain open. A copy of these is included in Appendix 4.

Table 6 below shows the number of Audit Wales recommendations overdue their original implementation date by 6 months or more (as at end of June 2025):

| Report Title | Original implementation date | Number overdue original implementation date - 6 months or more | Final Approver |
|---|---|---|---|
| Structured Assessment 2022 | 31/12/2023 | 1 | Chief Digital and Information Officer |
| Structured Assessment 2023 | 31/07/2024 | 2 | Director of Corporate Governance |
| Urgent and Emergency Care: Flow out of Hospital – North Wales Region | 31/10/2024 | 6 | Chief Operating Officer |
| Structured Assessment 2023 | 31/08/2024 | 1 | Executive Director of Finance |

The recommendations relating to the Structured Assessment in 2023 are in train and relate to the monitoring of non-audit recommendations and the financial accounting issues in 2021/22. It is anticipated that following review by Audit Wales these may be considered for closure in the next few months.

## 3.3 Audit Wales – approved recommendations for Audit Wales review

Table 7 below provides a summary of all external audit recommendations approved for closure by the respective Executive and Executive Committee – these will now be shared with Audit Wales via the Teams channel for review.

| Executive Lead | Approved for closure |
|---|---|
| Chief Operating Officer | 3 |
| Interim Executive Director of Transformation and Strategic Planning | 1 |
| Director of Corporate Governance | 3 |
| **Total** | **7** |

A summary of the closure narrative for each of the recommendations is included in Appendix 5.

## 3.4 Audit Wales – recommendations for closure consideration

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

As part of this continued process, the audit tracker current holds a number of External Audit recommendations that are awaiting Audit Committee closure. These are recommendations that have been approved for closure in line with the approved closure process by both the Executive Director and Executive Committee, and the next part of the closure process is approval for closure by Audit Wales and the Audit Committee.

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

These recommendations were presented to the May 2025 Audit Committee, but a decision was taken that these would remain open, and be presented again at the next Audit Committee. Details of the Audit Wales recommendations are included in Appendix 6.

3.5 **Audit Wales – recommendations returned for further evidence**

A total of 18 external audit recommendations were submitted to Audit Wales on 17th April 2025 for review prior to the Audit Committee. Audit Wales requested further time to review the evidence provided, and have since submitted an update on each recommendation.

Of the external audit recommendations submitted to Audit Wales for review, a total of 8 were returned requiring further evidence.

Table 8 below provide the number of recommendations returned, by Executive Director.

| | |
|---|---|
| **Executive Director of Nursing** | |
| Structured Assessment 2023 | 2 |
| **Interim Executive Director of Transformation and Strategic Planning** | |
| Structured Assessment 2022 | 1 |
| **Executive Director of Finance** | |
| Structured Assessment 2022 | 2 |
| Structured Assessment 2023 | 2 |
| **Chief Executive (approved for closure by Director of Corporate Governance)** | |
| Review of Board Effectiveness | 1 |

Appendix 7 shows the recommendations submitted, and the feedback received.

The feedback received has since been shared with Executive Directors and recommendations owners to source the additional evidence required. Once this is available, it will be shared with Audit Wales.

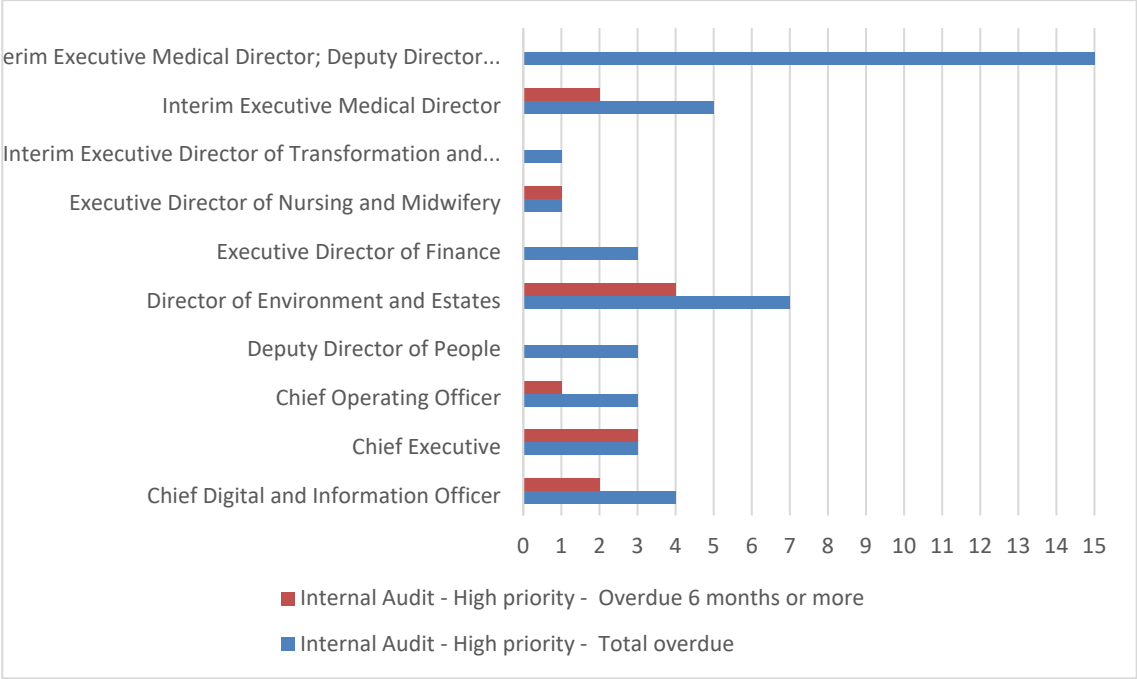
A new Teams channel has been set up with Audit Wales to share recommendation narrative updates and evidence.

# 4. AUDIT - OVERVIEW

## 4.1 Summary of all audit recommendations

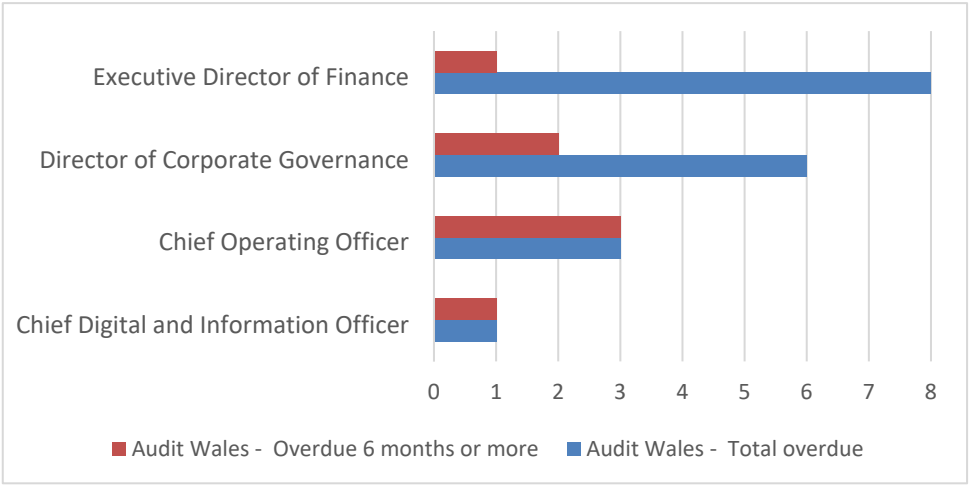
### 4.1.1 Open and overdue 'high priority' Internal Audit recommendations

Graph 3 below provides details of all open 'high priority' Internal Audit recommendations overdue the original implementation, and those overdue their original implementation date by 6 months or more (as at end of June 2025), listed by Executive Director.




### 4.1.2 Open and overdue Audit Wales recommendations

Graph 4 below provides details of all open Audit Wales recommendations including the number that are overdue the original implementation date by 6 months or more (as at end of June 2025), listed by Executive Director.



## 4.2 Overview of audit reports

Table 9 below provides an overview of the position relating to Audit Wales and Internal Audit reports and recommendations as at end of June 2025.

| Inspectorate/ Regulator | Open Reports | New reports | Closed Reports | Open reports which are overdue | High priority recommendations overdue original implementation date | High priority recommendations overdue implementation date by 6 months or more |
|---|---|---|---|---|---|---|
| Audit Wales | 6 | 0 | 42 | 5 | n/a | n/a |
| Internal Audit | 32 | 17 | 107 | 20 | 59 | 18 |

## 4.3 Overview of all recommendations

Table 10 below provides information as to number of ALL recommendations.

| | As at 14/03/25 | As at 24/04/25 | As at 29/07/25 |
|---|---|---|---|
| New Internal Audit recommendations | 46 | 60 | 98 |
| New Audit Wales recommendations | 8 | 24 | 0 |
| Pending - Executive to review | 0 | 0 | 0 |
| Approved by Executive Committee | 63 | 41 | 50 |
| With Internal Audit for review | 0 | 0 | 0 |
| With Audit Wales for review | 0 | 0 | 0 |
| For Audit Committee closure approval:<br>• recs approved for closure by Executive Director, Executive Team, and reviewed by Internal Audit but not presented to Audit Committee for closure approval<br>• recs outside scope of Internal Audit Charter for review, but need final approval for closure by the Audit Committee. | 0 | 0 | 59 |

## 4.4 Re-profiling of historic and unmanageable items

The Corporate Governance Directorate has not been made aware that there are any recommendations that need consideration as no longer relevant.

## 4.5 Development of audit action plans

The Corporate Governance Directorate has developed a BetsiNet intranet page relating to Internal Audit, which includes a training video around the purpose of Internal Audit, preparing for an audit review, and the reporting requirements. Any feedback on what additional information is required to be submitted to the Head of Statutory Compliance and Inquiries.

4.6 **Update on historical recommendations**

All the historical Internal Audit and Audit Wales recommendations that were approved for closure at the November 2024 and January 2025 Audit Committees have been closed on the tracker.

All Internal Audit recommendations that required a review by the Executive prior to closure have been reviewed by the relevant Executive, and are now closed on the tracker.

From those recommendations where Internal Audit requested further evidence before closure approval, 39 recommendations remain open. As these are historical, sourcing evidence is difficult for two main reasons:

- the recommendation owner and/or Executive no longer work at the Health Board, therefore the corporate memory in relation to that work does not exist, or;
- the likelihood that the recommendation was not implemented at the time, therefore there is no evidence available.

Work is ongoing to source this evidence, and if this proves fruitless, it will be escalated to the Director of Corporate Governance.

## 5. REGULATORY BODY REVIEWS (NON-AUDIT BODIES)

The Structured Assessment for 2024 reported a gap in terms of the Audit Committee oversight in terms of non-audit bodies, and therefore this report is intended to present the reports that have been received, noting that the oversight of these reports will take place at various committees and groups of the Health Board.

### 5.1 Healthcare Inspectorate Wales

Healthcare Inspectorate Wales (HIW) is the independent inspectorate and regulator of healthcare in Wales who inspect NHS services and regulate independent healthcare providers against a range of standards, policies, guidance and regulations to highlight areas requiring improvement. HIW also monitor the use of the Mental Health Act and review the mental health services to ensure that vulnerable people receive good quality of care in mental health services.

#### 5.1.1 Published reports

HIW have published an inspection report pertaining to the '*Unannounced Inspection of the Emergency Department at Wrexham Maelor*' on 13th March 2025. The inspection took place from 9th to 11th December 2024.

#### 5.1.2 Summary of findings and recommendations

Due to an immediate risk to patient safety, HIW issued the following Immediate Assurances to the Health Board:

- HIW required details on how the health board will ensure that measures are in place to ensure that medication and intravenous infusions expiry dates are checked on a regular basis, and to remove any items past their expiry dates.
- HIW required details on how the health board will ensure that medication is always stored in its original dispensing boxes, along with the relevant information sheets.

Due to an immediate risk to patient safety, HIW issued the following Immediate Assurances to the Health Board:

- HIW requires details on how the Health Board will ensure that measures are in place to ensure that medication and intravenous infusions expiry dates are checked on a regular basis, and to remove any items past their expiry dates.
- HIW requires details on how the Health Board will ensure that medication is always stored in its original dispensing boxes, along with the relevant information sheets.

### 5.1.3 Actions taken

As outlined within the inspection report, the Health Board has taken steps to address the immediate issues raised by HIW. Both the Immediate Improvement Plan and Main Improvement Plan are being monitored via the Health Boards Regulatory Assurance Group (RAG) which reports to the Executive Quality Delivery Group (EQDG), and up to the Quality Safety and Experience (QSE) Committee.

## 5.2 Care Inspectorate Wales

Care Inspectorate Wales (CIW) regulate adult services such as care homes for adults, domiciliary support services, adult placement services and residential family centre services. As the Health Board is one legal entity, it is a registered provider for multiple services which includes Enhanced Community Residential Service (MHLD) and Tuag Adref (across all three Integrated Health Communities).

### 5.2.1 Governance and assurance

To strengthen governance and assurance, a Quality-of-Care Review process has been implemented in line with the requirements set out in the Social Care (Wales) Act 2016. A standard six-month service quality review template has been developed for all registered services to complete, aimed at encouraging a culture of quality improvement. This template includes the four well-being areas, alongside a quarterly assurance declaration. These two formal processes support the overall annual declaration made by the Health Board.

The Nursing Professional Education and Revalidation Team have introduced a Social Care Wales Registration Pathway to ensure that all healthcare support staff working in a CIW registered service are regulated with Social Care Wales. This pathway also aims to increase assurance and oversight.

### 5.2.2 Quality of Care Review Visits

The Health Board aims to undertake six-monthly Quality of Care Review visits. Ahead of a visit, services are asked to complete a Quality-of-Care Review Report, providing an opportunity to demonstrate that they are meeting the four key well-being areas in line with legal requirements. The purpose is to assess their performance and identify opportunities for improvement and development. No immediate issues were raised during the visits undertaken by the Health Board's Responsible Individual in 2024.

The visit schedule for 2025 is underway to ensure that the Health Board meets its legal requirements for undertaking Quality of Care Reviews.

### 5.2.3 Amendment to CIW Registration

Both IHC Centre and IHC West have made formal requests to amend their service registration with CIW. These requests have been initially reviewed by the Quality Assurance and Regulation Team and the Responsible Individual for the Health Board. The Regulatory Assurance Group has reviewed and approved the requests. The requests have been made in line with the considerations outlined in the Regulation and Inspection of Social Care (Wales) Act 2016, confirming that the services are no longer providing the 'care' and 'support' as set out in the Act.

The Health Board's Responsible Individual has approved the requests, and the Health Board has liaised with CIW regarding the next steps. CIW has advised that the Health Board updates its Statement of Purpose, which will be done as part of the CIW Annual Return in May 2025.

## 5.3 Public Services Ombudsman for Wales

### 5.3.1 Public Interest Reports

In 2025, two Public Interest Reports have been issued to the Health Board. An action plan was developed for 2 cases. The recommendations made by the Public Services Ombudsman for Wales (PSOW) for these cases have all been actioned and evidence of compliance has been submitted to the Ombudsman's office.

PIR received August 2024 (Case Ref ID753 / 202206250)

The Ombudsman has confirmed compliance has been met on 24th March 2025 and closed the case. The Health Board's committee and Board has been sighted on this case.

PIR received March 2025 (Case ref ID2087 / 202301141)

The Ombudsman investigation considered whether the patient received appropriate review and treatment of her post-operative fluid collections and pelvic sepsis following her proctectomy in 2019, including adequate gynaecological input, and whether they received sufficient time and information to understand and consider the risks of the surgical removal of her post-operative fluid collections, and to give her fully informed consent before this surgery was carried out. In addition, the investigation considered prompt and appropriate investigation and treatment for her pain and reduced kidney function following surgery in March 2022, and timely and appropriate information about her hysterectomy, including advise about post-operative recovery, the menopause, and options for hormone replacement therapy.

The investigation also considered whether the Health Board dealt with the complaint in line with the PTR (Concerns, Complaints and Redress Arrangements) Regulations 2011.

The Ombudsman upheld the complaints and made several recommendations which the Health Board accepted. The Health Board are on track with the action plan, reporting progress to the Health Board's Regulatory Assurance Group (RAG), Executive Delivery Group (EDG) and Quality Safety and Experience (QSE) Committee.

## 5.4 Risk and Compliance Overview

Regulatory body reviews highlight areas of improvement required by the Health Board.

It is essential that the Health Board identifies opportunities for learning from regulatory body reviews, whether specific to the Health Board, or proactively from other health board/trust reviews.

# 6. POLICY MANAGEMENT

## 6.1 Executive Policy Oversight Group policy approvals

Table 11 below lists the policies reviewed and approved by the Executive Policy Oversight Group since 20th March 2025. Once approved, these policies are subsequently published on BetsiNet by the Statutory Compliance Team, pending any actions from the Group being completed. The Group is chaired by the Director of Corporate Governance,

| Policy Name and reference | Executive Lead | Last reviewed |
|---|---|---|
| PA05 - All Wales Independent Authorisation Blood Transfusion Components (IABT) | Executive Director of Nursing and Midwifery | 2023 |
| WP13 - Flexible Working Policy | Executive Director of People & Organisational Development | 2024 |
| WP49 - All Wales Pay Progression Policy | Executive Director of People & Organisational Development | 2015 |
| WP66 - All Wales Menopause Policy | Executive Director of People & Organisational Development | 2018 |
| WP81 - Neonatal Leave and Pay Policy | Executive Director of People & Organisational Development | New policy |
| OBS02 - Standards of Business Conduct Policy | Director of Corporate Governance | 2022 |
| MM42 - Unlicensed Medicines Policy | Executive Medical Director | 2019 |
| ISUE01 - Undertaking Patient Stories Policy | Executive Director of Nursing and Midwifery | 2021 |
| MM10 - Antimicrobial Prescribing Policy | Executive Medical Director | 2024 |
| ISU02 - Patient Information Policy | Executive Director of Nursing and Midwifery | 2021 |
| NU21 - Levels of Enhanced Care for Adult Inpatients Policy | Executive Director of Nursing and Midwifery | 2024 |
| NU01 - BCUHB Hospital Discharge Policy and Protocol | Chief Operating Officer | 2015 |
| MD09 - Sabbatical Leave Policy | Executive Medical Director | 2017 |
| Mat 74 – Corporate Breastfeeding Policy | Director of Midwifery and Women's Services | 2017 |
| NU06 - The Prevention and Management of Adult in Patient Falls Policy | Executive Director of Nursing | 2022 |
| WP26 - All Wales Job Evaluation | Executive Director of People and Organisational Development | New policy |
| MM01b - Policy & Procedure for the Safe Storage of Medicines in Clinical Areas | Executive Medical Director | New policy |

## 6.2 High-risk overdue policies update

The Audit Committee requested an update on overdue policies that posed the highest risk to the Health Board, and these were highlighted within that report to the Audit Committee at its meeting on 8th May 2025. A progress report on the review of those highest risk policies was requested at a future Audit Committee.

Below is an update on progress in reviewing those highest risk overdue policies.

### 6.2.1 High-risk policies reviewed

Table 12 below shows the number of high-risk policies that have been reviewed and approved, and are now live on BetsiNet.

| Name | Category | Responsible Director |
|---|---|---|
| IPC06 - Infection Prevention Hand Hygiene Policy & Procedure (An Element of Standard Infection Control Precautions).pdf | Patient safety | Executive Director of Nursing |
| MM42 - Unlicensed Medicines Policy - V1.pdf | Patient safety | Executive Medical Director |
| Mat 74 - BCUHB Breastfeeding Policy.pdf | Patient safety | Chief Operating Officer |

### 6.2.2 High-risk overdue policies awaiting review

Table 13 below shows all the high-risk overdue policies that are still awaiting a review.

| Name | Category | Review Date | Responsible Director |
|---|---|---|---|
| MHLD 0008 - Threats to the Person and Environment within Forensic Establishments Policy (Ty Llywelyn Medium Secure Unit).pdf | Patient safety | 01/01/2024 | Executive Director of Allied Health Professions and Health Science |
| MHLD 0020 - S-CAMHS to Adult Transition Policy - V3.pdf | Patient safety; Joint working/Collaboration | 01/03/2024 | Executive Director of Allied Health Professions and Health Science |
| MHLD 0027 - BCUHB Mental Health Division - Open Door Policy - V0.1pdf.pdf | Patient safety; Legal | 01/07/2020 | Executive Director of Allied Health Professions and Health Science |
| MHLD 0029 - Perinatal Mental Health Operational Policy - V0.1.pdf | Patient safety; Joint working/ Collaboration | 01/06/2019 | Executive Director of Allied Health Professions and Health Science |
| MHLD 0035 - Home Treatment Team Operational Policy - V0.5 (a).pdf | Patient safety; Legal | 01/04/2021 | Executive Director of Allied Health Professions and Health Science |
| MHLD 0040 - Ty Llywelyn Postal Packets & Section 134 (MHA 1983_2007) Policy - V0.1.pdf | Patient safety | 01/08/2021 | Executive Director of Allied Health Professions and Health Science |
| NU28 - Nurse Staffing Levels Policy.pdf | HR/Staff; Patient safety | 01/01/2025 | Executive Director of Nursing |
| MM05 - Intrathecal Chemotherapy Policy - V3.pdf | Patient safety | 01/03/2021 | Executive Medical Director |
| MD17 - Interventions Not Normally Undertaken (INNU) Policy - V1.1.pdf | Patient safety | 01/09/2021 | Executive Medical Director |
| MM01 - BCUHB Medicines Policy .pdf | Patient safety | 01/07/2022 | Executive Medical Director |
| MM02 - Injectable Medicines Policy.pdf | Patient safety | 08/07/2022 | Executive Medical Director |
| MM10 - Antimicrobial Prescribing Policy - V4.pdf | Patient safety | 01/05/2024 | Executive Medical Director |
| MM15 - Policy for Administration & Use of Emergency & Non Emergency Oxygen in Adults in Managed Services - V2.1.pdf | Patient safety | 01/02/2022 | Executive Medical Director |
| MM37 - Medical Gases - Staff Responsibilities across BCUHB - V1.1.pdf | Patient safety | 01/05/2021 | Executive Medical Director |
| CW01 - BCUHB Paediatric Escalation Policy - V3.pdf | Patient safety | 01/09/2019 | Chief Operating Officer |

Appendix 8 provides the updates received for each of the above high-risk overdue policies.

## 6.3 Overdue policies

Work continues to work with Executives and policy-related document owners to progress overdue policies. However, as can be seen from the information relating to high-risk policies above, progress to date is not as it should be.

## 6.4 Overdue policy-documents – by Executive

Due to the need to expedite the work around overdue policy-related documents, a review of all policy-related documents held on the Policy Management System has been undertaken, and identified the Executive Directors with the highest number of overdue policies in comparison to their total policies (see Table 14 below). This information is correct as of 20th June 2025.

Table 14 below provides the total number of all policies, procedures and other written control documents, including all-Wales documents. The totals do however exclude appendices to policy-related documents, and only include a total of one document where there is both a Welsh and English version available.

| | ALL POLICY-RELATED DOCUMENTS | | | ALL-WALES DOCUMENTS ONLY | | |
|---|---|---|---|---|---|---|
| **ALL POLICIES, PROCEDURES AND OTHER WRITTEN CONTROL DOCUMENTS** *(including all-Wales documents, excluding appendices and Welsh versions)* | **Total number of all documents** | **Overdue a review as at 20/06/2025** | **% of total documents that are overdue** | **Total number of all-Wales documents** | **Total all-Wales documents overdue a review as at 20/06/2025** | **% of total all-Wales documents that are overdue** |
| Executive Director of Transformation, Strategic Planning and Commissioning | 1 | 1 | 100% | 1 | 1 | 100% |
| Director of Environment and Estates | 6 | 5 | 83% | | | |
| Chief Executive | 2 | 1 | 50% | | | |
| Executive Director of Finance | 23 | 10 | 43% | 1 | 1 | 100% |
| Executive Director of Allied Health Professions and Health Science | 100 | 42 | 42% | 3 | 0 | 0% |
| Executive Medical Director | 206 | 86 | 42% | 6 | 4 | 67% |
| Chief Operating Officer | 160 | 59 | 37% | 8 | 4 | 50% |
| Director of Corporate Governance | 15 | 5 | 33% | | | |
| Executive Director of Workforce and Organisational Development | 115 | 30 | 26% | 17 | 8 | 47% |
| Executive Director of Nursing | 123 | 30 | 24% | 13 | 12 | 92% |
| Chief Digital Information Officer | 34 | 8 | 24% | 4 | 4 | 100% |
| Executive Director of Therapies and Health Science | 9 | 2 | 22% | | | |
| Executive Director of Public Health | 12 | 1 | 8% | | | |
| | **806** | **280** | **35%** | **53** | **34** | 64% |

Table 15 below provides the total number of all policies only, including all-Wales documents. The totals do however exclude appendices to policy-related documents, and only include a total of one document where there is both a Welsh and English version available.

| | POLICIES ONLY | | | ALL-WALES POLICIES ONLY | | |
|---|---|---|---|---|---|---|
| **POLICIES ONLY** *(including all-Wales documents, excluding appendices and Welsh versions)* | **Total number of policies** | **Policies overdue a review as at 20/06/2025** | **% of policies overdue** | **Total number of all-Wales policies** | **Total all-Wales policies overdue a review as at 20/06/2025** | **% of total all-Wales policies that are overdue** |
| Executive Director of Transformation, Strategic Planning and Commissioning | 1 | 1 | 100% | 1 | 1 | 100% |
| Executive Director of Finance | 5 | 4 | 80% | 1 | 1 | 100% |
| Director of Environment and Estates | 4 | 3 | 75% | | | |
| Chief Digital Information Officer | 8 | 5 | 63% | 4 | 4 | 100% |
| Executive Medical Director | 29 | 17 | 59% | 1 | 1 | 100% |
| Chief Operating Officer | 8 | 4 | 50% | 2 | 2 | 100% |
| Executive Director of Nursing | 7 | 3 | 43% | | | |
| Director of Corporate Governance | 5 | 2 | 40% | | | |
| Executive Director of Allied Health Professions and Health Science | 26 | 10 | 38% | | | |
| Executive Director of Workforce and Organisational Development | 43 | 13 | 30% | 13 | 7 | 54% |
| Chief Executive | 0 | 0 | 0% | | | |
| Executive Director of Therapies and Health Science | 1 | 0 | 0% | | | |
| Executive Director of Public Health | 0 | 0 | 0% | | | |
| | **137** | **62** | **45%** | 22 | 16 | 73% |

Please note that the policies assigned to the then Interim Executive Director of Therapies and Health Science have not been re-assigned to another Executive now that the post is not currently occupied.

## 6.5 Cleansing of the Policy Management System

Work has also commenced to ensure that all policies, procedures and other written control documents listed on the Policy Management System on BetsiNet are correctly aligned to the appropriate Executive, and that there is an assigned owner for each document. This will assist with the work around the new policy management process.

## 6.6 Policy Management process

Work is continuing to revise the current policy management process, policy and approvals, with initial consultations taken place with key stakeholders. The work around approvals is challenging due to the ongoing work around committee and meeting structures. An update on progress will be provided at a future meeting.

# 7. STATUTORY INQUIRIES

## 7.1 UK Covid-19 Inquiry

The Inquiry published its first report and recommendations following its investigation into the UK's 'Resilience and preparedness (Module 1)' on 18th July 2024, which examined the state of the UK's central structures and procedures for pandemic emergency preparedness, resilience and response. Reports related to the Inquiry's further Modules will be published later.

Public hearings took place for the Module 6 investigation into the care sector from 30th June 2025 to 31st July 2025.

The Inquiry's fourth Every Story Matters record has now been entered into evidence. This is informed by thousands of experiences in relation to the adult social care sector from families, care workers, unpaid carers and people with care and support needs. This important record is used to support the Module 6 investigation.

Module 7 public hearings, examining the different test, trace and isolate programmes across the four nations of the UK, has now concluded.

Public hearings for Module 8 (Children and Young People) will begin on 29th September 2025.

The Inquiry plans to hear evidence for Module 9 - Economic response across four weeks from 24th November 2025 to 18th December 2025.

Hearing for Module 10 - Impact of the pandemic on society, will start in February 2026.

The Inquiry has now held the last of nine roundtable discussions with various sectors to support Module 10 – this final roundtable was with the housing and homelessness sector. Information around insights shared during the discussions will support the Inquiry's investigation.

The Inquiry has listened to the stories of people who lost a loved one during the pandemic via a series of dedicated listening events held across the UK and online. These stores, together with those shared via the webform, by post and at earlier public events will inform the Module 10 investigation into the impact of the pandemic on society.

The Health Board has received a number of requests for information from the Inquiry, and many of these have been extremely challenging in nature, and has called on a number of different sources of information. However, those involved have been extremely accommodating, and have gone beyond to provide responses in a timely manner. Due to the confidential nature of the requests, no further information can be provided, other than what is publicly available on the Inquiry's website.

7.2 **Thirlwall Inquiry**

Lady Justice Thirlwall, the Chair of the Thirlwall Inquiry has drawn all evidence and submissions in the Inquiry to a close on 19th March 2025.

To date, the Health Board's involvement in the Inquiry has been minimal, but there is likely to be a number of opportunities for learning and recommendations contained within the Chair's report, which is expected to be published in Autumn 2025.

The Inquiry Chair issued a formal ruling refusing an application from four former senior managers at the Countess of Chester Hospital to pause the Inquiry.

7.3 **Learning from Inquiries**

Terms of reference for a 'Discovery and Learning Steering Group' have been drafted, with the purpose of proactively capturing and managing lessons and recommendations from the public inquiries such as the UK Covid-19 Inquiry, the National Nosocomial Covid-19 Programme, other public inquiries such as the Infected Blood Inquiry, Thirlwall Inquiry, major and independent reviews and major incidents, including those not specifically health-related such as the Grenfell Tower Inquiry.

Further work is ongoing in order to set up this Steering Group so that it is ready to receive reports and recommendations for consideration.

## 8. RECOMMENDATIONS

8.1 The Committee is asked to:

- **NOTE** the contents of the report
- **APPROVE** the Audit Wales recommendations put forward for closure,– see section 3.4, and Appendix 6.

## 9. BUDGETARY/FINANCIAL IMPLICATIONS

There are no budgetary implications associated with this paper as it is for information only.

Resources for progressing the work around any regulatory body reviews lie with the relevant directorate, division, or department as part of business-as-usual functions.

## 10. EQUALITY AND DIVERSITY IMPLICATIONS

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

However, Equality and Diversity compliance should be considered when implementing changes to processes and procedures in line with the requirements of regulatory body reviews.

## APPENDICES

APPENDIX 1 – INTERNAL AUDIT – OPEN ‘UNSATISFACTORY’ ASSURANCE RECOMMENDATIONS

APPENDIX 2 – INTERNAL AUDIT – OPEN ‘LIMITED’ ASSURANCE RECOMMENDATIONS

APPENDIX 3 – INTERNAL AUDIT– SUMMARY OF AUDIT RECOMMENDATIONS FOR INTERNAL AUDIT REVIEW

APPENDIX 4 – AUDIT WALES – OPEN RECOMMENDATIONS

APPENDIX 5 – AUDIT WALES – SUMMARY OF AUDIT RECOMMENDATIONS FOR AUDIT WALES REVIEW

APPENDIX 6 – AUDIT WALES – FOR AUDIT WALES AND AUDIT COMMITTEE CLOSURE CONSIDERATION

APPENDIX 7 - AUDIT WALES – RECOMMENDATIONS RETURNED FOR RE-WORK FOLLOWING AW REVIEW

APPENDIX 8 – POLICY MANAGEMENT – HIGH-RISK POLICIES THAT REMAIN OVERDUE A REVIEW

## OPEN 'UNSATISFACTORY' RECOMMENDATIONS

| ID | Report Title | Year | Overall Report rating - from Jan 2025 | Assurance Level | Priority | Recommendation Title | Recommendation | Management Response | Action Owner | Final Approver | Original implementation date | Revised implementation date | Number of Revisions | Latest update |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 0457 | Operating Model | 2024 | n/a | 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 | Work in progress. Executive Committee established and work being undertaken to review reporting groups. |
| 1427 | Consultant Job Planning | 2024 | n/a | Unsatisfactory | High | Objective 1: There is relevant and up to date procedures in place that are available to staff and align to the All-Wales guidance. | 1.1 **Health Board Policy**<br><br>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.<br><br>Limited training is provided to all individuals involved in the job plan process. | 1.1 Review and update Job Planning policy to be aligned with All Wales guidance and nationally agreed Consultant Contract, which is readily accessible to staff. | Sreeman Andole, Interim Executive Medical Director | Sreeman Andole, Interim Executive Medical Director; Jason Brannan, Deputy Director of People | 31/05/2025 | | | Still waiting all Wales guide. IHC MD discussions occuring to identify areas of commonality and areas of challenge |
| 1428 | Consultant Job Planning | 2024 | n/a | Unsatisfactory | High | Objective 1: There is relevant and up to date procedures in place that are available to staff and align to the All-Wales guidance. | 1.2 **Health Board Policy**<br><br>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.<br><br>Limited training is provided to all individuals involved in the job plan process. | 1.2 Continue with regular updates of compliance to IHC/Division, to reflect organisational job planning status. | Sreeman Andole, Interim Executive Medical Director | Sreeman Andole, Interim Executive Medical Director; Jason Brannan, Deputy Director of People | 31/05/2025 | | | No update as still waiting all Wales guide. Compliance circualted by OMD team |
| 1429 | Consultant Job Planning | 2024 | n/a | Unsatisfactory | High | Objective 1: There is relevant and up to date procedures in place that are available to staff and align to the All-Wales guidance. | 1.3 **Health Board Policy**<br><br>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.<br><br>Limited training is provided to all individuals involved in the job plan process. | 1.3 Complete a training needs analysis across BCUHB to establish training for medical and management teams by March 2025. | Sreeman Andole, Interim Executive Medical Director | Sreeman Andole, Interim Executive Medical Director; Jason Brannan, Deputy Director of People | 31/05/2025 | | | Training on Allocate for operational teams continueing.<br>Roadshows on hold until All Wales guidance shared<br>Regular IHC discussions occuring |
| 1430 | Consultant Job Planning | 2024 | n/a | Unsatisfactory | High | Objective 1: There is relevant and up to date procedures in place that are available to staff and align to the All-Wales guidance. | 1.4 **Health Board Policy**<br><br>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.<br><br>Limited training is provided to all individuals involved in the job plan process. | 1.4 Develop and deliver targeted training sessions for managers and consultants by April 2025. | Sreeman Andole, Interim Executive Medical Director | Sreeman Andole, Interim Executive Medical Director; Jason Brannan, Deputy Director of People | 31/05/2025 | | | Training on Allocate for operational teams continueing.<br>Roadshows on hold until All Wales guidance shared<br>Regular IHC discussions occuring |

| | | | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 1431 | Consultant Job Planning | 2024 | n/a | Unsatisfactory | Medium | Objective 1: There is relevant and up to date procedures in place that are available to staff and align to the All-Wales guidance. | 2.1 **Medical Resourcing**<br><br>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.<br><br>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.<br><br>There is possibility of duplication within the Health Board through the operation of standalone people systems and development of silo expertise. | 2.1 Provide comprehensive training for consultants and managers on job planning processes, focusing on linking individual objectives with organisational goals. | Sreeman Andole, Interim Executive Medical Director | Sreeman Andole, Interim Executive Medical Director; Jason Brannan, Deputy Director of People | 30/09/2025 | | | Training on Allocate for operational teams continueing.<br>Roadshows on hold until All Wales guidance shared<br>Regular IHC discussions occuring |
| 1432 | Consultant Job Planning | 2024 | n/a | Unsatisfactory | Medium | Objective 1: There is relevant and up to date procedures in place that are available to staff and align to the All-Wales guidance. | 2.2 **Medical Resourcing**<br><br>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.<br><br>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.<br><br>There is possibility of duplication within the Health Board through the operation of standalone people systems and development of silo expertise. | 2.2 Establish clear communication channels for escalating job planning concerns or discrepancies. | Sreeman Andole, Interim Executive Medical Director | Sreeman Andole, Interim Executive Medical Director; Jason Brannan, Deputy Director of People | 30/09/2025 | | | IHC meetings identifying discrepenacy but without All Wales guidance individual decisions only rather than pan HB guidance |
| 1433 | Consultant Job Planning | 2024 | n/a | Unsatisfactory | High | Objective 1: There is relevant and up to date procedures in place that are available to staff and align to the All-Wales guidance. | 3.1 **EJob Plan First and second sign-off**<br><br>Through a review of first and second sign off details in the Ejob plan system, and verification with the seven clinical directorates / divisions, there were several issues noted with the accuracy of the information on the system . This includes gaps in second approvers, officers no longer in post, and inconsistency with operational management included as either first or second sign off. There was also test data included in the live system. | 3.1 Develop a standardised and systematic approach to monitor job plan completion rates, reporting results to the appropriate forums. | Sreeman Andole, Interim Executive Medical Director | Sreeman Andole, Interim Executive Medical Director; Jason Brannan, Deputy Director of People | 30/04/2025 | | | Historic sign off SOP in place while waiting All Wales guidance |
| 1434 | Consultant Job Planning | 2024 | n/a | Unsatisfactory | High | Objective 1: There is relevant and up to date procedures in place that are available to staff and align to the All-Wales guidance. | 3.2 **EJob Plan First and second sign-off**<br><br>Through a review of first and second sign off details in the Ejob plan system, and verification with the seven clinical directorates / divisions, there were several issues noted with the accuracy of the information on the system . This includes gaps in second approvers, officers no longer in post, and inconsistency with operational management included as either first or second sign off. There was also test data included in the live system. | 3.2 Create escalation protocols for addressing non-compliance promptly and on regular basis and appropriate form. | Sreeman Andole, Interim Executive Medical Director | Sreeman Andole, Interim Executive Medical Director; Jason Brannan, Deputy Director of People | 30/04/2025 | | | Historic sign off SOP in place while waiting All Wales guidance |
| 1435 | Consultant Job Planning | 2024 | n/a | Unsatisfactory | Medium | Objective 1: There is relevant and up to date procedures in place that are available to staff and align to the All-Wales guidance. | 4.1 **Business Continuity**<br><br>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.<br><br>We have confirmed there is no documented business continuity plan in place centrally but are unsighted whether there are arrangements in | 4.1 The system is web based so accessible anywhere and backup by Allocate. | Jason Brannan, Deputy Director of People | Sreeman Andole, Interim Executive Medical Director; Jason Brannan, Deputy Director of People | 30/09/2024 | | | Business Impact Document in first draft, awaiting review from the BC team |
| 1436 | Consultant Job Planning | 2024 | n/a | Unsatisfactory | Medium | Objective 1: There is relevant and up to date procedures in place that are available to staff and align to the All-Wales guidance. | 4.2 **Business Continuity**<br><br>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.<br><br>We have confirmed there is no documented business continuity plan in place centrally but are unsighted whether there are arrangements in | 4.2 Testing and approval of Medical Dental and Elements report from ESR (sessional payments) which will all periodically audits to verify that job plans reconcile with system records and ensure session payments are accurate. | Jason Brannan, Deputy Director of People | Sreeman Andole, Interim Executive Medical Director; Jason Brannan, Deputy Director of People | 30/09/2024 | | | Meeting to review organised for 12 June 2025 |

| | | | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 1437 | Consultant Job Planning | 2024 | n/a | Unsatisfactory | Medium | Objective 1: There is relevant and up to date procedures in place that are available to staff and align to the All-Wales guidance. | 4.3 **Business Continuity**<br><br>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.<br><br>We have confirmed there is no documented business continuity plan in place centrally but are unsighted whether there are arrangements in | 4.3 Automate data entry processes wherever possible to reduce human error in transferring information to ESR. | Jason Brannan, Deputy Director of People | Sreeman Andole, Interim Executive Medical Director; Jason Brannan, Deputy Director of People | 30/09/2024 | | | Met with Allocate and there is no option at this time to automate the feed of data from Allocate directly into ESR |
| 1443 | Consultant Job Planning | 2024 | n/a | Unsatisfactory | High | Objective 3: Job plans include outcomes that are linked to the Health Board's organisational objectives, and the level of achievement is subject to appropriate assessment. | 7. **Evidencing achievement of the Board objectives**<br><br>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 | 7. To revisit with Office of the Medical Director the current outcomes section of the job plan and align more fully with the PADR process for other staff groups to ensure objectives can be aligned to allow Consultant & SAS Doctors to support in achieving them. | Sreeman Andole, Interim Executive Medical Director | Sreeman Andole, Interim Executive Medical Director; Jason Brannan, Deputy Director of People | 30/04/2025 | 30/10/2025 | 1 | No further update |
| 1446 | Consultant Job Planning | 2024 | n/a | Unsatisfactory | High | Objective 5: The completion rates of job plans are monitored and reported to an appropriate forum, with further escalation if there is low compliance | 10. **Medical and Dental Job Plan reporting**<br><br>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. | 10. Compliance report sent out each week to IHCs/Division which breaks down job plan compliance and can be filtered to obtain more detail as required. | Jason Brannan, Deputy Director of People | Sreeman Andole, Interim Executive Medical Director; Jason Brannan, Deputy Director of People | 30/04/2025 | | | Compliance report updated twice a week, and specialty managers and clinical managers are emailed the link link to report in column W |
| 1447 | Consultant Job Planning | 2024 | n/a | Unsatisfactory | High | Objective 5: The completion rates of job plans are monitored and reported to an appropriate forum, with further escalation if there is low compliance | 11.1 **Medical Workforce Group & People & Culture Executive Delivery Group (EDG)**<br><br>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.<br><br>Of the ten MWG meetings scheduled to take place this calendar year, only three have taken place (April, June and September 2024).<br><br>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. | 11.1 To establish the People and Culture EDG which the Medical Workforce Group will report into. The TORs for Medical Workforce are to be reviewed. | Jason Brannan, Deputy Director of People | Sreeman Andole, Interim Executive Medical Director; Jason Brannan, Deputy Director of People | 30/04/2025 | | | Copy of approved TORs provided |
| 1448 | Consultant Job Planning | 2024 | n/a | Unsatisfactory | High | Objective 5: The completion rates of job plans are monitored and reported to an appropriate forum, with further escalation if there is low compliance | 11.2 **Medical Workforce Group & People & Culture Executive Delivery Group (EDG)**<br><br>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.<br><br>Of the ten MWG meetings scheduled to take place this calendar year, only three have taken place (April, June and September 2024).<br><br>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. | 11.2 Dashboards will be provided to Medical Workforce Group | Jason Brannan, Deputy Director of People | Sreeman Andole, Interim Executive Medical Director; Jason Brannan, Deputy Director of People | 30/04/2025 | | | No update |
| 1449 | Consultant Job Planning | 2024 | n/a | Unsatisfactory | High | Objective 5: The completion rates of job plans are monitored and reported to an appropriate forum, with further escalation if there is low compliance | 11.3 **Medical Workforce Group & People & Culture Executive Delivery Group (EDG)**<br><br>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.<br><br>Of the ten MWG meetings scheduled to take place this calendar year, only three have taken place (April, June and September 2024).<br><br>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. | 11.3 Reports are sent out on weekly basis to IHC/Divisions with link to access Power BI to review all relevant data. | Jason Brannan, Deputy Director of People | Sreeman Andole, Interim Executive Medical Director; Jason Brannan, Deputy Director of People | 30/04/2025 | | | OMD are issuing the link and files for the compliance report 2/3 times per week People Services have updated the summary tab to update weekly. Action completed |

| | | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 1551 | Waiting List Initiative payments – IHC Centre | 2025 | Limited | Unsatisfactory | High | Objective 1: There is a current WLI procedure in place that is available for all staff that align with the Amendment to the National Consultant Contract in Wales. | 1. **Health Board Procedure**<br>The Health Board has no Procedure detailing the planning, authorising, recording and monitoring of Waiting List Initiative (WLI) work in relation to medical and dental staff. We have noted Cardiff and Vale University Health Board have published a dedicated procedure that could be used as a template for developing one in the Health Board (Reference: Waiting List Initiative Procedure - Medical & Dental Staff UHB 515). | 1. The Health Board develop, in partnership, and ratify a Waiting List Initiative Procedure to ensure Waiting List Initiative sessions are applied consistently and subject to effective scrutiny and approval across the Health Board, eliminating any inconsistent practice that may be in place with localised, undocumented procedures. The Central IHC, on behalf of the Chief Operating Officer, will lead the development of a BCUHB Waiting List Initiative Procedure. | Gareth Evans, IHC Director - Central | Tehmeena Ajmal, Chief Operating Officer | 31/07/2025 | | | Audit Report received 06/05/2025 |
| 1558 | Effective Governance - Cancer Services | 2025 | Limited | Unsatisfactory | High | Objective 3: The service is progressing and monitoring tier 2/3 clinical audits and contributing to tier 1 audits as required, with processes in place to share details of lessons learnt. | 3. **Clinical Audit**<br>Management advised that due to absence of Clinical Director, the service is not progressing or monitoring tier 2/3 clinical audits. A gap is identified and will therefore be reviewed by the SLT during 25/26. | Level 3 audits within radiotherapy are in their infancy and this is a piece of work that we are addressing following the HIW visit. We have asked an SAS Dr to support the mortality reviews with the Clinical Lead for Radiotherapy which addresses in part level 2 audits.<br>Cancer SLT have also fed back that the Health Board needs to invest in a Chief Clinical Information Officer.<br>Oncology is currently reliant on locum and agency medics who have no SPAs in their job plans only DCCs resulting in limited capacity.<br>The clinical Leads will focus on creating roles with Clinical Audit responsibilities within Consultant Job Plans as we continue to recruit into vacancies on a substantive basis. | Oncology Clinical Lead | Tehmeena Ajmal, Chief Operating Officer | 31/03/2026 | | | Audit Report received 06/05/2025 |

## OPEN 'LIMITED' RECOMMENDATIONS

| ID | Report Title | Year | Overall Report rating - from Jan 2025 | Assurance Level | Priority | Theme | Recommendation Title | Recommendation | Management Response | Action Owner | Final Approver | Original implementation date | Revised implementation date | Number of Revisions | Latest update |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 0298 | Falls Management | 2023 | n/a | Limited | High | No theme | Matter Arising 3: Training (Operation and Design) | 3.1a: To review training compliance for all areas relating to Patient Handling training and ensure staff who require training undertake this as soon as possible. | 3.1a: Manual Handling (MH) is a Tier One risk on the BCUHB risk register scoring 16 requiring regular review of actions being completed. MH training compliance data cascaded monthly to respective IHC's/Division Director of Operations to include compliance, did not attend rates and available capacity for upcoming 2 months. Capacity within the MH training team to be optimised with focused recruitment drive for Band 6 posts (x3) supported by workforce. | Lynne Bushell - Head of Health, Safety and Security | Angela Wood, Executive Director of Nursing and Midwifery | 01/01/2024 | 31/07/2025 | 6 | At the end of the financial year 31/03/2025 training compliance stood at 77.93% for Permanent and Fixed Term Temporary Workers, and 73.04% for Bank, Locum and Honorary Workers. This is a fluctuating picture over a 12-month period; however a steady increase can be seen for substantive staff at the end of this reporting period. Whilst a dip can be seen for bank staff, at the close of this financial year an overall increase of 23.30% has been recorded in comparison to the close of the last financial year, which was 60.81%.<br><br>Recruitment to 2 x substantive B6 Manual Handling and Ergonomic Advisor posts was successful. Start date 01/07/2025.<br>Training venues continue to be an issue and will remain until appropriate venues can be sourced.<br><br>JD and PS for Generic Health and Safety Trainer has |
| 0491 | Health and Safety - 2024 | 2024 | n/a | Limited | Medium pre 01/10/2024 | No theme | 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 | Lynne Bushell, Head of Health, Safety and Security | Stuart Keen, Director of Environment and Estates | 01/09/2024 | | | Executive Director Now in post, HSE delivered a briefing to Execs (not Training). In June, further training to be agreed with Pam Wenger |
| 0493 | Health and Safety - 2024 | 2024 | n/a | Limited | High | No theme | 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 | Lynne Bushell, Head of Health, Safety and Security | Stuart Keen, Director of Environment and Estates | 30/04/2024 | | | Whilst initial gap analysis was completed in February 2024 and presented at SOHSG, a revised gap analysis against the NHS employers H&S standards was commenced by Head of Service in February, this in itself will inform the strategic plan going forward. |
| 1340 | Corporate Legislative Compliance - Fire Safety | 2024 | n/a | Limited | High | No theme | 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 | Stuart Keen, Director of Environment and Estates | Stuart Keen, Director of Environment and Estates | 29/10/2024 | 10/04/2025 | 1 | Discussed at february SOHSG, new TOR will require further review now H&S is within Environment and Estates Directorship |
| 1341 | Corporate Legislative Compliance - Fire Safety | 2024 | n/a | Limited | Medium | No theme | Matter Arising 2: Policy for the Management of Fire Safety (Design) | 2.1a The Health Board review and update its policy for the Management of Fire Safety to ensure compliance with the Welsh Health Technical Memorandum (WHTM) 05-01 'Firecode – Managing healthcare fire safety', and Welsh Assembly Government NHS Wales Fire Safety Policy. | 2.1a Fire Safety Policy to be reviewed and updated to reflect the current management structure and contents in accordance with current legislation and WHTM 05-01 Firecode - Managing healthcare fire safety. | Arwel Hughes, Head of Operational Estates | Stuart Keen, Director of Environment and Estates | 20/03/2025 | | | The Fire Safety Policy has been reviewed by the Director of Environment and Estates and is going through the governance process for submission on BetsiNet |
| 1342 | Corporate Legislative Compliance - Fire Safety | 2024 | n/a | Limited | Medium | No theme | Matter Arising 3: Fire Risk Assessments (Operation) | 3.1a All officers accountable for Fire Risk Assessments ensure documents are reviewed and updated at regular intervals to ensure potential and new risks have been identified and evaluated. This should be monitored and escalated via the Fire Safety Management Group. | 3.1a Fire Safety Advisors to ensure Fire Risk Assessments are undertaken within the recognised timeframes contained within HTM05-03: Operational provisions Part K - Guidance on fire risk assessments in complex healthcare premises. Reports will be generated and presented to the Fire Safety Management Group. Results will be escalated as appropriate. | Arwel Hughes, Head of Operational Estates | Stuart Keen, Director of Environment and Estates | 26/03/2025 | | | As of the end of March 2025, the HB is 93% compliant with the reviews of FRA across the Estate. Report on compliance is presented at the Fire Safety Management Group. |
| 1343 | Corporate Legislative Compliance - Fire Safety | 2024 | n/a | Limited | High | No theme | 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 | Stuart Keen, Director of Environment and Estates | 20/03/2025 | | | Fire Safety Training is being delivered by the Fire Safety Team in accordance with the training delivery plan, staff compliance level are reported through the Fire Safety Management Group. Training to be reviewed on introduction of the WHTM 05-03 Part A. |
| 1345 | Corporate Legislative Compliance - Fire Safety | 2024 | n/a | Limited | High | No theme | Matter Arising 6: Site Specific Issues / Documentation (Operation) | 6.1a (i) Management ensure issues identified in Appendix C of this report should be progressed through local arrangements and assurance provided to the Fire Safety Management Group on progress / completion. | 6.1a (i) Action plan has been generated to address the issues raised in Appendix C of this report and progress on resolving the findings will be reported to the Fire Safety Management Group. | Arwel Hughes, Head of Operational Estates | Stuart Keen, Director of Environment and Estates | 20/03/2025 | | | The Action Plan is presented to to Fire Safety Management Group and updated accordingly. Current compliance with action plan is 90% completed. |
| 1346 | Corporate Legislative Compliance - Fire Safety | 2024 | n/a | Limited | High | No theme | Matter Arising 6: Site Specific Issues / Documentation (Operation) | 6.1a (ii) Management ensure issues identified in Appendix C of this report should be progressed through local arrangements and assurance provided to the Fire Safety Management Group on progress / completion. | 6.1a (ii) Review the current arrangements for the undertaking of pre-planned maintenance and present the findings and recommendations to the Fire Safety Management Group. | Arwel Hughes, Head of Operational Estates | Stuart Keen, Director of Environment and Estates | 20/03/2025 | | | Contract awarded for maintenance of fire fighting equipment and update presented at the Fire Safety Management Meeting in January 2026. |
| 1347 | Corporate Legislative Compliance - Fire Safety | 2024 | n/a | Limited | High | No theme | Matter Arising 6: Site Specific Issues / Documentation (Operation) | 6.1a (iii) Management ensure issues identified in Appendix C of this report should be progressed through local arrangements and assurance provided to the Fire Safety Management Group on progress / completion. | 6.1a (iii) Report the number and results of Fire Drills to the Fire Safety Management Group. | Arwel Hughes, Head of Operational Estates | Stuart Keen, Director of Environment and Estates | 27/11/2024 | | | Fire drills are reported through the Fire Safety Management Meeting. |
| 1348 | Corporate Legislative Compliance - Fire Safety | 2024 | n/a | Limited | High | No theme | Matter Arising 6: Site Specific Issues / Documentation (Operation) | 6.1a (iv) Management ensure issues identified in Appendix C of this report should be progressed through local arrangements and assurance provided to the Fire Safety Management Group on progress / completion. | 6.1a (iv) Review the current arrangements for the undertaking of Fire drills across BCUHB and present the findings and recommendations to the Fire Safety Management Group. | Arwel Hughes, Head of Operational Estates | Stuart Keen, Director of Environment and Estates | 27/11/2024 | | | Fire Drills are reported within the Fire Safety Management Meeting, minutes of meeting forwarded as assurance |

| | | | | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 1438 | Consultant Job Planning | 2024 | n/a | Limited | High | Contractual | Objective 2: Job plans accurately reflect both the individual and organisation activity requirements and are completed in a timely manner. | 5.1 **Job Plan annual review**<br><br>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.<br><br>The Health Board is not compliant with its responsibility for ensuring annual job plan reviews are undertaken every twelve months and ensuring adequate narrative is completed around additional SPA sessions and place of work. | 5.1 The Medical Dental and Elements pay report from ESR once approved will identify employment start date, which would be their incremental date. | Sreeman Andole, Interim Executive Medical Director; Jason Brannan, Deputy Director of People | Sreeman Andole, Interim Executive Medical Director; Jason Brannan, Deputy Director of People | 30/04/2025 | | | Meeting to review organised for 12 June 2025 |
| 1439 | Consultant Job Planning | 2024 | n/a | Limited | High | Contractual | Objective 2: Job plans accurately reflect both the individual and organisation activity requirements and are completed in a timely manner. | 5.2 **Job Plan annual review**<br><br>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.<br><br>The Health Board is not compliant with its responsibility for ensuring annual job plan reviews are undertaken every twelve months and ensuring adequate narrative is completed around additional SPA sessions and place of work. | 5.2 Use the power BI compliance report as an evaluation framework to assess the level of achievement of these outcomes regularly. | Sreeman Andole, Interim Executive Medical Director; Jason Brannan, Deputy Director of People | Sreeman Andole, Interim Executive Medical Director; Jason Brannan, Deputy Director of People | 30/04/2025 | | | Compliance observed via Power BI in place, Job Planning compliance has increased from 22% January 2025 to 37% June 2025 |
| 1440 | Consultant Job Planning | 2024 | n/a | Limited | High | Contractual | Objective 2: Job plans accurately reflect both the individual and organisation activity requirements and are completed in a timely manner. | 5.3 **Job Plan annual review**<br><br>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.<br><br>The Health Board is not compliant with its responsibility for ensuring annual job plan reviews are undertaken every twelve months and ensuring adequate narrative is completed around additional SPA sessions and place of work. | 5.3 To ensure detailed information around SPA sessions is captured within job plans by IHC/Division. | Sreeman Andole, Interim Executive Medical Director; Jason Brannan, Deputy Director of People | Sreeman Andole, Interim Executive Medical Director; Jason Brannan, Deputy Director of People | 30/04/2025 | | | No update as still waiting all Wales guide. |
| 1441 | Consultant Job Planning | 2024 | n/a | Limited | High | Performance Monitoring | Objective 2: Job plans accurately reflect both the individual and organisation activity requirements and are completed in a timely manner. | 6.1 **Directorate/Specialty objectives are explicit**<br><br>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".<br><br>From our review, we are unclear how management are approving job plans without expected service objectives.<br><br>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. | 6.1 Establish with the team a cross-departmental assessment to address identified areas not complete, for example service outcomes not recorded. | Sreeman Andole, Interim Executive Medical Director | Sreeman Andole, Interim Executive Medical Director; Jason Brannan, Deputy Director of People | 30/04/2025 | | | Ongoing work to upload dept outcomes and priorities as job plans occur - discussed at IHC meeting |
| 1442 | Consultant Job Planning | 2024 | n/a | Limited | High | Performance Monitoring | Objective 2: Job plans accurately reflect both the individual and organisation activity requirements and are completed in a timely manner. | 6.2 **Directorate/Specialty objectives are explicit**<br><br>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".<br><br>From our review, we are unclear how management are approving job plans without expected service objectives.<br><br>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. | 6.2 Schedule regular reviews of job planning practices to ensure continuous improvement and compliance with audit standards. | Sreeman Andole, Interim Executive Medical Director | Sreeman Andole, Interim Executive Medical Director; Jason Brannan, Deputy Director of People | 30/04/2025 | | | Ongoing work to upload dept outcomes and priorities as job plans occur - discussed at IHC meeting |
| 1444 | Consultant Job Planning | 2024 | n/a | Limited | High | Financial Management & Control | Objective 4: Completed job plans reconcile to system records and session payments are correct. | 8. **Regular review of payments to agreed job plan commitments**<br><br>We identified six (27%) of the twenty-two job plans with a variance between the sessions paid and that recorded on the job plan.<br><br>We also found a variance in Intensity Band payments and are unclear whether these payments are subject to annual reviewor simply roll-over.<br><br>The payment of only whole sessions could adversely impact the Health Board to deliver against its waiting lists as this does not always | 8. Medical Dental and Elements report from ESR (under development) will be able to flag up issues with sessional pay, intensity bandings. | Jason Brannan, Deputy Director of People | Sreeman Andole, Interim Executive Medical Director; Jason Brannan, Deputy Director of People | 30/04/2025 | | | Meeting to review organised for 12 June 2025 |

| | | | | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 1445 | Consultant Job Planning | 2024 | n/a | Limited | Medium | Resourcing | Objective 4: Completed job plans reconcile to system records and session payments are correct. | 9. **Additional sessions undertaken outside of the substantive post**<br><br>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. | 9. IHC/Divisions need to have detailed meetings with Consultants to breakdown the job plan, to identify what sessions are additional and justification of still being required to be completed. | Sreeman Andole, Interim Executive Medical Director | Sreeman Andole, Interim Executive Medical Director; Jason Brannan, Deputy Director of People | 30/09/2025 | | | On going work focusing on high session job plans |
| 1501 | Establishment Control | 2025 | Reasonable | Limited | High | Finance Management & Control | Objective 3: ESR staff in post figures are accurate and subject to regular validation. | 5. Data discrepancies – ESR and Ledger Funded posts on the General Ledger should match the information of the establishment (position WTE) for all posts on ESR.<br><br>Through testing the data provided by Finance Business Systems and People and OD we have identified through data matching a variance of 391.84 WTE where the ESR position establishment WTE is higher than the actual funded WTE in the | 5. Finance will review the process for negative budgets with Chief Finance Officers and IHC Directors to ensure a consistent approach is utilised and applied to aid matching information in ESR and the Ledger. | Nick Graham, Associate Director - Workforce Optimisation; Joanna Garrigan Finance Director - Commissioning and Strategy | Russell Caldicott, Executive Director of Finance | 31/03/2025 | 30/06/2025 | 1 | Work continues to be carried out in the systems to ensure ESR and ledger information is a more accurate reprentaitve of the vacancy position. |
| 1513 | Transformation & Improvement | 2025 | Reasonable | Limited | High | Governance | Objective 3: Progress and achievements are reported through to the Health Board via its Committees / Groups to provide assurance. | 3. **Assurance reporting**<br>We have been unable to determine the Transformation and Improvement team are subject to effective oversight or scrutiny through their reporting via the Health Board's governance structure, concerning areas they are supporting or accountable for through to whether changes made in transformation have made a difference. | 3. Agree schedule of regular oversight reporting to the Executive Committee through to the appropriate Board Sub Committee | Paolo Tardivel, Director of Transformation and Improvement | Paolo Tardivel, Interim Executive Director of Transformation and Strategic Planning | 30/04/2025 | | | It has been agreed that the Programme Boards for all Major Change Programmes will report directly to the Executive Committee. All other key transformation related programmes of work, including challenged services and key programmes, will report to the Srategic Planning and Service change group, and onwards to the Executive Committee and through to PPHP. The second meeting of this group took place on the 5th June and the agreed areas within scope will be reported through a cycle of business. |
| 1524 | Clinical Audit - 2025 | 2025 | Limited | Limited | Medium | Policies & Procedures | Objective 4: Learning from clinical audits is documented in line with Health Board guidance and shared at appropriate forum(s) across the Health Board. | 3. Overdue Service Assessment of Compliance proformas We were unable to observe evidence of escalation emails for overdue SAoCs being sent for two of the three overdue audits we sampled. | 3. The Clinical Effectiveness Facilitator (CEF) will as part of the SOP ensure the following will be required:<br>(a) Evidence of email escalations to be saved to the project folder by the CEF team and an update of the SOP to ensure this is part of the process<br>(b) Schedule regular departmental audits of project folders to confirm that evidence is there – on quarterly basis to be captured with reports produced<br>(c) Document evidence of escalations in The Audit Management and Tracking (AMaT) to make the process transparent – this will show which areas have not replied and ensure that this information is captured by the CEF and monitored properly or escalated as necessary | Joanne Shillingford, Head of Clinical Effectiveness | Sreeman Andole, Interim Executive Medical Director | 01/04/2025 | 30/06/2025 | 1 | Evidence available end of June as being reviewed and monitored in line with Quarterly reports |
| 1525 | Clinical Audit - 2025 | 2025 | Limited | Limited | High | Policies & Procedures | Objective 4: Learning from clinical audits is documented in line with Health Board guidance and shared at appropriate forum(s) across the Health Board. | 4. Escalation process for overdue action plans For Tier 1 audits, when an action becomes overdue, weekly reminder emails are sent to the action owner generated from the AMaT system. If the owner does not respond, there is no escalation process in place to ensure the action is completed. | 4. We will develop a process for this, to ensure that moving forward that progress is included with Tier 1 improvement actions and included in the Monthly Assurance report that is sent out to IHCs and Divisions. Need to ensure tighter controls are incorporated in our SOPs and that monitored on regular basis to raise and escalate with actions that are overdue | Joanne Shillingford, Head of Clinical Effectiveness | Sreeman Andole, Interim Executive Medical Director | 01/04/2025 | 30/06/2025 | 1 | Evidence available end of June as being reviewed and monitored in line with Quarterly reports |
| 1526 | Clinical Audit - 2025 | 2025 | Limited | Limited | High | Lessons Learnt | Objective 4: Learning from clinical audits is documented in line with Health Board guidance and shared at appropriate forum(s) across the Health Board. | 5. Lessons learnt shared to appropriate forum We have not been able to demonstrate oversight in collecting data on lessons learned/shared and in developing action plans to address issues from Tier 2 audits. | 5. Tier 2 audit details have been captured through Strategic CEG updates and within quarterly reports, however going forward there needs to be a more robust process, similar to Tier 1 and Tier 3. A form will be development to roll out from April 2025 to capture learning, where shared and development of actions plans. | Joanne Shillingford, Head of Clinical Effectiveness | Sreeman Andole, Interim Executive Medical Director | 01/04/2025 | 30/06/2025 | 1 | Evidence available end of June as being reviewed and monitored in line with Quarterly reports |
| 1527 | Clinical Audit - 2025 | 2025 | Limited | Limited | High | Quality, Safety & Patient Experience | Objective 5: Local (Tier 3) audits are registered with the Clinical Effectiveness Team, are progressed in line with timescales stated, and appropriate documentation completed | 6. Overdue Tier 3 audits<br><br>A large number of Tier 3 audits (183) are overdue with no revised dates of completion.<br><br>We recognise the clinical effectiveness team have introduced a process to improve completion rates, however Integrated Health Communities (IHCs) and Services are responsible for monitoring their Tier 3 audits, and ensuring the E-tool system is up to date with expected time scales. | 6. Prior to the internal audit, we had already development and were getting these steps in place:<br><br>The Clinical Effectiveness Department emails auditors that have overdue projects, to ask them to update the e-tool (either with an updated completion date, mark as complete by uploading report or mark as abandoned).<br>This has been agreed within the team that once this has been requested 3 times non-progress will be reported through departmental Clinical Effectiveness NICE/Audit Group (CENAG) and will then be raised within IHC/Divisions/Services | Joanne Shillingford, Head of Clinical Effectiveness | Sreeman Andole, Interim Executive Medical Director | 01/04/2025 | 30/06/2025 | 1 | Evidence available end of June as being reviewed and monitored in line with Quarterly reports |
| 1532 | Board Assurance Framework and Risk Management | 2025 | Reasonable | Limited | High | Training & Development | Objective 5: There is targeted risk management training available to staff throughout the Health Board, with completion / compliance monitored. | 1. No level 1 mandatory training taking place but note an e learning video has been created and is awaiting upload.<br>We are unable to determine the number of staff who require Level 2 and/or Level 3 training versus those who have received the training.<br>Not all Health Board Members and regular attendees attended the training session on risk management. | 1. A new risk management system is being procured, and this will be able to demonstrate all handlers and owners (level 2) requiring training. This will be in place Feb 2026. However, training compliance figures for Level 1 and Level 3 will be shared with the Executive Committee, Directorate, and Divisions, with the support of the Corporate Risk Team. This will facilitate a Health Board-wide approach and ensure commitment | Pam Wenger, Director of Corporate Governance; Nesta Collingridge, Head of Risk | Pam Wenger, Director of Corporate Governance | 01/03/2026 | | | Level 1, basic risk awareness video is now live on ESR and shared through the newsletter. It has not be approved by the Executive Committee to make this mandatory in an effort to reduce the number of training and associated costs. We can see from the ESR report 16 people have watched this video. A communication strategy is in development to ensure we regularly communicate that this video exists. It will not show up for staff otherwise. More level 2 and 3 dates have been communicated to targeted staff groups to increase compliance in June. Trackers are being updated to ensure they are more robust and reports requested from WOD on starters and leavers. |
| 1534 | Contracted Patient Services: Quality and Safety Arrangements - Follow-up | 2025 | Limited | Limited | High | No theme | 1. Process Management | 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: 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. | Stephen Powell, Director of Performance and Commissioning | Stephen Powell, Director of Performance and Commissioning | 30/06/2025 | | | Work will be progressed for completion in Q1 2025/26 |
| 1535 | Contracted Patient Services: Quality and Safety Arrangements - Follow-up | 2025 | Limited | Limited | High | No theme | 2. Contractual Obligations | 2.1: 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: 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. | Stephen Powell, Director of Performance and Commissioning | Stephen Powell, Director of Performance and Commissioning | 30/06/2025 | | | Work will be progressed for completion in Q1 2025/26 |
| 1536 | Contracted Patient Services: Quality and Safety Arrangements - Follow-up | 2025 | Limited | Limited | High | No theme | 3. Quality Measures | 3.1: Management to review contractual quality measures to ensure they are robust, effective, and appropriate. | 3.1: For the 2023/2024 period, quality schedules will be included in contracts that reflect national requirements. | Stephen Powell, Director of Performance and Commissioning | Stephen Powell, Director of Performance and Commissioning | 30/06/2025 | | | Work will be progressed for completion in Q1 2025/26 |

| | | | | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 1537 | Contracted Patient Services: Quality and Safety Arrangements - Follow-up | 2025 | Limited | Limited | High | No theme | 3. Quality Measures | 3.2: Management to ensure procedures have provision for addressing and escalating quality issues that fall outside the agreed measures. | 3.2: 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. | Stephen Powell, Director of Performance and Commissioning | Stephen Powell, Director of Performance and Commissioning | 30/06/2025 | | | Work will be progressed for completion in Q1 2025/26 |
| 1538 | Contracted Patient Services: Quality and Safety Arrangements - Follow-up | 2025 | Limited | Limited | High | No theme | 4. Board Assurance | 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: 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. | Stephen Powell, Director of Performance and Commissioning | Stephen Powell, Director of Performance and Commissioning | 30/06/2025 | | | Work will be progressed for completion in Q1 2025/26 |
| 1540 | Discretionary Capital Funding Allocation | 2025 | Reasonable | Limited | High | Finance Management & Control | Objective 2: A risk-based approach is taken to review, scrutinise and prioritise bids for funding. | 2. **Prioritising Discretionary Capital**<br>We requested a list of all schemes not approved for funding to establish reasons for this. Management advise that the Capital programme goes through the approval process detailed and that the Health Board is free to prioritise the sum allocated as it best sees fit and as such different from the Capital programme that requires Welsh Government approval.<br><br>The Head of Capital Development advised that all bids are prioritised by the respective IHC's and regional group Senior Leadership Teams prior to submission. We have been unable to verify this from information provided and subsequently could not establish reason why some potential investments have taken priority over others. We recognise that whilst it is at the Health Board's discretion to allocate the funding, management should demonstrate why some bids have been prioritised over others prior to the development of a business case. This would ensure that the funding is allocated to priority areas. | 2. As a course of action the capital programme follows a prioritisation process before approval. However, it is acknowledged that although we have 2 year plan there is in year pressures that will take precedent over the initial agreed programme. We will ensure that when this does happen all submissions will be considered at CIG for change control and in line with the SFIs follow approval if required. | Head of Capital Estates; Denise Roberts, Head of Capital, Compliance and Business Improvement | Russell Caldicott, Executive Director of Finance | 30/04/2025 | | | We will evidence any in year prioritisation and pressures including approvals in CIG. |
| 1552 | Waiting List Initiative payments – IHC Centre | 2025 | Limited | Limited | High | Financial Management & Control | Objective 2: WLI activity is only commissioned and agreed to be undertaken in uncontracted time. | 2.1 **WLI Payments**<br>We have been unable to verify the WLI claims made and approved comply in full with the requirements of the National Consultant Contract in Wales. Eighty percent (80%) of the Consultants in our sample do not have agreed and locked-down job plans to verify the completion of WLI sessions are undertaken in uncontracted time. | **Action 1**. The procedure (above) and agreement of WLI sessions /claim forms to include confirmation that WLI activity complies with requirements of the Consultant Contract. This is a field that will be included in the new BCUHB electronic form to be used to monitor WLI compliance. | Steve Harper, Head of Business Systems | Tehmeena Ajmal, Chief Operating Officer | 31/05/2025 | | | Work in progress to update field on system in line with procedure - further update will be provided following completion |
| 1553 | Waiting List Initiative payments – IHC Centre | 2025 | Limited | Limited | High | Financial Management & Control | Objective 2: WLI activity is only commissioned and agreed to be undertaken in uncontracted time. | 2.2 **WLI Payments**<br>We have been unable to verify the WLI claims made and approved comply in full with the requirements of the National Consultant Contract in Wales. Eighty percent (80%) of the Consultants in our sample do not have agreed and locked-down job plans to verify the completion of WLI sessions are undertaken in uncontracted time. | **Action 2**. Supported by the agreed management actions following the Consultant Job Planning Internal Audit report in January 2025, we will ensure an improvement to enable completion of annual job plans to 80% within each year and sustain every year thereafter. | IHCs, MH&LD, Diagnostic and Women's Medical Directors | Tehmeena Ajmal, Chief Operating Officer | 31/03/2026 | | | *New report - no update yet* |
| 1554 | Waiting List Initiative payments – IHC Centre | 2025 | Limited | Limited | High | Financial Management & Control | Objective 2: WLI activity is only commissioned and agreed to be undertaken in uncontracted time. | 2.3 **WLI Payments**<br>We have been unable to verify the WLI claims made and approved comply in full with the requirements of the National Consultant Contract in Wales. Eighty percent (80%) of the Consultants in our sample do not have agreed and locked-down job plans to verify the completion of WLI sessions are undertaken in uncontracted time. | **Action 3.** BCUHB must clarify its interpretation of section 2.38 of the contract which states - Such sessions may be undertaken in uncontracted time. This will bring clarity to the process, managers involved and clinicians and standardisation in terms of how this is interpreted across specialties. For example, some specialities / IHC interpret uncontracted sessions to include SPA while others do not, as revealed in this audit. | Deputy Medical Director | Tehmeena Ajmal, Chief Operating Officer | 31/06/2025 | | | *New report - no update yet* |
| 1555 | Waiting List Initiative payments – IHC Centre | 2025 | Limited | Limited | High | Financial Management & Control | Objective 2: WLI activity is only commissioned and agreed to be undertaken in uncontracted time. | 2.4 **WLI Payments**<br>We have been unable to verify the WLI claims made and approved comply in full with the requirements of the National Consultant Contract in Wales. Eighty percent (80%) of the Consultants in our sample do not have agreed and locked-down job plans to verify the completion of WLI sessions are undertaken in uncontracted time. | **Action 4**. Whilst the procedure is under development, additional controls will be implemented to ensure agreed WLI activity is undertaken in uncontracted time noting the need for clarification from action 3. The new electronic form will capture confirmation that the activity is being performed in uncontracted time which will be audited by operational and medical leadership teams. | Steve Harper, Head of Business Systems | Tehmeena Ajmal, Chief Operating Officer | 31/05/2025 | | | Work in progress to update field on system in line with procedure - further update will be provided following completion |
| 1557 | Partnerships, Engagement and Communication | 2025 | Limited | Limited | Medium | Information, Data Quality & Data Accuracy | Objective 2: There is progress in delivery of the strategy elements, and evidence of improvements to date. Where these have not been delivered, there is evidence that these have been subject to discussion / change and, where appropriate, are included in future plans. | 2. **Assurance to Board / Committees**<br>We reviewed the agendas and minutes of all Board meetings and Planning, Population Health and Partnerships (PPHP) Committees held between January 2024 and March 2025 and found the following limitations: • No assurance was provided regarding the progress / delivery of the PEC Strategy or Listening to Citizens Independent Review. • The PEC Strategy and Independent Review action plans have not been submitted to the Board or PPHP for review and scrutiny. | **2. Strengthening Evidence and Impact Assurance for Improvement Actions**<br>To improve the consistency, transparency, and assurance of progress reporting, a revised approach will be adopted to strengthen the submission and verification of evidence for all improvement actions.<br>This will include:<br>• Introduction of two new columns to the PEC Delivery Plan:<br>o Benefits/Improvements – outlining the intended or actual change resulting from the action.<br>o Evidence – detailing the supporting documentation or data required to verify delivery and impact.<br>• Named leads for each action in the Delivery Plan will be responsible for collating appropriate evidence and submitting updates against this framework.<br>• Quarterly internal assurance checks will be introduced to assess the quality and completeness of submitted evidence and to support ongoing audit readiness.<br>**Target Implementation Date**: The revised approach will be implemented in Q1 2025–26 (by end June 2025) and apply to all actions | Helen Stevens-Jones, Director of Partnerships, Engagement and Communications | Helen Stevens-Jones, Director of Partnerships, Engagement and Communications | 30/06/2025 | | | All actions on track for end June delivery<br>- plan is on track for delivery end June 2025<br>- Named leads within the plan<br>- Internal assurance embedded within senior leadership team quarterly meetings |

| | | | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 1558 | Partnerships, Engagement and Communication | 2025 | Limited | Limited | High | Information, Data Quality & Data Accuracy | Objective 2: There is progress in delivery of the strategy elements, and evidence of improvements to date. Where these have not been delivered, there is evidence that these have been subject to discussion / change and, where appropriate, are included in future plans. | 3.1 **Staff resources**<br>We reviewed the evidence provided and found the following issues and limitations:<br>• There is no SOP/policy in place outlining the engagement process and requirements.<br>• Engagement toolkits – 2/7 published toolkits require staff to use their personal email addresses/contact details to access and use the resources.<br>• Several documents (7/14) published on the Public Engagement Guides and Resources BetsiNet page are dated 2021/2022 – require review and updating to ensure continued relevance.<br>• The Welsh Government Guidance on Service Change and Key Lines of Enquiry Framework document referred to is not accessible via BetsiNet. | 3.1 Consolidate and strengthen the governance and accessibility of engagement resources to ensure staff have clear, current, and secure tools to support high-quality engagement practice.<br>Key Deliverables:<br>1. **Develop and implement a standard operating procedure (SOP)** that outlines:<br>• The Health Board's expectations for engagement.<br>• Required steps and responsibilities at each stage of the process.<br>• Links to national guidance (e.g. WG guidance on service change).<br>• Monitoring, assurance, and reporting requirements. | Rob Callow, Head of Engagement | Helen Stevens-Jones, Director of Partnerships, Engagement and Communications | 30/09/2025 | | | SOP is on track for delivery end June 2025. |
| 1559 | Partnerships, Engagement and Communication | 2025 | Limited | Limited | High | Information, Data Quality & Data Accuracy | Objective 2: There is progress in delivery of the strategy elements, and evidence of improvements to date. Where these have not been delivered, there is evidence that these have been subject to discussion / change and, where appropriate, are included in future plans. | 3.2 **Staff resources**<br>We reviewed the evidence provided and found the following issues and limitations:<br>• There is no SOP/policy in place outlining the engagement process and requirements.<br>• Engagement toolkits – 2/7 published toolkits require staff to use their personal email addresses/contact details to access and use the resources.<br>• Several documents (7/14) published on the Public Engagement Guides and Resources BetsiNet page are dated 2021/2022 – require review and updating to ensure continued relevance.<br>• The Welsh Government Guidance on Service Change and Key Lines of Enquiry Framework document referred to is not accessible via BetsiNet. | 3.2 Consolidate and strengthen the governance and accessibility of engagement resources to ensure staff have clear, current, and secure tools to support high-quality engagement practice.<br>Key Deliverables:<br>2. **Review and update all published toolkits and guides on the Public Engagement Guides and Resources BetsiNet page**:<br>• Update all materials dated 2021/2022 by July 2025.<br>• Ensure all resources reflect current policy, best practice, and staff feedback.<br>• Include version control, update dates, and named contact for each document. | Rob Callow, Head of Engagement | Helen Stevens-Jones, Director of Partnerships, Engagement and Communications | 30/09/2025 | | | On track for delivery end September 2025 |
| 1560 | Partnerships, Engagement and Communication | 2025 | Limited | Limited | High | Information, Data Quality & Data Accuracy | Objective 2: There is progress in delivery of the strategy elements, and evidence of improvements to date. Where these have not been delivered, there is evidence that these have been subject to discussion / change and, where appropriate, are included in future plans. | 3.3 **Staff resources**<br>We reviewed the evidence provided and found the following issues and limitations:<br>• There is no SOP/policy in place outlining the engagement process and requirements.<br>• Engagement toolkits – 2/7 published toolkits require staff to use their personal email addresses/contact details to access and use the resources.<br>• Several documents (7/14) published on the Public Engagement Guides and Resources BetsiNet page are dated 2021/2022 – require review and updating to ensure continued relevance.<br>• The Welsh Government Guidance on Service Change and Key Lines of Enquiry Framework document referred to is not accessible via BetsiNet. | 3.3 Consolidate and strengthen the governance and accessibility of engagement resources to ensure staff have clear, current, and secure tools to support high-quality engagement practice.<br>Key Deliverables:<br>3. **E**nsure all toolkits and resources do not advise the use of personal emails | Rob Callow, Head of Engagement | Helen Stevens-Jones, Director of Partnerships, Engagement and Communications | 30/09/2025 | | | On track for delivery end September 2025 |
| 1561 | Partnerships, Engagement and Communication | 2025 | Limited | Limited | High | Information, Data Quality & Data Accuracy | Objective 2: There is progress in delivery of the strategy elements, and evidence of improvements to date. Where these have not been delivered, there is evidence that these have been subject to discussion / change and, where appropriate, are included in future plans. | 3.4 **Staff resources**<br>We reviewed the evidence provided and found the following issues and limitations:<br>• There is no SOP/policy in place outlining the engagement process and requirements.<br>• Engagement toolkits – 2/7 published toolkits require staff to use their personal email addresses/contact details to access and use the resources.<br>• Several documents (7/14) published on the Public Engagement Guides and Resources BetsiNet page are dated 2021/2022 – require review and updating to ensure continued relevance.<br>• The Welsh Government Guidance on Service Change and Key Lines of Enquiry Framework document referred to is not accessible via BetsiNet. | 3.4 Consolidate and strengthen the governance and accessibility of engagement resources to ensure staff have clear, current, and secure tools to support high-quality engagement practice.<br>Key Deliverables:<br>4. **Restore access to all key documents reference**d:<br>• Upload the Welsh Government Guidance on Service Change and the Key Lines of Enquiry Framework to BetsiNet.<br>• Ensure all links are checked quarterly for functionality. | Rob Callow, Head of Engagement | Helen Stevens-Jones, Director of Partnerships, Engagement and Communications | 30/09/2025 | | | On track for delivery September 2025 |
| 1562 | Partnerships, Engagement and Communication | 2025 | Limited | Limited | High | Information, Data Quality & Data Accuracy | Objective 2: There is progress in delivery of the strategy elements, and evidence of improvements to date. Where these have not been delivered, there is evidence that these have been subject to discussion / change and, where appropriate, are included in future plans. | 3.5 **Staff resources**<br>We reviewed the evidence provided and found the following issues and limitations:<br>• There is no SOP/policy in place outlining the engagement process and requirements.<br>• Engagement toolkits – 2/7 published toolkits require staff to use their personal email addresses/contact details to access and use the resources.<br>• Several documents (7/14) published on the Public Engagement Guides and Resources BetsiNet page are dated 2021/2022 – require review and updating to ensure continued relevance.<br>• The Welsh Government Guidance on Service Change and Key Lines of Enquiry Framework document referred to is not accessible via BetsiNet. | 3.5 Consolidate and strengthen the governance and accessibility of engagement resources to ensure staff have clear, current, and secure tools to support high-quality engagement practice.<br>Key Deliverables:<br>5. **Introduce a maintenance and review schedule**:<br>• Annual check and update of all engagement resources, with oversight by the Public Engagement and Communications Team.<br>• Assign responsible owner(s) for each section or toolkit | Rob Callow, Head of Engagement | Helen Stevens-Jones, Director of Partnerships, Engagement and Communications | 30/09/2025 | | | On track for delivery September 2025 |
| 1563 | Partnerships, Engagement and Communication | 2025 | Limited | Limited | High | Reporting | Objective 2: There is progress in delivery of the strategy elements, and evidence of improvements to date. Where these have not been delivered, there is evidence that these have been subject to discussion / change and, where appropriate, are included in future plans. | 4. **Operational oversight**<br>We did not receive meeting Terms of References, minutes, or agendas for several of the oversight forums referred to above. Where meeting minutes were provided, they did not demonstrate the extent of scrutiny, review of progress, or raising of issues for escalation. | **4. Enhancing the Recording and Escalation of Progress and Issues**<br>Introduce a standardised and reliable approach to documenting progress updates and escalation of key issues across all relevant internal meeting types. This will include: 1. Ensure log of progress and escalation is used during: o One-to-one meetings between director and senior team leads o Team meetings o Bi-monthly senior leadership team (SLT) meetings 2. Ensure all significant updates and risks related to key programmes within the PEC Delivery Plan are: o Recorded clearly with context, actions taken, and any decisions made o Flagged for formal escalation where appropriate 3. Maintain a central repository (e.g. via SharePoint or Microsoft Teams) for securely storing and retrieving progress records and escalations, accessible to relevant leads and governance teams. 4. Review records quarterly to ensure completeness and identify recurring barriers or delivery challenges requiring escalation to senior governance forums | Helen Stevens-Jones, Director of Partnerships, Engagement and Communications | Helen Stevens-Jones, Director of Partnerships, Engagement and Communications | 30/09/2025 | | | On track for delivey end September 2025 |

| | | | | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 1564 | Partnerships, Engagement and Communication | 2025 | Limited | Limited | High | Performance Monitoring | Objective 3: The effectiveness of actions taken above have/are being measured to demonstrate whether anticipated benefits are being achieved. | 5.1 **Benefits Realisation**<br>There is no consistent formal benefits realisation process in place to manage and monitor benefits / improvements post implementation. We noted the following limitations:<br>• Benefits / improvements were not clearly defined at the outset.<br>• Benefits / improvements are not consistently reviewed, measured or reported for all implemented actions.<br>• Difficult to reconcile reported benefits / impact to specific implemented improvement actions.<br>• Limited evidence of benefits provided for review. | 5.1 Integrate expected benefits and evidence of impact into routine delivery and monitoring.<br>Key Deliverables:<br>1. Integrate benefits tracking into the PEC Delivery Plan, including:<br>o Two new columns: "Expected Benefit/Improvement" and "Evidence of Impact"<br>o Routine completion and updates by action owners as part of monitoring cycles<br>**Target Implementation Date**: The PEC Delivery Plan will be finalised and approved by the end of Q1 2025–26 (June 2025), quarterly reviews to start Q2 (July 2025) and reports to PPHP Committee from Q3 (September 2025) | Helen Stevens-Jones, Director of Partnerships, Engagement and Communications | Helen Stevens-Jones, Director of Partnerships, Engagement and Communications | 30/06/2025 | | | Consolidated delivery plan in progress and on track for completion by due date. |
| 1565 | Partnerships, Engagement and Communication | 2025 | Limited | Limited | High | Performance Monitoring | Objective 3: The effectiveness of actions taken above have/are being measured to demonstrate whether anticipated benefits are being achieved. | 5.2 **Benefits Realisation**<br>There is no consistent formal benefits realisation process in place to manage and monitor benefits / improvements post implementation. We noted the following limitations:<br>• Benefits / improvements were not clearly defined at the outset.<br>• Benefits / improvements are not consistently reviewed, measured or reported for all implemented actions.<br>• Difficult to reconcile reported benefits / impact to specific implemented improvement actions.<br>• Limited evidence of benefits provided for review. | 5.2 Integrate expected benefits and evidence of impact into routine delivery and monitoring.<br>Key Deliverables:<br>2. Implement quarterly benefits reviews, at the bi monthly senior leadership team meeting to assess progress against expected outcomes and ensure supporting evidence is being collected and analysed.<br>**Target Implementation Date**: The PEC Delivery Plan will be finalised and approved by the end of Q1 2025–26 (June 2025), quarterly reviews to start Q2 (July 2025) and reports to PPHP Committee from Q3 (September 2025) | Helen Stevens-Jones, Director of Partnerships, Engagement and Communications | Helen Stevens-Jones, Director of Partnerships, Engagement and Communications | 31/07/2025 | | | On track. Quarterly reviews in the diary and PPHP Committee slots requested. |
| 1566 | Partnerships, Engagement and Communication | 2025 | Limited | Limited | High | Performance Monitoring | Objective 3: The effectiveness of actions taken above have/are being measured to demonstrate whether anticipated benefits are being achieved. | 5.3 **Benefits Realisation**<br>There is no consistent formal benefits realisation process in place to manage and monitor benefits / improvements post implementation. We noted the following limitations:<br>• Benefits / improvements were not clearly defined at the outset.<br>• Benefits / improvements are not consistently reviewed, measured or reported for all implemented actions.<br>• Difficult to reconcile reported benefits / impact to specific implemented improvement actions.<br>• Limited evidence of benefits provided for review. | 5.3 Integrate expected benefits and evidence of impact into routine delivery and monitoring.<br>Key Deliverables:<br>3. Report benefits realisation status bi-annually to the PPHP Committee<br>**Target Implementation Date**: The PEC Delivery Plan will be finalised and approved by the end of Q1 2025–26 (June 2025), quarterly reviews to start Q2 (July 2025) and reports to PPHP Committee from Q3 (September 2025) | Helen Stevens-Jones, Director of Partnerships, Engagement and Communications | Helen Stevens-Jones, Director of Partnerships, Engagement and Communications | 30/09/2025 | | | On track. Quarterly reviews in the diary and PPHP Committee slots requested. |
| 1567 | Partnerships, Engagement and Communication | 2025 | Limited | Limited | High | Governance | Objective 4: There are robust governance arrangements in place to ensure that delivery of the Strategy, plan and recommendations from the independent report are subject to Health Board oversight and scrutiny, and assurance of progress is provided to the Board and / or relevant Committees. | 6. **Assurance to Board / Committees**<br>We reviewed the agendas and minutes of all Board meetings and Planning, Population Health and Partnerships (PPHP) Committees held between January 2024 and March 2025 and found the following limitations: • No assurance was provided regarding the progress / delivery of the PEC Strategy or Listening to Citizens Independent Review. • The PEC Strategy and Independent Review action plans have not been submitted to the Board or PPHP for review and scrutiny. | 6. Establish a formal reporting and assurance process to ensure the PPHP Committee receives regular updates on progress, risks, and impact related to the PEC Delivery Plan 2025/26.<br>Key Steps:<br>1. **Biannual Highlight Reports** – Provide biannual update papers to PPHP each November and March, including: o Current delivery position o Key achievements o Issues for escalation<br>2. **Committee Scheduling** – Work with Board Secretariat to agree a standing slot in the PPHP Committee annual workplan to ensure formal visibility and expectation of updates.<br>3. **Strategic Oversight Role of PEC SLT** – Ensure the PEC SLT has responsibility for reviewing assurance drafts prior to submission, enabling consistency and quality control. | Helen Stevens-Jones, Director of Partnerships, Engagement and Communications | Helen Stevens-Jones, Director of Partnerships, Engagement and Communications | 30/11/2025 | | | On track, PPHP slots requested and SLT working in strategic oversight way. |
| 1568 | Effective Governance - Cancer Services | 2025 | Limited | Limited | High | Governance | Objective 1: There is an appropriate governance and reporting structure in place within the service to provide assurance on services and ensure oversight of all areas of responsibility. Reporting includes ward to board assurance, audit results, ward accreditation information and monitoring of actions resulting from external reviews such as Healthcare Inspectorate Wales and Audit Wales | 1. Governance arrangements The Terms of Reference (ToR) for the Senior Leadership Team sets out the remit of the group, and there is a standing agenda item which includes all areas for discussion at each meeting. A review of the minutes for January, February and March 2025 meetings show that whilst most areas on the agenda are discussed within the PFIG Update – Performance, Finance, Information Governance item, there was no update provided on Cancer Pathway Performance at the January and February meetings. We also noted through reports to the Health Board and Committee that performance is not at a level it should be but found minutes did not record specific action to improve on performance. | 1. It is noted that PFIG updates to the SLT on the Cancer Pathway performance were not provided during January and February meetings due to annual leave of the cancer network lead. An update was presented at the 17th March 2025 meeting evidenced in the minutes. PFIG updates on the cancer pathway performance will continue to be provided as a standing agenda item to SLT with contingency arrangements in place to ensure cover during leave. | Geraint Roberts, Divisional General Manager | Tehmeena Ajmal, Chief Operating Officer | 30/06/2025 | | | *New report - no update yet* |
| 1569 | Effective Governance - Cancer Services | 2025 | Limited | Limited | High | Finance Management & Control | Objective 2: There are appropriate financial governance arrangements in place to manage budgets, with regular review of savings and budgets. Where services are not operating within agreed budgetary allocation, appropriate actions and monitoring arrangements are in place. | 2. **Delivering financial balance**<br>There is regular reporting of financial performance however the service is forecasting an overspend position at year end and is not forecast to achieve its set savings target. | 2. The division took further actions in respect of grip and control of expenditure, with cost reductions & control actions aligned to the control total target issued by the health board being met and exceeded. Further action re delivery of CRES savings resulting achieving an over recovery of targets of £2k. However, it is recognised that a final £1m deficit remains against budget allocated and therefore non-compliant with requirements of Standing Financial Instruction 5.2.2<br>The overspend is represented by Drug related expenditure and commissioning contracts aligned to demonstratable growth. These issues have been escalated & reported through the health board and the various committees such as Execs & PFIG.<br>Actions<br>• An Oncology business case has been presented with final approval at board pending May 25 to secure recurrent budget. A further business case is ongoing to address further cost pressures linked to demand, activity, quality & governance pan BCU.<br>• Ensure working focus groups such as SACT improvement etc are documented as reports for information or minuted through attendance at PFIG or SLT to demonstrate ongoing improvement for patient safety, quality, efficiencies and finance. | Geraint Roberts, Divisional General Manager | Tehmeena Ajmal, Chief Operating Officer | 31/03/2026 | | | *New report - no update yet* |
| 1571 | Effective Governance - Cancer Services | 2025 | Limited | Limited | High | Quality, Safety & Patient Experience | Objective 4: Complaints, concerns, incidents and staff concerns (via Speak Up Safely) are investigated, reviewed, and responded to in a timely manner. Learning from these is captured and reviewed / shared as appropriate. | 4. **Open / Overdue Incidents**<br>As of March 2025, the service has 195 open incidents, with 154 of these overdue. | 4. The number of incidents since March has decreased significantly to 98. This is due to an agreed action of discussing and encouraging the investigating and closing of incidents in a timely manner through discussions at the daily Patient Safety Huddle, weekly e-mail reminders to incident handlers by the Patient Safety team and by further monitoring through the monthly PSQG Meeting. | Head of Nursing | Tehmeena Ajmal, Chief Operating Officer | 31/10/2026 | | | *New report - no update yet* |

| | | | | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 1573 | Standards of Business Conduct – Declarations of Interest, Gifts and Hospitality - follow-up | 2025 | Limited | Limited | Medium | No theme | Matter Arising 1: Policy (Design) | 1.2 The Head of Corporate Governance will issue a guidance note to all Managers as part of the development of a Corporate Governance Hub. | 1.2 Management:<br>• 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). | Phillippa Peake-Jones, Head of Corporate Governance | Pam Wenger, Director of Corporate Governance | 30/09/2025 | | | *New report - no update yet* |
| 1574 | Standards of Business Conduct – Declarations of Interest, Gifts and Hospitality - follow-up | 2025 | Limited | Limited | High | No theme | Matter Arising 2: Declare System (Operation) | 2.1 (a) To review the process for Declarations for Board Members and Executive Team. | 2.1 (a) Management:<br>• Ensure all scheduled notifications are functioning as intended.<br>• Ensure published data is accurate and can be reconciled to source data.<br>• Ensure published guidance documentation is consistent with NHS Wales requirements and relevant to Health Board staff. | Phillippa Peake-Jones, Head of Corporate Governance | Pam Wenger, Director of Corporate Governance | 30/09/2025 | | | *New report - no update yet* |
| 1575 | Standards of Business Conduct – Declarations of Interest, Gifts and Hospitality - follow-up | 2025 | Limited | Limited | High | No theme | Matter Arising 2: Declare System (Operation) | 2.1 (b) To introduce a monitoring process for declarations in accordance with the revised Standards of Business Conduct Policy approved by the Audit Committee in May 2025. | 2.1 (b) Management:<br>• Ensure all scheduled notifications are functioning as intended.<br>• Ensure published data is accurate and can be reconciled to source data.<br>• Ensure published guidance documentation is consistent with NHS Wales requirements and relevant to Health Board staff. | Phillippa Peake-Jones, Head of Corporate Governance | Pam Wenger, Director of Corporate Governance | 31/10/2025 | | | *New report - no update yet* |
| 1576 | Standards of Business Conduct – Declarations of Interest, Gifts and Hospitality - follow-up | 2025 | Limited | Limited | High | No theme | Matter Arising 3: Audit Committee Reporting (Operation) | 3.1 The Business Cycle for Audit Committee to be reviewed to ensure it is consistent with the Standards of Business Conduct Policy. | 3.1 Management:<br>• Review reporting arrangements and ensure staff declarations are subject to Audit Committee oversight and scrutiny in line with policy requirements. | Phillippa Peake-Jones, Head of Corporate Governance | Pam Wenger, Director of Corporate Governance | 31/08/2025 | | | *New report - no update yet* |
| 1577 | Standards of Business Conduct – Declarations of Interest, Gifts and Hospitality - follow-up | 2025 | Limited | Limited | High | No theme | Matter Arising 4: Board Members declarations of interest (Operation) | **SAME AS 2.1 (a)**<br>4.1 (a) The Director of Corporate Governance:<br>• Ensures Board Member declarations are accurate and comprehensive throughout the year – not limit due diligence work to year end.<br>• Reminds Board Members of the requirement to declare all outside employment as part of their mandatory annual declaration of interest, and to notify the Office of the Board Secretary (Corporate Governance Directorate April 2024 onwards) of any changes as and when they arise.<br>• Ensures the public register of Board Member interests is maintained and kept up to date. | **SAME AS 2.1 (a)**<br>4.1 (a): Management:<br>• Ensure all scheduled notifications are functioning as intended.<br>• Ensure published data is accurate and can be reconciled to source data.<br>• Ensure published guidance documentation is consistent with NHS Wales requirements and relevant to Health Board staff. | Phillippa Peake-Jones, Head of Corporate Governance | Pam Wenger, Director of Corporate Governance | 30/09/2025 | | | *New report - no update yet* |
| 1578 | Standards of Business Conduct – Declarations of Interest, Gifts and Hospitality - follow-up | 2025 | Limited | Limited | High | No theme | Matter Arising 4: Board Members declarations of interest (Operation) | **SAME AS 2.1 (b)**<br>4.1 (b) The Director of Corporate Governance:<br>• Ensures Board Member declarations are accurate and comprehensive throughout the year – not limit due diligence work to year end.<br>• Reminds Board Members of the requirement to declare all outside employment as part of their mandatory annual declaration of interest, and to notify the Office of the Board Secretary (Corporate Governance Directorate April 2024 onwards) of any changes as and when they arise.<br>• Ensures the public register of Board Member interests is maintained and kept up to date. | **SAME AS 2.1 (b)**<br>4.1 (b): Management:<br>• Ensure all scheduled notifications are functioning as intended.<br>• Ensure published data is accurate and can be reconciled to source data.<br>• Ensure published guidance documentation is consistent with NHS Wales requirements and relevant to Health Board staff. | Phillippa Peake-Jones, Head of Corporate Governance | Pam Wenger, Director of Corporate Governance | 31/10/2025 | | | *New report - no update yet* |
| 1579 | Standards of Business Conduct – Declarations of Interest, Gifts and Hospitality - follow-up | 2025 | Limited | Limited | High | No theme | Matter Arising 5: BCU staff declarations of interest (Operation) | **SAME AS 2.1 (a)**<br>5.1 (a) Management:<br>• Ensure line mangers are aware of their responsibilities regarding approving declarations of interest (and gifts and hospitality).<br>• Ensure staff understand when, and how often, a declaration should be made.<br>• Establish controls and /or oversight arrangements to manage and escalate non responses (from Decision Makers) and failure to approve (by line managers).<br>• Ensure data extracted from Declare is reviewed and adjusted appropriately prior to reporting (e.g. to Audit Committee). | **SAME AS 2.1 (a)**<br>5.1 (a): Management:<br>• Ensure all scheduled notifications are functioning as intended.<br>• Ensure published data is accurate and can be reconciled to source data.<br>• Ensure published guidance documentation is consistent with NHS Wales requirements and relevant to Health Board staff. | Phillippa Peake-Jones, Head of Corporate Governance | Pam Wenger, Director of Corporate Governance | 30/09/2025 | | | *New report - no update yet* |
| 1580 | Standards of Business Conduct – Declarations of Interest, Gifts and Hospitality - follow-up | 2025 | Limited | Limited | High | No theme | Matter Arising 5: BCU staff declarations of interest (Operation) | **SAME AS 2.1 (b)**<br>5.1 (b) Management:<br>• Ensure line mangers are aware of their responsibilities regarding approving declarations of interest (and gifts and hospitality).<br>• Ensure staff understand when, and how often, a declaration should be made.<br>• Establish controls and /or oversight arrangements to manage and escalate non responses (from Decision Makers) and failure to approve (by line managers).<br>• Ensure data extracted from Declare is reviewed and adjusted appropriately prior to reporting (e.g. to Audit Committee). | **SAME AS 2.1 (b)**<br>5.1 (b): Management:<br>• Ensure all scheduled notifications are functioning as intended.<br>• Ensure published data is accurate and can be reconciled to source data.<br>• Ensure published guidance documentation is consistent with NHS Wales requirements and relevant to Health Board staff. | Phillippa Peake-Jones, Head of Corporate Governance | Pam Wenger, Director of Corporate Governance | 31/10/2025 | | | *New report - no update yet* |
| 1581 | Standards of Business Conduct – Declarations of Interest, Gifts and Hospitality - follow-up | 2025 | Limited | Limited | High | No theme | Matter Arising 6: Gifts, Hospitality, and Sponsored Events (Operation) | 6.1 (a) To undertake specific improvement project looking at the processes at an IHC level in relation to Declaring Gifts and Hospitality . (March 2026) | 6.1 (a) Management:<br>• 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.<br>• All hospitality and sponsored events to be approved by a Director / Assistant Director.<br>• Ensure all declarations pending approval are reviewed and approved / declined.<br>• Ensure provider details are recorded to enable effective monitoring per policy requirements. | Phillippa Peake-Jones, Head of Corporate Governance | Pam Wenger, Director of Corporate Governance | 31/03/2026 | | | *New report - no update yet* |
| 1582 | Standards of Business Conduct – Declarations of Interest, Gifts and Hospitality - follow-up | 2025 | Limited | Limited | High | No theme | Matter Arising 6: Gifts, Hospitality, and Sponsored Events (Operation) | 6.1 (b) To establish Governance Network working with operational leads to support the implementation of this work . | 6.1 (b) Management:<br>• 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.<br>• All hospitality and sponsored events to be approved by a Director / Assistant Director.<br>• Ensure all declarations pending approval are reviewed and approved / declined.<br>• Ensure provider details are recorded to enable effective monitoring per policy requirements. | Phillippa Peake-Jones, Head of Corporate Governance | Pam Wenger, Director of Corporate Governance | 31/03/2026 | | | *New report - no update yet* |

| | | | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 1587 | Grievance Management | 2025 | Reasonable | Limited | High | Reporting | Objective 5: There is an analysis of grievance cases, including satisfaction and feedback of the employees and managers involved in the process, allowing trends or themes to be identified, follow up action to be monitored and regular sharing of learning. | 2. **Themes**<br>Whilst we are advised that grievance cases are reviewed and discussed locally and by the senior team within People Services, there is no documented information / data that identifies themes and trend of grievances across areas / the Health Board, and reports on these to an appropriate forum. This information should be reviewed to ensure appropriate actions are taken to minimise potential future grievances. | 2. Quarterly review of closed R&R cases to collect data on the themes / trends, which will be reported via People and Culture meetings / Committee. Local People & OD teams will do this at the end of a case. | Jason Brannan, Deputy Director of People; Associate Directors People Services | Jason Brannan, Deputy Director of People | 31/08/2025 | | | *New report - no update yet* |
| 1588 | Grievance Management | 2025 | Reasonable | Limited | Medium | Lessons Learnt | Objective 5: There is an analysis of grievance cases, including satisfaction and feedback of the employees and managers involved in the process, allowing trends or themes to be identified, follow up action to be monitored and regular sharing of learning. | 3. **Lessons learnt**<br>The All-Wales policy does not require lessons learnt to be captured, but suggests reflection and learning from the process. We recognise that outcomes and learning from cases is often discussed informally within meetings however it would be beneficial to capture that information and report via the Health Board governance structure to provide assurance that there is learning from grievance cases / actions taken to reduce likelihood of similar grievances being raised. | 3. Lessons learned to be reviewed by Employment team / one to one's / Team locally. This will also go to the Executive Team for review and follow up, along with the information relating to delays for escalated cases. | Jason Brannan, Deputy Director of People; Associate Directors People Services | Jason Brannan, Deputy Director of People | 31/08/2025 | | | *New report - no update yet* |
| 1611 | Effective Governance – Integrated Health Community - East | 2025 | Limited | Limited | High | Finance Management & Control | Objective 2: There are appropriate financial governance arrangements in place to manage the financial position, with regular review of savings and financial position. Where services are not operating within the agreed budgetary allocation, appropriate actions and monitoring arrangements are in place. | 2. **Accountability Letters**<br><br>A number of IHC East accountability letters for 2024/25 have not been signed, as required by Standing Financial Instructions. Out of a total of 89 letters, 73% (65) have been accepted, 23% (20) have had no response and 4% (4) are outstanding with a valid reason noted (not confirmed). | 2. Sign accountability letters. | Michelle Greene, Integrated Health Community Director (East) | Tehmeena Ajmal, Chief Operating Officer | 31/07/2025 | | | *New report - no update yet* |
| 1612 | Effective Governance – Integrated Health Community - East | 2025 | Limited | Limited | High | Finance Management & Control | Objective 2: There are appropriate financial governance arrangements in place to manage the financial position, with regular review of savings and financial position. Where services are not operating within the agreed budgetary allocation, appropriate actions and monitoring arrangements are in place. | 3. **Delivering financial balance**<br><br>There is regular reporting of financial performance however the service is forecasting an overspend position at year end and is not forecast to achieve its set savings target | 3. Review forecast year end position with finance team. | Michelle Greene, Integrated Health Community Director (East) | Tehmeena Ajmal, Chief Operating Officer | 30/09/2025 | | | *New report - no update yet* |

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

| | | | Summary of recommendation with rationale for closure |
|---|---|---|---|
| **EXECUTIVE DIRECTOR OF NURSING** | | | |
| 1 | 0304 | Falls Management | 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. |
| 2 | 0326 | Lessons Learnt | Integrated Policy is embedded and daily huddles in place and embedded as practice. Organisational learning forums/Thematic Review/EICOP embedded in core meeting structure. Digital platforms that record and share learning are within planned pieces of work captured and monitored within organisational action plans, with clear timeframe for socialistaion and training. NHS executive Duty of Quality programme of works in place. Recent internal audit assurance received. |
| 3 | 0359 | Deprivation of Liberty Safeguards (DoLS) - 2024 | Monitoring of progress and review of all actions is undertkaing and delivered at the Mental Health Legislative Committee.<br>The DoLS SOP is reviewed annually with governance attached to the Safeguarding and public Protection Policy and Procedure Group, this feeds into the Safeguarding Performance and Governance Group, QSE, and the Mental Health Legislative Committee for assurance.<br>MCA Training shows an upward trajectory, this is again monitored as per the above governance process with areas of non-compliance targeted with bespoke and where necessary face-to-face training sessions.<br>BIA's have a greater presence at DGH sites. This provides an on-site service to support with MCA and DoLS decisions.<br>BCUHB are now undertaking the Welsh Government led pilot with regard to the Form of the DoLS application.<br>There has been a substantial reduction in the number of errors recorded within DoLS and MCA paperwork, this is testament to the hard work of the team and services across the Health Board.<br>This is monitored monthly and reported quarterly. |
| **INTERIM EXECUTIVE MEDICAL DIRECTOR** | | | |
| 1 | 1311 | Corporate Legislative Compliance: NHS (Appointment of Consultants) (Wales) (Amendment) Regulations 2005 | The model questions and answers have now been finalised, and will be provided with AAC interview pack - effective immediately |
| 2 | 1312 | | |
| 3 | 1521 | Clinical Audit | The Clinical Audit Policy has been updated and is now live on BetsiNet. |
| 4 | 1522 | | Tier 2 will be reviewed on COB every six months.<br>Evidence provided:<br>• Email to all members of SCEG requesting to review the Tier 2 plan, taking not that there is a balancing of national and local guidance, and the need to address specific local risks, strategic interests, and concerns.<br>• Tier 2 audit plan that was agreed, and the category of risk, objectives and priorities noted<br>• Minutes from Feb SCEG on discussions and feeding back if any further information or Tier 2 audits needed to be considered<br>• EQDG – confirmation that the Tier 2 Audit Plan was approved<br>• Chair's report that noted discussions in SCEG, also to be included in the TOR and COB<br>• QSE Bundle with reference to Clinical Audit and Tier 2 within the paper we submitted |
| **DIRECTOR OF CORPORATE GOVERNANCE** | | | |
| 1 | 1273 | Standards of Business Conduct - Declarations of Interest, Gifts and Hospitality - June 2024 | Policy Approved at Audit Committee and the Executive Policy Oversight Group. Policy now live and published on BetsiNet |
| 2 | 1282 | | |
| **DEPUTY DIRECTOR OF PEOPLE** | | | |
| 1 | 0150 | Nursing Roster Management: Introduction of e-timesheets for Agency staff | The SOP that supports the e-Roster policy has been reviewed by the policy group and signed off by the People Services Directors group. |

| INTERIM EXECUTIVE DIRECTOR OF TRANSFORMATION AND STRATEGIC PLANNING | | | |
|---|---|---|---|
| 1 | 1313 | Value Based Healthcare | The VBHC Programme currently reports within the organisation's change portfolio via the Value and Sustainability Programme. The V&S programme board reports to the Integrated Performance Executive Delivery Group meeting chaired by the CEO; which in turn provides a Chair's report to the Performance and Information Governance Committee. As per the recent recommendations within the Audit Report, the emerging governance structure, seeks to combine the previously separate Value Based Health Care & Value & Sustainability agendas into a single coherent 'Value' programme, with an appropriate accountability framework to oversee progress. Following informal advice on the development of the governance structure from Pam Wenger in Dec-24, presented for approval at the inaugural Programme Board on 27.01.25 for ratification. |
| 2 | 1511 | Transformation & Improvement | A) The dispute with the vendor regarding these costs has been resolved following legal intervention, and all invoices have been cancelled by the vendor. Therefore the costs previously reported in 23/24 and 24/25 have been reversed and neutralised i.e. no costs were ultimately incurred by T&I.<br>B) The impact of the reduction in RIGA funds has not impacted on the financial position of the T&I cost centre, as the T&I has contained costs within the available resource. The reduction in funding has not caused an over spend against the available budget. |

| EXECUTIVE DIRECTOR OF FINANCE | | | |
|---|---|---|---|
| 1 | 1400 | Charitable Funds - 2024 | Cycle of business approved at CFC meeting on 3 June |
| 2 | 1402 | | Cycle of business approved at CFC meeting on 3 June |
| 3 | 1410 | | Operational Plan included in 12/11/24 CFC agenda and approved. |
| 4 | 1411 | | Verbal presentation of the Charity's Strategy and Operational plan provided at the January Board meeting 31/01/25 Trustee meeting. |
| 5 | 1412 | | All BCUHB staff update on intranet now in place |
| 6 | 1416 | | TORs approved by the Charitable Funds Committee. |
| 7 | 1417 | | Policies and Procedures review included on Cycle of Business, and policies added to the workplan as required |
| 8 | 1418 | | |

| CHIEF DIGITAL AND INFORMATION OFFICER | | | |
|---|---|---|---|
| 1 | 1376 | Intelligence Led Organisation | Requirements included in DDaT growth paper shared with Executives. WG resource secured for a further 12 months to complete WPAS project phase 5 activities. |
| 2 | 1379 | | As reported against Q3 milestone 5D.4. Role based training needs assessment undertaken with Analysis team. Identified forecasting, modelling, advanced SQL and cloud based analytics as learning / development requirements. WPAS team undertaken a review of systems knowledge and skills gaps. Further development requirements will also be identified as part of DDaT wider workforce strategy work, survey circulated to DI&I teams. |
| 3 | 1381 | | Slide pack developed. Interested colleagues identified, pool to be confirmed to ensure representation at all possible events across North Wales. |
| 4 | 1382 | | Follow up meeting took place with Bangor Uni. Lead analyst identified as key contact to ensure ongoing engagement. |
| 5 | 1385 | | 2 x analysts on Advanced Analytics Programme. Internal cohort of Python training ongoing. Development team working through Google Cloud Skills Boost Programme. |
| 6 | 1386 | | Review of progress against Google Cloud skills boost undertaken across Development and Analysis Teams and further participants and learning identified. |
| 7 | 1389 | | Operational Data Quality Groups in place across IHCs. Core agenda items identified and DQ dashboards used to guide discussion. Further dashboard developments will help focus attention to priority areas (ID1394). |
| 8 | 1393 | | Data model developed, kite mark applied to PTL report, subject to feedback will be applied to further waiting list datasets over the course of Q1. |
| 9 | 1394 | | Data Quality priority measures identified for year end. Lessons learnt session to be held on 28th April to inform DQ dashboard developments. These will be used to inform agenda of Operational DQ groups. |
| 10 | 1397 | | Initial UEC baseline assessment undertaken. Work with UEC programme underway to identify next steps to increase maturity. |

| CHIEF OPERATING OFFICER | | | |
|---|---|---|---|
| 1 | 0464 | Discharge Arrangements | Optimal Hospital Flow Facilitators have commenced training sessions with Matrons and ward staff initially at YGC and a wider roll out plan across the other sites has been developed. The training includes the communication and engagement with staff of the optimal flow frameowrk including SAFER, Red to Green, D2RA pathways including identification and reporting of pathways / actions to progress discharge, onto STREAM timely through regular reviews at board rounds. This work is being monitored through the UEC workstreams / 6 Goals programme of work and reporting into the NHS Executive national meetings for Goals 5 and 6.<br>Evidence of JD for OHFF has been provided |
| 2 | 0471 | | Monthly meetings at a NW region including H&SC colleagues are held with the NHS Executive team overseeing the work for the ministerial targets that includes the POCDs performance. POCD action plan that has been developed with LA partners has been provided as evidence against this action together with slides presented at the NW regional meetings. |
| 3 | 0476 | | Monthly meetings at a NW region including H&SC colleagues are held with the NHS Executive team overseeing the work for the ministerial targets that includes the review of Trusted Assessor roles and functions. TA action plan that has been developed with LA partners. |
| 4 | 0477 | | |
| 5 | 0478 | | All areas now have an Adverse Discharge group based on the learning from the early adopter areas. Care home awareness sessions continue on a regular monthly programme. As part of the workstream 4 work a consistent approach to discharge documentation has been developed and rolled out across the 3 x IHCs. |
| 6 | 0500 | Effective Governance – Women's Directorate | Current compliance 77.27%. Concerns continue to be reviewed twice weekly operational meeting which feeds into the weekly Women's Integrated Concerns Meeting. The Service present their Incidents and Concern position to the Corporate Concerns and Incident's meeting on a weekly basis. To note, Celyn Ward, Ysbyty Glan Clwyd is not an outlier with any trends to note. |

| DIRECTOR OF ENVIRONMENT AND ESTATES | | | |
|---|---|---|---|
| 1 | 0494 | Health and Safety - 2024 | Action plans now standardised. |
| 2 | 1339 | Corporate Legislative Compliance - Fire Safety | Terms of Reference has been updated to reflect the new reporting structure, and approved at the Fire Safety Management Group meeting on 01/05/2025 - item 4 refers to the TOR. |
| 3 | 1344 | | Fire Safety Audit sumitted and reported at Strategic Occupational Health and Safety Meeting in September 2024 by means of a AAA report. |

| CHIEF EXECUTIVE (APPROVED FOR CLOSURE BY THE DIRECTOR OF CORPORATE GOVERNANCE) | | | |
|---|---|---|---|
| 1 | 0488 | Health and Safety - 2024 | Director for Environment and Estates is now in post |
| 2 | 0492 | | Revised H&S strategy plan submitted for Board approval |
| 3 | 1315 | Recruitment of substantive and interim executive and senior posts Final Internal | The Remuneration Committee approved the Protocol in September. Remuneration Committee agreed a local allowance for hybrid working, in exceptional circumstances. |
| 4 | 1319 | | The Report format for the VSM has been updated with clarity in terms of the recommendations and decisions required by the committee. The new VSM report has been approved by the Direcor of Corporate Governance |

## AUDIT WALES - OPEN RECOMMENDATIONS

| ID | Report Title | Year | Overall Report rating - from Jan 2025 | Assurance Level | Priority | Recommendation Title | Recommendation | Management Response | Action Owner | Final Approver | Original implementation date | Revised implementation date | Number of Revisions | Latest update |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 0394 | Structured Assessment 2022 | 2023 | n/a | N/A | N/A | Recommendation 12: Improve performance and financial oversight for digital and estates | R12b: 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:<br>• 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.<br>• introduce periodic committee reports that not only focus on actions completed but the impact its digital and estates strategies are having on the | R12b: Although addressing deficiencies and risks are the priority proof of value, work in small affordable pockets are progressing and demonstrating the benefits that can be delivered if scaled. | Dylan Roberts, Chief Digital and Information Officer; Russell Caldicott, Executive Director of Finance | Dylan Roberts, Chief Digital and Information Officer | 31/12/2023 | 31/03/2025 | 1 | 2025/26 Opening Budget allocated with forecast outturn variance of £2,370,000 overspend.<br>RIGA 1 funding allocated on non-recurrent basis which is currently funding recurrent posts.<br>Currently 19% of DDaT allocated annual budget is non-recurrent.<br>Cost Pressure bids (including DHCW costs, Microsoft and known inflationary increases) have been submitted to Finance with yet no confirmed allocation returned.<br>Growth bids have been submitted to Finance, with yet no confirmed allocation returned. |
| 0399 | Structured Assessment 2023 | 2023 | n/a | N/A | N/A | Recommendation tracking | R5a: Currently, there is insufficient committee oversight to monitor progress made against recommendations made by non-audit bodies. The Health Board should introduce effective committee oversight for monitoring progress made against recommendations of regulators, including, but not limited to, Healthcare Inspectorate Wales, the Coroner, Welsh Language Commissioner, the Health and Safety Executive and the Public Services Ombudsman for Wales. | R5a: Agreed. A recent review of all of the Board Committee cycle of business (received at the Board in January 2024) has made some provision for recommendations received by non audit bodies. This includes QSE Committee and a People and Culture Committee. | Glesni Driver, Head of Statutory Compliance and Inquiries | Pam Wenger, Director of Corporate Governance | 31/07/2024 | 31/03/2026 | 2 | An update on the regulatory body reports received by the Health Board will be reported to the Executive Committee and Audit Committee on a regular basis, which will be the first step of the work to introduce effective committee oversight for monitoring progress made against regulatory recommendations. There is considerable work to do on this, therefore the revised implementation date of 31/03/2025 will need to be extended, with the work likely to take the remainder of 2025/26 to be fully implemented |
| 0400 | Structured Assessment 2023 | 2023 | n/a | N/A | N/A | Recommendation tracking | R5b: Currently, there is insufficient committee oversight to monitor progress made against recommendations made by non-audit bodies. The Health Board should introduce effective committee oversight for monitoring progress made against recommendations of regulators, including, but not limited to, Healthcare Inspectorate Wales, the Coroner, Welsh Language Commissioner, the Health and Safety Executive and the Public Services Ombudsman for Wales. | R5b: The Director of Corporate Governance will put in place a process and system to ensure that recommendations by other bodies are co-ordinate and have appropriate oversight at Committee and where appropriate Board level. | Glesni Driver, Head of Statutory Compliance and Inquiries | Pam Wenger, Director of Corporate Governance | 31/07/2024 | 31/03/2026 | 2 | An update on the regulatory body reports received by the Health Board will be reported to the Executive Committee and Audit Committee on a regular basis, which will be the first step of the work to introduce effective committee oversight for monitoring progress made against regulatory recommendations. There is considerable work to do on this, therefore the revised implementation date of 31/03/2025 will need to be extended, with the work likely to take the remainder of 2025/26 to be fully implemented |
| 0404 | Structured Assessment 2023 | 2023 | n/a | N/A | N/A | Monitoring progress against accounting issues | R8: Ensure that the Audit Committee receives assurance on the progress that the Health Board is making to address the complete range of issues identified in the Audit Wales 2021-22 and 2022-23 audit of accounts, and the subsequent EY review has been slower than intended. | R8: Agreed. Progress reports will be scheduled of part of the Audit Committee Programme of work. | Russell Caldicott, Interim Executive Director of Finance | Russell Caldicott, Executive Director of Finance | 31/08/2024 | | | Progress against the issues raised has been well documented both within the special measures action plan and the finance special measures action plan (incorporating the former financial control environment plan). Closure of open actions has been endorsed by the WG, and therefore is recommend this action is closed. Also the 2023/24 Audit Wales opinion is that the Financial Accounts state a true and fair position. |
| 1363 | Urgent and Emergency Care: Flow out of Hospital – North Wales Region | 2024 | n/a | 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: THIS RECOMMENDATION CONSISTED OF 8 DIFFERENT ACTIONS, AND HAS BEEN SPLIT DOWN TO SEPARATE RECOMMENDATIONS - SEE 1363-1372 AND 15-14-1520)**<br>1. Cyngor Sir Ynys Môn, Cyngor Gwynedd and the Health Board already have an information sharing pilot in place awaiting evaluation. (OWNER: Director of AHPs - West) | Dylan Roberts, Chief Digital and Information Officer; 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; Justine Parry, Assistant Director of Compliance and Business Management | Tehmeena Ajmal, Chief Operating Officer | 31/10/2024 | 31/03/2026 | 1 | This is no longer happening as WCCIS is no longer being progressed due to the system not fitting the needs of the Allied Health Professionals.<br><br>Physiotherapy and Occupational Therapy staff working in the Community Resource Teams on Anglesey agreed to undertake a 3 month pilot, using WCCIS to assess the functionality required to managae the services as well as sharing information with Local Authorities. Without significant change, the system did not support Service managers in terms of reports and managing waiting lists etc. The system required more administrative support than the current system in use.<br><br>Work is ongoing at an All Wales Level looking at an alternative solution, working first with Mental Health initially, then community and will then bring in AHP. |

| | | | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 1364 | Urgent and Emergency Care: Flow out of Hospital – North Wales Region | 2024 | n/a | 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:**<br>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<br>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.<br>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 | N/A | Ongoing | | | Therapy Services now in the process of replacing Therapy Manger (Patient record system ) with an interim plan while solutions is worked through . Mental Health is the priority for this , followed by Community survives and then Therapy services |
| 1371 | Urgent and Emergency Care: Flow out of Hospital – North Wales Region | 2024 | n/a | 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:<br>16.1 addressing any outstanding adverse incidents or concerns, communicating clearly with the relevant local authority | **Health Board:**<br>Each IHC to establish an Adverse Discharge Group with clear ToRs | Jane Trowman, Acting Assistant Director – Care Homes Support & CHC Commissioning | Tehmeena Ajmal, Chief Operating Officer | 31/10/2024 | | | Each IHC has now got Discharge Improvement Meetings established, with Terms of Reference.<br>TO BE CLOSED |
| 1450 | Structured Assessment 2024 | 2024 | n/a | N/A | N/A | Recommendation 1 | 1. The Health Board should progress its plans to introduce arrangements for an Executive Committee and its related operating arrangements by April 2025. | 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:<br><br>**1. Terms of Reference approved by the Board**<br>**2. Agreed operating and reporting arrangements**<br>**3. Reporting at each meeting of the Board items considered by the Executive Committee** | Pam Wenger, Director of Corporate Governance | Pam Wenger, Director of Corporate Governance | 30/04/2025 | | | In progress<br>2. **Agreed operating and reporting arrangements** - In progress, reviewing the reporting groups to the Executive Committee |
| 1453 | Structured Assessment 2024 | 2024 | n/a | N/A | N/A | Recommendation 2 | 2. 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. | 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.<br><br>Key actions include:<br>**• Review of the operational governance arrangements including the role of the Senior Leadership Team** | Pam Wenger, Director of Corporate Governance | Pam Wenger, Director of Corporate Governance | 31/07/2025 | | | This is being picked up as part of the Foundations for the Future Programme. |
| 1456 | Structured Assessment 2024 | 2024 | n/a | N/A | N/A | Recommendation 5 | 5. The Health Board should develop a structured programme of Board member visits, to include a mechanism to provide feedback to the Board. | 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.<br><br>Key actions include:<br>**• Agree how the Board can engage with services, which will include plans in terms of service reviews;**<br>**• Establish a reporting mechanism to the Board in terms of service visits** | Pam Wenger, Director of Corporate Governance | Pam Wenger, Director of Corporate Governance | 30/06/2025 | | | This will be picked up as part of the Governance Improvement Plan for 2025. |
| 1459 | Structured Assessment 2024 | 2024 | n/a | N/A | N/A | Recommendation 7 | 7. 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. | The Health Board is considering the approach to dealing with reports from external regulatory bodies as part of 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.<br><br>Action:<br>**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.** | Glesni Driver, Head of Statutory Compliance and Inquiries | Pam Wenger, Director of Corporate Governance | 30/04/2025 | | | Audit reports are considered by the appropriate committee, eg, Job Planning, Clinical Audit etc. |
| 1462 | Review of Cost Savings Arrangements | 2024 | n/a | N/A | N/A | Recommendation 1.1 | The Health Board should seek to obtain better ownership of financial targets and savings requirements by Directorates and the Integrated Health Communities (IHCs) through:<br><br>R1.1: Demonstrating that base budgets have been informed by a clear understanding of the costs of services that are to be delivered. | 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. | Russell Caldicott, Executive Director of Finance | Russell Caldicott, Executive Director of Finance | 31/10/2025 | | | The 25/26 budget was set based upon information relating to the underlying position, as provided by the finance leads for individual IHCs. The information contained detail around cost pressures, and these were considered on the basis of avoidable and unavoidable, with some difficult decisions needing to be made regarding what could and couldn't be funded to enable the setting of a balanced budget. Some of the pressures that haven't been funded are identified as a risk, and these are being managed. In addition some developments are still under consideration, with funding remaining in reserves for the short term. |
| 1463 | Review of Cost Savings Arrangements | 2024 | n/a | N/A | N/A | Recommendation 1.2 | The Health Board should seek to obtain better ownership of financial targets and savings requirements by Directorates and the Integrated Health Communities (IHCs) through:<br><br>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. | 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. | Russell Caldicott, Executive Director of Finance | Russell Caldicott, Executive Director of Finance | 31/10/2025 | | | This is ongoing, and whilst the immediate focus of the V & S workstreams is to support the delivery of the 25/26 savings requirement, some longer term schemes are under consideration, and the ambition is to ensure a continual pipeline of savings is developed to support and inform future financial plans and where savings targets can be applied. |

| | | | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 1465 | Review of Cost Savings Arrangements | 2024 | n/a | N/A | N/A | Recommendation 2.1 | The Health Board should strengthen its approach to the identification and delivery of savings by:<br><br>2.1: Identifying viable savings schemes to meet the Health Board's overall savings target earlier in the financial planning cycle. | 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.<br><br>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.<br><br>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 Directors also held accountable within this forum for | Russell Caldicott, Executive Director of Finance | Russell Caldicott, Executive Director of Finance | N/A | | | This is ongoing, and whilst the immediate focus of the V & S workstreams is to support the delivery of the 24/25 savings requirement, some longer term schemes are under consideration, and the ambition is to ensure a continual pipeline of savings is developed to support and inform future financial plans and where savings targets can be applied. |
| 1466 | Review of Cost Savings Arrangements | 2024 | n/a | N/A | N/A | Recommendation 2.2 | The Health Board should strengthen its approach to the identification and delivery of savings by:<br><br>R2.2: Taking earlier remedial action to bring under-performing saving schemes back on track. | 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. | Russell Caldicott, Executive Director of Finance | Russell Caldicott, Executive Director of Finance | 31/03/2025 | | | A monthly value and sustainability programme board has been set up which will consider the progresss of the savings movement through the cycle from opportunity, to green rated plans, to delivery of savings. This forum will allow for discussion and escalation of challenges and blockages to delivery. |
| 1467 | Review of Cost Savings Arrangements | 2024 | n/a | N/A | N/A | Recommendation 2.3 | The Health Board should strengthen its approach to the identification and delivery of savings by:<br><br>R2.3: Maintaining a focus on the identification of saving schemes that deliver recurrent savings. | 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). | Russell Caldicott, Executive Director of Finance | Russell Caldicott, Executive Director of Finance | 31/03/2025 | | | The focus remains on driving recurrent savings for the Health Board for 24/25. |
| 1470 | Review of Cost Savings Arrangements | 2024 | n/a | N/A | N/A | Recommendation 3.1 | When updating its savings guidance, the Health Board should ensure:<br><br>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. | 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. | Russell Caldicott, Executive Director of Finance | Russell Caldicott, Executive Director of Finance | Ongoing 2025 | | | This is an ongoing item, and is currently under review by the new Head of Financial Improvement. |
| 1471 | Review of Cost Savings Arrangements | 2024 | n/a | N/A | N/A | Recommendation 3.2 | When updating its savings guidance, the Health Board should ensure:<br><br>R3.2: That the guidance reflects the new savings approach based around its Value and Sustainability Board framework. | 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. | Russell Caldicott, Executive Director of Finance | Russell Caldicott, Executive Director of Finance | 31/03/2025 | | | The guidance has been updated to incorporate reference to the value and sustainability framework. A copy of the guidance is attached as evidence and it is anticipated that this action can now be closed. |
| 1514 | Urgent and Emergency Care: Flow out of Hospital – North Wales Region | 2024 | n/a | 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: THIS RECOMMENDATION CONSISTED OF 8 DIFFERENT ACTIONS, AND HAS BEEN SPLIT DOWN TO SEPARATE RECOMMENDATIONS - SEE 1363-1372 AND 15-14-1520)**<br>2. Conwy, Denbighshire & Flintshire local authorities and the Health Board have a WASPI in place since the implementation of the SPOAs. (OWNER: CHC Commisioning Manager) | Dylan Roberts, Chief Digital and Information Officer; 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; Justine Parry, Assistant Director of Compliance and Business Management | Tehmeena Ajmal, Chief Operating Officer | 31/10/2024 | 01/06/2025 | 1 | This has been escalated to the Regional Collaborative and will be discussed at RLG. Gethin Morgan leading |

| | | | | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 1515 | Urgent and Emergency Care: Flow out of Hospital – North Wales Region | 2024 | n/a | 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: THIS RECOMMENDATION CONSISTED OF 8 DIFFERENT ACTIONS, AND HAS BEEN SPLIT DOWN TO SEPARATE RECOMMENDATIONS - SEE 1363-1372 AND 15-14-1520)** 3. 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. (OWNER: Directors of AHPs / Director of Corporate Governance) | Dylan Roberts, Chief Digital and Information Officer; 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; Justine Parry, Assistant Director of Compliance and Business Management | Tehmeena Ajmal, Chief Operating Officer | 31/10/2024 | 31/03/2026 | 1 | a) In addition to the Information Sharing Agreement in place (as per response to 2 above), there are a number of schemes already in place across North Wales to support the sharing of information between Health and Local Authorities. These include:<br><br>- Within Wrexham and Flintshire there is a jointly funded post between the Local Authorities and BCUHB who liaises with all social workers to share appropriate information.<br>- As part of the Home First Service, East Health staff have access to Wrexham and Flintshire Local Authority system as part of joint working arrangements.<br>- In the West and Central Region whilst there is no dedicated post, there is the regular sharing of non-identifiable information on a regular basis.<br>- CHC - as part of CHC processes there is a secure Sharepoint Collobaration Site wet up with organisations Finance Teams<br><br>b) In addition to this, it was proposed that the Health Board look to agree a standard approach to how we communicate with our partners and this should be considered by the Director of Corporate Governance.<br><br>c) As part of the new Data Strategy Development, accessibility for external agencies and the |
| 1516 | Urgent and Emergency Care: Flow out of Hospital – North Wales Region | 2024 | n/a | 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: THIS RECOMMENDATION CONSISTED OF 8 DIFFERENT ACTIONS, AND HAS BEEN SPLIT DOWN TO SEPARATE RECOMMENDATIONS - SEE 1363-1372 AND 15-14-1520)** 4. Central Area will consider how this can be incorporated into the scope of the new Connecting Care procurement process. (OWNER: Chief Technology Officer) | Dylan Roberts, Chief Digital and Information Officer; 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; Justine Parry, Assistant Director of Compliance and Business Management | Tehmeena Ajmal, Chief Operating Officer | 31/10/2024 | | | a) This is about access as part of functional requirements built into the tender / procurement requirements. |
| 1520 | Urgent and Emergency Care: Flow out of Hospital – North Wales Region | 2024 | n/a | 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: THIS RECOMMENDATION CONSISTED OF 8 DIFFERENT ACTIONS, AND HAS BEEN SPLIT DOWN TO SEPARATE RECOMMENDATIONS - SEE 1363-1372 AND 15-14-1520)** 8. Actively seek ways to increase local authority access for systems held within BCUHB. (OWNER: Acting Assistant Director of Care Homes Support) | Dylan Roberts, Chief Digital and Information Officer; 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; Justine Parry, Assistant Director of Compliance and Business Management | Tehmeena Ajmal, Chief Operating Officer | 31/10/2024 | 31/04/2025 | 1 | Pathways of Care Delays - Currently setting up a dashboard with data to be available for Local Authority colleagues via Cloud solutions.<br><br>Please refer to the screenshot of the dashboard. |

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

| | | | Summary of recommendation with rationale for closure |
|---|---|---|---|
| **DIRECTOR OF CORPORATE GOVERNANCE** | | | |
| 1 | 1454 | Structured Assessment 2024 | Reporting of financial implications as part of the decision-making process included in the Corporate Governance Report to the Board |
| 2 | 1455 | | Minutes of meetings are available and brought to the next available meeting as per the cycle of business |
| 3 | 1458 | | The Board Assurance Framework was approved by the Board in January 2025 and is linked to the strategic objectives. The Planning team are currently building the BAF in the portal so milestones will auto populate from plans to ensure it aligns fully with the final approved plan and next years plans going forward. |
| **INTERIM EXECUTIVE DIRECTOR OF TRANSFORMATION AND STRATEGIC PLANNING** | | | |
| 1 | 1461 | Structured Assessment 2024 | A full change control exercise has taken place for the milestones within the 24/25 plan which did not complete in year. This has resulted in a clear outcome with milestones either retired, added to the 25/26 plan or mapped across to existing priorities within the IMTP. This has all been presented to the May Board for approval. |
| **CHIEF OPERATING OFFICER** | | | |
| 1 | 1367 | Urgent and Emergency Care: Flow out of Hospital – North Wales Region | Data is shared monthly across the Region and RPB. Monthly Ministerial priority meetings are also held with HB and partners. This is now business as usual. |
| 2 | 1370 | | |
| 3 | 1372 | | Discharge webinars have taken place and is part of a rolling programme of education and awareness. |

## EXTERNAL AUDIT RECOMMENDATIONS FOR AUDIT WALES AND AUDIT COMMITTEE CLOSURE CONSIDERATION

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

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

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

**AUDIT RECOMMENDATIONS APPROVED FOR CLOSURE BY EXECUTIVE AND EXECUTIVE COMMITTEE**
**SUBMITTED TO AUDIT WALES AND RETURNED REQUIRING FURTHER EVIDENCE**

| EXECUTIVE DIRECTOR OF NURSING | | | |
|---|---|---|---|
| | **ID** | **Report** | **Feedback from Audit Wales** |
| 1 | 397 | Structured Assessment 2023 | Recommendation was about the sudden drop in complaints. Though original management response stated this was still being looked at there has been no subsequent confirmation that this information has been reviewed and produced/did not produce an explanation for the drop. Therefore recommendation has not been addressed. Request further evidence that information was reviewed and what the outcome of that review was. |
| 2 | 401 | Structured Assessment 2023 | Recommendation was about the tracking of recs by other regulators, which is separate to the (also very important point) about incorporating recs into planning. Recognise that a new risk is being developed on capturing recs from other regulators (discussed on 8 May AC), ongoing discussion about under which committee this oversight will sit. Once the process is agreed and in place we believe the recommendation will be closed. AW to await further evidence of process to monitor new risk CRR 24-28. |

| INTERIM EXECUTIVE DIRECTOR OF TRANSFORMATION AND STRATEGIC PLANNING | | | |
|---|---|---|---|
| | **ID** | **Report** | **Feedback from Audit Wales** |
| 1 | 389 | Structured Assessment 2022 | Request copy of evidence before we can support closure. |

| EXECUTIVE DIRECTOR OF FINANCE | | | |
|---|---|---|---|
| | **ID** | **Report** | **Feedback from Audit Wales** |
| 1 | 382 | Structured Assessment 2022 | Update does not address the recommendation which related to performance reporting, not plan reporting. No evidence supplied to support closure. Remain open. |
| 2 | 393 | Structured Assessment 2022 | Appears that point 1 has been addressed in relation to identifying funding gaps in the HB's digital ambitions, but not aware of updates on digital strategy delivery to PFIG or other committees. Suggest we seek to include a follow-up of this rec as part of the scope of the current deep dive review of digital. No evidence supplied in relation to estates work. AW to provide view as part of current review of digital transformation. Evidence requested in relation to estates. |
| 3 | 403 | Structured Assessment 2023 | Accept the update provided, however our 2024 SA maintained that the HB was still relying on non-recurring savings and required a longer-term financial plan, supported by the development of a long-term clinical plan and organisational strategy. There is no evidence supplied to support the completion of this recommendation since the report was issued. AW to request further evidence to consider this action closed. |
| 4 | 404 | Structured Assessment 2023 | Our SA 2024 stated that the way in which actions were transferred from the finance special measures action plan to the annual plan made it difficult to identify the transferred actions and consequently know whether actions had been adequately addressed. AW have not seen any subsequent papers to identify whether actions have been complete. Furthermore Director of Corporate Governance has indicated that further learning will be reported from the EY review later in 2025. AW to request further evidence to consider this action closed. |

| CHIEF EXECUTIVE (approved for closure by Director of Corporate Governance) | | | |
|---|---|---|---|
| | **ID** | **Report** | **Feedback from Audit Wales** |
| 1 | 433 | Review of Board Effectiveness | Update does not confirm whether Executive and IM portfolios have been aligned. AW to request further evidence to consider this action closed. |

# HIGH-RISK POLICIES PRESENTED TO APRIL AUDIT COMMITTEE THAT REMAIN OVERDUE A REVIEW AS AT 20/06/2025

| Name | Category | Review Date | Responsible Director | Update as at 31/03/2025 | Update as at 20/06/2025 |
|---|---|---|---|---|---|
| MHLD 0008 - Threats to the Person and Environment within Forensic Establishments Policy (Ty Llywelyn Medium Secure Unit).pdf | Patient safety | 01/01/2024 | Executive Director of Allied Health Professions and Health Science | Policy has been approved at EPOG, EqIA reviewed on old template. Amended EqIA being approved by author. | Previously submitted to EPOG, incorrect EQIA template and other actions from EPOG outstanding |
| MHLD 0020 - S-CAMHS to Adult Transition Policy - V3.pdf | Patient safety; Joint working/Collaboration | 01/03/2024 | Executive Director of Allied Health Professions and Health Science | Following review it was agreed policy needed a complete overhaul and has therefore been re-written. This is still in draft as author advised they struggled to gain engagement however, they are aiming to include in next scheduled Steering Grp meeting on 26th March 2025. | No update provided |
| MHLD 0027 - BCUHB Mental Health Division - Open Door Policy - V0.1pdf.pdf | Patient safety; Legal | 01/07/2020 | Executive Director of Allied Health Professions and Health Science | Remains outstanding, requires a full rework | Head of Nursing reviewing and updating policy |
| MHLD 0029 - Perinatal Mental Health Operational Policy - V0.1.pdf | Patient safety; Joint working/ Collaboration | 01/06/2019 | Executive Director of Allied Health Professions and Health Science | Author will consider the classification of document when reviewing. Going through MHLD approval prior to sending to PSG for approval in March. | Submitted to Patient Safety Group on 25/03/2025, then to Executive Quality Group on 9th June 2025. With Policies team for 1st QA on 12/06/2025. Returned to Policy Owner for amendments. |
| MHLD 0035 - Home Treatment Team Operational Policy - V0.5 (a).pdf | Patient safety; Legal | 01/04/2021 | Executive Director of Allied Health Professions and Health Science | Author will consider the classification of document when reviewing. Minor amendments following consultation, author asked to consider if a procedure rather than a policy. | Central Head of Nursing reviewing post consultation |
| MHLD 0040 - Ty Llywelyn Postal Packets & Section 134 (MHA 1983 2007) Policy - V0.1.pdf | Patient safety | 01/08/2021 | Executive Director of Allied Health Professions and Health Science | Awaiting confirmation of review date, prior to upload onto BetsiNet. Awaiting update from Author | Submitted to EPOG in October 2024, where amendments to the documentation was requested. BCU Policies awaiting return of updated documents with amendments made. |
| NU28 - Nurse Staffing Levels Policy.pdf | HR/Staff; Patient safety | 01/01/2025 | Executive Director of Nursing | The delay is unfortunately due to absence of Lead Reviewer and review temporarily was paused. Lead reviewer has since returned to review the staffing policy and NSA calculation procedure concurrently. Both documents are anticipated to be ready for further progress by the end of week 20th April 2025. | NU28 policy has been delayed due to operational pressures and the need for substantial revisions to the policy, amounting to an almost complete rewrite. Now progressing through appropriate consultation and ratification processes. |
| MM05 - Intrathecal Chemotherapy Policy - V3.pdf | Patient safety | 01/03/2021 | Executive Medical Director | Author will consider the classification of document when reviewing. On track for completion | Classification of the document as a policy has been confirmed. Policy delayed due to possibility of the operational need to centralise the Intrathecal service onto one site. This will impact on policy content. An SBAR is being prepared for consideration by cancer services and for a decision on location of centralised service. |
| MD17 - Interventions Not Normally Undertaken (INNU) Policy - V1.1.pdf | Patient safety | 01/09/2021 | Executive Medical Director | Still under discussion - talk of a National Policy, all HBs are now considering beginning to initiate their own reviews - no movement yet though | Document has been split into a policy and procedure. With Director of Performance and Commissioning and Deputy Medical Director for review. EQIA and IAST completed. |
| MM01 - BCUHB Medicines Policy .pdf | Patient safety | 01/07/2022 | Executive Medical Director | Storage of medicines chapter of MM01 was sent out on 18.02.25 for consultation, author has split up MM01 as it so large and much more manageable as different docs.<br>CD one and storage will go to MPPPG on 5th March then DTG end of March.<br>Once the author has finished the comments for the CD doc, there are a lot unfortunately, and has that submitted to MPPPG they will then work on rest of MM01.<br>Author currently on planned sick leave for an operation so is unlikely to be ready by end of March it will definitely be complete by end of quarter 1. | Current MM01 Policy has been revised and reformatted into separate documents to aid readability. The chapter relating to medicine storage is now MM01b: Policy and Procedure for the Safe Storage of Medicines in Clinical Areas. Approved by EQDG on 9.6.25, awaiting EPOG approval. The controlled drugs chapter is now MM01a – Policy and Procedure for the Safe Custody, Management and Use of Controlled Drugs , approved by DTG and submitted to PSG for review on 24.6.24. Remaining chapters MM01 Medicines Policy - review complete and BCU wide consultation to commence, aiming for submission for approval August 25. |
| MM02 - Injectable Medicines Policy.pdf | Patient safety | 08/07/2022 | Executive Medical Director | Has been consulted upon and changes identified but need to update these into the document and then get it to policies and procedures group, in March. Need to move to new Qtr1 2025/26 | Changes with document have been identified and agreed, there has been a delay in inplementing the changes. The policy is now ready for broader consultation. Estimated completion by Qtr 2 2025/26 |

| | | | | | |
|---|---|---|---|---|---|
| MM10 - Antimicrobial Prescribing Policy - V4.pdf | Patient safety | 01/05/2024 | Executive Medical Director | Approved by DTG on 5th Feb - Advised authors that this will need most probably SCEG (although to send to both Nicky and Cindy for clarity), and will need exec quality group approval as a policy. On track for 31.03.25. | Approved at the Executive Policy Oversight Group on 19/06/2025, pending some minor amendments |
| MM15 - Policy for Administration & Use of Emergency & Non Emergency Oxygen in Adults in Managed Services - V2.1.pdf | Patient safety | 01/02/2022 | Executive Medical Director | Document being finalised now that the mandatory training is sorted. Some outstanding work on the some of the appendices | On the agenda for approval at Patient Safety Group end of June and then will go to EQDG. |
| MM37 - Medical Gases - Staff Responsibilities across BCUHB - V1.1.pdf | Patient safety | 01/05/2021 | Executive Medical Director | Author will consider the classification of document when reviewing. On MPPP agenda for 22.01.25 - on track. Classification of the document as a policy has been considered, and should remain - There is a more general Estates operational procedures document for medical gas pipeline systems (OPD HTM 02-01) that could include this information which is overdue review but think it will be a while until it has been reviewed by estates and therefore think we need MM37 in the meantime. | The Policy has been subject to BCU wide consultation and was reviewed by Medicines Policy and Procedure Subgroup of Drug and Therapeutics Group (DTG) on 22.1.25. Document was deferred due to several points needing clarification relating to responsibilities. The author is also considering whether the policy is needed at all as could be incoprorated into OPD HTM02-01 Operational Estates and Facilities Operational Procedures Document Medical Gas Pipeline Systems document that is currenty under review. |
| CW01 - BCUHB Paediatric Escalation Policy - V3.pdf | Patient safety | 01/09/2019 | Chief Operating Officer | Author to consider classification of document when reviewing. The document has been reviewed, but not submitted to the Policies Team for QA | The document has been reviewed, but not submitted to the Policies Team for QA. |

| | |
|---|---|
| **Teitl adroddiad:**<br><br>***Report title:*** | **REVIEW OF THE STANDING ORDERS, SCHEME OF RESERVATION AND DELEGATION AND STANDING FINANCIAL INSTRUCTIONS** |
| **Adrodd i:**<br><br>***Report to:*** | Audit Committee |
| **Dyddiad y Cyfarfod:**<br><br>***Date of Meeting:*** | Tuesday, 19 August 2025 |
| **Crynodeb Gweithredol:**<br><br>***Executive Summary:*** | This paper presents a comprehensive review of the Health Board's governance framework, specifically the **Scheme of Reservation and Delegation (SORD)**, **Standing Orders**, and **Standing Financial Instructions (SFIs)**. The review aims to enhance clarity, accountability, and alignment with strategic priorities, ensuring that decision-making processes are robust, transparent, and fit for purpose.<br><br>The Executive Committee have reviewed the Scheme of Reservation and Delegation (SORD), Standing Orders, and Standing Financial Instructions (SFIs) and proposed a number of changes.<br><br>Key updates include:<br><br>• A **revised format** of the SORD document with detailed delegation provisions; including a section on additional delegations<br>• **Updated job titles** and executive portfolios to reflect current organisational structure.<br>• Introduction of a **tiered financial delegation model**, promoting consistency and clarity across the organisation (section xx).<br>• Proposed changes to the approval process for **Continuing Health Care (CHC)** packages exceeding £250k, aligning with operational needs and governance standards<br>• Proposed changes to the approval process for 'Leases' with a tiered approach (section 15, Table 15F)<br>• Inclusion of Capital Approval process which aligns with the Capital Manual and also feedback from Internal Audit (section 15, Table 15E)<br><br>The review has been informed by feedback from the **Foundations for the Future** engagement sessions and internal consultation with executive colleagues. It supports the Health Board's strategic objectives and strengthens its governance arrangements in line with Welsh Government expectations, particularly regarding procurement reforms. |
| **Argymhellion:**<br><br>***Recommendations:*** | • **NOTE** the report and the proposed changes to the Scheme of Reservation and Delegation; |

| | |
|---|---|
| | • **NOTE** the Standing Financial Instructions are being reviewed in line with Welsh Government direction to incorporate the changes to the procurement act; and<br>• **SUPPORT** the revised Scheme of Reservation and Delegation and Standing Financial Instructions for onward consideration to the Health Board (subject to comments from individual members). |
| **Arweinydd Gweithredol:**<br><br>***Executive Lead:*** | Pam Wenger – Director of Corporate Governance<br>Russell Caldicott, Executive Director of Finance |
| **Awdur yr Adroddiad:**<br><br>***Report Authors:*** | Pam Wenger – Director of Corporate Governance |

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

| | | | | |
|---|---|---|---|---|
| **Lefel sicrwydd:**<br><br>***Assurance level:*** | Arwyddocaol<br>*Significant*<br>☐<br>Lefel uchel o hyder/tystiolaeth o ran darparu'r mecanweithiau / amcanion presennol<br><br>*High level of confidence/evidence in delivery of existing mechanisms/objectives* | Derbyniol<br>*Acceptable*<br>☒<br>Lefel gyffredinol o hyder/tystiolaeth o ran darparu'r mecanweithiau / amcanion presennol<br><br>*General confidence / evidence in delivery of existing mechanisms / objectives* | Rhannol<br>*Partial*<br>☐<br>Rhywfaint o hyder/tystiolaeth o ran darparu'r mecanweithiau / amcanion presennol<br><br>*Some confidence / evidence in delivery of existing mechanisms / objectives* | Dim Sicrwydd<br>*No Assurance*<br>☐<br>Dim hyder/tystiolaeth o ran y ddarpariaeth<br><br>*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:**<br><br>***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:**<br><br>***Link to Strategic Objective(s):*** | This work links to all strategic objectives of the Health Board as Corporate Governance is a key enabler for them. |
| **Goblygiadau rheoleiddio a lleol:**<br><br>***Regulatory and legal implications:*** | The Health Board is required to act according to its Standing Orders. This report contains |

| | |
|---|---|
| | information to allow the Health Board to conform to this.<br><br>It is essential that the Board has robust arrangements in place for Corporate Governance and failure to do so could have legal implications for the Health Board. |
| **Yn unol â WP7, a oedd EqIA yn angenrheidiol ac a gafodd ei gynnal?**<br><br>***In accordance with WP7 has an EqIA been identified as necessary and undertaken?*** | This is not applicable for this report. |
| **Yn unol â WP68, a oedd SEIA yn angenrheidiol ac a gafodd ei gynnal?**<br><br>***In accordance with WP68, has an SEIA identified as necessary been undertaken?*** | This is not applicable for this report. |
| **Manylion am risgiau sy'n gysylltiedig â phwnc a chwmpas y papur hwn, gan gynnwys risgiau newydd (croesgyfeirio at y BAF a'r CRR)**<br><br>***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***<br><br>***Financial implications as a result of implementing the recommendations*** | The effective management of Governance has the potential to leverage a positive financial dividend for the Health Board through better integration of risk management into business planning, decision-making and in shaping how care is delivered to our patients thus leading to enhanced quality and less waste |
| **Goblygiadau gweithlu o ganlyniad i roi'r argymhellion ar waith**<br><br>***Workforce implications as a result of implementing the recommendations*** | Failure to have effective Corporate Governance can impact adversely on the workforce. |
| **Adborth, ymateb a chrynodeb dilynol ar ôl ymgynghori**<br><br>***Feedback, response, and follow up summary following consultation*** | Not applicable |
| **Cysylltiadau â risgiau BAF:**<br>(neu gysylltiadau â'r Gofrestr Risg Gorfforaethol)<br><br>***Links to BAF risks:***<br>*(or links to the Corporate Risk Register)* | BAF24-01 Building an Effective and Accountable Organisation |

| | |
|---|---|
| **Rheswm dros gyflwyno adroddiad i fwrdd cyfrinachol (lle bo'n berthnasol)**<br><br>***Reason for submission of report to confidential board (where relevant)*** | Not applicable |
| ***Next Steps:***<br>• To finalise the documentation in advance of the September Board | |
| ***List of Appendices:***<br><br>Appendix 1 Summary<br><br>**Supporting Pack**<br>• Schedule 1 to Standing Orders<br>• Schedule 2 Standing Financial Instructions | |

**REVIEW OF THE STANDING ORDERS, SCHEME OF RESERVATION AND DELEGATION AND STANDING FINANCIAL INSTRUCTIONS**

## 1. INTRODUCTION

This paper seeks to set out:

- The governance context for the Board Scheme of Delegation and current related activities in relation to the development of strategic outcomes measures and the holistic changes to organisational structure to align with strategic priorities.

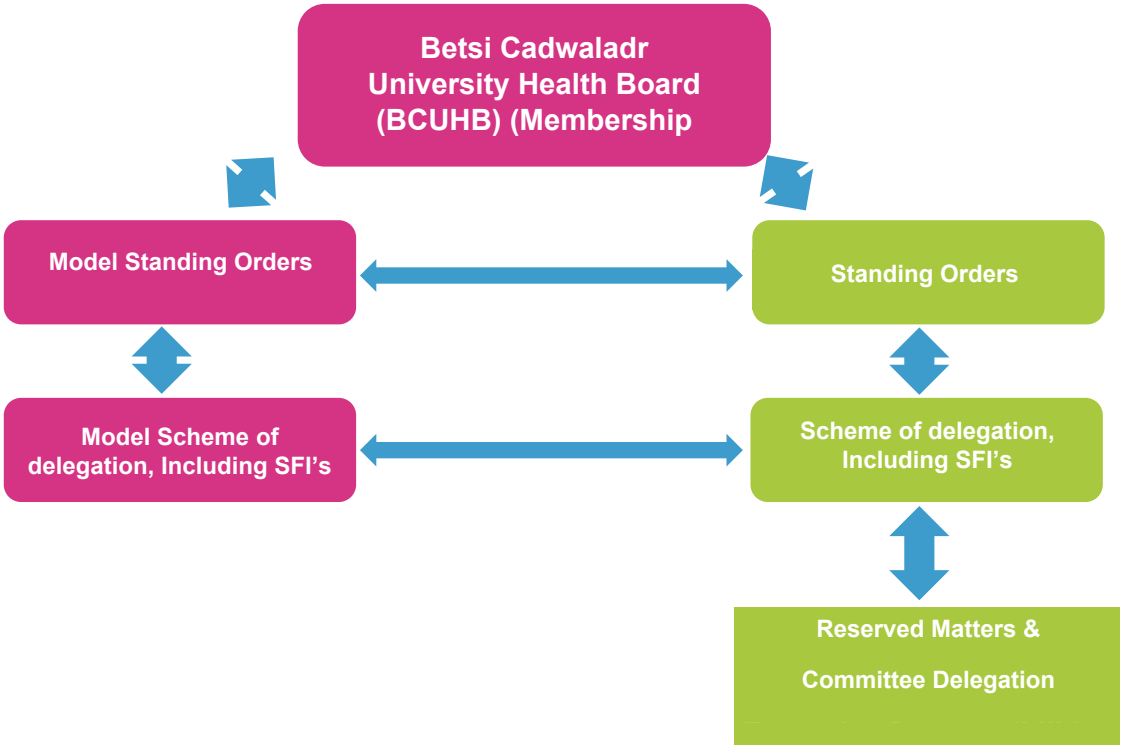
- A set of principles and the proposed steps to achieve a revised Board Scheme of Delegation

## 2. BACKGROUND

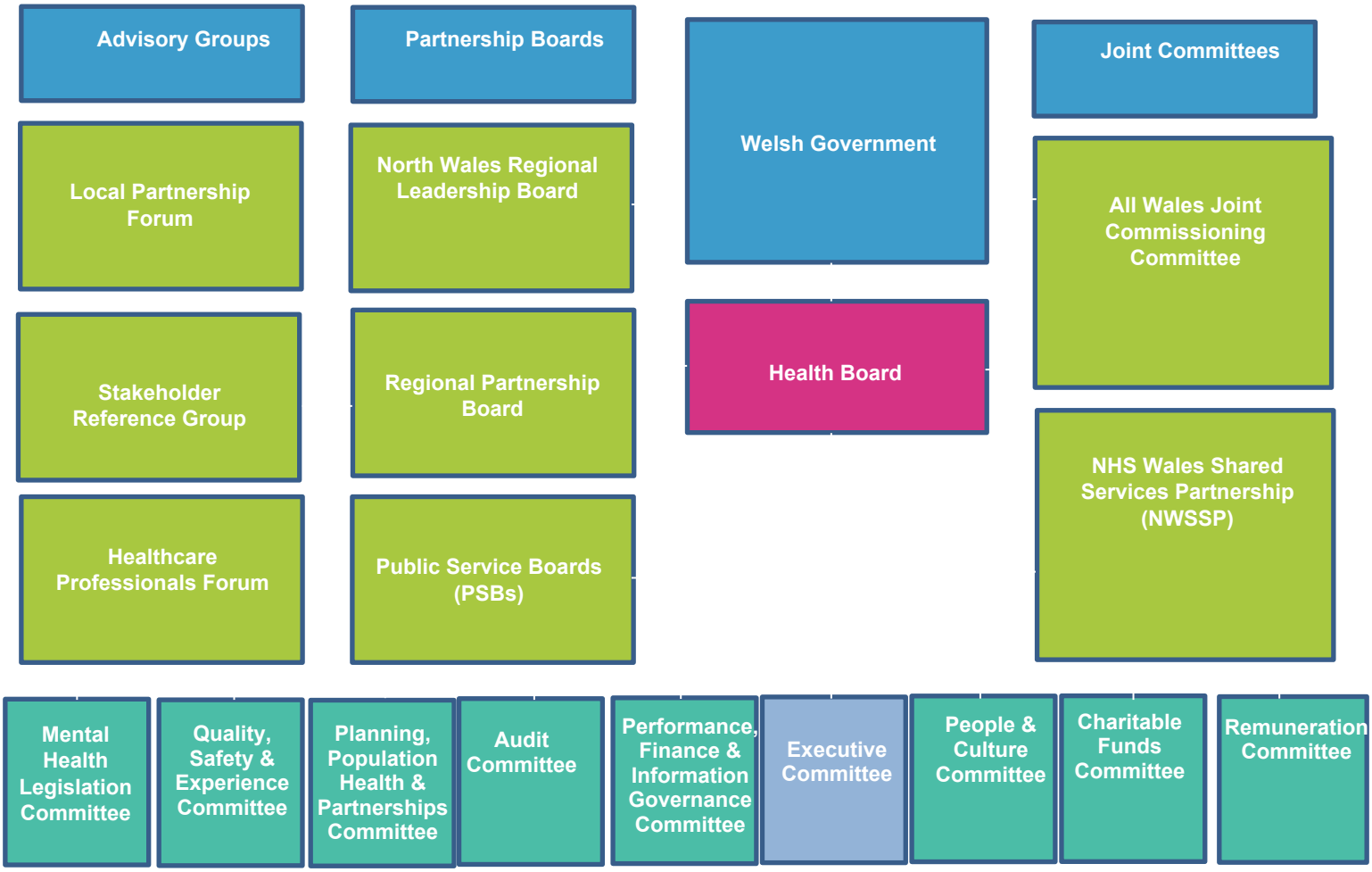
This report presents the updated **Scheme of Reservation and Delegation of Powers (SORD)** for Betsi Cadwaladr University Health Board, approved in **November 2024** and aligned with the revised **Standing Orders** (March 2025). The Scheme is a cornerstone of the Health Board's governance framework, ensuring that decision-making is transparent, accountable, and appropriately distributed across the organisation.

The Scheme of Delegation:

- **Defines decisions reserved to the Board**, including strategic direction, annual plans, budgets, and statutory compliance.
- **Delegates operational authority** to Executive Directors, Committees, and designated officers, enabling timely and effective management of services while maintaining oversight.



## HEALTH BOARD GOVERNANCE FRAMEWORK




Certain Matters are Reserved for the Board (and therefore cannot be delegated); these include:

- **Strategic Direction**: Setting the overall strategic direction and approving the organisation's strategic plans.
- **Financial Oversight**: Approving budgets, financial plans, and major financial decisions.
- **Risk Management**: Overseeing risk management strategies and ensuring appropriate controls are in place.
- **Policy Approval**: Approving key policies and frameworks that guide the organization's operations.
- **Performance Monitoring**: Monitoring organizational performance against strategic objectives and targets.
- **Major Contracts**: Approving significant contracts and agreements.
- **Governance**: Ensuring robust governance structures and processes are in place.

**Key Delegated Authorities Include:**

- **Chief Executive Officer (CEO):** Delegated authority for the overall management of the organisation, including implementation of Board-approved strategies, operational delivery, and performance management.

- **Executive Directors:** Delegated responsibilities aligned to their portfolios (e.g., Finance, Nursing, Medical, Workforce), including budgetary control, service delivery, and compliance with statutory duties.
- **Committees of the Board:** Such as the Audit Committee, Quality, Safety & Experience Committee, and Finance, Performance and Information Governance (PFIG) Committee, are delegated authority to scrutinise, monitor, and provide assurance on specific areas of governance.
- **Executive Director of Finance:** Delegated authority for financial stewardship, including approval of expenditure within defined limits, financial reporting, and compliance with Standing Financial Instructions (SFIs).
- **Director of Corporate Governance:** Delegated responsibility for maintaining the governance framework, ensuring compliance with Standing Orders, and supporting the Board and its Committees.
- **Operational Managers and Budget Holders:** Delegated authority for day-to-day decision-making within defined financial and operational thresholds, as set out in the SFIs and supporting policies.

The Scheme also includes:

- **Clear escalation protocols** for decisions exceeding delegated limits.
- **Regular review mechanisms** to ensure alignment with organisational priorities, regulatory changes, and risk appetite.
- **Integration with the Health Board's Values and Standards of Behaviour Framework**, reinforcing ethical and transparent conduct.

## 3. CURRENT POSITION

### 3.1 Standing Orders and Scheme of Reservation and Delegation (SORD)

The current Scheme of Reservation and Delegation has been in place since 2023 with minor amendments since that date. The last review of the Scheme of Delegation in November 2024 to reflect the changes to legal services moving to the Director of Corporate Governance.

The Standing Orders have been reviewed and there are no changes proposed other than Schedule 1 which is dealt with separately.

A key theme through the Foundations for the Future engagement sessions has been the lack of clarity on the decision-making processes and delegations in the Health Board. This review of the SORD is part of a wider programme of governance improvements which are being led through the 'Processes Workstream' led by the Director of Corporate Governance and Executive Director of Finance.

A review of the 'Director' remits is currently underway and once finalised any changes will form part of the Governance Framework for the Health Board.

### 3.2 Review of Standing Financial Instructions (SFIs)

The Standing Financial Instructions have been reviewed following the amended model SFIs being issued by Welsh Government to incorporate the changes to the Procurement Act. A summary of the changes are:

11.3 Legislation Governing Public Procurement – amended to reflect the new legislation, the Procurement Act 2023 and the PSR (Provider Selection Regime) Wales Regulations. The PSR Wales Regulations apply to "In-Scope Health Services" and the Procurement Act 2023 applies to "Goods and Non-Health Services".

11.4 Procurement Principles and Objectives – states the legal and governing principles guiding the procurement of “In-Scope Health Services” and “Goods and Non-Health Services”.

11.6 Notification to Welsh Government and consent from the Welsh Ministers – updated to refer to the new Schedule 1, General Consent to enter individual contracts, of the SFIs.

11.7 Sustainable Procurement – provides more details of the requirements for the Health Board on meeting it’s well-being duty and adopting the principles of the Well-being of Future Generations (Wales) Act 2015.

11.10 Procurement Process – update thresholds for minimum competition requirements for tenders to the prevailing Procurement Act 2023 threshold.

11.11 Procurement Thresholds – details of difference in requirements for “In-Scope Health Services” and “Goods and Non-Health Services”.

11.12 Designing Competitions – details of difference in requirements for “In-Scope Health Services” and “Goods and Non-Health Services”.

11.17 Extending and Varying Contracts – details of difference in requirements for “In-Scope Health Services” and “Goods and Non-Health Services”.

Schedule 1 General Consent to Enter into Individual Contracts – updated guidance for Health Boards regarding entering into contracts and the requirements for consideration, authorisation and consent from the Director General, Health Social Care and Early Years.

In reviewing the SFIs a number of local modifications have been included in the SoRD which are detailed below**:**

**11G**

In exceptional circumstances it may be necessary to secure goods/services/works from a single supplier. In these circumstances a Single Quote / Tender Application (Waiver) must be completed. The Executive Director of Finance must approve such applications up to £25,000; the Chief Executive or designated deputy, and Executive Director of Finance, are required to approve applications exceeding £25,000.

This requirement for a Single Quote / Tender Application (Waiver) applies even if the award is a Direct Award under a ‘procurement framework’.

The Standing Financial Instructions are included in the supporting pack.

## 4. PROPOSALS FOR CONSIDERATION

### 4.1 Changes to the Scheme of Reservation and Delegation

4.1.1 The format of the document has been completely revised and the additional delegations have been included in the revised document as opposed to the Table A and B as this was considered to be overly complex. This has resulted in the delegation provisions within it outlined in more detail. The current Scheme of Delegation is based on the current organisational model and sets out the delegations in accordance with the matters

reserved for the Board, matters delegated to Committees and Members of the Executive Team.

4.1.2 Changes to job titles to reflect the Executive Team structure and portfolios.

4.1.3 The introduction of a 'tier' for financial delegations, this is to ensure that there is consistency in terms of the levels of delegations across the organisation.

4.1.4 For any Continuing Health Care packages above £250k / annum these will follow the SORD which will require quality assurance by the Complex Care Panel and approval by the Executive Committee. This is due to the Complex Care Panel being established as an assurance mechanism to support the sign off of high-cost cases.

4.1.5 Addition of section 5B Authority to Commit Resources Above Expenditure Baselines Set Within the Financial Plan, provides the Chief Executive and Executive Director of Finance with the authority to approve specific Business Cases up to £0.25 million and states delegated authority for Business Cases up to £1 million. Above £1 million would need the approval of Board.

4.1.6 Section 9 – Income, Fees and Charges. Introduction of detailed information on the accountability and delegated responsibilities for income including authority for approval of various income sources and categories and delegated limits.

**Financial Delegations.**

The following principles will apply:

i. Financial limits at the discretion of the Board;
ii. In an officer's absence, financial limits can be delegated in part or in total either generally or for specific items;
iii. Directors can limit delegated budget holders to less than £150k at their discretion
iv. These limits apply to requisition authorisation, which is where the control lies;
v. In exceptional circumstances, the Chair may have delegated authority on behalf of the Board and the use of the delegated authority to the Chair must be included in the minutes of the next meeting of the Board;
vi. Each Director has the responsibility of cascading the delegation within their area and ensuring that authorised signatories are in place, it may be appropriate for some areas of expenditure to be notified to the Board even if they are within the budget holders limits

The Chief Executive and each Director (Tiers 2, 3 and 4) is responsible for delegation within their department. They shall produce a scheme of delegation for matters within their Directorate/or Department, which shall set out how the Directorate budget and procedures for approval of expenditure are delegated. The Chief Financial Officers will advise on the local scheme of delegation.

**Table 1: Financial Delegations**
Responsibility for **authorising** contracts for goods and services including capital and Service Level agreements and Memorandum of Understandings with **non-NHS bodies** are subject to the delegated level of authority as follows:

| TIER | FINANCIAL DELEGATION | Authority Delegated to | Oracle Approvers |
|---|---|---|---|
| 0 | Board | Above £1,000,000 | Chief Executive following approval by Board and Welsh Government |
| 1 | Chief Executive | Up to £1,000,000 | Executive Director of Finance or Chief Executive |
| 2 | Executive Director of Finance | Up to £500,000 | An Executive Director and Executive Director of Finance (2 to sign) |
| 3 | Executive Directors | Up to £300,000 | Executive Directors |
| 4 | Executive Team Members *(not included in tier 3 including Director of Corporate Governance, Director of Performance and Commissioning, Director of Communications and Engagement and Director of Estates and Environment)* | Up to £250,000 | Executive Team Members<br>Service Directors |
| 5 | Assistant / Associate / Deputy Directors or Heads of Service | Up to £150,000 | Assistant / Associate / Deputy Directors or Heads of Service |
| 6 | Nominated Budget Holder for specific cost centres | Up to £50,000 | Nominated Budget Holder for specific cost centres |
| 7 | Service Lead or Site / General Manager | Up to £30,000 | Service Lead or Site / General Manager |
| 8 | Contracts Manager or Head of Operations | Up to £25,000 | Contracts Manager or Head of Operations |

Where new contracts are above £1 million, these must be approved by the Welsh Government (except for those contracts let under Sections 33 and 192 of the NHS (Wales) Act 2006 and those covered by guidance issued by the Welsh Government on "General Consent" (SFI 11.6.1).

**Examples of areas not requiring consent for contracts exceeding £1m include: -**

- Supply of goods and services by Local Authorities (excluded as per section 32 of the 2006 Act)
- Payment towards expenditure to community services (excluded as per section 194 of the 2006 Act)
- Payments in connection with services to be provided by a Voluntary Sector organisation (excluded as per section 195 of the 2006 Act.
- Provision of Primary Medical or Dental Services (excluded as per section 14/50/64 of the 2006 Act UHB are obliged to make arrangements for the provision of these services
- Procurements of healthcare services as part of the UHB's statutory function such as Continuing Health Care.
- Procurement of NHS services both within Wales and external to Wales.
- Agreement of Individual Patient Placements.
- General Medical Services Out of Hours Service
- Procurement of Drugs

**Table 2 (5B in the SORD) - Authority to commit resources above expenditure baselines set within delegated budgets**

| Ref | Revenue Case Value | Approved by: |
|---|---|---|
| 1 | Up to £0.25m | Chief Executive and Executive Director of Finance<br>All approvals retrospectively reported to Executive Committee in accordance with the Terms of Reference of the Executive Committee |
| 2 | Above £0.25m, up to £0.5m | Relevant Executive Director and Executive Director of Finance and then approval by Executive Committee. |
| 3 | Above £0.5m, up to £1.0m | Relevant Executive Director and Executive Director of Finance and then approval by Executive Committee plus the Performance, Finance & Information Governance Committee |
| 4 | Above £1.0m | Relevant Executive Director and Executive Director of Finance and then approval by Executive Committee plus the Performance, Finance & Information Governance Committee plus approval by Board and Welsh Government |

4.2 The Board approved the establishment of an Executive Committee in January 2025, the terms of reference are included within the Standing Orders.

4.3 There are several reasons why a decision would need to be made during the year this is not a definitive list of the triggers that would initiate this process, however, below is a list of those common triggers.

- Strategic Programme (local or national)
- Service Change (temporary and/or longer term)
- New Guidance
- New Service Contract
- Expiring Contract Notice
- Quality Issue
- Feedback from people and communities
- Annual Planning

4.4 In reviewing the Scheme of Reservation and Delegation, the following decisions will **require** Executive Committee approval (unless delegated) **(subject to discussion and agreement):**

a) Overall priorities and project mandates for capital schemes
b) Authority to commit resources above expenditure baselines set within the financial plan
c) Leases £250k and above
d) Health Care Agreements and Contracts with other NHS Bodies above £250k
e) Approval to commission healthcare services from new organisations - NHS, third sector, primary care, private or independent sector
f) For contracts anticipated to be in excess of £1m, Welsh Government approval required in advance of contract planning
g) Individual Continuing Healthcare Placements/Packages above £250k - Authorisation of individual placements/packages following recommendation from the Complex Care Panel:
h) Agreement of changes to contracts where this would place a cost pressure on the organisation which cannot be funded within existing budgets;

i) Individual Patient Commissioning Agreements – NHS Providers and non-NHS providers above the Chief Executive delegation (Tier 1)
j) All external consultancy support

A copy of the 'draft' summary of the delegations is included at **Appendix 1.**

### 4.5 Escalation

The following principles apply in terms of decision making:

- Tier 2, 3 and 4 have the authority to make decisions in line with their individual and personal accountabilities;
- Some decisions may have an impact wider than individual Directorates and, in these instances, where it relates to a Pan operational service or across more than one Integrated Health Community this should be escalated to the Operational Leadership Team (OLT);
- Some specific 'red' flags which the IHC cannot make decisions on relate to those matters which are Reserved for the Board, which include service change;
- Issues which are likely to have a reputational impact should also be escalated corporately;
- Proposals/business case which there is no budget and would be a change of direction from the IMTP should only be escalated if there is a serious quality concern and cannot be managed locally in accordance with the Health Board risk appetite; and
- Contractual issues that cannot be resolved and require a further corporate decision in accordance with the terms of reference of the Executive Committee.

### 4.5 Capital Schemes

Capital investment in NHS Wales is governed by the **All-Wales Capital Programme (AWCP)** and **Discretionary Capital Allocations**. There are no changes to the delegations however, the following tables (3 and 4) aim to provide clarity in terms of the approval routes.

The 'draft' process is required for all capital approvals (subject to confirmation):

**Table 3 : Capital Schemes funded by Discretionary Allocation**

| Discretionary Capital Programme Approvals | | Gross Expenditure on Whole Project | | |
|---|---|---|---|---|
| **Approval / Sign Off by:** | **Initial Annual Discretionary Programme** | **New Approvals Schemes under £500k** | **Scheme over £500K to £1m** | **Schemes over £1m*** |
| Strategic Planning and Service Change Group (SPSC) | | | Agree project mandate and priority | |
| Tier 4 | Sign Abbreviated Business Case up to £50K | Sign Abbreviated Business Case up to £50K | - | Sign Abbreviated Business Case |
| Tier 3 or 4 | Sign Abbreviated Business Case over £50K | Sign Abbreviated Business Case over £50K | Sign Abbreviated Business Case and BJC | Sign Business Justification Case |
| Executive Director / Senior Responsible Officer (Tier 3 or 4) | - | - | Sign Business Justification Case | Sign Business Justification Case |
| Executive Director of Finance (Tier 3) | - | - | Review and agreement | Review and agreement |
| Capital Investment Group (CIG) | Recommend | Recommend | Recommend | Recommend |
| Strategic Planning and Service Change Group (SPSC) | Recommend for onward consideration for board governance | **Approve** | **Approve Business Justification Case** | **Recommend** |
| Performance, Finance and Information Governance Committee (PFIG) | Recommend | - | - | Recommend |
| Health Board | Approve | - | - | **Approve** |

**Table 4: Capital Schemes funded by Welsh Government**
The following sign off process is required for all schemes funded by Welsh Government

| Scheme under £1m | Scheme over £1m |
|---|---|
| Executive Committee considers overall priorities and project mandates (unless otherwise delegated) | |
| ↓ | ↓ |
| Scoping document submitted to Welsh Government (WG) followed by a scoping meeting with WG to jointly sign off | Scoping document submitted to WG followed by a scoping meeting with WG to jointly sign off |
| ↓ | ↓ |
| Business Justification Template signed off by lead Senior Responsible Officer and Executive Director | Strategic Outline Case signed off by Strategic Planning and Service Change Group (SPSC) , Performance, Finance and Information Governance (PFIG) Committee and |
| ↓ | ↓ |
| Capital Investment Group Recommend | Outline Business Case signed off by Executive Committee, PFIG Committee and the Board |
| ↓ | ↓ |
| Strategic Planning and Service Change Group Approve | Full Business Case signed off by Executive Committee, PFIG Committee and the Board |
| ↓ | ↓ |
| Submission to WG for approval | Final approval required from WG at each stage of Business Case process |

## 5. GOVERNANCE AND ASSURANCE

The review of the Scheme of Reservation and Delegation has been undertaken by the Director of Corporate Governance and the Executive Director of Finance. The detailed mapping of the revised scheme has been led by the Finance Team and Corporate Governance Team.

Consultation on the Scheme of Reservation and Delegation was undertaken at an informal executive team in April 2025 and comments on the current levels of delegations invited from colleagues. The Executive Committee received the report at the last meeting on 6th August 2025 and comments invited in advance of the Audit Committee.

Internal Audit have reviewed the 'draft' document and the changes have been incorporated and clarified.

## 6. CONCLUSION

This paper presents the review of the Health Board's governance framework—encompassing the Standing Orders, Scheme of Reservation and Delegation (SORD). The Standing Financial Instructions (SFIs) are being reviewed in accordance with the changes directed by Welsh Government. The proposed revisions reflect current operational needs, incorporate feedback from key stakeholders, and align with Welsh Government expectations, particularly in relation to procurement reforms.

The introduction of a tiered financial delegation model, updated executive portfolios, and clarified decision-making protocols will enhance consistency and confidence in governance processes.

The Audit Committee is invited to note and comment on the proposed changes and agree that the Executive Committee will finalise the documentation subject to comments for the Board in September.

## 7. RECOMMENDATIONS

The Audit Committee is asked to:

- **NOTE** the report and the proposed changes to the Scheme of Reservation and Delegation;
- **NOTE** the Standing Financial Instructions are being reviewed in line with Welsh Government direction to incorporate the changes to the procurement act; and
- **SUPPORT** the revised Scheme of Reservation and Delegation and Standing Financial Instructions for onward consideration to the Health Board (subject to comments from individual members).

| Description | Specific | More information | Welsh Government | Board | Performance, Finance and Information Governance (PFIG) Committee | Executive Committee | Strategic Planning and Service Change Group | Charitable Funds Committee | Capital Investment Group (CIG) | Chief Executive | Executive Director of Finance | An Executive Director and the Executive Director of Finance | An Executive Director and the Finance Director: Commissioning and Financial Planning | Chief Operating Officer | Executive Medical Director | Executive Directors | Finance Director: Commissioning and Strategic Planning | Other Officers as delegated by Executive Directors | Notes |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | | **Any expenditure approval must be within the funding limits of approved budgets.<br>Budget holders are responsible for providing services within the available financial resources delegated to them and are held accountable for managing within their budget.** | | | | | | | | | | | | | | | | |
| **Budget changes** | Transfers between budget managers (Virements) | Budgetary control procedure | | £1m+ | | | | | | Above £0.5m, below £1m | Above £0.5m, below £1m | | | | | Within own delegated budget | Up to £0.5m | Within own delegated budget | |
| **General Non-pay Expenditure** | The values refer to individual orders / requisitions (for the total life of the contract). Goods or services should be sourced from the approved catalogue, or if this is not possible, via a public sector contract framework. Where an item is not on catalogue or framework, Procurement Services should be requested to undertake quotation / tendering exercise. All orders for goods and services must be accompanied by an official order number in accordance with the No PO, No Pay policy. | Purchase to Pay Procedure | £1m+ | £1m+ | | | | | | Above £0.5m, below £1m | Above £0.5m, below £1m | | Above £0.3m, below £0.5m | | | Up to £0.3m | Up to £0.25m | Up to £0.25m. Refer to Operational Schemes of Delegation | In addition to delegated limits, competition requirements apply when procuring goods. Advice should be sought from Procurement Services before entering into or extending existing contracts as the ability to extend is not automatic. |
| **Healthcare agreements** | NHS - These are agreements that the HB will enter into to commission healthcare services for its resident population from other NHS providers. | New contract or variation to existing contract | | £10m+ (£1m+ to be retrospectively reported) | | £0.25m+ | | | | Above £5m, below £10m | Above £5m, below £10m | | Above £0.25m, below £5m | Up to £0.25m | | | | | Annual contract schedule for 'long-term' agreements are approved by Board via annual budget approval process.<br><br>ALL CONTRACTS ABOVE £0.25m MUST ALSO BE APPROVED BY EXECUTIVE COMMITTEE |
| | Private / 3rd Sector / Grants / Primary Care / Local Authorities<br><br>For contracts £1m+ Welsh Government approval required in advance of contract planning | New contract or variation to existing contract | £1m+ | £1m+ (up to £1m to be retrospectively reported) | All Primary Care | £0.25m+ | | | | Above £0.5m, below £1m | Above £0.5m, below £1m | Up to £0.25m | Above £0.25m, below £0.5m | | | | | | ALL CONTRACTS ABOVE £0.25m MUST ALSO BE APPROVED BY EXECUTIVE COMMITTEE |
| | Individual Continuing Health Care (CHC) Placements/Packages<br><br>APPROVAL REQUIREMENTS EXCLUDES 'FAST TRACK' PROCESS AS PER THE WALES NATIONAL FRAMEWORK | Via the 'local' CHC Panels for up to £0.2m, and the Complex / High Cost CHC Panel for cases over £0.2m | | £1m+ (up to £1m to be retrospectively reported) | | £0.25m+ | | | | £1m+ | Above £0.125m, below £1m* | | | Up to £0.125m | | | | | *EDoF to approve with COO up to £0.25m<br><br>ALL CONTRACTS ABOVE £0.25m MUST ALSO BE APPROVED BY EXECUTIVE COMMITTEE |
| **Capital** | Property, Plant, Machinery and Equipment (including IT) should be capitalised if the cost of the item is ≥ £5,000. This includes assets which individually may be less than £5,000 but together form a single collective asset (grouped asset) with a group value of ≥ £5,000 (including VAT where this is not recoverable) that fulfil the following criteria - the items are functionally interdependent; the items are acquired at about the same date and are planned for disposal at about the same date; the items are under single managerial control; and each individual asset thus grouped has a value of at least £250, however this de-minimus value does not apply in dealing with the initial equipping of hospitals.<br>IT Assets: IT hardware may be considered interdependent if it is attached to a network, even if capable of stand-alone use. In effect all IT equipment purchases, where the final three criteria above apply, will be capitalised. | Tha HB Capital Manual details the process for the annual discretionary capital programme and Business Case requirements for schemes funded by Welsh Government | £1m+<br><br>Approval is via IFRS16 and Business Case process.<br>ADL approval required for expenditure above £0.5m | £1m+ | £1m+ | | ALL TO BE APPROVED | | Capital projects/ schemes must be recommended for approval for sign off via the Scheme of Delegation | Above £0.5m, below £1m | Above £0.5m, below £1m | | | | | | Up to £0.5m | Up to £0.15m | The Capital Investment Group (CIG) consider proposals from Capital Sub-groups on the allocation of capital and agree recommendations to the Board. |
| **Leases** | All leases which are covered under the scope of IFRS 16, including land and buildings, equipment, managed service contracts and business use vehicles.<br>Lease renewals: Leases between £0.5m and £1m notification to WG ministers of intention to enter into a contract. Leases >£1m approval required from WG ministers.<br>New leases: Leases greater than £0.5m, discussion required with WG Capital Estates and Facilities Team regarding required approval process. | Total contract value | £1m+<br>ADL required for above £0.5m but below £1.0m | £1m+ (Property leases below £1m and signed under Seal will be retrospectively reported) | Above £0.25m | Above £0.25m | | | | Above £0.5m, below £1m | Above £0.25m, below £0.5m | Up to £0.25m | | | | | | | ALL LEASES ABOVE £0.25m MUST ALSO BE APPROVED BY THE EXECUTIVE COMMITTEE AND PFIG COMMITTEE |
| **Consultancy** | Approval for all external consultancy support (total contract value for duration of service) to be approved by Executive Committee prior to orders / agreements being approved as per signing authority | | £1m+ | £0.5m+ | | ALL TO BE APPROVED | | | | Up to £0.5m | Up to £0.5m | | Up to £0.25m | | | | | | In addition to delegated limits, competition requirements apply when procuring goods. Advice should be sought from Procurement Services before entering into or extending existing contracts as the ability to extend is not automatic. |
| **Losses/special payments** | Different limits apply dependent on category of claim, for example, clinical negligence and personal injury claims, and dependent on legal obligation. Approval required from Welsh Gov dependent on category and value as per Losses and Special Payments Procedure. | Losses and Special Payments Procedure | Terminations £50k+ | | | | | | | | | | | | | | | | Terminations up to £50,000 approved by Executive Director of People and Organisational Development; VERS approved by Remuneration Committee |

| Description | Specific | More information | Welsh Government | Board | Performance, Finance and Information Governance (PFIG) Committee | Executive Committee | Strategic Planning and Service Change Group | Charitable Funds Committee | Capital Investment Group (CIG) | Chief Executive | Executive Director of Finance | An Executive Director and the Executive Director of Finance | An Executive Director and the Finance Director: Commissioning and Financial Planning | Chief Operating Officer | Executive Medical Director | Executive Directors | Finance Director: Commissioning and Strategic Planning | Other Officers as delegated by Executive Directors | Notes |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| **Ex-gratia payments** | Ex-gratia payments are payments which a Health Body is not obliged to make or for which there is no statutory cover or legal liability. These limits are for ex-gratia payments for personal effects / property claims relating to both patients and staff | Losses and Special Payments Procedure | £50k+ | | | | | | | Up to £50k | Up to £50k | | | | | | | | |
| **New Drugs** | Value based on annual costs after relevant approval | | | £1m+ | | | | | | Up to £1.0m following relevant approval | Up to £1.0m following relevant approval | | | | Up to £1.0m following relevant approval | | | Up to £0.5m following relevant approval | For new drugs and the commitment to expenditure after year one of the treatment fund arrangements, the approval process is as follows:<br>a) NICE Implementation Group, onwards to<br>b) Drugs and Therapetic Group (DTG), onwards to<br>c) Senior Leadership Team for approval up to £0.5m, onwards to<br>d) Executive Director of Finance, Executive Medical Director or Chief Executive for approval up to £1m<br>e) Board approval for £1m+ |
| **Procurement Waivers - Single Tender/Quotation Action** | Goods and services should be procured through fair and open competition to secure value for money and ensure propriety and regularity. However, there may be situations where it is more appropriate to approach a single provider through the use of a single tender/quotation action (STA/SQA). A STA/SQA should only be undertaken when there is no feasible alternative and due process is followed. | Single Tender Action Procedure | | | | | | | | £25k+ | Up to £25k | | | | | | | | All Single Waivers are created within the Services. In addition to the initial 'local' approval, the Executive Director with that area of responsibility must also approve prior to submission to NWSSP Procurement Services.<br>Retrospective Reporting to Audit & Risk Committee |
| **Staffing** | New posts (Increase in funded establishment) | | | | | | | | | Approve new posts across HB | Approve new posts across HB | | | | | Approve new posts within own structure in line with delegated budgets and limits | | Approve new posts within own structure in line with delegated budgets and limits | |
| | Agency and waiting list initiatives | | | | | | | | | | | | | | | Approve in advance in own structure in line with delegated budgets and limits | | Approve in advance in own structure in line with delegated budgets and limits | |
| **Charitable Funds** | Charitable funds are used exclusively for charitable purposes and must satisfy both the objects of the registered charity and any restrictions of the specific income source or fund. All items of expenditure will need to be approved using the appropriate authorisation level and relevant processes and controls are in place for reviewing the expenditure and justification for spend to ensure all spend is eligible prior to it being incurred. The procedures for requisitioning and approving any expenditure for items or services using charitable funds is identical to that for the Health Board, therefore all procurement policies apply equally. | Your Charity Procedures | £1m+ | £1m+ | | | | £5,000+ (Plus contentious expenditure below £5,000) | | | | | | | | | | Authorised Charitable Fund Advisors may approve 'non-contentious' expenditure up to £5,000 from their charitable fund | The term "contentious" refers to the appropriateness of the expenditure either due to its nature or its compatibility with fund objectives as detailed in 'Your Charity Procedures'. |
| **Income** | Different limits apply dependent on category / source of income, for example, contracts for servicess, research projects or grants. Approval required dependent on category and value as per Scheme of Reservation and Delegation.<br><br>The Executive Director of Finance must be informed of all funding bids to Welsh Government or other organisations. | As per Table 9D (1) of SoRD | | | | | | | | | | | | | | | | | The HB welcomes additional sources of funding to help deliver services and improve patient care. Good governance would suggest that bids should be reviewed by the relevant Chief Finance Officer in the first instance and that all bids for funding are forwarded for review by the Finance Director: Commissioning and Financial Planning before submission. |
| **Non-Welsh Government sourced income generation from research and development activities** | Each Project undertaken by the HB which is funded by an external partner requires a contract between both parties. | | | | | £100k+ | | | | | £100k+ (following agreement by Executive Committee) | | | | Up to £100k (with relevant finance agreement) | | | | Executive Medical Director to approve up to £100k with agreement from the Finance Director: Commissioning and Financial Planning (up to £50k) or the Executive Director of Finance (between £50k and £100k) |

| | |
|---|---|
| **Teitl adroddiad:**<br><br>***Report title:*** | Board Assurance Framework |
| **Adrodd i:**<br><br>***Report to:*** | Audit Committee |
| **Dyddiad y Cyfarfod:**<br><br>***Date of Meeting:*** | Tuesday, 19 August 2025 |
| **Crynodeb Gweithredol:**<br><br>***Executive Summary:*** | This report provides the Audit Committee with assurance on the current status and progression of strategic risks outlined in the Board Assurance Framework (BAF) for 2025. The BAF serves as a strategic tool to support the Health Board in achieving its objectives by identifying, managing, and mitigating risks aligned with its five strategic priorities.<br><br>As of August 2025:<br><br>• **24 actions (over 25%)** have been completed.<br>• **53 actions (60%)** are progressing.<br>• **6 actions (7%)** are delayed, primarily within **BAF24-02: Digital Transformation**, which requires close monitoring.<br><br>Each risk has been reviewed and rated by its respective lead committee, with oversight provided by the Risk Scrutiny Group through monthly deep dives. Recent deep dives focused on:<br><br>• **BAF24-02**: Strategic Development and Digital Transformation.<br>• **BAF24-06**: Transforming Care and Enhancing Outcomes (Patient Safety & Public Health).<br><br>The BAF will be escalated to the Board in September 2025 via the Audit Committee Chair's assurance report, with the next full BAF submission scheduled for January 2026.<br><br>The overall assurance rating is **Acceptable**, with no areas currently rated as "No Assurance." However, several risks remain under **Limited Assurance**, particularly in digital transformation, financial sustainability, and workforce capacity, indicating areas requiring further action and investment.<br><br>Key next steps include:<br><br>• Continued monitoring of delayed actions.<br>• Alignment of BAF actions with the final Strategic Plans.<br>• Ongoing bi-monthly reviews by the Risk Scrutiny Group and Executive Committee, with quarterly reporting to Committees and bi-annual reporting to the Board.<br><br>The Committee is asked to **receive and consider** the contents and assurance ratings of the BAF. |

| | | | | |
|---|---|---|---|---|
| **Argymhellion:**<br><br>***Recommendations:*** | The Committee is asked to**:**<br><br>• To **receive** and **consider** the contents and assurance rating of the Board Assurance Framework. | | | |
| **Arweinydd Gweithredol:**<br><br>***Executive Lead:*** | Pam Wenger, Director of Corporate Governance | | | |
| **Awdur yr Adroddiad:**<br><br>***Report Author:*** | Nesta Collingridge Head of Risk Management | | | |
| **Pwrpas yr adroddiad:**<br><br>***Purpose of report:*** | I'w Nodi<br>*For Noting*<br>☐ | I Benderfynu arno<br>*For Decision*<br>☒ | Am sicrwydd<br>*For Assurance*<br>☐ | |
| **Lefel sicrwydd:**<br><br>***Assurance level:*** | Arwyddocaol<br>*Significant*<br>☐<br>Lefel uchel o hyder/tystiolaeth o ran darparu'r mecanweithiau / amcanion presennol<br><br>*High level of confidence/evidence in delivery of existing mechanisms/objectives* | Derbyniol<br>*Acceptable*<br>☒<br>Lefel gyffredinol o hyder/tystiolaeth o ran darparu'r mecanweithiau / amcanion presennol<br><br>*General confidence / evidence in delivery of existing mechanisms / objectives* | Rhannol<br>*Partial*<br>☐<br>Rhywfaint o hyder/tystiolaeth o ran darparu'r mecanweithiau / amcanion presennol<br><br>*Some confidence / evidence in delivery of existing mechanisms / objectives* | Dim Sicrwydd<br>*No Assurance*<br>☐<br>Dim hyder/tystiolaeth o ran y ddarpariaeth<br><br>*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:**<br><br>***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:**<br><br>***Link to Strategic Objective(s):*** | Detailed in the BAF report and how the CRR aligns to the revised BAF | | | |
| **Goblygiadau rheoleiddio a lleol:**<br><br>***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?**<br><br>***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?** | Not applicable for this report | | | |

| | |
|---|---|
| ***In accordance with WP68, has an SEIA identified as necessary ben undertaken?*** | |
| **Manylion am risgiau sy'n gysylltiedig â phwnc a chwmpas y papur hwn, gan gynnwys risgiau newydd (croesgyfeirio at y BAF a'r CRR)**<br><br>***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***<br><br>***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**<br><br>***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**<br><br>***Feedback, response, and follow up summary following consultation*** | Risk Scrutiny Group feedback 09/07/2025<br><br>The Risk Scrutiny Group held a deep dive on the 'Not Delivering Strategic Development and Digital Transformation' risk. Suggested updates on the controls and actions are yet to be completed and will be completed prior to committee (to be updated 13th Aug).<br><br>Wider suggestions made by the group around the impact score not being reduced for the target will be feedback when requesting updates. |
| **Cysylltiadau â risgiau BAF:**<br>(neu gysylltiadau â'r Gofrestr Risg Gorfforaethol)<br><br>***Links to BAF risks:***<br>*(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)**<br><br>***Reason for submission of report to confidential board (where relevant)*** | |
| **Camau Nesaf:**<br><br>***Next Steps:***<br>1. Delayed risk actions to be monitored. | |

2. The actions within the BAF will all be reviewed in line with the final version of the Strategic Plans to ensure full alignment.
3. Business as usual reporting and monitoring: Bi-monthly Review at Risk Scrutiny Group and Executive Committee, monitoring of actions within risks. Reporting to Committee quarterly and Board bi-annually as per Risk Management Framework.

**Rhestr o Atodiadau:**

***List of Appendices:***
Appendix 1 – Full Board Assurance Framework

GIG CYMRU NHS
Bwrdd Iechyd Prifysgol
Betsi Cadwaladr
University Health Board

# Board Assurance Framework

# Board Assurance Framework Report

## Purpose

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

The purpose of this BAF is threefold:

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

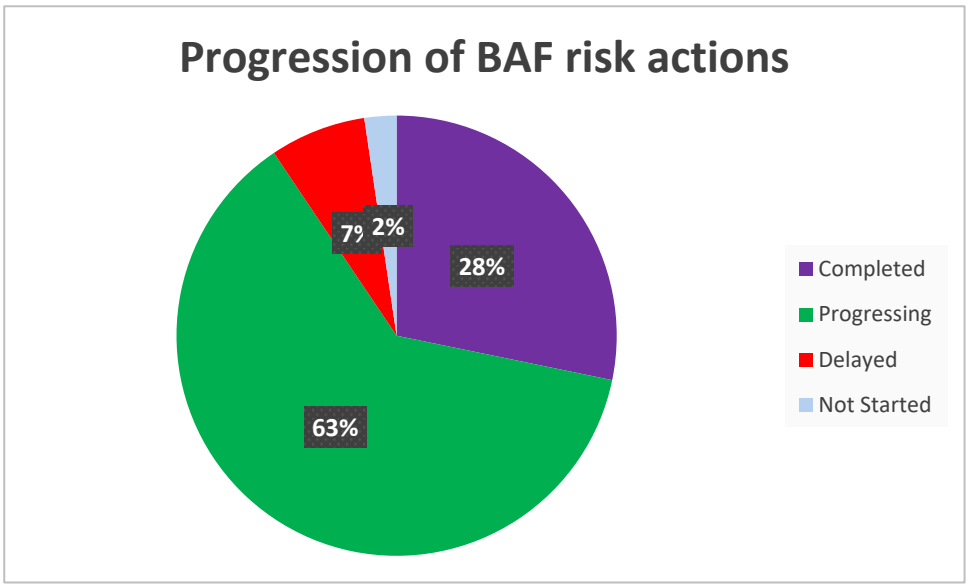
By integrating the BAF with our strategic priorities and operational plans, we can ensure that our risk management efforts directly support our mission to improve health outcomes, enhance patient safety, and foster a culture of accountability within BCUHB.

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

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

### Key Highlights

Over a quarter of BAF actions have been completed since the last report to the committee, demonstrating good progress. Minimal revised actions. However digital have presented a number of delayed actions within their risk and have since presented this to the Risk Scrutiny Group and Executive Committee.




## Next Steps

- Delayed risk actions to be monitored.
- The actions within the BAF will all be reviewed in line with the final version of the Strategic Plans to ensure full alignment.
- The Board Assurance Framework will be maintained and reported to the Risk Scrutiny Group; Executive Committee (bi-monthly) and Committees (quarterly) and Board (bi-annually) as per the Risk Management Framework.

# Board Assurance Framework (BAF): June 2025

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:

| | |
|---|---|
|  **Substantial Assurance** | The Committee is satisfied that there is reliable evidence supporting the effectiveness of the current risk treatment strategy in mitigating the threat, with minimal gaps in control. While the majority of actions have been addressed, some minor actions may still require completion before the risk score is reduced. However, the Committee has good assurance regarding action progress. Likelihood of risk materialising: Low. |
|  **Reasonable Assurance** | The Committee has seen sufficient evidence that the most significant actions to reduce the risk have been completed. There is assurance that the planned actions within the current risk treatment strategy are appropriate, with the majority of control and assurance gaps having been addressed. Likelihood of risk materialising: Low to moderate. |
|  **Limited Assurance** | The Committee does not have sufficient evidence for assurance that the current risk treatment strategy is effectively mitigating the threat. There remains to be some key gaps in controls that require management attention, and further external validation is needed. Until further controls are in place, there remains a number of actions to reduce the score. Likelihood of risk materialising: Moderate. |
|  **Unsatisfactory Assurance** | The Committee has no/little evidence for assurance that the current risk treatment strategy is effectively managing the threat. There remains to be several key gaps in controls that require management attention, and further external validation is needed. Until further controls are in place, there remains a number of actions to reduce the score. Likelihood of risk materialising: High |

# Board Assurance Framework (BAF): June 2025

Bwrdd Iechyd Prifysgol Betsi Cadwaladr University Health Board

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

| Reference | Principal risk: There is a risk of… | Lead Executive | Lead Committee | Initial date of assessment | Last reviewed by Executive Team | Previous risk score (at previous review/update) C x L | Current risk score C x L | Target risk score C x L |
|---|---|---|---|---|---|---|---|---|
| BAF24-01 | Not Fully Building an Effective and Accountable Organisation | Director of Corporate Governance and Executive Team oversight | Performance, Finance and Information Governance | 20/10/2024 | 21/07/2025 | 4x 3= 12 | **4x 3= 12** | 2x 2= 4 |
| BAF24-02 | Not Delivering Strategic Development and Digital Transformation | Executive Director of Transformation and Strategic Planning & Chief Digital & Information Officer | Planning, Population Health & Partnership | 20/10/2024 | 21/07/2025 | 5x 4= 20 | **5x 4= 20** | 3x 3= 9 |
| BAF24-03 | Not Achieving Long Term Financial Sustainability | Executive Director of Finance | Performance, Finance and Information Governance | 20/10/2024 | 21/07/2025 | 5x 4= 20 | **5x 4= 20** | 3x 3= 9 |
| BAF24-04 | Not Establishing a Compassionate Culture, Leadership, Engagement and workforce capacity and capability | Deputy Director of People Services | People & Culture | 20/10/2024 | 21/07/2025 | 4x 4= 16 | **4x 4= 16** | 3x 3= 9 |
| BAF24-05 | Not Engaging with Citizens, Partners and Communities | Director of Partnerships/Communications and Engagement | Planning, Population Health & Partnership | 20/10/2024 | 21/07/2025 | 2x 3= 6 | **2x 3= 6** | 2x 2= 4 |
| BAF24-06 | Not Delivering the Required Improvements to Transform Care and Enhance Outcomes | Executive Director of Nursing<br>Executive Director of Public Health<br>Executive Medical Director<br>Executive Director of Allied Health Professionals and Health Science | Quality, Safety and Experience / Planning, Population Health & Partnership | 20/10/2024 | 21/07/2025 | 5x 4= 20 | **5x 4= 20** | 5x 2= 10 |
| BAF24-07 | Not Delivering Timely Access to Care Resulting In Potential Clinical Harm, Poor Delivery of Performance Targets and Reputational Risk | Chief Operating Officer | Performance, Finance and Information Governance | 20/10/2024 | 21/07/2025 | 4x 4= 16 | **4x 4= 16** | 4x 2= 8 |
| BAF24-08 | Not Implementing Evidenced Based Improvement and Innovation | Executive Medical Director & Chief Digital & Information Officer | Planning, Population Health & Partnership | 20/10/2024 | 21/07/2025 | 4x 3= 12 | **4x 3= 12** | 3x 2= 6 |

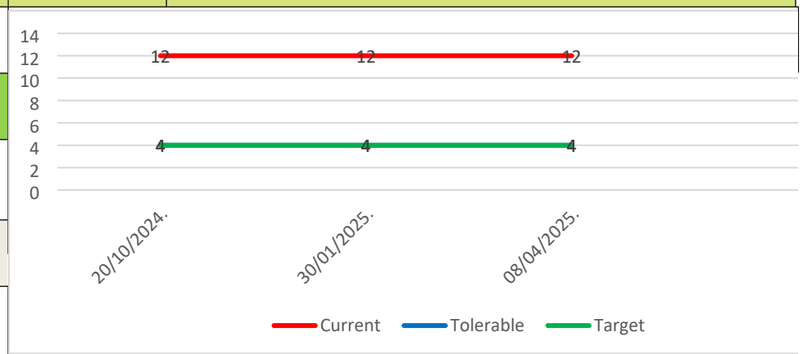
GIG CYMRU NHS WALES
Bwrdd Iechyd Prifysgol Betsi Cadwaladr University Health Board

## 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: Not Fully Building an Effective and Accountable Organisation**<br><br>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 with Executive Committee Oversight | **Risk appetite** | Open <16 | | |
| **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 by Committee:** | 29/04/2025 |
| **Risk rating** | **12. Moderate** | **4. Low** | **4. Low** | **Last updated by Executive:** | 06/08/2025 |




**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?) | **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 Statutory Compliance and Inquiries/Assistant Director of Occupational Health, Safety And Security/ EPRR Lead | Accountable: | Executive Committee |

# Board Assurance Framework (BAF): June 2025

| Strategic threat (what might cause this to happen) | Primary risk controls (what controls/ systems & processes do we **already** have in place to assist us in managing the risk and reducing the likelihood/ impact of the threat) | Gaps in control (are further controls possible in order to reduce risk exposure within tolerable range?) | Sources of assurance (and date) (**Evidence** that the controls/ systems which we are placing reliance on are effective) | Gaps in assurance / actions to address gaps and issues | Assurance rating |
|---|---|---|---|---|---|
| **Threat:** the HB may not be compliant. This could lead to poor decision-making, unaddressed performance gaps, and a lack of ownership over key outcomes, ultimately reducing the Health Board's ability to deliver its strategic goals effectively. | • Health and Safety Policy<br>• HS03 General Risk Assessment Procedure<br>• HSG65 Plan, Do, Check, Act process for continuous improvement<br>• Service Sector Health and Safety Self-Assessment and Health and Safety Reviews<br>• Security Assessment of Premises<br>• Some Civil Contingencies and Emergency Preparedness plans<br>• Annual emergency preparedness evaluations improvement | • Remaining gaps in civil contingency planning post-pandemic<br>• Incomplete integration of HSE recommendations into operational plans | **Management:** Health and Safety compliance reporting to Strategic Occupational Safety and Health Group (SOSHG)<br><br>Monthly reviews of Health, Safety and Security KPIs<br><br>**Risk and compliance:** Risk Register reporting but noted gap on the Gap analysis reporting for compliance and gaps of general legislative gap analysis. System in development.<br><br>**Independent assurance:**<br>• HSE audit and compliance checks<br>• Civil Contingencies Act compliance review | • Gap analysis reporting general legislative gap analysis<br>• Limited Assurance Internal Audit report for Health and Safety & Corporate Legislative Compliance. Improvement action plan in place and monitored at SOSHG. | **Limited Assurance** |

| Plans to improve control (are further controls possible in order to reduce risk exposure within tolerable range?) | Action Handler | Status of Actions | Date when action will be completed |
|---|---|---|---|
| Approval and progression of the gap analysis for health and safety measures as set out in the updated Health and Safety Strategy and Plan 2024-2026 dated September 2024. | Lynne Bushell | Complete | 30/09/2024 |
| New approach for Health and Safety Management System being developed aligned to NHS Employers Health and Safety Standards, to include Violence Prevention and Reduction Standards | Lynne Bushell | Progressing | 31/12/2025 |

| Responsible: | Director of Performance and Commissioning | Accountable: | Director of Corporate Governance/CEO |
|---|---|---|---|

| Strategic threat (what might cause this to happen) | Primary risk controls (what controls/ systems & processes do we **already** have in place to assist us in managing the risk and reducing the likelihood/ impact of the threat) | Gaps in control (are further controls possible in order to reduce risk exposure within tolerable range?) | Sources of assurance (and date) (**Evidence** that the controls/ systems which we are placing reliance on are effective) | Gaps in assurance / actions to address gaps and issues | Assurance rating |
|---|---|---|---|---|---|
| **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<br>• Integrated Performance reports aligned<br>• Clear accountability matrix and escalation for senior and mid-level management<br>• Performance scorecards for service delivery units | • Inconsistent application of performance tools across departments<br>• Review Integrated Performance Framework to re-align with new strategic objectives Triangulation with risk management | **Management:**<br>• Reviews of performance metrics at Executive Team level<br>• Regular reporting to Committees<br><br>**Risk and compliance:**<br>• Monthly accountability reviews if in escalation for services SLT<br>• Performance Reviews held by the CEO<br>• Monthly performance reviews by Welsh Government<br><br>**Independent assurance**:<br>• External NHS Wales and Health Boards performance benchmarking and NHS benchmarking network | • Reports on performance at IHC<br>• Commissioning reports on out of area | **Limited Assurance** |

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

| Responsible: | Director of Corporate Governance | Accountable: | CEO |
|---|---|---|---|

| | | | | | |
|---|---|---|---|---|---|
| **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<br>• Business Partnering approach for clinical and corporate leadership<br>• Staff co-producing a new Operating Model | • Delays in decision-making due to leadership duplication<br>• Lack of integrated systems reducing efficiency<br>• Service reconfiguration plans based on population health needs<br>• Digital tools (Microsoft 365) to streamline operations | **Management:**<br>• Service-level performance audits<br>**Risk and compliance:**<br>• Assessments of operating model efficiency and insight reports<br>**Independent assurance:**<br>• Operating model effectiveness review by internal and external stakeholders<br>• Internal Audit report on duplication of roles and decision-making timelines | • Limited Assurance Internal Audit report for Operating Model & Effective Governance (IHC) Central | **Limited Assurance** |

| ⬆ | **Plans to improve control** (are further controls possible in order to reduce risk exposure within tolerable range?) | **Action Handler** | **Status of Actions** | **Date when action will be completed** |
|---|---|---|---|---|
| | Completion of the discovery phase reviewing of the operating model based on stakeholder feedback | Julie Parry | Complete | 30/11/2024 |
| | Implement a streamlined decision-making protocol by Q3 and looking a re-design phase | Pam Wenger | Progressing | 31/10/2025 |
| | Review of the Scheme of Delegation and establishment of a formal Executive Committee with reporting groups with clear delegations. Scheduled to for presentation at the next Audit Committee 11/08/2025 – paper presented to Executive Committee in August. | Philippa Peak Jones | Progressing | 25/09/2025 |

| 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.<br>• Risk Appetite set 24/25<br>• Board Development Programme<br>• Internal Audit Tracking of Recommendations<br>• 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.<br>• Policy Management system and overdue policies.<br>• Self-assessment of board effectiveness<br>• Robust Internal Audit Tracking software and systems.<br>• Incomplete recruitment of executive roles.<br>• Equality Impact Assessment Process integrated within Impact Assessment Impact Screening Tool to ensure compliance | **Management:**<br>• Risk reporting at local level and strategic level.<br>**Risk and compliance:**<br>• Risk reporting to the Executive Team and Committees Key Performance Indicators (KPIs) on risk management performance<br>**Independent assurance:**<br>• Internal Audit Reporting - Reasonable assurance with areas of substantial<br>• 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<br>• Audit Wales governance recommendations | **Limited Assurance** |

| ⬆ | **Plans to improve control** (are further controls possible in order to reduce risk exposure within tolerable range?) | **Action Handler** | **Status of Actions** | **Date when action will be completed** |
|---|---|---|---|---|
| | Improved Scrutiny of Corporate Risks. & Development of the BAF | Nesta Collingridge | Complete | 30/01/2025 |
| | Improved Data Analytics of Governance around Risk (Dashboard) and driving improvement of metrics. N.B This work will be ongoing now to ensure the KPIs remain in tolerance (risks being updated) and reported to Audit Committee quarterly. | Nesta Collingridge | Complete | 30/01/2025 |
| | Review of the current system once progress has been made on the overdue policies. System approved for procurement which will support automated tracking. | Glesni Driver | Progressing | 31/03/2026 |
| | Reviewing current systems to have a more effective way of tracking and reporting audit recommendations. Corporate Governance (policies/tracking) /Risk Management and System approved for procurement 22/01/25, new software in place by 30/12/25 but piloted in 2026 which will support automated tracking. This will not be embedded until 2026-2027. | Glesni Driver | Progressing | 30/09/2026 |
| | Executive Team recruitment ongoing with some progress made on appointments. Director of People and OD currently out to advert with interim arrangements in place. | Georgina Roberts | Progressing | 31/03/2026 |

## 2: Developing strategy and long-lasting change

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

| | | | | | |
|---|---|---|---|---|---|
| **Principal risk** (what could prevent us achieving this strategic objective) | **BAF24-02: Not Delivering Strategic Development and Digital Transformation**<br>**There is a risk we won't achieve our strategic and operational objectives as a Health Board, caused by having inadequate arrangements and skills for identification, commissioning and delivery of Digital, Data & Technology enabled change.**<br>**This will lead to an inability to deliver new models of care in line with national and local strategies, which results in a degradation in patient safety, quality of care, public confidence, financial controls and reputation**<br>. | | | **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 Transformation and Strategic Planning / Chief Digital & Information Officer | | **Risk appetite** | Open <16 | |
| **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 | 5. Major | **Initial date of assessment** | 20/10/2024 |
| **Likelihood** | **4. Somewhat likely** | 2. Unlikely | 2. Unlikely | **Last reviewed by Committee:** | 01/05/2025 |
| **Risk rating** | **20. High** | **8. Medium** | **10. Medium** | **Last updated by Executive:** | 07/04/2025 |


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

# Board Assurance Framework (BAF): June 2025

| Strategic threat (what might cause this to happen) | Primary risk controls (what controls/ systems & processes do we **already** have in place to assist us in managing the risk and reducing the likelihood/ impact of the threat) | Gaps in control (are further controls possible in order to reduce risk exposure within tolerable range?) | Sources of assurance (and date) (**Evidence** that the controls/ systems which we are placing reliance on are effective) | Gaps in assurance / actions to address gaps and issues | Assurance rating |
|---|---|---|---|---|---|
| Responsible: Assistant Director of Compliance and Business Management | | Accountable: Chief Digital & Information Officer | | | |
| **Threat**: 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 | • Cyber Security Plan (and evidenced of reasonable assurance through recent internal audit)<br>• Plans to recruit key skills and capabilities gaps<br>• Business case developed for Mental Health and Acute and Community EHR<br>• Clear benchmarking with Gartner IT Score to assess and guide us on what we need to do.<br>• Skills and capabilities augmentation contracts in place with third party companies to support the internal teams in delivering what is required | • Lack of recurrent funding and support the recruitment of critical roles<br>• Lack of support to procure flexible augmentation contracts | **Management:**<br>• Quarterly reviews of digital objectives including projects at service level to Senior Leadership Team<br>• Performance and accountability meetings for Annual Plan objectives<br><br>**Risk and compliance:**<br>• Annual audit of data governance and cyber security measures<br>• Corporate Risk in place<br><br>**Independent assurance**:<br>• Internal and external audits of data governance and technology<br>• Information Commissioners office<br>• Continual Benchmarking from Gartner Group and Service Desk Institute against best practice | | **Limited Assurance** |

| **Plans to improve control** (are further controls possible in order to reduce risk exposure within tolerable range?) | Action Handler | Status of Actions | Date when action will be completed |
|---|---|---|---|
| Senior Posts for reviewing Digital architecture and EHR. Funding for Architecture and EHR Teams is temporary and has been sourced from various non-recurrent budgets. Teams likely to have to stand down from April 2025 onwards and therefore progress halted (subject to budget setting process). NB. This is a 3-to-5-year piece of work. Activity which is required by 31st March 2025 will be completed. | Sion Jones | Delayed | 31/03/2025 |
| Roll-out of key priority digital transformation projects. No funding from April 2025 onwards, to progress EHR Programme and other augmentation projects to improve the current digital environment. NB. This is a 3-to-5-year piece of work. The Electronic Health Record (EHR) – Acute and Community, Outline Business Case (OBC) first draft was handed over from the external consultants in March 25, the OBC is currently being quality checked internally by legal, finance, procurement and DDaT. In addition, some high level engagement has started with the Integrated Health Communities (IHC) with further engagement planned in May. It is due t go to the Board in July 25. Currently, there is no funding to progress this further. The Mental Health EHR is progressing with the Invitation to Tender going out on the 7th May 25 with a light Full Business Case (FBC) and contract award going for board approval in November 25. | Andrea Williams | Delayed | 31/03/2025 |
| System integration – This action needs removing as there is limited system integration work being carried out due to the complexities of the technologies and the lack of integration skills. | Justine Parry | Delayed | 31/03/2025 |
| Transformation of the DDaT Operating Model. Lack of available recurrent funding has hampered this piece of work. Alternative solutions being explored | Justine Parry | Delayed | 31/03/2025 |
| Proposals, (repeated from previous years) for 2025/26 onwards are being progressed for consideration. Cost Pressures and Growth proposals submitted to Executive Team for consideration. Only RIGA 1 additional funding resource received which doesn't take into consideration the required pressures or growth initiatives. Will continue to review funding gaps and available schemes. | Justine Parry | Delayed | 31/03/2025 |

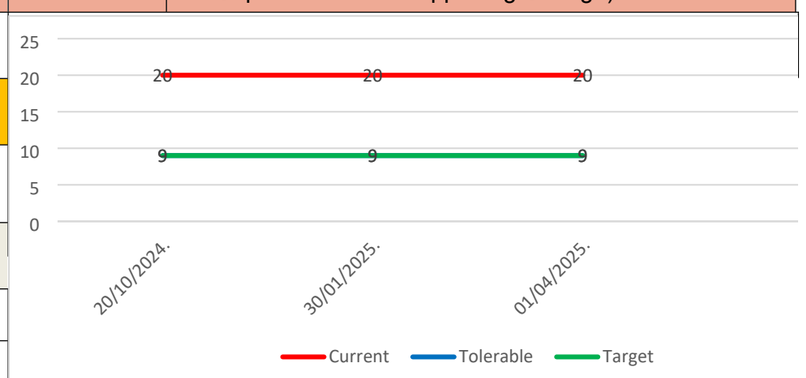
# Board Assurance Framework (BAF): June 2025

| Strategic threat (what might cause this to happen) | Primary risk controls (what controls/ systems & processes do we **already** have in place to assist us in managing the risk and reducing the likelihood/ impact of the threat) | Gaps in control (are further controls possible in order to reduce risk exposure within tolerable range?) | Sources of assurance (and date) (**Evidence** that the controls/ systems which we are placing reliance on are effective) | Gaps in assurance / actions to address gaps and issues | Assurance rating |
|---|---|---|---|---|---|
| Responsible: | Assistant Director of Health Strategy & Planning | Accountable: | Executive Director of Transformation and Strategic Planning | | |
| **Threat:** Lack of a relevant long term 10-Year Strategy and Clinical Services Plan that can be used to strategically guide our short to medium term plans. | • Ensure strategy development aligns with population needs assessments.<br>• Prioritise internal and external stakeholder engagement, collaboration and co-production.<br>• Integrated planning framework updated with learning from each planning cycle.<br>• Alignment of finances, workforce and performance via the Planning process.<br>• | • Limited public engagement and stakeholder input at the early formative stages of strategy development and planning.<br>• Effective mechanisms to prioritise resources to strategic priorities.<br>• Integrated view of impact of plans, demonstrating which outcomes have improved for the population. | **Management:**<br>• Annual review of planning cycle.<br>• Annual Delivery Plan progress reports on strategy development milestones.<br>**Risk and compliance:**<br>• External benchmarking of planning effectiveness through the Planning Maturity Matrix.<br>**Independent assurance**:<br>• Independent review as part of special measures.<br>• Welsh Government annual assessment of submitted IMTP. | • None identified at present | **Limited Assurance** |

| | **Plans to improve control** (are further controls possible in order to reduce risk exposure within tolerable range?) | Action Handler | Status of Actions | Date when action will be completed |
|---|---|---|---|---|
| | Strategic intent for North Wales to be developed with Partners in order to develop and deliver the 10-Year Strategy (subject to creating sufficient capacity in the Planning team to take this work forward)... | Kamala Williams | Progressing | 30/12/2025 |
| | Implement phase 1 of Clinical Services Plans in relation to the Challenged Services | Geraint Parry | Progressing | 30/03/2026 |
| | Develop phase 2 of the Clinical Services Plan for implementation - a blueprint for services across North Wales | Kamala Williams | Not started | 30/03/2027 |

| **Principal risk** (what could prevent us achieving this strategic objective) | **BAF24-03: Not Achieving Long Term Financial Sustainability** | | | **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 <16 | | |
| **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 | 5. Moderate | **Initial date of assessment** | 20/10/2024 |
| **Likelihood** | **4. Somewhat likely** | 3. Possible | 2. Possible | **Last reviewed by Committee:** | 29/04/2025 |



# Board Assurance Framework (BAF): June 2025

| Risk rating | 20. High | 9. Medium | 10. Medium | Last updated by Executive: | 01/04/2025 | N.B. Tolerable and Target score lines stacked as both are 9. |
|---|---|---|---|---|---|---|

| Strategic threat (what might cause this to happen) | Primary risk controls (what controls/ systems & processes do we **already** have in place to assist us in managing the risk and reducing the likelihood/ impact of the threat) | Gaps in control (are further controls possible in order to reduce risk exposure within tolerable range?) | Sources of assurance (and date) (**Evidence** that the controls/ systems which we are placing reliance on are effective) | Gaps in assurance / actions to address gaps | Assurance rating |
|---|---|---|---|---|---|
| **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.<br><br>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'<br>• Monthly reporting of financial performance, articulating risk to delivery, drivers of any financial risk and suggested actions in place to mitigate risk<br>• Monthly reporting to Welsh Government financial performance each month, again articulating drivers of risk to delivery and mitigating actions<br>• Corporate risk for shorter term sustainability in place | • Financial governance framework aligned with the organisation's strategic priorities.<br>• An endorsed Clinical Strategy that articulates demand and capacity modelling by speciality.<br>• Financial capital resource availability<br>• Integration of financial planning with performance and risk management processes<br>• The Health Board has a planned deficit in year, not achieving the key 1st duty to attain break-even. This presents a current unmitigated risk to balancing financial allocations with spending in year.<br>Inconsistent alignment between financial planning and strategic service goals | **Management:**<br>• Monthly financial reporting and budgetary controls<br>**Risk and compliance:**<br>• Oversight by Audit Committee<br>• Annual audit of financial governance effectiveness<br>• Regular financial performance reviews<br>**Independent assurance**:<br>• Internal and external audit reports on financial controls<br>• Annual review of compliance with Welsh Government financial guidelines<br>• Monthly oversight of financial performance by Welsh Government | • Limited Assurance Internal Audit report for Delivery of Health Board Transformational Savings & Budgetary Control<br>• Limited assurance report on budgetary control environment<br>• Head of Internal Control Opinion articulating limited assurance over systems of internal control<br>• Qualification of accounts 2022/23 and Qualification for regulatory breach 2024/25<br>• All containing actions to address gaps | **Limited Assurance** |

| Plans to improve control (are further controls possible in order to reduce risk exposure within tolerable range?) | Action Handler | Status of Actions | Date when action will be completed |
|---|---|---|---|
| Implementation of Value Based Healthcare and a Value and Sustainability approach to savings development. Implemented and principle approach agreed, savings will be developed through Executive leads through transactional and transformational schemes. | Joanna Garrigan | Progressing | 31/03/2026 |
| Strengthen financial forecasting and integrate financial risks into operational planning. Progressing through IMTP production. | Joanna Garrigan | Progressing | 30/09/2025 |
| Develop further the control environment for addressing planned position and implementation of any corrective actions. Additional control actions have been implemented to support the HB . | Joanna Garrigan | Complete | 31/03/2025 |
| Enhanced Accountability & Performance framework to hold officers to account for delivery. Areas for escalation have been identified and separate meetings held with services chaired by CEO. | Joanna Garrigan | Complete | 27/12/2025 |

| Responsible: | | Head Of Capital Development | Accountable: | Executive Director of Finance | |
|---|---|---|---|---|---|
| **Threat**: Inadequate Capital Investment to Support Organisational Change | • Estates Strategy<br>• Capital prioritisation programme aligned with strategic objectives that involves operational and clinical teams in prioritisation of limited resources<br>• Project management for capital investments, the Health Board having substantial material schemes in train | • Delays in capital project approvals and implementation.<br>• End of year wrap up report on overheads and programme progress.<br>• Implement stronger project management controls to track capital investments. | **Management:**<br>• Monthly financial reporting of plan verse actual expenditure and budgetary controls<br>**Risk and compliance:**<br>• Some reviews to assess the alignment of capital investments with strategic goals Board<br>**Independent assurance:** | • Reports on alignment of capital investments with strategic goals Board<br>• Prioritisation plans being endorsed through Executive for inclusion within the IMTP endorsed through Health Board and Committees. | **Limited Assurance** |

| | | | | | |
|---|---|---|---|---|---|
| | • Prioritisation of investments in infrastructure to support clinical services and statutory requirements<br>• Capital Manual<br>• Capital prioritisation for urgent projects<br>• Six facet survey being completed for all provider infrastructure | • Discretionary capital use in prioritisation between medical equipment, IM&T and Estates works (relative prioritisation between asset classes not undertaken)<br><br>• Prioritisation of substantial business cases within the plans of the Health Board that aligns to Clinical Strategy | • Internal Governance of capital project progress and expenditure and reporting up to Committee and Welsh Government.<br>• Welsh Government monthly reviews of plans for expenditure in year verse allocated resources. | • External support secured to service major capital developments.<br><br>• Capital Investment Group formed, reporting into Executive on Capital works. | |

| **Plans to improve control** (are further controls possible in order to reduce risk exposure within tolerable range?) | **Action Handler** | **Status of Actions** | **Date when action will be completed** |
|---|---|---|---|
| Decarbonisation Board reporting of key objectives through to Committee (PPHP) completed, articulating goals and objectives through to Health Board. Revised NHS Wales decarb plan due for review in 2025, once finalised the HB will produce and action plan. | Stuart Keen | Progressing | 31/03/2026 |
| Ongoing development of Estates strategy to be informed by completion of six facet survey (review of estates which will take 12* months) with the view of generating capital through disposals. | Stuart Keen | Progressing | 31/03/2026 |
| Monthly reporting of this year's expenditure verse plans in order to ensure delivery of this year's capital programme, fully embedded and forms new control. | Executive Director of Finance | Complete | 31/03/2026 |
| Prioritisation of major capital works within the strategy for the Health Board in completion of the three-year IMTP. Schemes and priorities discussed at Execs. | Ian Howard | Progressing | 31/03/2026 |

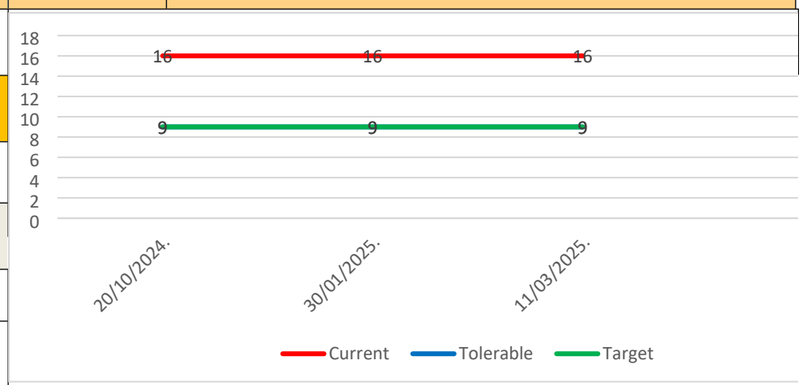
Bwrdd Iechyd Prifysgol Betsi Cadwaladr University Health Board

## 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: Not Establishing a Compassionate Culture, Leadership, Engagement and workforce capacity and capability**<br>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** | Open <16 |
| **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 by Committee:** | 10/04/2025 |
| **Risk rating** | **16. High** | **9. Medium** | **9. Medium** | **Last updated by Executive:** | **11/03/2025** |




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

# Board Assurance Framework (BAF): June 2025

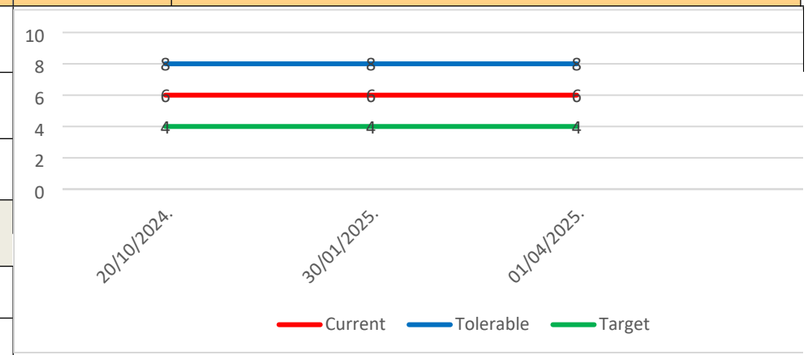
| Strategic threat (what might cause this to happen) | Primary risk controls (what controls/ systems & processes do we **already** have in place to assist us in managing the risk and reducing the likelihood/ impact of the threat) | Gaps in control (Specific areas / issues where further work is required to manage the risk to accepted appetite/ tolerance level) | Sources of assurance (and date) (**Evidence** that the controls/ systems which we are placing reliance on are effective) | Gaps in assurance / actions to address gaps and issues | 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<br>• Skill-mix review and capacity-building programmes<br>• Strategic partnership with Bangor University<br>• Integrated Leadership Development Framework<br>• Staff Engagement Plan<br>• Continuous feedback loops for leadership performance<br>• All Wales International Recruitment programme for nurses and doctors.<br>• Improved Internal Audit Assurance with recruitment of senior and interim staff<br>• Staff counselling / Occupational Health support<br>• Strategic Equality Plan key driver in the culture change required for a compassionate and inclusive culture. | • Critical vacancies, particularly in clinical and leadership roles<br>• Underdeveloped retention and progression pathways<br>• Further embedding of Integrated Leadership Development Framework<br>• Further leadership development initiatives<br>• Current Equality governance arrangements require strengthening | **Management:**<br>• Service Led skill-mix efficiency and commissioning requirements<br>• Annual staff engagement surveys and reports to Committee and Board<br>• People & Culture Dashboard to Committee<br><br>**Risk and compliance:**<br>• Corporate risks CRR24-01 People, Culture and Wellbeing CRR24-16 Leadership/Special Measures reported to committee.<br>• Review of all Organisational Development risks reported. Local Workforce and Organisational Development risk meeting.<br>• Quarterly performance reviews to CEO of Directorates/ Divisions<br>• Freedom to Speak Up Guardian report<br><br>**Independent assurance**:<br>• Annual workforce plan reviews with HEIW<br>• Internal Audit reports | • Limited Assurance Internal Audit report for Review of Workforce Planning Arrangements | **Limited Assurance** |

| **Plans to improve control** (are further controls possible in order to reduce risk exposure within tolerable range?) | Action Handler | Status of Actions | Date when action will be completed |
|---|---|---|---|
| Prioritise workforce plans for 'challenged services' | Georgina Roberts/ Nick Graham | Progressing | 31/03/2026 |
| Continue reducing agency usage and improve value and sustainability of workforce | Georgina Roberts/ Nick Graham | Progressing | 31/03/2026 |
| Implementing Values and Behaviours Framework | Georgina Roberts | Progressing | 31/03/2026 |
| Embedding Integrated Leadership Development Framework | Georgina Roberts | Progressing | 31/03/2026 |

# Board Assurance Framework (BAF): June 2025

| | | | | | |
|---|---|---|---|---|---|
| **Principal risk** (what could prevent us achieving this strategic objective) | **BAF24-05: Not Engaging with Citizens, Partners and Communities**<br>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 <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 by Committee:** | 01/05/2025 |
| **Risk rating** | **6. Low** | **8. Medium** | **4. Low** | **Last updated by Executive:** | 01/04/2025 |




| **Strategic threat** (what might cause this to happen) | **Primary risk controls** (what controls/ systems & processes do we **already** have in place to assist us in managing the risk and reducing the likelihood/ impact of the threat) | **Gaps in control** (are further controls possible in order to reduce risk exposure within tolerable range?) | **Sources of assurance (and date)** (**Evidence** that the controls/ systems which we are placing reliance on are effective) | **Gaps in assurance / actions to address gaps 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<br>• Strategic partnerships with local authorities and community organisations<br>• Partnership governance frameworks<br>• Comprehensive inclusive and diverse citizen engagement strategy<br>• Accessible feedback mechanisms such as surveys and public engagement activity<br>• Regular updates to the public on strategic priorities<br>• Survey of engagement across the Health Board<br>• Collaboration on complaint's process | • Communication back to the public on their influence from feedback<br>• Lack of structured feedback from key partners<br>• Limited cross-sector collaboration in specific service areas<br>• Anchor Institute Framework | **Management:**<br>• Citizen experience reports to Board<br>• Feedback from engagement and where required public consultations.<br><br>**Risk and compliance:**<br>• Partnership feedback sessions<br>• Forward Plan and oversight of Regional Partnership Board by the Planning, Population Health & Partnership Committee<br><br>**Independent assurance**:<br>• Perception survey with partners<br>• Independent Advisor for external perspective on engagement approach | Risk Register for Partnerships/Communications and Engagement. | **Limited Assurance** |

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

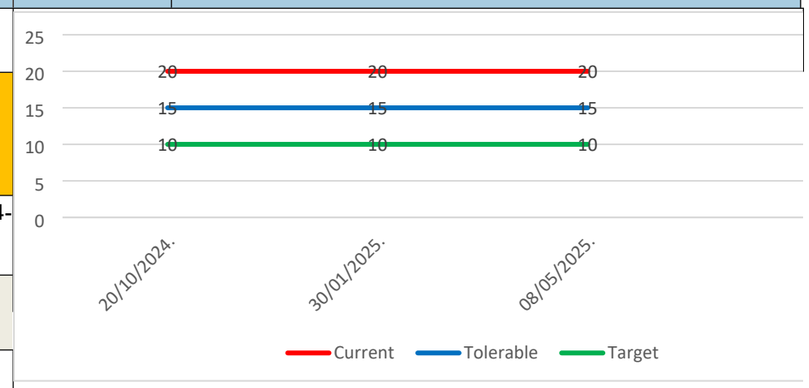
| | | | | |
|---|---|---|---|---|
| | Improve the feedback loop to ensure timely action on public input – ongoing, with review of Board actions against key themes by 31/01/25. January Citizen's Engagement report as evidence | Helen Stevens-Jones | Complete | 31/01/2025 |

Bwrdd Iechyd Prifysgol Betsi Cadwaladr University Health Board

## 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: Not Delivering the Required Improvements to Transform Care and Enhance Outcomes**<br>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<br>Executive Director of Public Health<br>Executive Medical Director<br>Executive Director of Allied Health Professionals and Health Science | **Risk appetite** | Open <16 | | |
| **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 by Committee:** | 01/05/2025 |
| **Risk rating** | 20. High | 15. High | 10. Medium | **Last updated by Executive:** | 08/05/2025 |

# Board Assurance Framework (BAF): June 2025

| **Strategic threat** (what might cause this to happen) | **Primary risk controls** (what controls/ systems & processes do we **already** have in place to assist us in managing the risk and reducing the likelihood/ impact of the threat) | **Gaps in control** (Specific areas / issues where further work is required to manage the risk to accepted appetite/tolerance level) | **Sources of assurance (and date)** (**Evidence** that the controls/ systems which we are placing reliance on are effective) | **Gaps in assurance / actions to address gaps and issues** (Insufficient evidence as to effectiveness of the controls or negative assurance) | **Assurance rating** |
|---|---|---|---|---|---|
| Responsible: | Deputy Executive Director of Nursing | Accountable: | Executive Director of Nursing | Responsible Committee | Quality, Safety and Experience Committee |
| **Threat:** 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 | • Integrated Concerns Policy and daily Hub meetings in place to review all concerns of moderate , grade4/5 and above<br>• Patient incident/feedback systems and policies<br>• Data analysis and learning at service level<br>• Datix Reporting<br>• Patient safety Staff training - Quality governance arrangements at Health Board, IHC/division & service levels including:<br>  ○ Local ICOG and Exec EICOG Groups<br>  ○ BCUHB patient safety, infection prevention , safeguarding and patient experience groups<br>  ○ BCUHB SCEG, meetings<br>  ○ Local and Exec Quality Delivery Groups<br>  ○ Clinical audit programme & monitoring arrangements<br>  ○ Ward accreditation/ metrics<br>• Integrated Concerns Policy and Toolkit<br>• Concerns Hub<br>• Rapid review Sign-off process for incidents and Nationally Reported Incidents<br>• Executive Led Oversight Group<br>• Quality assurance visits<br>• Internal Reviews against External National Reports<br>• Getting it Right First Time (GIRFT)<br>• Localised deep dives, reports and action plans<br>• Operational grip on workforce gaps<br>• Patient Advice and Liaison Service Activity<br>• Comprehensive Cultural Competence training and awareness | • Operational oversight of sustainable change, evidence of learning and improvement measures | **Management:**<br>• Learning from deaths Report to QC and Board<br>• Quarterly Strategic Priority Report to Board.<br>• Divisional risk reports to SRG bi-annually.<br>• Guardian of Safe Working report to Board<br>• Quality and Governance Reporting Pathway.<br>Quality Safety and Experience Committee reports include:<br>  ○ Safeguarding Annual Report to QSE<br>  ○ Infection Control Annual Report<br>  ○ Health and Safety Annual Report<br>  ○ Bimonthly Quality Report<br>  ○ Deep dive Reports<br>  ○ Risk Management Report<br>  ○ Integrated Performance Report<br>  ○ Duty of Quality annual report<br><br>**Risk and compliance:**<br>• Quality Dashboard<br>• Duty of Candour<br>• Corporate Risks<br>• Ombudsman Annual Letter<br><br>**Independent assurance**:<br>• Health Inspectorate Wales Reports<br>• Care Inspectorate Wales Reports<br>• Coroners' reports:<br>• Internal Audit reports.<br>• Royal College Reports<br>• Llais Reports<br>• Ombudsman<br><br>Screening Quality Assurance Services assessments and reports of:<br>• Antenatal and New-born screening<br>• Breast Cancer Screening Services<br>• Bowel Cancer Screening Services<br>• Cervical Screening Services<br><br>External Accreditation/Regulation annual assessments and reports of;<br>• Pathology (UKAS)<br>• Endoscopy Services (JAG)<br>• Medical Equipment and Medical Devices (BSI) | Limited Assurance Internal Audit report for Limited Assurance: Lessons Learnt, Falls, Deprivation of Liberty<br><br>1 action outstanding in the DOLS plan then closed<br><br>Internal Audit review of the Falls audit to be completed in Q1 to ensure actions are completed<br><br>• Nursing & Midwifery Vision Embedding (launched May 2025)<br>• Allied Health Professional Strategy<br>• Clinical services plan | **Limited Assurance** |

| | | | | | |
|---|---|---|---|---|---|
| | | | • Blood Transfusion Annual Compliance Report (MHRA)<br>• Ionising Radiation (Medical Exposure) Regulations | | |

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

| **Strategic threat** (what might cause this to happen) | **Primary risk controls** (what controls/ systems & processes do we **already** have in place to assist us in managing the risk and reducing the likelihood/ impact of the threat) | **Gaps in control** (Specific areas / issues where further work is required to manage the risk to accepted appetite/tolerance level) | **Sources of assurance (and date)** (**Evidence** that the controls/ systems which we are placing reliance on are effective) | **Gaps in assurance / actions to address gaps and issues** (Insufficient evidence as to effectiveness of the controls or negative assurance) | **Assurance rating** |
|---|---|---|---|---|---|
| Responsible: | Head Of Public Health Assurance & Development | Accountable: | Executive Director of Public Health | Responsible Committee | Population Health & Partnership Committee |
| **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<br>• Integrated prevention strategies focused on population health and wellbeing to reduce health inequalities<br>• Continuation of Grant funding confirmed 25/26<br>• Ministerial Priorities include Prevention and Population Health | • Limited access to timely integrated data supporting prevention activity.<br>• Insufficient integration between prevention and clinical services<br>• Services fail to prioritise prevention as part of the delivery of effective services and outcomes.<br>• Large proportion of budget is non-recurrent grant funding<br>• Diabetes Pathway Programme delivery plans (service level) - dependent on options for change agreement | **Management:**<br>• Regular reports against a range of outcomes from the public health outcomes framework to Planning, Population Health & Partnership Committee<br>**Risk and compliance:**<br>• CRR24-08 Delivering a population health approach to health and wellbeing and CRR24-18 Outbreak Management reported to Planning, Population Health & Partnership Committee.<br>• Operational Risk Register maintained.<br>**Independent assurance:**<br>• 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. | **Limited Assurance** |

| ↑ | **Plans to improve control** (are further controls possible in order to reduce risk exposure within tolerable range?) | **Action Handler** | **Status of Actions** | **Date when action will be completed** |
|---|---|---|---|---|
| | Increase collaboration with community partners | Brian Laing | Complete | 31/03/2025 |
| | Strengthen the integration of prevention into service and Health Board planning | Gwyneth Page | Complete | 31/03/2025 |
| | DDAT/Public Health Integrated approach to population health and clinical data and intelligence embedded in Health Board plans | Kathryn Lang / Rob Atenstaedt | Complete | 30/09/2025 |
| | Diabetes Pathway Programme – completion of case for change and next steps agreed | Jane Moore | Progressing | 30/07/2025 |
| | Deliver Primary Care based approaches to improving the compliance with NICE guidance | Service Leads | Progressing | 30/10/2025 |
| | Grant funded Programme plans approved by Welsh Government and Public Health Wales | Gwyneth Page | Complete | 30/04/2025 |

# Board Assurance Framework (BAF): June 2025

| | | | | |
|---|---|---|---|---|
| | Prevention embedded in Board Major Programmes | Programme Leads / SRO | Progressing | 31/03/2026 |

| **Strategic threat** (what might cause this to happen) | **Primary risk controls** (what controls/ systems & processes do we **already** have in place to assist us in managing the risk and reducing the likelihood/ impact of the threat) | **Gaps in control** (Specific areas / issues where further work is required to manage the risk to accepted appetite/tolerance level) | **Sources of assurance (and date)** (**Evidence** that the controls/ systems which we are placing reliance on are effective) | **Gaps in assurance / actions to address gaps and issues** (Insufficient evidence as to effectiveness of the controls or negative assurance) | **Assurance rating** |
|---|---|---|---|---|---|

| | | | | | |
|---|---|---|---|---|---|
| Responsible: | Director of Mental Health & Learning Disabilities | Accountable: | Executive Director of Allied Health Professionals and Health Science | Responsible Committee | Quality, Safety and Experience Committee |

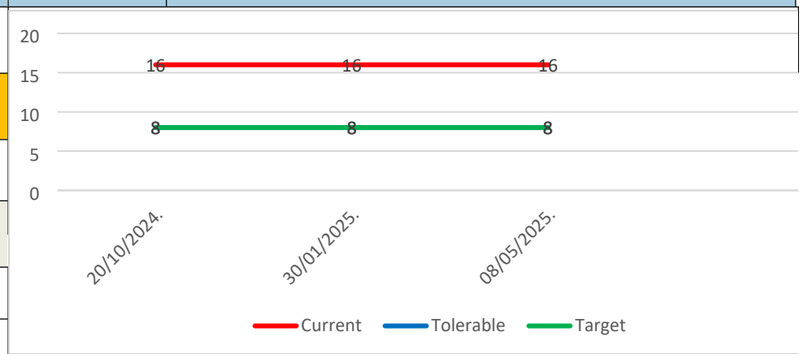
| | | | | | |
|---|---|---|---|---|---|
| **Threat**: Risk of insufficient focus on Mental Health, wellbeing and Learning Disabilities in the Health Board strategy, planning and operations leading to sub optimal patient outcomes, lack of an holistic approach, regulatory non-compliance and reputational harm. | • Alignment with Welsh Government National strategies for Mental Health and wellbeing, Learning Disabilities and Substance Misuse<br>• Adherence to Royal College and Clinical standards<br>• National NHS Executive Mental Health and Learning Disabilities (MHLD) Strategic Improvement Programme<br>• Established Royal College Psychiatry Improvement programme with Health Board wide reporting and governance<br>• Established reporting through existing HB Governance Frameworks, Oversight committees and routine audits to ensure compliance and monitor progress.<br>• Inclusion in Health Board Annual Plan and monitoring mechanisms<br>• Inclusion in organisational Major change programme, oversight and reporting<br>• Clinically led Physical health work stream in MHLD<br>• Primary care pathways<br>• Crisis Care Concordat in place | • Recruitment and Retention challenges impacting on workforce including interim posts<br>• Engagement and collaboration with physical health services<br>• 'Foundations for the Future' programme maturity<br>• Insufficient focus on health inequalities<br>• Lack of integrated Electronic Health Record and other digital systems<br>• Limited visibility of Mental health and Learning disabilities data at Board level<br>• Current risk to balanced financial position<br>• Greater focus on community and earlier intervention services | **Management:**<br>• External reviews in 2023-24, undertaken as part of Special Measures all recommendations completed and managed.<br>• Performance Management and reporting<br>• Civica and patient reporting metrics<br><br>**Risk and compliance:**<br>• Compliance with Royal College Standards<br>• Audit Reports<br><br>**Independent assurance:**<br>• Development of co-produced Patient Carer engagement work<br>• Expert advisory group<br>• External reviews<br>• National and Local performance reporting<br>• Together 4 Mental Health Partnership Board in place | • Lack of integrated patient care records impacting on care, planning and reporting<br>• Increasing the scope of performance reviews focusing on patient pathways.<br>• Improving our real time patient data<br>• Visibility of community mental health activity | **Limited Assurance** |

| **Plans to improve control** (are further controls possible in order to reduce risk exposure within tolerable range?) | **Action Handler** | **Status of Actions** | **Date when action will be completed** |
|---|---|---|---|
| Recruitment plans for substantive workforce | Carole Evanson | Progressing | 31/09/2025 |
| Increased pathways with Primary care | Alberto Salmoiraghi | Progressing | 31/12/2025 |
| Active engagement with the Foundations for the future programme | Carole Evanson | Progressing | 31/10/2025 |
| Electronic Health Record programme with MHLD as early adopter | Iain Wilkie | Progressing | 31/03/2026 |
| Enhanced Savings plans | Nicola Hyde | Progressing | 31/03/2026 |
| Responsive annual plan | Vicky Jones | Complete | 31/03/2025 |
| Implementation of Communication strategy, will remain dynamic and developmental | Vicky Jones | Complete | 31/12/2025 |
| Alignment with Learning Disabilities national programme- Improving Care Improving lives review | Carole Evanson | Progressing | 31/03/2026 |

# Board Assurance Framework (BAF): June 2025

| | | | | | |
|---|---|---|---|---|---|
| **Principal risk** (what could prevent us achieving this strategic objective) | **BAF24-07: Not Delivering Timely Access to Care Resulting In Potential Clinical Harm, Poor Delivery of Performance Targets and Reputational Risk**<br><br>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 <16 | | |
| **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 by Committee:** | 01/05/2025 |
| **Risk rating** | **16. High** | **8. Medium** | **8. Medium** | **Last updated by Executive:** | 08/05/2025 |




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

| **Strategic threat** (what might cause this to happen) | **Primary risk controls** (what controls/ systems & processes do we **already** have in place to assist us in managing the risk and reducing the likelihood/ impact of the threat) | **Gaps in control** (Specific areas / issues where further work is required to manage the risk to accepted appetite/tolerance level) | **Sources of assurance (and date)** (**Evidence** that the controls/ systems which we are placing reliance on are effective) | **Gaps in assurance / actions to address gaps and issues** (Insufficient evidence as to effectiveness of the controls or negative assurance) | **Assurance rating** |
|---|---|---|---|---|---|
| Responsible: Interim Associate Director for Emergency Care/ Associate Director of Planned Care/ Professional Service Manager Radiography/ Assistant Area Director – Children | | Accountable: 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<br>• Improved planning including the Winter Resilience Plan with clear principles to protect urgent and planned care pathways<br>• Major change programmes for Urgent and Emergency Care (UEC) and Planned Care<br>• Strengthening preventative support through integrating services such as SICAT and GP out of hours with active community pathways<br>• Strengthening capability and capacity to lead and deliver services with clear executive Senior Responsible Officers (SRO) in place supported by clinical and operational leads<br>• Cancer recovery plan<br>• Planned care delivery plan against the agreed trajectories supported with resource allocations<br>• Diagnostics delivery plan against the agreed trajectories supported with resource allocations<br>• Governance framework for accountability including weekly executive led progress reviews for UEC and Planned Care<br>• Chief Operating Officer and Director of Performance and commissioning collective leadership oversight for operational performance with support from the executive team<br>• Clear workstreams (4) for UEC incorporated into operational planning and delivery as a framework aligned to the national 6 goals for UEC | • Clinical variations and lack of standardised operational processes across the Health Board<br>• Limited integration of pathways and care processes between primary, community and secondary care<br>• Insufficient capacity in challenged services and Neurodevelopment<br>• Strategic approach for equipment replacement scheme to ensure service efficiency and sustainability<br>• Estates strategy to address service needs<br>• Challenges in workforce retention and gaps in critical roles affecting service delivery<br>Need for enhanced digital infrastructure to support predictive analytics and proactive planning | **Management:**<br>• Integrated Quality Performance Delivery<br>• Tracking referrals and waiting times<br>• Performance tracking on ambulance handovers<br>• Monthly Performance monitoring<br>• Strategic Improvement Development Groups.<br>• Reviewing consistency in triage processes<br><br>**Risk and compliance:**<br>• Performance reports to Integrated Performance Executive Delivery Group & Board<br>• Corporate Risk reporting<br>• Patient-reported outcome measures (PROMs) and Patient-reported | • Independent reviews (focused on areas of concern)<br>• Daily Health Board wide oversight grip in control for UEC performance and reporting<br>• Health Board resource plan for seven-day UEC care model<br>• Health Board workforce plan to align demand and capacity on a seven-day basis<br>• Clear structure and delivery for pathways of care delays for North Wales as a system<br>• Ensuring compliance with Joint Advisory Group on Gastrointestinal Endoscopy (JAG) accreditation.<br>• Lack of consistent and reliable performance data at daily and weekly level. | **Unsatisfactory** |

| | | | | | |
|---|---|---|---|---|---|
| | • Optimised hospital flow through SAFER programmes and discharge protocols ensuring resilience to protect planned care pathways<br>• Access to care based on clinical urgency and then chronological wait across all programmes of care<br>• Developing close partnership working with the 6 Local Authorities, Welsh Ambulance Service Trust (WAST), third sector and other providers to maximise care outcomes<br>• Effective utilisation through planning and robust governance for use of nationally allocated resources for planned care and UEC<br>• Regional approach in strategic planning through the Regional Partnership Board ensuring a North Wales approach for delivering services for our citizens | | experience measures (PREMs) data<br><br>**Independent assurance:**<br>• Internal Audit findings demonstrating substantial assurance<br>• Welsh Government Targets<br>• Joint Executive Team WG<br>• UEC Programme Board with WG attendance<br>• NHS Executive touch points<br>• Significant guidance and steer with National Imaging Programme<br>• CAMHS & Neurodevelopment National Programme links established. National Specification being worked towards.<br>• Regional ND, CAMHs meetings for improvement.<br>• CAMHS & Neurodevelopment Enhanced Monthly NHS Exec meeting with performance leads. | • Health Board workforce plan at modality level.<br>• Specific diagnostics assurance process to delivery national patient standard for wait levels.<br>• CAMHS & Neurodevelopment Improvement programme reporting to be defined and governance structure | |

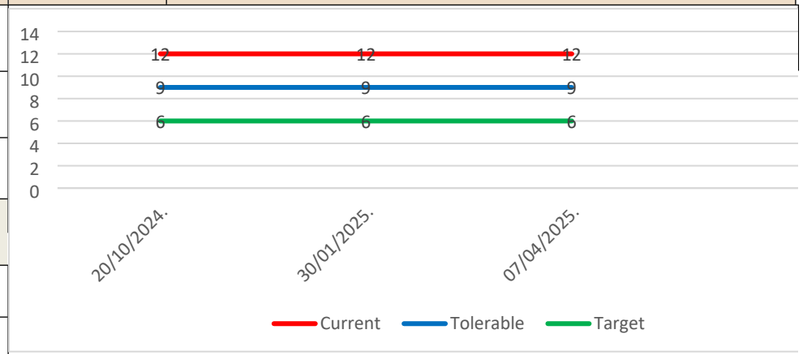
| **Plans to improve control** (are further controls possible in order to reduce risk exposure within tolerable range?) | **Action Handler** | **Status of Actions** | **Date when action will be completed** |
|---|---|---|---|
| Major change programmes for UEC and planned care aligned to the Six Goals for Urgent and Emergency Care (UEC) framework and national objectives (such as timely access to care and building community capacity). Governance structure completed, all workstreams now all aligned. | Alison Bishop | Complete | 31/03/2025 |
| UEC improvement programme review to ensure the necessary improvements and outcomes are having the required impact on quality and safety of UEC services. Sept midway review. | Alison Bishop | Progressing | 30/09/2025 |
| Use of data analytics to identify high-risk populations (completed) and optimise resource allocation, as a part of workstream one, needs aligning to enhanced community care. | Alison Bishop | Progressing | 31/03/2026 |
| Deployment of live dashboards for real-time monitoring (complete) of performance and governance metrics. Standardise data collection and reporting processes to reduce variability in decision-making. Review of various dashboards to align input criteria and date. Data quality and alignment to data dictionary review ongoing. Dashboard designs work ongoing. Design phase to be complete by 31/07/2025. Once designed, build and deployment to take place with timescale tbc | Alison Bishop/ David Hutton | Progressing | 31/06/2025 |
| Strengthen digital capabilities to support service teams (such as e-triage, further roll out of home adaptations particularly rural areas, single patient tracking lists). Align digital plan to UEC plans. | Alison Bishop/Danielle Edwards | Progressing | 31/03/2026 |
| Standardising care pathways across the Health Board. Current mapping exercise. Sits within clinical service strategy, community health pathways being rolled out for development in elective care. | Alison Bishop/Vicky Freeman | Progressing | 31/03/2026 |
| Winter Resilience Plan milestones and adherence to ministerial requirements for capacity building, plan complete evaluation and lessons learnt. Winter learning and planning events have been held. Planning phase has started. 31/08/2025 | David Hutton | Complete | 31/05/2025 |
| Revised Access policy to ensure standardised practice across the Health Board | Rhys Blake | Complete | 30/01/2025 |
| Re-enforce specialty level planning cycle through service line demand and capacity plan across the Health Board. Reinforced with services, complete. To be evidenced in April 2026 through Plans | Stephen Powell/Kathryn Lang | Progressing | 31/03/2026 |
| Strengthened workforce planning for key areas linked to challenged services | Tracey Rosco/Paolo | Progressing | 31/03/2026 |
| Telehealth care to strengthen out of hospital care including home systems and video facilitated care forms workstream 1 or 4 for UEC | Alison Bishop | Progressing | *TBC* |

| | | | | |
|---|---|---|---|---|
| | Continued efforts to further strengthen collaboration with local authorities and voluntary sectors for integrated care delivery models. Milestones to be reported | Chief Operating Officer | Progressing | 31/03/2026 |
| | Incorporate public health needs analysis to service planning (such as deprivation links to access for UEC, Planned Care, CAMHS and Womens services) | Chief Operating Officer /Executive Director of Public Health | Progressing | 31/03/2026 |
| | Regional approach for services such as Child and Adolescent Mental Health (CAMHS) | Louise Bell | Progressing | 31/09/2025 |

## 5: Establishing an effective environment for Learning

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

| | | | | | |
|---|---|---|---|---|---|
| **Principal risk** (what could prevent us achieving this strategic objective) | **BAF24-08: Not Implementing Evidenced Based Improvement and Innovation**<br>Lack of support, capability and agility to optimise strategic and operational opportunities to improve patient care | | | **Strategic objective** | 5: Effective Environment for Learning<br>5A: University Partnership; 5B: Research, Development and Innovation & 5C: Academic Careers) |
| **Lead Committee** | Planning, Population Health & Partnership Committee | **Risk type** | Quality | | |
| **Risk Lead** | Executive Medical Director /Chief Digital & Information Officer | **Risk appetite** | Open <16 | | |
| **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 by Committee:** | 01/05/2025 |
| **Risk rating** | **12. Medium** | **9. Medium** | **6. Low** | **Last updated by Executive:** | 07/04/2025 |

| **Strategic threat** (what might cause this to happen) | **Primary risk controls** (what controls/ systems & processes do we **already** have in place to assist us in managing the risk and reducing the likelihood/ impact of the threat) | **Gaps in control** (are further controls possible in order to reduce risk exposure within tolerable range?) | **Sources of assurance (and date)** (**Evidence** that the controls/ systems which we are placing reliance on are effective) | **Gaps in assurance / actions to address gaps and issues** | **Assurance rating** |
|---|---|---|---|---|---|
| Responsible: | Assistant Director Data, Intelligence & Insight | Accountable: | Chief Digital & Information Officer | | |

# Board Assurance Framework (BAF): June 2025

| Strategic threat (what might cause this to happen) | Primary risk controls (what controls/ systems & processes do we **already** have in place to assist us in managing the risk and reducing the likelihood/ impact of the threat) | Gaps in control (are further controls possible in order to reduce risk exposure within tolerable range?) | Sources of assurance (and date) (**Evidence** that the controls/ systems which we are placing reliance on are effective) | Gaps in assurance / actions to address gaps and issues | Assurance rating |
|---|---|---|---|---|---|
| **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)<br>• Information account Managers to ensure data is interpreted correctly<br>• Some Integrated data analytics and reporting in place<br>• Integrated Leadership Framework & Performance Appraisal and Development Review (PADR) policy, staff development toolkit.<br>• Continuous professional development opportunities for staff | • Regular data analytics reviews and intelligence reports for further assurances<br>• More Assurance on evidence of being intelligence-led<br>• Insufficient integration of data analytics consistently across all service areas<br>• Data driven decision-making framework for services<br>• Limited use of real-time data in clinical decision-making<br>• Inconsistent access to learning opportunities across different service areas<br>• Limited evaluation of the impact of training on service delivery<br>• Limited collaboration on research projects | **Management:**<br>• Monthly data governance reviews<br>• Progress against annual plan to committees<br>• Result of internal data maturity assessment<br>• Utilisation Statistics in IRIS<br><br>**Risk and compliance:**<br>• Annual reviews of the effectiveness of learning initiatives (OMD)<br><br>**Independent assurance:**<br>• Clinical body reporting on external evaluations of learning and development programmes (OMD) | • No external evaluation of statistics or use of statistics | **Limited Assurance** |

| | **Plans to improve control** (are further controls possible in order to reduce risk exposure within tolerable range?) | **Action Handler** | **Status of Actions** | **Date when action will be completed** |
|---|---|---|---|---|
| | Develop BCU's data warehouse, broadening the range of datasets available. This was a milestone in the Annual Plan 2024/25. Evidence provided on additional datasets created. This now forms business as usual activity as and when new datasets are required. | Kathryn Lang | Complete | 31/03/2025 |
| | Standardise access to learning opportunities for recipient of intelligence products as well as in house team. Additional training provided, with Training Needs Analysis being completed. Once results are returned, a further training programme will be developed. | Kathryn Lang | Complete | 31/03/2025 |
| | Exploring the links with universities on opportunities to work together on data analytics.<br>Meeting held with Bangor Universities with introductory meeting set up with Wrexham and Swansea Universities. | Kathryn Lang | Progressing | 30/09/2025 |
| | Launch of IRIS2 to improve accessibility and useability of information products. | Kathryn Lang | Progressing | 30/06/2025 |
| | Develop a model for Cancer Referrals and activity for single modality. | Kathryn Lang | Progressing | 30/06/2025 |
| | Refresh Urgent and Emergency Care Winter Plan Model. | Kathryn Lang | Progressing | 31/07/2025 |
| | Undertake a data maturity assessment for planned and urgent and emergency care to test for improvement from baseline position. | Kathryn Lang | Progressing | 30/06/2025 |
| | Development of a Training Needs Analysis and Training Programme for Intelligence Team and also for Planned Care data recipients | Kathryn Lang | Progressing | 30/09/2025 |

| Responsible: | Associate Director Research & Development & Programme Director – North Wales Medical School | 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<br>• Memorandum of Understanding in place with Bangor University<br>• Dedicated governance structure for North Wales Medical School and related projects<br>• Research governance structure<br>• Collaboration with external research bodies and innovation hubs | • Inconsistent engagement with academic partners across all healthcare services<br>• Lack of investment in healthcare innovation projects<br>• Limited career progression opportunities in academia for clinical and non-clinical staff<br>• No Memorandum of Understanding in place with Wrexham University at present | **Timescale: 2025/26** (next update provided will be quarterly milestones based off annual plan) | **Management:**<br>• Clinical Effectiveness Group reporting<br><br>**Risk and compliance:**<br>• Regular joint project reviews and risk register for projects maintained<br><br>**Independent assurance:**<br>• External evaluations of projects<br>• Welsh Government Annual review of university designation criteria | • Strategic partnership with Wrexham University to be established with a supporting Memorandum of Understanding<br>• Internal governance arrangements and reporting to Clinical Effectiveness Group to be strengthened.<br>• Reporting and monitoring of academic career pathways, assessments of joint academic roles and impact on healthcare delivery | **Limited Assurance** |

| | | | | | | |
|---|---|---|---|---|---|---|
| | • All Wales Innovation Pathway deployed | | | | • Commitment to joint investment in research and innovation<br>• Partnership reviews with universities.<br>• Further review of independent assurance requirements | |

| **Plans to improve control** (are further controls possible in order to reduce risk exposure within tolerable range?) | **Action Handler** | **Status of Actions** | **Date when action will be completed** |
|---|---|---|---|
| Strengthen collaborative research projects with university partners. | Lynne Grundy & Lea Marsden | Progressing | 31/03/2026 |
| Strengthen academic career pathways with universities | Lynne Grundy & Lea Marsden | Progressing | 31/03/2026 |
| Increase R&D collaboration with industry and academic institutions | Lynne Grundy & Lea Marsden | Progressing | 31/03/2026 |
| Secure additional funding for healthcare innovation projects | Lynne Grundy & Lea Marsden | Progressing | 31/03/2026 |
| Increase the number of joint appointments between the Health Board and academic institutions | Lynne Grundy & Lea Marsden | Progressing | 31/03/2026 |

| | | | | |
|---|---|---|---|---|
| **Teitl adroddiad:**<br><br>***Report title:*** | Fire Safety Annual Performance Report | | | |
| **Adrodd i:**<br><br>***Report to:*** | Audit Committee | | | |
| **Dyddiad y Cyfarfod:**<br><br>***Date of Meeting:*** | Tuesday, 19 August 2025 | | | |
| **Crynodeb Gweithredol:**<br><br>***Executive Summary:*** | The purpose of the report is to provide the Health Board with a summary of principal activity and outcomes relating to the management of fire safety within Betsi Cadwaladr University Health Board during the financial year 2024-2025.<br><br>The report summarises the prevailing legislative framework within which health and safety is managed and addressed, and outlines the local governance arrangements that underpin health and safety management within the Health Board. | | | |
| **Argymhellion:**<br><br>***Recommendations:*** | The Committee is asked to accept the ASSURANCE provided in the report. | | | |
| **Arweinydd Gweithredol:**<br><br>***Executive Lead:*** | Stuart Keen; Director of Environment and Estates | | | |
| **Awdur yr Adroddiad:**<br><br>***Report Author:*** | Arwel Hughes, Head of Operational Estates<br>Gareth Griffiths – Senior Estates Officer – Fire Safety | | | |
| **Pwrpas yr adroddiad:**<br>***Purpose of report:*** | I'w Nodi<br>*For Noting*<br>☐ | I Benderfynu arno<br>*For Decision*<br>☐ | Am sicrwydd<br>*For Assurance*<br>☒ | |
| **Lefel sicrwydd:**<br><br>***Assurance level:*** | Arwyddocaol<br>*Significant*<br>☐<br>Lefel uchel o hyder/tystiolaeth o ran darparu'r mecanweithiau / amcanion presennol<br><br>*High level of confidence/evidence in delivery of existing mechanisms/objectives* | Derbyniol<br>*Acceptable*<br>☒<br>Lefel gyffredinol o hyder/tystiolaeth o ran darparu'r mecanweithiau / amcanion presennol<br><br>*General confidence / evidence in delivery of existing mechanisms / objectives* | Rhannol<br>*Partial*<br>☐<br>Rhywfaint o hyder/tystiolaeth o ran darparu'r mecanweithiau / amcanion presennol<br><br>*Some confidence / evidence in delivery of existing mechanisms / objectives* | Dim Sicrwydd<br>*No Assurance*<br>☐<br>Dim hyder/tystiolaeth o ran y ddarpariaeth<br><br>*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:**<br><br>***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:**<br><br>***Link to Strategic Objective(s):*** | Objective 1: Building an effective organisation<br>Objective 4: Improving Quality, Outcomes and Experience | | | |

| | |
|---|---|
| **Goblygiadau rheoleiddio a lleol:**<br><br>***Regulatory and legal implications:*** | Stated in the report. |
| **Yn unol â WP7, a oedd EqlA yn angenrheidiol ac a gafodd ei gynnal?**<br><br>***In accordance with WP7 has an EqlA been identified as necessary and undertaken?*** | No |
| **Yn unol â WP68, a oedd SEIA yn angenrheidiol ac a gafodd ei gynnal?**<br><br>***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)**<br><br>***Details of risks associated with the subject and scope of this paper, including new risks( cross reference to the BAF and CRR)*** | All risks associated with the subject and scope of this paper are already highlighted and managed through the current risk management structures within the organisation |
| **Goblygiadau ariannol o ganlyniad i roi'r *argymhellion ar waith***<br><br>***Financial implications as a result of implementing the recommendations*** | There is no additional costs associated with this paper at this time. |
| **Goblygiadau gweithlu o ganlyniad i roi'r argymhellion ar waith**<br><br>***Workforce implications as a result of implementing the recommendations*** | There are no direct implications associated with this paper at this time. |
| **Adborth, ymateb a chrynodeb dilynol ar ôl ymgynghori**<br><br>***Feedback, response, and follow up summary following consultation*** | Not applicable |
| **Cysylltiadau â risgiau BAF:**<br>(neu gysylltiadau â'r Gofrestr Risg Gorfforaethol)<br><br>***Links to BAF risks:***<br>*(or links to the Corporate Risk Register)* | CRR 24-15 |
| **Rheswm dros gyflwyno adroddiad i fwrdd cyfrinachol (lle bo'n berthnasol)**<br><br>***Reason for submission of report to confidential board (where relevant)*** | Not applicable |
| ***Next Steps:***<br>***Ongoing refinement of this report to support committee oversight*** | |
| ***List of Appendices: Fire Safety Annual Performance Report*** | |

# BETSI CADWALADR UNIVERSITY HEALTH BOARD

## 2024/25 Annual Fire Safety Report



### 1. Introduction

Fire safety remains topical within the national media, with the Grenfell inquiry publishing it's second and final report in September 2024 following the fire that occurred on June 14th 2017 in the 24 story Grenfell tower residential building located in North Kensington in London which resulted in the loss of 72 lives. Its chair, Martin Moore-Bick, set out 58 recommendations for the construction industry, architecture and government to avoid another disaster of this scale. Although currently the Building Safety Act refers to buildings over 18 meters there is a recommendation to review urgently the definition of a higher-risk building for the purposes of the Building Safety Act to include the nature of its use and, in particular, the likely presence of vulnerable people, for whom evacuation in the event of a fire or other emergency would be likely to present difficulty. If this amendment is introduced, of the 58 recommendations the majority are building industry focused however at least 10 will be relevant to Health Boards.

As Building Regulations are devolved in Wales, while the Inquiry's findings are formally addressed to the UK Government and English bodies, the Welsh Government has confirmed that many of its key recommendations have equal resonance to us here in Wales they accept the Inquiry's findings and stand ready to work with the UK Government, and the Governments of Scotland and Northern Ireland, to implement the recommended reforms. This includes recommendations on both reserved matters and where it makes sense to take a coordinated and UK-wide approach. Accordingly, the fire-related and building control legislative position is in a state of evolution to reflect the Grenfell recommendations. This includes ongoing consultations and development of secondary legislation related to the design and construction of new higher risk buildings, work on existing higher risk buildings and wider changes to the building regulations in Wales.

Furthermore, the Home Office has stated, they intend to bring into law, mandatory competence requirements for fire risk assessors, to be independently verified by a UKAS-accredited certification body and overseen by a regulator. These changes will apply and affect the NHS in Wales.

## 2. Management Arrangements

The management arrangements for Fire Safety within BCUHB are contained within ES04 Policy for the management of Fire Safety. This policy is due for review.

Guidance on the management arrangements is contained within Welsh Health Technical Memorandum (WHTM 05-01) Firecode, Managing Healthcare Fire Safety. This document was amended in February 2019.

An updated version published by NHS England is currently out for consultation due to be published in the autumn of 2025, following which it will be reviewed and issued in Wales as WHTM 05-01. On publication a full review of ES04 will be undertaken.

The effectiveness and compliance to BCUHB's fire safety policy is reported to Health Board through the BCUHB's corporate governance structure, namely;

- Local area fire safety teams, East, Central and West
- Fire Safety Management Group (FSMG)
- Strategic Occupational Health and Safety Group (SOHSG)
- People and Culture Committee
- Health Board

## 3. Corporate Risk (CRR24-06)

There are two fire related risks on the Corporate Risk Register with a risk score of 16.

1. There is a risk of fire within sites across BCUHB due to non compliance of fire safety systems, leading to a risk of avoidable harm to patients and staff caused by a failure of the Health Board to provide safe systems of work in line with legislation.

2. Fire Safety and infrastructure non-compliance at Ysbyty Gwynedd due to deficiencies with the fire compartmentation in the main building which may result in an increased likelihood of uncontrolled spread of smoke and fire resulting in injury, loss of life and loss of estate and critical clinical services.

## 4. NHS Wales Shared Services Partnership, - Web-based Annual Fire Audits

NWSSP-SES monitors the fire safety activities of all Health Boards in Wales through the electronic fire safety audit reporting system.

Health Boards are required to submit annual returns in May/June of each year. The audit is divided into two elements:

Level 1 audit for the whole Organisation.

Level 2 audit for all hospitals providing in-patient facilities and a selection of 10-20% of other premises such as, clinics, health centres or administrative sites.

The 2023-2024 audit was submitted in August 2024. The audit submission is attached with the main findings highlighted below:

- Fire Safety Policy is overdue for updating.
- No Car Parking Policy
- The Organisation does not have access to up-to-date fire safety legislation and guidance.
- The Organisation does not undertake risk assessments in accordance with the Dangerous Substances and Explosive Atmosphere Regulations 2002 (DSEAR)
- The Responsible Person does not have access to up-to-date fire drawings for their site indicating fire safety measures.
- Fire Compartmentation is not subject to a periodic inspection regime.

The results of the annual audit are submitted through the Shared Services Fire Safety system and the findings are reported to the SOHSG. An action plan has been created from the findings and updates are provided to the FSMG.

Data submitted by BCUHB is analysed by the NWSSP-SES and is thereafter used as the basis of their reports to Welsh Assembly Government.

General matters raised in the last report completed following the 2021/22 audit are as follows: -

- Throughout the NHS estate in Wales the necessity to ensure the highest fire safety standards are achieved and maintained must remain a high priority.

- NHS Organisations are reminded of the statutory and mandatory duties imposed by legislation and Firecode and that they are responsible for ensuring effective fire management systems are implemented across their respective estates.

- Aspects of particular concern raised in this report are the deteriorating performance with regard to Fire Risk Assessments (FRA) and maintenance of key fire safety provisions all of which are critical for ensuring adequate fire safety management and compliance with the Fire Safety Order (FSO)

- Furthermore, NHS Organisations must implement procedures to address the deficiencies identified through their own audit processes and FRA's.

- NHS Organisations must also establish longer term strategic plans to rectify significant fire backlog issues, reversing the continual deferral of compliance.

- Fire safety across Wales is enforced by the three Fire and Rescue Authorities who have each implemented an audit and inspection regime as part of their

enforcement role. Within the South Wales and Mid & West Wales regions several enforcement notices have already been served upon the NHS.

- As well as jeopardising the fire safety of patients, staff and visitors, failure to adequately manage fire safety is a contravention of the legislation and may well result in further enforcement action or prosecution brought against the organisation or a responsible individual.

**5**. **NHS Wales Shared Services Partnership - Web-based Fire Safety Risk Assessments.**

Undertaking fire safety risk assessments is the primary role of the Fire Safety Advisor, each is responsible for completion and review of assessments of premises within their area. Pressure to provide support to Capital Development on new schemes over recent years and resource challenges have resulted in slippage in the completion of the risk-based re-inspection programme within the requisite timeframe, however significant inroads have been made to reduce the backlog over the last twelve months.

Within the reporting period, of the seven hundred and ten (710) assessment areas across one hundred and thirty-five (135) premises contained within the system, forty-six (46) are outside their identified review date which equates to approximately 6% of the assessments. Priority is given to ensuring clinical areas providing overnight care are completed on schedule.

Over the next twelve months an audit of the on-line system will be undertaken to cleanse the data and to remove any assessments that are no longer valid and to introduce further assessments which may be required as a result of relocation of staff or taking over the management responsibility of premises. This will then feed into a re-inspection programme which will aim to complete all outstanding assessments over the next nine to twelve months.

The system acts as a property asset register from a fire safety perspective which once each FRA is completed and action plan generated will together with the fire safety audits feed into the discretionary capital programme and the higher risks will be captured within a fire specific risk register which will be developed through the Datix platform.

The system has recently undergone a review by NHS Wales Shared Services Partnership (NWSSP) in collaboration with Digital Health Care Wales (DHCW), identifying a need for some significant improvements. These improvements are in line with current practices regarding digital delivery and management of FRAs, with particular emphasis on the management of outputs arising from recommendations. It should be noted that at a time when scrutiny of fire safety is at its highest since the Grenfell Tower incident, it is essential that the FRA process is robust, efficient and fit for purpose, in order to satisfy legislative requirements.

As a result, a re-design of the system has been completed, including the use of mobile technology (tablets) as well retaining the ability to access data via desktop means. This should enable the assessor to adopt a more efficient method of assessment and data collection, providing completed reports in a timelier manner.

The format established is a follow on from the existing system, that being a means for recording and managing FRAs for the whole NHS Estate in Wales, at the same time ensuring that any data entered is suitable and sufficient for the purposes of complying with the FSO.

One of the identified weaknesses of the old system was that once the FRA had been completed and submitted and report sent to the Responsible Person, there was no method of monitoring the completion of actions within the recommended timeframes. The new system allows the Responsible Person to log into the system and update the actions accordingly. This allows

reports to be created for IHC and directorates thus timely escalations can be made where necessary.

Initial use of the system would indicate that there are limited training implications as Responsible Persons will receive notification and instructions by email and the system once accessed is in a format which is similar to excel.

**6**. **NHS Wales Shared Services Partnership – Independent Review of Fire Precautions.**

During November 2024, on behalf of the Welsh Government, NWSSP – Specialist Estates Services (NWSSP-SES) commenced an independent review of the fire precautions at Ruthin Community Hospital, in accordance with the monitoring procedures outlined in Facilities Services Notification FSN12/10. We are awaiting the final report which is currently going through their quality assurance process.

In June 2024 we received a report following the independent review of the fire precautions in Bryn Beryl Hospital carried out in October 2023. The findings of this report undertaken by NWSSP-SES identify a number of measures necessary to improve fire safety standards at Bryn Beryl Hospital. Many of the recommendations made reinforce the findings of the Board's own FRA's and related action plan.

- The report recognises the Board's comprehensive approach to FRA's but also emphasises the importance of ensuring remedial works are completed in a timely manner.

- The report makes a series of recommendations aimed at improving the quality of the site-specific documentation, including recommendations to update the 'as installed' fire drawings.

- The report acknowledges the Board's proactive fire management arrangements but draws attention to a need for strengthening the number of fire warden appointments and localised improvements to storage arrangements.

- The report makes recommendations to review and test the response and evacuation procedures specifically addressing aspects such as bariatric and vertical evacuation, in addition to improvements to the means of escape.

- The fire response procedures are influenced and instigated upon activation of the fire alarm. Therefore, a series of recommendations are made to enhance the effectiveness of the fire alarm and detection system, particularly regarding; replacement of obsolete equipment, zoning arrangements, device addressing, and cause and effect.

- The report supports the Board's own FRA's recommendations to conduct surveys of the compartmentation, fire doors and escape lighting and to address remedial actions as necessary.

- The report recognises the ongoing improvements to the planned maintenance regimes and promotes continued activity in this regard to comply with the current British Standards.

- The report supports the Board's comprehensive training delivery plan, however recommendations are made to enhance evacuation exercises including the use of evacuation aids.

- NWSSP-SES suggests the earliest possible implementation of the recommendations, prioritised according to risk, the Board should develop a prioritised action plan for implementing these remedial measures, in addition to addressing the significant findings identified through the Board's FRA's, in an acceptable timeframe agreed with the Fire and Rescue Service (FRS).

The recommendations are incorporated into an action plan and managed through the FSMG.

## 7. Staff Training Arrangements and Statistics

### Mandatory fire training

Mandatory fire training is undertaken in accordance with the policy for the management of fire safety ES04. Appendix C&D provide the details of the training delivery plan and training matrix.

Fire safety training is provided either by the fire safety trainer or the on-line module provided through the Electronic Staff Record platform (ESR).

Staff who are in patient facing roles are expected to undertake 'face to face' training on an annual basis which is delivered at one of our acute or community sites or via Microsoft teams. Staff in other departments undertake the on-line and face to face options in alternate years. Dates of sessions are normally published 3 months in advance or requests for site specific training can be requested via the fire safety trainer.

Records are kept on ESR and it is expected that their respective line managers ensure that staff complete the requisite training within the recognised time frames. The fire safety trainer ensures that a roll call is undertaken at each session to ensure attendance can be recorded against the registration details.

Reporting of mandatory fire safety training is carried out via the Fire Safety Management Group meeting using information provided through the BCU workforce compliance dashboard.

Figures contained within the ESR system indicate that compliance levels for BCUHB staff across all Directorates at the end of April 2025 is that 19068 have undertaken training within the specified timeframes and 2417 have not which relates to an 88.75% compliance rate. The measure used within this reporting process is over a two-year period and may not reflect the expectations of the fire safety training delivery plan.

| Competency Name | Fire Safety - 2 Years | | |
|---|---|---|---|
| Org L4 | Compliant | Non-Compliant | Compliance % |
| Health Community Centre (HCCX) | 4428 | 654 | 87.13% |
| Health Community East (HCEX) | 4668 | 510 | 90.15% |
| Health Community West (HCWX) | 3644 | 488 | 88.19% |
| Integrated Clinical Delivery - Primary Care (ICDP) | 401 | 28 | 93.47% |
| Integrated Clinical Delivery - Regional Care (ICDR) | 1304 | 199 | 86.76% |
| Mental Health & LDS (MX00) | 1990 | 199 | 90.91% |
| Midwifery and Womens Services (WX00) | 706 | 122 | 85.27% |
| Corporate Services | 1927 | 217 | 89.88% |
| **Total** | **19068** | **2417** | **88.75%** |

An adhoc audit of staff understanding is undertaken via Q&A of staff during the fire risk assessment process or through fire drills.
Fire Safety within the healthcare environment follows the guidance set out within the 'Firecode' suite of documents, recent amendments to the documentation have resulted in specific guidance on training through the 'Health Technical Memorandum 05-03 Part A Training' This document has already been published in England and it is expected that the version appertaining to Wales will be published this summer. (WHTM 05-03 Part A Training)

It is proposed to undertake a review of the current fire safety training delivery plan against the guidance provided within the new document on publication. We will also use this opportunity to review the current reporting tools to ensure they more accurately reflect Policy and the needs of the Health Board.

**Fire Warden Training**

Fire Wardens are appointed by the Designated Responsible Persons (DRP) in all hospital wards and departments to assist with fire safety management. They receive specific training on how to react in a fire situation.

**8. Fire-code Compliance Work**

The primary source of funding is the Operational Estates discretionary capital and statutory compliance reserve, based on a five-year investment Programme. Fire safety improvements are included within major capital schemes and refurbish projects. However, currently the there is insufficient capital and revenue funding to maintain or upgrade the passive and active fire safety systems to ensure compliance, this has been captured on the corporate risk register.

During the period Welsh Government's Estate Funding Advisory Board (EFAB) initiative directed additional investment towards fire safety improvements as shown below. These schemes had been identified and prioritised through either independent review, fire safety risk assessments or EFPMS:

| **NHS Estates Funding Advisory Board 2023-24- Fire** | | | |
|---|---|---|---|
| **Scheme** | **Expenditure 2023/24 WG** | **Expenditure 2024/25 HB** | **Overall Total** |
| Ysbyty Gwynedd compartmentation upgrade. | 600,000 | 600,000 | 1,200,000 |
| Ysbyty Glan Clwyd - Fire Detection and Fire Alarm Reconfiguration | 160,000 | | 160,000 |
| Abergele - Fire Alarm System and compartmentation Improvement Programme | 110,000 | 110,000 | 220,000 |
| Fire door and compartmentation upgrade at Ysbyty Maelor | 200,000 | | 200,000 |
| Chirk Community Hospital - Fire Compartmentation Upgrade | 90,000 | | 90,000 |
| Mold Community Hospital<br>Fire alarm panel upgrade | 60,000 | | 60,000 |
| Pan BCUHB fire alarm upgrades | 300,000 | | 300,000 |
| Pan BCUHB fire engineering upgrades | 100,000 | | 100,000 |
| Fire alarm upgrade Colwyn Bay | 96,000 | | 96,000 |
| **Total** | **1,716,000** | **710,000** | **2,426,000** |

Following a similar format, the above-mentioned EFAB initiative has been recently rebranded as the Targeted Estates Funding (TEF) which allocates additional investment across the next two financial years, noting BCUHB's successful fire-related bids amount to circa £4.7m.

Two Programme Business Cases have previously been submitted to Welsh Government, one for Ysbyty Maelor Wrexham due to the infrastructure challenges associated with an aging site and Ysbyty Gwynedd owing to fire safety deficiencies, both requiring significant investment in fire safety measures beyond that available through the EFAB/TEF initiatives.

**9. Fire and Rescue Service Audits**

Enforcement of fire safety within healthcare premises is the responsibility of the Fire and Rescue Authority, within this area this undertaken by North Wales Fire and Rescue Service. Audits are normally undertaken based on a risk-based re-inspection programme, following a fire or due to the number of Unwanted Fire Signals received.

During the reporting period the FRS carried out three (3) post fire audits within BCUHB premises.

On the 04/11/24 a 'Post Fire' audit was undertaken at the Dental Unit on the Royal Alexandra Hospital site, following an incident involving the failure of a ballast unit in a fluorescent light. The Inspecting Officer was satisfied with the findings and issued a letter with one recommendation which was to install a fire zone plan adjacent to the fire alarm panel.

A 'Post Fire' audit was undertaken on the 28/11/24 at Llandudno Community Hospital following a deliberate fire started by youths in a storage garage at the rear of the hospital. No correspondence has been received following this visit.

The third audit was a 'Post Fire' audit at Deeside Community Hospital following an electrical fire involving a hot water boiler in the ward kitchen. The outcome of the audit was a letter containing four (4) recommendations, a targeted action plan has been developed which is being managed through the Operational Estates Department in Wrexham and overseen by the Fire Safety Management Group.

**10. Fire Service Liaison and Site Visits**

The introduction of the FSO has strengthened the Fire and Rescue Service's enforcing role. In order to develop good working relationships with the Fire & Rescue Services the 'Working Together in Partnership' Concordat between the Welsh Assembly Government's Department for Health and Social Services and the Chief Fire Officers' Association Wales has been introduced to;

1. Promote compliance with all relevant fire safety legislation;
2. Agree and develop fire risk assessment protocols;
3. Identify key contacts for each NHS provider organisation;
4. Promote the reduction of unwanted fire signals;
5. Work towards a consistent approach on all fire safety issues.

Regular meetings have been set up at Fire Safety Manager level to ensure that objectives of the concordat are being achieved and to update each other on current and future plans.

The North Wales Fire & Rescue Service (NWFRS) officers continue to visit the three district general hospitals and to a lesser extent the community hospitals, across BCUHB on pre-arranged visits.

NWFRS Operational Officers also visit other sites to obtain site specific data which is accessed by the fire appliances' on-board computer systems. This information is used to brief the fire fighters attending fire incidents. These visits are followed up by the watches to familiarise themselves with the sites during the day, at night and at weekends.

Many of the BCUHB's patients are cared for in the community. In some circumstances BCUHB staff provided constant on-site care. In these situations, the Fire Advisors liaise with the Fire Service and the care teams in a co-coordinating role to ensure that the staff cover and fire safety arrangements are suitable and sufficient.

**11. Fire Incidents**

There has been a total of nineteen (19) fire incidents reported to the fire safety team over the reporting period 2024/2025. This figure is more than 2023/2024 during which we had a total of twelve (12) fire incidents. (63% increase)

One (1) of the incidents involved a patient within a mental health facility deliberately starting a fire using a lighter. One of the main concerns across Wales remains the number of deliberate fires caused within the Mental Health sector. Another Health Board in Wales is currently being prosecuted by the Fire Authority for failing to control ignition sources within a MHU, the first such case in the UK.

Two (2) incidents were caused by deliberate ignition of buildings on hospital sites. One in an unlocked storage unit and the other in a derelict building within the hospital grounds.

It is recommended that all Health Boards continually review the potential for deliberate fire raising where greater control of ignition sources is necessary to mitigate the risk. Reference should be made to WHTM 05-03 Part F and SESN 19/06 which provide comprehensive guidance on Arson control.

Two (2) incidents were a fire caused by a discarded cigarette within a bin located near a hospital entrance door on our acute sites.

All NHS organisations operate smoke free policies on sites across their estate, in line with the Welsh Government's smoking legislation. However illicit smoking remains a common sight at entrances and secluded areas.

Eleven (11) of the fires were attributed to electrical defects, namely three (3) incidents of failure of ballast units in fluorescent lighting units. Operational Estates are currently undertaking a replacement programme to install LED lighting which will eliminate this problem over time. Two (2) incidents involving the failure of components within Calomax wall mounted boilers which resulted in the company making adaptations to a number of boilers across our sites.

The recurring number of electrical fire incidents highlights the importance of on-going maintenance and testing of both fixed installations and portable appliances

Electrical defects accounted for the largest number of recorded fires (58%) followed by deliberate ignition (16%) cooking (11%) and smoking (10%) this is consistent with the top identified causes of fires in healthcare premises across Wales according to the Annual Fire Statistics Report 2024 for the NHS Estate in Wales. Electrical fires (39%) deliberate ignition (16%) smoking (18%) and cooking (14%)

**Table detailing Recorded Fire Incidents in 2024/25**

| Date/Time | Site | Area type | Cause |
|---|---|---|---|
| 15/04/2024 13:40 | Ysbyty Glan Clwyd | External | Bin fire outside main entrance caused by a discarded cigarette |
| 29/04/2024 08:30 | Ysbyty Maelor | Catering | Cooking fire – Catering staff transferring bacon from one container into another above the servery spilled fat over the hot element resulting in the ignition of the fat. |
| 04/07/2024 18:20 | Holywell Community Hospital | Catering | Cooking fire - Food left unattended in a microwave oven which had been incorrectly set which resulted in smoke emitting from the cooker. |
| 04/07/2024 18:30 | Ysbyty Maelor | External | Bin fire outside main entrance caused by a discarded cigarette |
| 24/10/2024 09:45 | Royal Alex Hospital | Dental Clinic | Electrical fire caused by the failure of a ballast unit in a fluorescent lighting unit |
| 24/10/2024 15:33 | Llandudno Community Hospital | Main stores | Deliberate ignition of an air mattress within a storage shed at the rear of the hospital by local youths. |
| 08/11/2024 04:07 | Deeside Community Hospital | General Medical Ward | Electrical Fire caused by the failure of a component within the control module of a Calomax boiler located within the local kitchen of Gladstone Ward. |
| 13/11/2024 07:30 | Abergele Hospital | External Building | Deliberate Ignition of an empty external building formally used as an artist's shed for patient rehabilitation |
| 19/11/2024 12:00 | Ysbyty Maelor | A&E | Electrical issue caused by the overheating of an electric plug attached to a 3KW wall mounted heater. |
| 28/11/2024 19:56 | Ysbyty Maelor | Retail Area | Electrical issue caused by the overheating of an electric plug attached to a 3KW wall mounted heater. |
| 04/12/2024 00:07 | Ysbyty Alltwen | Catering | Electrical issue caused by the failure of a component within the control module of a Calomax boiler located within the catering area |
| 09/12/2024 16:15 | Rhosllanerchrugog Clinic | Clinic | Electrical issue caused by overheating on the live feed of a wall mounted distribution board. |
| 13/12/2024 16:00 | Ysbyty Maelor | Out Patients | Electrical issue caused by overheating of a component on a potentiometer (dimmer switch) within an eye examination room |
| 09/01/2025 12:40 | Llandudno Community Hospital | Out Patients | Electrical fire caused by the failure of a ballast unit in a fluorescent lighting unit |
| 21/01/2025 16:55 | CAHMS Talarfon | Administration | Electrical fire caused by the failure of a ballast unit in a fluorescent lighting unit |

| | | | |
|---|---|---|---|
| 29/01/2025 12:00 | Ysbyty Glan Clwyd | Pathology | Inappropriate container being placed in a microwave oven resulting in the overheating of a metal edged paper plate. |
| 20/03/2025 14:40 | Tan y Castell | Mental Health Ward | Attempted Deliberate ignition of curtains by a patient within a bedroom with an un-authorised lighter |
| 25/03/2025 19:00 | Ablett Unit | Mental Health Ward | Electrical Fire caused by the overheating of a component within a circuit board located within a fire damper panel. |

**12. Unwanted Fire Signals**

The total number of unwanted fire signals reported during 2024/25 was three hundred and fifty one (351) compared to four hundred and twenty one (421) in 2023/2024 a decrease of 70. It is below the three year average of four hundred and twenty two (422)

The decrease in the number of fire alarm activations in 2024/25 have occured across a number of sites, including all the acute sites with a decrease of sixty eight (68) at Ysbyty Maelor Wrexham a 64% reduction on the previous year. However as indicated below some premises incidents have increased.

Staff residences account for 37% of all unwanted fire signals recieved across BCUHB sites with the vast majority of these can be attributed to cooking fumes. A disturbing statistic is that across Wales the highest cause of UWfS attributed to cooking being left unattended, occurred within BCUHB premises, 83% of which occurred in staff accommodation.

Cooking accounted for the largest number fire alarm activations (33%), followed by system faults (17%) and other environmental effect (13%). These figures are consistent with the top three (3) identified causes of UwFS according to the Annual Fire Statistics Report 2024 for the NHS Estate in Wales, although manual call point is the top cause in healthcare premises across Wales (17%) followed by system fault (24%). and cooking (19%).

Although not amongst the highest causes, one constant cause is the number of incidents due to contactors failing to follow management procedures, which account for at least 5% of unwanted fire signals annually.

**UwFS by premises over the last three years**

| | **24-25** | **23-24** | **22-23** |
|---|---|---|---|
| Ysbyty Gwynedd | **35** | **44** | **39** |
| Ysbyty Glan Clwyd | **44** | **45** | **76** |
| Ysbyty Maelor | **58** | **111** | **110** |
| Ysbyty Abergele | **3** | **15** | **6** |
| Ysbyty Alltwen | **0** | **1** | **0** |
| Ysbyty Bryn Beryl | **0** | **1** | **1** |
| Ysbyty Bryn y Neuadd | **15** | **26** | **18** |
| Ysbyty Cefni | **0** | **1** | **0** |
| Ysbyty Chirk | **0** | **2** | **0** |

| | | | |
|---|---|---|---|
| Ysbyty Colwyn Bay | **0** | **0** | **0** |
| Ysbyty Deeside | **1** | **1** | **3** |
| Ysbyty Denbigh | **0** | **0** | **0** |
| Ysbyty Dolgellau | **0** | **1** | **0** |
| Ysbyty Eryri | **2** | **9** | **5** |
| Ysbyty Holywell | **0** | **1** | **1** |
| Ysbyty Llandudno | **27** | **9** | **16** |
| Ysbyty Mold | **0** | **4** | **3** |
| Ysbyty Penley | **0** | **0** | **2** |
| Ysbyty Penrhos Stanley | **2** | **1** | **1** |
| Ysbyty Ruthin | **1** | **2** | **0** |
| Ysbyty Tywyn | **1** | **0** | **0** |
| Ablett MHU | **9** | **9** | **22** |
| Coed Celyn MHU | **1** | **3** | **3** |
| Hergest MHU | **3** | **15** | **13** |
| North Wales Child and Adolescent Service | **14** | **5** | **1** |
| Royal Alex Rhyl | **2** | **0** | **0** |
| Staff Residences -YG | **79** | **72** | **91** |
| Staff Residences -YGC | **42** | **26** | **41** |
| Staff Residences- YMW | **0** | **11** | **11** |
| Clinics | **4** | **0** | **1** |
| | | | |
| Total | **351** | **421** | **466** |
| | | | |

**UwFS by cause over the last three years.**

| Item | **24/25** | **23/24** | **22/23** | **3-year total** | **3 years %** |
|---|---|---|---|---|---|
| Accidental damage | 19 | 15 | 11 | **45** | **3.6%** |
| Alarm activated by patient or public | 37 | 51 | 80 | **168** | **13.3%** |
| Cooking fumes | 116 | 122 | 137 | **379** | **29.7%** |
| Good intent | 4 | 0 | 10 | **16** | **1.3%** |
| Insects | 4 | 1 | 1 | **6** | **0.5%** |
| Malicious | 8 | 0 | 7 | **20** | **1.6%** |
| Management procedures not complied with | 3 | 2 | 2 | **7** | **0.6%** |
| Other environmental effect | 48 | 75 | 105 | **240** | **19.0%** |
| Smoking | 12 | 32 | 14 | **60** | **4.8%** |
| System fault/design | 62 | 104 | 68 | **234** | **18.5%** |
| System procedures not complied with | 20 | 12 | 27 | **60** | **4.8%** |
| Unknown | 18 | 7 | 4 | **31** | **2.5%** |
| Grand total | **351** | **421** | **466** | **1266** | |

North Wales Fire & Rescue Service share data on a regular basis, according to their data that they received three hundred and four (304) calls and attended two hundred and twelve incidents (212) at BCUHB sites over this reporting period compared to three hundred and forty four (344) calls and attending two hundred and thirty four (234) incidents across the BCUHB during 2022/23. The difference between the call numbers and attendance is due to our switchboard operators informing them that the fire alarm signal has been investigated and FRS assistance is not required.

The Annual Fire Statistics Report 2024 for the NHS Estate in Wales publish a report using the information contained in the all-Wales Fire Auditing and Reporting System, which is populated by each Health Board. The findings of this report are shared and they make a number of recommendations, which include the following:

During 2024, 51 fire incidents were reported, continuing the upward trend seen during the previous year and representing a 6.3% increase in reported fires compared to 2023.

There is an obvious need to maintain a clear focus on the causes of fires and on how these might be prevented, particular attention again being paid to the control of ignition sources within the Mental Health sector. During November there was a major fire incident within a mental health facility resulting in significant damage and a patient being hospitalised for several days due to smoke inhalation following rescue by the Fire and Rescue Service. Fire incidents will always have the attendant disruption to health service delivery and possible legal action from the FRS, if it is seen that there were any weaknesses in policy or procedures.

In 2024, the highest cause of fires was attributed to electrical failure 39%, followed by smoking 18% and then deliberate fire-raising 16%. This emphasises the need for robust electrical testing and maintenance, improved management of smoking policies and a greater awareness and control of arson prevention.

Overall, the majority of fires were detected early and dealt with effectively, averting much more serious outcomes. However, there were fire incidents where without the intervention of either hospital staff, FRS personnel or both, the outcomes could have been more serious. This underlines the importance of maintaining staff awareness and robust training regimes addressing such issues as good housekeeping, effective response procedures and management of ignition sources and electrical equipment.

During 2024, UwFS decreased by 10% to 1529 incidents. The data indicates that human behaviour remains an influencing factor on a large proportion of UwFS, highlighting the need for increased management awareness. In addition, system fault related incidents could be reduced by replacement of obsolete equipment and ‘designing out’ UwFS with the use of technological advances.

As noted previously these incidents cause considerable disruption to both the NHS and the FRS. Continued efforts to reduce the occurrence of UwFS should be regarded as a high priority and will contribute significantly to the saving of time and resources needed in dealing with these incidents, both for the healthcare sector and FRS. However, on no account should the endeavours to reduce UwFS jeopardise patient safety.

Accuracy of reporting and identification of specific cause information will enhance trend analysis and performance management. It should be noted that all fire alarm activations should be recorded whether or not the FRS are informed and irrespective of their attendance.

NHS organisations should regularly update the online system with respect to the number of actuation devices fitted in their facilities. Notwithstanding this requirement, there remain several sites where numbers of devices have not been specified. This process enables the calculation of accurate performance scores which are reflected in Appendix C and D. Furthermore, NHS organisations should endeavour to achieve the defined targets for reduction of UwFS calculated through the online system.

Target premises within BCUHB identified in the report:

| Premises | Required Reduction |
|---|---|
| Ysbyty Maelor Wrexham | 10% |
| Ysbyty Glan Clwyd | 10% |
| Ysbyty Gwynedd | 10% |
| Ablett MHU YGC | 40% |
| North Wales Child & Adolescent Service | 40% |
| Staff Residence Bron y Nant | 40% |
| Staff Residences - YG | 40% |
| Staff Residences - YGC | 40% |
| Eryri Hospital | 10% |
| Bryn y Neuadd Hospital | 10% |
| Hergest MHU YG | 10% |
| Llandudno Community Hospital | 10% |
| Ysbyty Penrhos Stanley | 10% |

**13. Internal Audit**

Between June and October 2004 NWSSP Audit and Assurance undertook an review of Fire Safety to assess the compliance with the requirements of WHTM 05-01 Firecode Managing Healthcare Fire Safety.

Following the audit fire safety was issued with Limited Assurance on three (3) of the objectives identified and Reasonable assurance on the remaining one (1) these objectives are listed below.

1. There are appropriate governance arrangements in place for fire safety.
2. There is effective central monitoring and reporting to ensure compliance with the Health Board's Policy and legislation.
3. There are effective local arrangements in place to manage fire risks.
4. There are appropriate policies and procedures in place that outline requirements of staff and monitoring arrangements, and these have been communicated to staff.

An action plan has been formulated and agreed and is managed through the Fire Safety Management Group.

**14. SESN and other Guidance.**

The following guidance documents have been issues during the reporting period.

**Specialist Estates Services Notification 24/11**

**Bariatric/Plus Size Patient Emergency Evacuation Procedures - General Guidance Note**

The attached best practice guidance note, prepared and endorsed by the all-Wales Fire Safety Manager's Forum, is intended to be an aide-memoir highlighting a series of questions to consider when admitting Bariatric/Plus Size patients. Accordingly, it is recommended that NHS Organisations consider this guidance when admitting Bariatric/Plus Size patients and reviewing their associated fire safety management arrangements.

**Specialist Estates Services Notification 24/05**
**Fire Alarm Survey Report**

Following an all-Wales online survey, the attached report (here) evaluates key aspects of the current state of fire alarm systems installed across NHS Wales inpatient healthcare facilities. The findings identify significant issues that reduce the effectiveness of the existing systems, which represents a risk to patient and staff safety.

**Specialist Estates Services Notification 25/03**
**NHS ESTATE IN WALES - FIRE STATISTICS REPORT**
**FIRE INCIDENTS AND UNWANTED FIRE SIGNALS 2024**

The report reviews the fire incidents and unwanted fire signals (UwFS) reported by the NHS Health Boards and Trusts in Wales, through the online Fire and UwFS Incident Reporting System between January-December 2024, as mandated in WHC (2006) 74 and WHTM 05-03 Part H: Reducing false alarms in healthcare premises.

**Health Technical Memoranda**

**HTM 05-03: Operational provisions Part A: Training**

**HTM 05-03: Operational provisions Part B: Fire detection and alarm systems including the reduction of false alarm and unwanted fire signals.**

**HTM 05-03: Operational provisions Part K: Guidance on fire risk assessments in complex healthcare premises.**

These documents are published by NHS England and provide comprehensive advice and guidance on fire safety in healthcare premises. These documents will now be reviewed on behalf of the Welsh Government and issued in the form of WHTM's.

Once published the WHTM versions will be followed as they provide guidance on healthcare specific elements of standards, policies and up to date established best practice. They are applicable to new and existing sites, and are for use at various stages during the building lifecycle.

## 15. Conclusion

There is a need to keep a clear focus on fire safety, this includes investigating the causes of fire and how they might be prevented including appropriate action to prevent reoccurrence. The more fires that occur the greater chance of a serious incident. Fires will always have the

attendant disruption to health service delivery and possible legal action from the FRS if it is seen that there were weaknesses in policies and procedures.

Management of ignition sources must be considered to reduce the fire risk within the hospital; it is one of the main causes associated with fires within the mental health setting; however, it is also a hazard within the wider healthcare setting.

Although the Health Board operates a no smoking policy on their sites there are visible signs of non-compliance and in some instances the careless discarding of smoking materials can lead to fires.

Hospital evacuation strategies are developed on the principle of Progressive Horizontal Evacuation, this concept relies on compartmentation, reliable fire alarm systems and competent staff to manage the response to incidents. It is vital that processes are in place to ensure appropriate Pre Planned Maintenance (PPM) of our passive and active systems and robust training for staff.

| | |
|---|---|
| **Teitl adroddiad:**<br>***Report title:*** | **Conformance Report: Q4 2024/25** |
| **Adrodd i:**<br>***Report to:*** | Audit Committee |
| **Dyddiad y Cyfarfod:**<br>***Date of Meeting:*** | Tuesday, 19 August 2025 |
| **Crynodeb Gweithredol:**<br><br>***Executive Summary:*** | This conformance report provides an update to the Committee on areas that relate to regulatory compliance or assurance and good practice expectations.<br><br>The areas covered in this report are:<br><br>• **Purchase orders that are non-compliant with SFI's (January to March 2025)**<br><br>This data set relates to orders being raised after the invoice has been received.<br><br>Non-compliance for the period is 196 in January, 184 in February and 263 in March 2025. The total 643 breaches during quarter 4 (Q4) is a slight improvement compared to 707 in Q4 2023-24. A significant proportion of the orders are for known expenditure such as utilities charges, external contracts, and contractual clinical services, however, the variable nature of the volume means that retrospective orders are produced.<br><br>The Health Board's Oracle users are regularly reminded of the 'No PO No Pay' policy and that all staff must have approval before committing to expenditure.<br><br>An approved purchase order (PO) exemption list is now been issued and forms part of the updated No Purchase Order No Pay Policy on behalf of NHS Wales.<br><br>NHS Wales Shared Services Partnership (NWSSP) have worked with the Health Board to implement a new process involving 'File Notes' to capture and record instances of procurement spend outside of the SFIs/Scheme of Reservation and Delegation (SoRD).<br><br>During Quarter 4, the number of file notes approved was 9 with a total contract value of £0.3m.<br><br>• **Single Waivers (January to March 2025)**<br><br>The number of waivers issued year to date has significantly decreased compared to this period last year.<br><br>Single Tenders – 11 approved in Q4, compared to 10 last year.<br><br>Single Quote – 5 approved in Q4, compared to 4 last year.<br><br>• **Receivables and conformance with payroll procedures**<br><br>The Health Board has procedures in place to ensure that balances owed to the Health Board are invoiced promptly. Escalation procedures are in place to ensure that debtors are collected in a timely manner or highlighted for further action. |

As at 31st March 2025, there were 3,464 outstanding invoices, totalling £13.9m, of which 973 invoices, totalling £8.0m were less than 30 days old.

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

For the period January to March 2025 there were 127 staff overpayments, with a gross value of £0.355m, comparable to 127 and £0.307m in the previous Financial Year. Failure to complete forms on time remains the main cause of overpayments (112 cases). Staff overpayment breaches are included in service/area monthly management reports and discussed as part of the budget monitoring process in order to improve future compliance.

As at 31st March 2025 the balance outstanding was £1.078m, compared to £1.235m at 31st March 2024.

- **Payables and conformance with Public Sector Payment Policy (PSPP)**

  The Health Board aims to ensure that all balances are paid within 30 days of receipt of a valid payable invoice. Best Practice (by number) is set at 95%. The 2024-25 achievement for non-NHS invoices by number is 96%.

- **Losses and special payments**

  Losses and special payments should be exceptional in nature. The Health Board must administer losses in accordance with procedures set out by Welsh Government. Individual losses in excess of £50,000 require approval from the Welsh Government (£1,000,000 in the case of negligence claims).

  Clinical negligence claims account for the largest element of loss. Amounts in excess of £25,000 can be claimed from the Welsh Risk Pool Service in accordance with the risk pooling arrangements in place for NHS Wales. However, as the Welsh Risk Pool is funded from the NHS Wales healthcare budget these costs are still met by NHS Wales.

  Clinical negligence claims are managed by Legal and Risk Services and there were 316 active claims at the end of March 2025. Of these 173 matters were assessed as either probable or certain of settlement with a cumulative estimated value of £205m (before reimbursement from the Welsh Risk Pool).

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

  As at 31st March 2025 the number of claims outstanding is 60.

- **Chairs Action in Quarter 4 2024/25**
  There were no Chairs actions in relation to financial compliance during the period.

<table>
<tr><td></td><td colspan="4">

- **Contract Procurement Review Update**
  In total 16 finance procedures have been reviewed and updated over the last year and 4 new procedures have been written, approved and implemented. One policy remains outstanding, this has been reviewed and updated and will be circulated for wider consultation prior to being presented for approval.

  Contract Register – Health Board staff are working in partnership with an external software solutions company to create a pan-BCU document and records management system for contracts. This is currently with the external company and is at the development stage using Microsoft SharePoint as the basis for the system. The use of SharePoint will allow for future internal maintenance and support without the need for significant additional upkeep costs.

</td></tr>
<tr><td>Argymhellion:<br><br>Recommendations:</td><td colspan="4">The Audit Committee is asked to:<br>1. To note and discuss the below elements of performance<br>• Purchase orders that are non-compliant with SFI’s<br>• Single Waivers<br>• Receivables and conformance with payroll procedures<br>• Payables and conformance with Public Sector Payment Policy (PSPP)<br>• Welsh Risk Pool Penalties – Learning from Events Report<br>• Contract Procurement Review Update<br>2. Approve the Losses and Special Payments (January to March 2025)</td></tr>
<tr><td>Arweinydd Gweithredol:<br>Executive Lead:</td><td colspan="4">Russel Caldicott, Interim Executive Director of Finance</td></tr>
<tr><td>Awdur yr Adroddiad:<br>Report Author:</td><td colspan="4">Denise Roberts, Head of Capital, Business Improvement and Compliance</td></tr>
<tr><td>Pwrpas yr adroddiad:<br>Purpose of report:</td><td>I’w Nodi<br>For Noting<br>☒</td><td colspan="2">I Benderfynu arno<br>For Decision<br>☒</td><td>Am sicrwydd<br>For Assurance<br>☒</td></tr>
<tr><td rowspan="2">Lefel sicrwydd:<br><br>Assurance level:</td><td>Arwyddocaol<br>Significant<br>☐</td><td>Derbyniol<br>Acceptable<br>☒</td><td>Rhannol<br>Partial<br>☐</td><td>Dim Sicrwydd<br>No Assurance<br>☐</td></tr>
<tr><td>Lefel uchel o hyder/tystiolaeth o ran darparu'r mecanweithiau / amcanion presennol<br><br>High level of confidence/evidence in delivery of existing mechanisms/objectives</td><td>Lefel gyffredinol o hyder/tystiolaeth o ran darparu'r mecanweithiau / amcanion presennol<br><br>General confidence / evidence in delivery of existing mechanisms / objectives</td><td>Rhywfaint o hyder/tystiolaeth o ran darparu'r mecanweithiau / amcanion presennol<br><br>Some confidence / evidence in delivery of existing mechanisms / objectives</td><td>Dim hyder/tystiolaeth o ran y ddarpariaeth<br><br>No confidence / evidence in delivery</td></tr>
<tr><td colspan="5">Cyfiawnhad dros y gyfradd sicrwydd uchod. Lle bo sicrwydd 'Rhannol' neu 'Dim Sicrwydd' wedi'i nodi uchod, nodwch gamau i gyflawni sicrwydd 'Derbyniol' uchod, a'r terfyn amser ar gyfer cyflawni hyn:<br><br>Justification for the above assurance rating. Where ‘Partial’ or ‘No’ assurance has been indicated above, please indicate steps to achieve ‘Acceptable’ assurance or above, and the timeframe for achieving this:</td></tr>
</table>

| | |
|---|---|
| **Cyswllt ag Amcan/Amcanion Strategol:**<br><br>***Link to Strategic Objective(s):*** | Standing Orders, Standing Financial Instructions and the Scheme of Reservation and Delegation are designed to ensure that expenditure is committed in line with stipulated governance and incurred on the intended purpose. |
| **Goblygiadau rheoleiddio a lleol:**<br>***Regulatory and legal implications:*** | Areas of identified non-conformance highlight risk of failing to meet regulatory and legal requirements, and expected good practice. Mitigating actions are designed to manage highlighted risks effectively. |
| **Yn unol â WP7, a oedd EqlA yn angenrheidiol ac a gafodd ei gynnal?**<br>***In accordance with WP7 has an EqlA been identified as necessary and undertaken?*** | Not applicable |
| **Yn unol â WP68, a oedd SEIA yn angenrheidiol ac a gafodd ei gynnal?**<br>***In accordance with WP68, has an SEIA identified as necessary been undertaken?*** | Not applicable |
| **Manylion am risgiau sy'n gysylltiedig â phwnc a chwmpas y papur hwn, gan gynnwys risgiau newydd (croesgyfeirio at y BAF a'r CRR)**<br><br>***Details of risks associated with the subject and scope of this paper, including new risks( cross reference to the BAF and CRR)*** | BAF: 2.3 & CRR 24-05 – Delivery of the Annual Financial Plan. |
| **Goblygiadau ariannol o ganlyniad i roi'r *argymhellion ar waith***<br>***Financial implications as a result of implementing the recommendations*** | Management of financial risk of not achieving value for money. |
| **Goblygiadau gweithlu o ganlyniad i roi'r argymhellion ar waith**<br>***Workforce implications as a result of implementing the recommendations*** | None |
| **Adborth, ymateb a chrynodeb dilynol ar ôl ymgynghori**<br>***Feedback, response, and follow up summary following consultation*** | Not applicable |
| **Cysylltiadau â risgiau BAF:**<br>(neu gysylltiadau â'r Gofrestr Risg Gorfforaethol)<br>***Links to BAF risks:***<br>*(or links to the Corporate Risk Register)* | BAF: 2.3 & CRR 24-05 – Delivery of the Annual Financial Plan. |
| **Rheswm dros gyflwyno adroddiad i fwrdd cyfrinachol (lle bo'n berthnasol)**<br>***Reason for submission of report to confidential board (where relevant)*** | Not applicable |
| **Camau Nesaf:**<br>**Gweithredu argymhellion**<br>***Next Steps:***<br>***Implementation of recommendations***<br>• ***The report is for noting and, in the case of losses and special payments, approval*** | |
| **Rhestr o Atodiadau:**<br>***List of Appendices:***<br>1. Appendix 1: Conformance Report – Quarter 4 (January to March 2025)<br>2. Appendix 2: Approved Single Tender Waivers between 1st January – 31st March 2025<br>3. Appendix 3: Approved Single Quote Waivers between 1st January – 31st March 2025 | |

**Appendix 1: Conformance Report – Quarter 4 (January to March 2025).**

**Section 1 - Conformance with Procurement Procedures**

**a) SFI requirements**

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

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

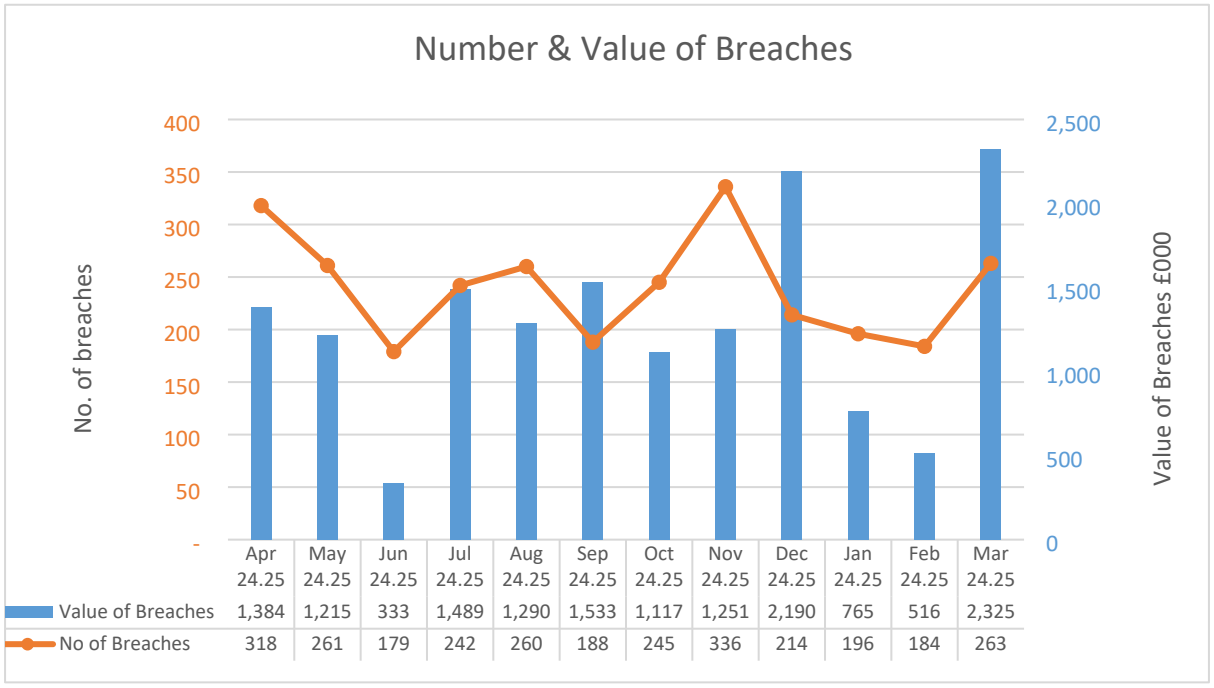
*Exemptions apply (see SFIs)

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

**b) Purchase Orders**

The use of a formal purchase order system is a key control to ensure expenditure is only committed following proper approval and all committed expenditure is recorded. The trend in the graph below shows that there has been a 21% decrease in the value of Purchase Order breaches in quarter 4 (Q4), with 643 breaches reported with a value of £3.6m. During the same period last Financial Year, the number of breaches were 707 with a value of £3.3m.

The value and number of breaches between April 2024 and March 2025 are detailed below:



Of the 'No PO (Purchase Order) No Pay' breaches, the 5 individual orders with the highest value for Q4 are as follows:

| Division | Month of Breach | Item Description | PO Amount £000's |
|---|---|---|---|
| Health Community West | Mar-25 | ENDOSCOPY LISTS FROM W/END OF 04.01.2025 - 30.03.2025 INC. DIAGNOSTIC LISTS ONLY | 314 |
| Utilities and Rates | Mar-25 | ELECTRIC CHARGES FOR YSBYTY GLANCLWYD 01-31/01/2025 | 277 |
| Utilities and Rates | Mar-25 | ELECTRIC CHARGES FOR GLAN CLWYD HOSPITAL<br>ACC- 9888114523<br>01-28/02/2025 | 251 |
| Utilities and Rates | Mar-25 | ELECTRICAL CHARGES FOR MAELOR HOSPITAL 01-31/01/205 | 229 |
| Utilities and Rates | Mar-25 | ELECTRIC CHARGES FOR WREXHAM MAELOR ACCOUNT NUMBER 4625960600<br>01-28/02/2025 | 209 |

The Divisions with the highest number of PO breaches have been listed below (£'000s):

| Division | Apr-24 | May-24 | Jun-24 | Jul-24 | Aug-24 | Sep-24 | Oct-24 | Nov-24 | Dec-24 | Jan-25 | Feb-25 | Mar-25 | YTD |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| East | 119 | 86 | 70 | 75 | 86 | 64 | 76 | 94 | 55 | 68 | 57 | 66 | 916 |
| Centre | 83 | 64 | 39 | 57 | 126 | 40 | 74 | 108 | 63 | 54 | 43 | 80 | 831 |
| West | 51 | 51 | 40 | 62 | 93 | 40 | 80 | 87 | 75 | 37 | 47 | 68 | 731 |
| Regional Services | 27 | 38 | 24 | 17 | 36 | 25 | 22 | 33 | 20 | 34 | 18 | 36 | 330 |
| Mental Health & LDS | 27 | 37 | 19 | 26 | 35 | 17 | 25 | 31 | 20 | 14 | 26 | 11 | 288 |

| Expenditure Type | Q1 | Q2 | Q3 | Q4 |
|---|---|---|---|---|
| Pay (Agency, Fees etc) | 494,397 | 279,110 | 307,865 | 393,806 |
| Managed Practices | 129,987 | 136,041 | 115,372 | 42,796 |
| Non-Pay | 2,307,822 | 3,896,810 | 4,134,814 | 3,179,579 |
| **Total** | **2,932,206** | **4,311,961** | **4,558,051** | **3,606,181** |

Divisions have been reminded of the SFI requirements and to take action to ensure future breaches do not re-occur. An approved purchase order (PO) exemption list is now been issued and forms part of the updated No Purchase Order No Pay Policy on behalf of NHS Wales.

The Health Board's Oracle users are regularly reminded of the 'No PO No Pay' policy and that all staff must have approval before committing to expenditure. Reminder bulletins on procurement rules are issued in procurement communications.

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

NHS Wales Shared Services Partnership (NWSSP) have worked with the Health Board to implement a new process involving 'File Notes' to capture and record instances of procurement spend outside of the SFIs/Scheme of Reservation and Delegation (SoRD).

During Quarter 4, the number of file notes approved was 9 with a total contract value of £0.3m. The table below provides detail for each file note:

| FILE NOTE REFERENCE NO: | NAME OF SUPPLIER | DESCRIPTION OF GOODS OR SERVICES REQUIRED | REASON FOR BREACH | DEPARTMENT | CONTRACT PERIOD | TOTAL CONTRACT VALUE |
|---|---|---|---|---|---|---|
| 2425-201-FN-BCU | BMJ PUBLISHING GROUP | BMJ SUBSCRIPTION | ORDER RISED RETROSPECTIVELY – BREACHED 5K | WOD | ONE OFF | £23,161.60 |
| 2425-181-FN-BCU | TOTAL MERCHANDISE | HELP ME QUIT, BCULB PROMOTIONAL ITEMS | ORDER RISED RETROSPECTIVELY – BREACHED 5K | PRIMARY AND COMMUNITY CARE | ONE OFF | £9,245.14 |
| 2425-180-FN-BCU | INSIGHT DIRECT (UK) LTD | INSTALLATION OF ELECTRICAL CABLING AND ASSOCIATED SWITCHGEAR | BREACHED 5K THRESHOLD - SPEND COMMITED | ICT | ONE OFF | £15,010.06 |
| 2425-169-FN-BCU | EARLYYES LTD | BABIES IN MIND TRAINING – STARTING FEBRUARY 2025 | ORDER RISED RETROSPECTIVELY – BREACHED 5K | CAMHS | ONE OFF | £12,000.00 |
| 2425-162-FN-BCU | AVIDITY SCIENCE LTD | FILTER CASCADE AND UV FOR GLAN CLWYD | BREACHED 5K THRESHOLD - SPEND COMMITED | CAPITAL | ONE OFF | £9,996.20 |
| 2425-128-FN-BCU | COGNALYTIC LTD | ANNUAL LEASE / LICENCE FEE FOR MY KIT CHECK PAN BCU | BREACHED 5K THRESHOLD - SPEND COMMITED | ICT | 12 MONTHS | £11,750.00 |
| 2425-121-FN-BCU | DAISY COMMUNICATIONS | ORDER FOR RELEPHONE CALLS | ORDER RISED RETROSPECTIVELY – BREACHED 5K | ICT | ONE OFF | £7,500.00 |
| 2425-101-FN-BCU | ROYAL MAIL GROUP PLC | 2 MONTHS OF WEEKLY COLLECTIONS CALL OFF ORDER | BREACHED 5K THRESHOLD - SPEND COMMITED | ICT | 2 MONTHS | £170,000.00 |
| 2425-078-FN-BCU | SECURITAS TECHNOLOGY LTD | RENTAL, SUPPORT & MAINTENANCE OF ON-SITE PAGING SYSTEM FOR YG | RETROSPECTIVE WAIVER REQUEST RECEIVED PERIOD TO COVER ALREADY STARTED | ICT | 5 MONTHS | £15,393.24 |

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

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

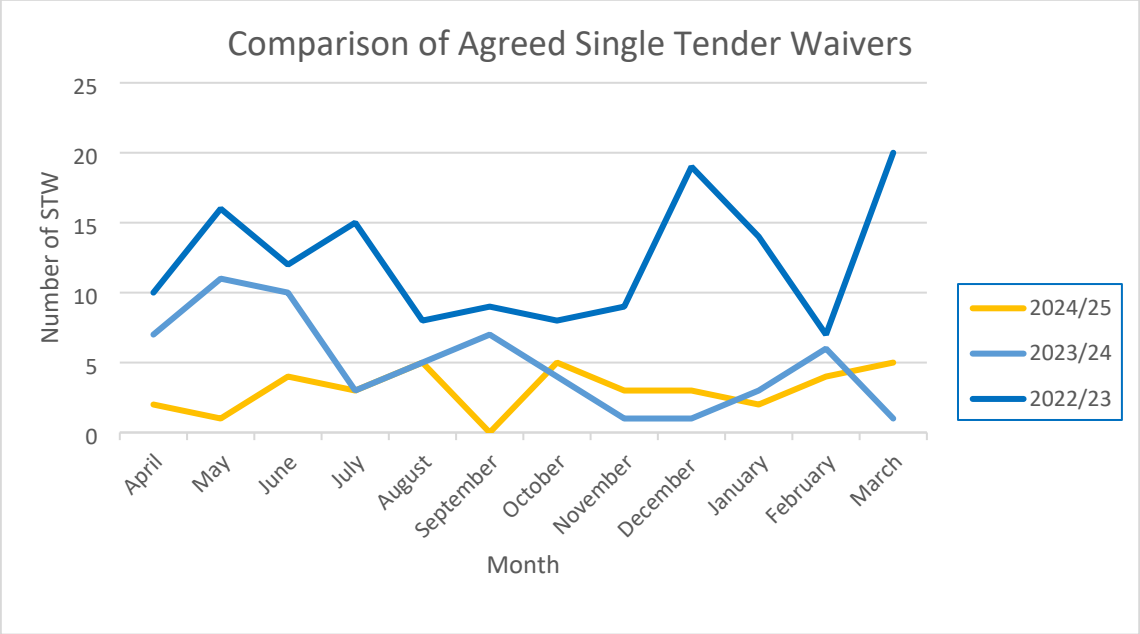
- Follow-up work where a provider has already undertaken initial work in the same area (and where the initial work was awarded from open competition);
- A technical compatibility issue which needs to be met, e.g., specific equipment required, or compliance with a warranty cover clause;
- A need to retain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

**The table below provides a summary of waiver activity for the year and the comparator data of last year.**

| Single Tender Waivers | 2023-24 Q4 | 2023-24 FYE | 2024-25 Q4 | 2024-25 FYE |
|---|---|---|---|---|
| Waivers Issued | 26 | 100 | 13 | 44 |
| Waivers Approved | 10 | 59 | 11 | 37 |
| Value of Approved Waivers | £0.6m | £4.5m | £1.8m | £4.6m |
| Waivers approval above EU Threshold | 0 | 8 | 2 | 3 |
| Cancelled Waivers | 2 | 13 | 2 | 8 |

The number of approved waivers has increased in comparison to the same period last year.

The chart below provides a monthly profile of the approvals to waive tender requirements during 2024-25, compared with 2023-24 and 2022-23. Further information is detailed in **Appendix 1**.



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

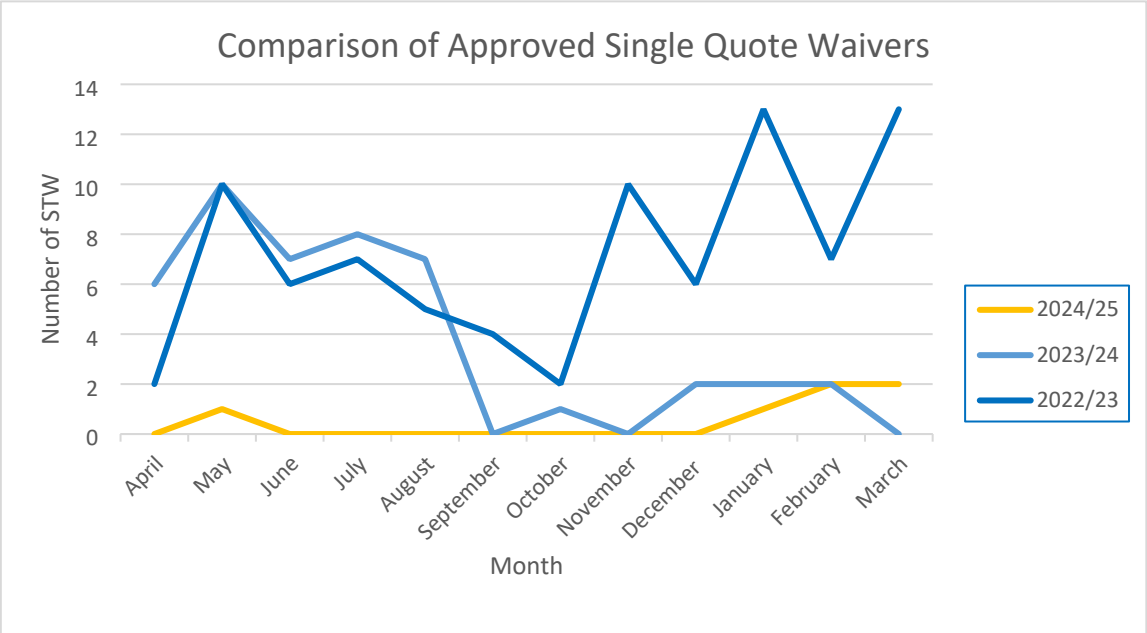
It is normal practice to obtain three quotes. Where this is not possible, then a single quote waiver should be obtained and approved ahead of expenditure being committed.

**The table below provides a summary of waiver activity for the year and the comparator data of last year.**

| Single Quote Waiver | 2023-24 Q4 | 2023-24 FYE | 2024-25 Q4 | 2024-25 FYE |
|---|---|---|---|---|
| Waivers Issued | 21 | 94 | 11 | 60 |
| Waivers Approved | 4 | 45 | 5 | 6 |
| Value of Approved Waivers | £0.05m | £0.59m | £0.06m | £0.07m |
| Cancelled Waivers | 0 | 10 | 0 | 0 |

The number of approved waivers is consistent compared to the same period last year.

The chart below provides a summary of the approvals to waive quote requirements for 2024-25, compared with 2023-24 and 2022-23. Further information is detailed in **Appendix 2**.



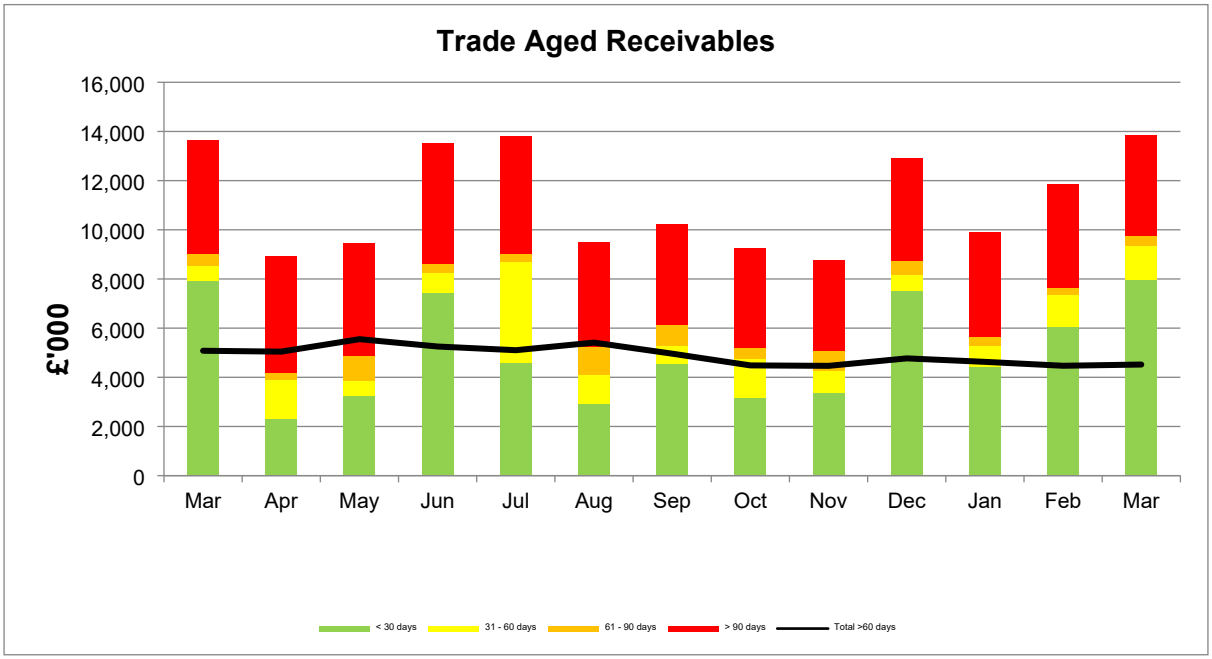
## Section 2 – Receivables and Conformance with Payroll Procedures

### a) Overview of Balances Owed

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

As at 31st March 2025, there were 3,464 outstanding invoices, totalling £13.9m, of which 973 invoices, totalling £8.0m were less than 30 days old.

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




**Provisions for bad and doubtful debts**

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

**Receivable balances over £10,000 and in excess of 6 months old as at 30th June 2024**

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

| Customer | £000's | Number of Invoices | Analysis and Further Action | Date Debt Raised |
|---|---|---|---|---|
| The Walton Centre | 202 | 10 | All queries were responded to by the Income Team. The Walton Centre is in dispute with BCU that will need to be resolved before the debt is cleared. | Jul 23 to Jul 24 |
| NHS Cheshire and Merseyside ICB | 187 | 6 | Charges were queried by the debtor. BCU has responded with evidence to support the charge in November 2024, awaiting response. | Oct 23 to Jul 24 |
| University Hospital Southampton NHS Foundation Trust | 183 | 1 | Awaiting PO – Last chased March 2025. | Sep-24 |
| St Helens and Knowsley NHS Trust | 97 | 1 | Minimal response from debtor despite chasing. Assistance has been requested from the service. | Sep-22 |
| NHS GP Practice | 77 | 1 | Approval agreed, awaiting payment. | Sep-24 |
| NHS GP Practice | 58 | 1 | Approval agreed, awaiting payment. | Mar-24 |
| Salary Overpayment | 39 | 1 | Employee and Union representative awaiting meeting – email discussion took place 2 April 2025 – BCU requested meeting arranged as soon as possible. | Dec-23 |
| Overseas Patient | 28 | 1 | This debt has been referred to CCI. | Sep-22 |
| NHS South West London ICB | 22 | 1 | AR discussing with ICB due to confusion over payment. Problem arose when changed from CCG to ICB. Invoice is outstanding. | Jan-23 |
| Overseas Patient | 20 | 1 | This debt has been referred to CCI. | Aug-22 |
| SMT Ireland Limited | 20 | 1 | Continuing to chase with minimal response. Under review for referral CCI. | Jul-24 |
| Spirit Healthcare Limited | 18 | 1 | Invoice has now been resolved, awaiting payment. | Sep-24 |
| NHS Greater Manchester ICB | 17 | 1 | After a dispute with an invoice being placed on hold, we have been informed that payment must be authorised by somebody that is currently on leave. | Oct-23 |
| Moderna Tx | 16 | 1 | Chased again February 2025. Under review for referral CCI. | Sep-24 |
| Salary Overpayment | 16 | 1 | The Counter Fraud team are now involved with this case. | Feb-22 |

| Customer | £000's | Number of Invoices | Analysis and Further Action | Date Debt Raised |
|---|---|---|---|---|
| Overseas Patient | 14 | 1 | The debtor is seeking asylum. No invoices will be paid until a decision has been made on this. | Jul-24 |
| Salary Overpayment | 12 | 1 | This debt has been referred to CCI. | Apr-24 |
| Salary Overpayment | 10 | 1 | Part credit note raised to resolve this query in February 2025. The remaining debt continues to be chased. | Feb-24 |
| Salary Overpayment | 10 | 1 | 7 days to pay letter sent end of March 2025. If unsuccessful, the next step is referral CCI. | Sep-24 |
| Private Patient | 10 | 1 | Invoice raised for charge for inpatient treatment has been referred to the patient's insurance company. Accounts Receivable are working with insurance to obtain payment, contract restraints are not making it possible to refer to CCI. | Oct-20 |
| Q4 Total<br>Q3 Total<br>Q2 Total<br>Q1 Total<br><br>Movement in current quarter | 1,513<br>1,230<br>1,061<br>1,602<br><br>283 | 41<br>40<br>38<br>43<br><br>1 | | |

- *St David's Hospice - Agreed repayment plan over a 3-year period*

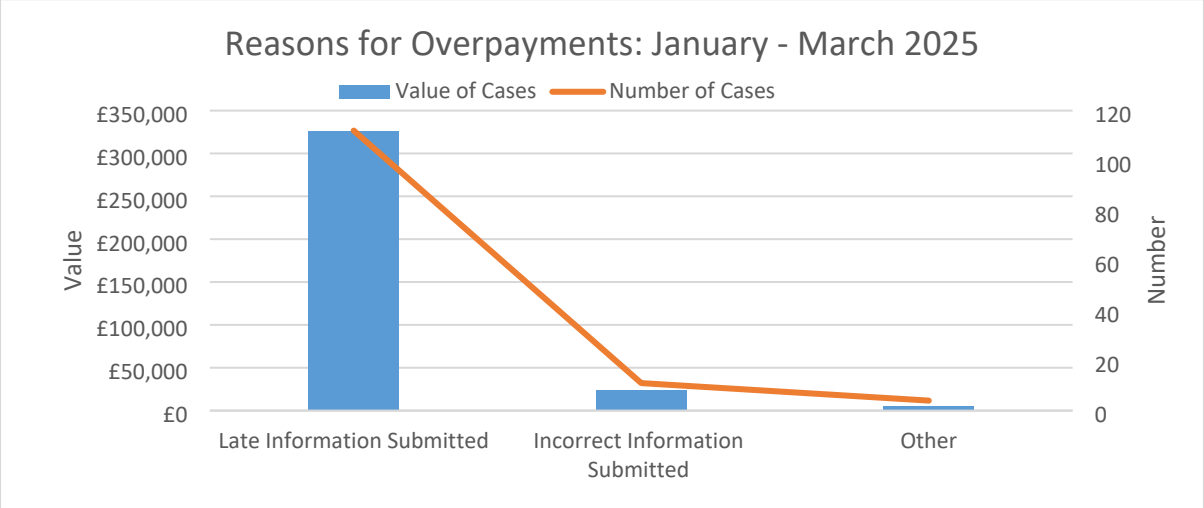
**b) Staff Overpayments**

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

| | 2023/24 Q4 | 2023/24 FYE | 2024/25 Q4 | 2024/25 FYE |
|---|---|---|---|---|
| **Number of Salary Overpayments** | 127 | 482 | 127 | 514 |
| **Value of Salary Overpayments** | £0.307m | £1.216m | £0.355m | £1.272m |

For the period January to March 2025 there were 127 staff overpayments, with a gross value of £0.355m, comparable to 127 and £0.307m in the previous Financial Year.

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




The Establishment Control (EC) team support an establishment control leaver management process.

The specific actions undertaken by the team are:

- Where an Establishment Control request details that a member of staff is leaving, the EC team send a leavers reminder e-mail. This reminds the manager to ensure they action the leaver form and consider items such as an exit questionnaire;
- There is a monthly review of EC requests which details a staff member is leaving. The team compare the details of the staff member noted on the EC request with the ESR Leavers Report and follow up the action with the EC requestor regarding why the team member hasn't moved departments or been terminated;
- The EC Team produces a monthly ESR Leavers Report, which is compared to the ESR Change Event Log by Division. This highlights the number of leavers terminated in ESR after the leaving date and is shared with Division for their information and action.

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

It should be noted that overpayments as a result of internal process failures can affect the individual's universal credits, requiring the Health Board to write off the difference to ensure individuals income are not negatively affected.

***Staff Overpayment Repayments***

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

As at 31st March 2025 the balance outstanding was £1.078m (31st March 2024 £1.235m). The debt, by collection stage, is detailed below:

| | No. of Cases | % of Total Outstanding | Value of Total Outstanding |
|---|---|---|---|
| **Agreed Instalment Plans** | 232 | 34% | £0.242m |
| **Collection Agents** | 286 | 42% | £0.389m |
| **In Dispute or Under Review** | 86 | 13% | £0.245m |
| **Reminder Stage** | 30 | 4% | £0.138m |
| **Invoice Stage** | 39 | 6% | £0.064m |

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

The extremely aged debts are there because either:

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

NHS Wales Shared Services Partnership has approved and issued an All Wales overpayment procedure that should strengthen the Health Boards current governance and processes on recovering salary overpayments. The procedure is due to progress to the People and Culture Committee for endorsement.

**Section 3 - Conformance with Losses and Special Payments Procedures**

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

The losses and special payments table below provides an overview of the losses incurred to March 2025. Clinical negligence claims account for the largest element of loss. Amounts in excess of £25,000 can be claimed from the Welsh Risk Pool Service in accordance with the risk pooling arrangements in place for NHS Wales. However, as the Welsh Risk Pool is funded from the NHS Wales healthcare budget these costs are still met by NHS Wales.

In common with the rest of the NHS, the Health Board has experienced an increase in the volume of claim activity within recent years and the table below provides information in relation to clinical negligence claims. Clinical negligence claims are managed by Legal and Risk Services and there were 316 active claims at the end of March 2025. Of these 173 matters were assessed as either probable or certain of settlement with a cumulative estimated value of £205m (before reimbursement from the Welsh Risk Pool). The table below shows the age profile of these claims.

45% of the caseload (143 matters) relate to claims in the early stages and whilst a significant number of these will be successfully defended, there are ongoing financial challenges. However, they are an indicator of future quality and require ongoing monitoring to ensure that any lessons are identified and actioned.

| Year claim registered | No of claims |
|---|---|
| 2024/25 | 77 |
| 2023/24 | 61 |
| 2022/23 | 53 |
| 2021/22 | 34 |
| 2020/21 | 37 |
| 2019/20 | 26 |
| 2018/19 | 13 |
| 2017/18 | 2 |
| 2016/17 | 3 |
| 2015/16 | 3 |
| 2014/15 | 2 |
| 2013/14 | 0 |
| 2011/12 | 1 |
| 2010/11 | 1 |
| 2009/10 | 2 |
| 2008/09 | 1 |
| **Total claims** | **316** |

**Losses and Special Payments**

| | Q1 24/25<br>£ | Q2 24/25<br>£ | Q3 24/25<br>£ | Q4 24/25<br>£ | Latest quarter analysis and further action |
|---|---|---|---|---|---|
| **Medical Negligence** | | | | | |
| Gross cost | 4,446,078 | 4,811,287 | 7,453,235 | 6,497,793 | Payments were made on 177 cases, of which 18 came under the Redress Scheme. |
| WRPS Reclaim | -3,989,599 | -4,260,545 | -6,676,066 | -5,764,116 | |
| Net Cost | 456,479 | 550,742 | 777,169 | 733,677 | |
| **Personal Injury** | | | | | |
| Gross cost | 53,115 | 81,719 | 44,898 | 80,174 | Payments were made on 49 cases. |
| WRPS Reclaim | -406 | -984 | 0 | 0 | |
| Net cost | 52,709 | 80,195 | 44,898 | 80,174 | |
| **Loss of cash** | 165 | 0 | 320 | 0 | No loss of cash was reported in Q4. |
| **Debtors written off** | 0 | 41,440 | -54 | 107.146 | Debtors are only written off as a last resort, after all means of collection have been exhausted. |
| **Loss or damage to equipment, property and stock** | 67,606 | 55,447 | 110,970 | 98,152 | Relates to the loss of Pharmacy stock due to damage, breakages or expiry and obsolete stock written off. There are plans in place to improve this performance through introducing Pharmacy Automated Vending machines and aligning controls across the Health Board. |
| **Ex-gratia payments** | 43,493 | 20,156 | 5,448 | 12,907 | Relates to 6 payments for loss/damage of patient's property, 3 ex-gratia payments and 6 ombudsman payments for delayed and unsatisfactory treatment. |
| **VERS Payments** | 0 | 0 | 0 | 0 | All payments are approved by the Remuneration Committee. |
| **Total** | **620,452** | **747,980** | **938,751** | **1,032,056** | |

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

**Section 4 – Welsh Risk Pool Penalties – Learning from Events Report**

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

WRP can levy a penalty of between £2,500 to £25,000 per case, which is recharged to divisions where the LFER or evidence is late. 66 penalties have been applied this year to date costing the Health Board £165,000.

The Health Board has implemented a new process, approved by the Executive Team in December 2024. As part of the process, data is provided to divisions on a weekly basis to support local recovery of overdue submissions in real time with the aim of clearing the backlog position by the end of June 2025.

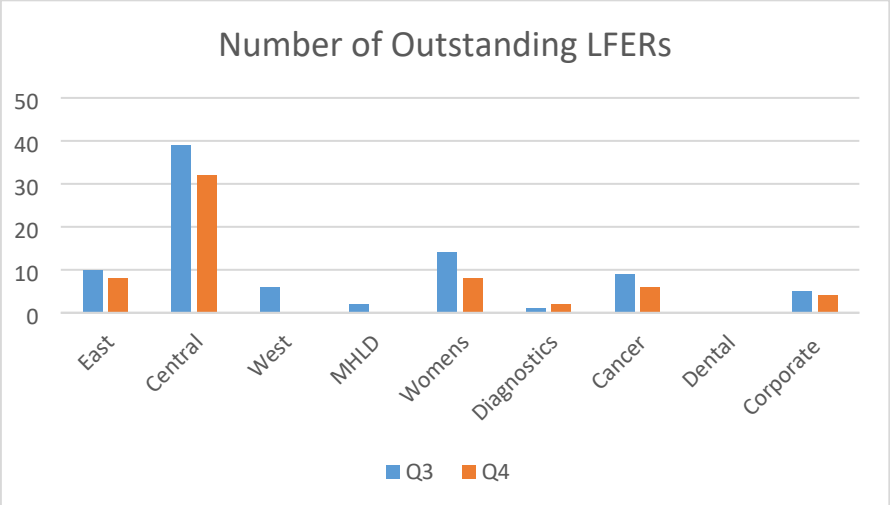
Legal Services hold a bi-weekly meeting to support and scrutinise the division's recovery efforts and performance is reported regularly to the WRP. All divisions have now embedded LFER monitoring into their governance structures.

As at 31st March 2025 the total number of outstanding LFERs was 60 (31st December 2024, 86)

The overdue LFERs, by category and division, are detailed below:

| IHC/Division | Claims | Claims Deferred | Redress | Redress Deferred | Total |
|---|---|---|---|---|---|
| East | 4 | 1 | 1 | 2 | **8** |
| Central | 14 | 9 | 7 | 2 | **32** |
| West | 0 | 0 | 0 | 0 | **0** |
| MHLD | 0 | 0 | 0 | 0 | **0** |
| Womens | 7 | 1 | 0 | 1 | **8** |
| Diagnostics | 1 | 1 | 0 | 0 | **2** |
| Cancer | 4 | 1 | 1 | 0 | **6** |
| Dental | 0 | 0 | 0 | 0 | **0** |
| Corporate | 4 | 0 | 0 | 0 | **4** |
| **Total** | **34** | **13** | **9** | **5** | **60** |

The chart below provides a summary of the outstanding LFER's per quarter:



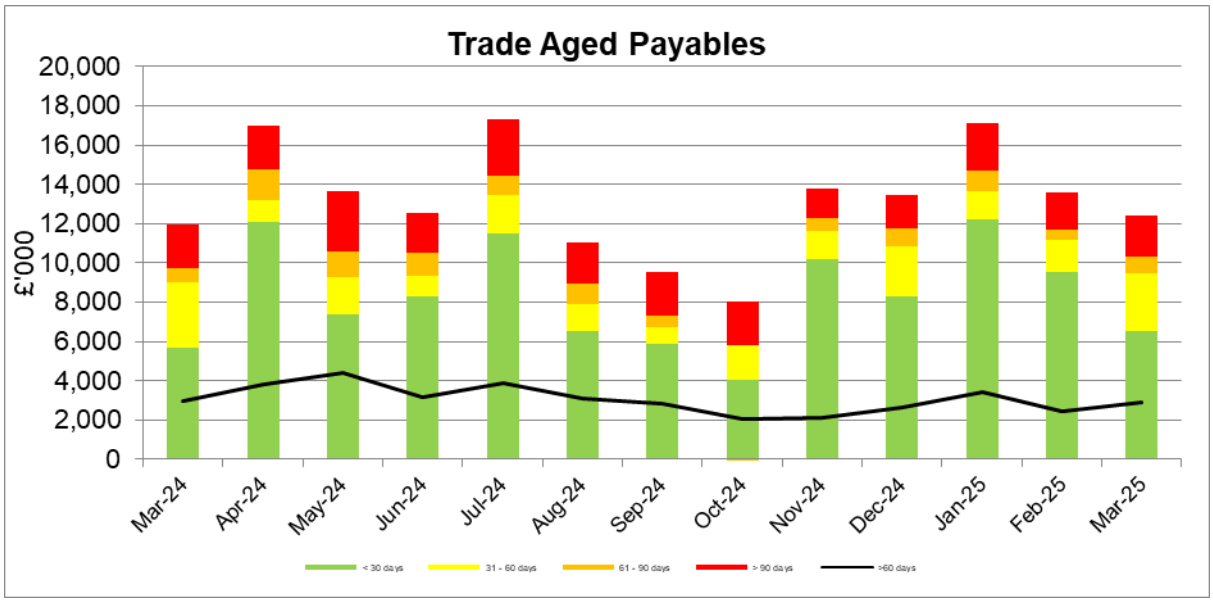
## Section 5 - Conformance with Payable Procedures

### PSPP Conformance

The Health Board aims to ensure that all balances are paid within a reasonable timeframe (or received for receivables), mainly within 30 days of receipt of a valid payable invoice (or issue of a receivables invoice). Best Practice of 95% (by number) is set for non-NHS invoices at 95%. The 2024/25 achievement for non-NHS invoices by number is 96%.

### High Value (£10,000 plus) Exceptions

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




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

**Payable balances over 6 months old and over £10,000 as at 31st March 2025**

| Supplier | £000's | No of Invoices | Analysis and further action | Invoice Date |
|---|---|---|---|---|
| Linea Partners Ltd | 245 | 12 | Invoices have been formally disputed with the company; the Health Board has sought legal advice. BCU has won the legal case, Invoices will be cancelled | Jul - Oct 23 |
| Medtronic Ltd | 71 | 3 | Duplicate invoices, supplier has been contacted for credits | Jul 22, Mar 23 & Feb 24 |
| Flintshire County Council | 50 | 2 | Additional requisition has been raised as insufficient value on PO, still awaiting final approval. VAT query, awaiting resolution | Apr 24 & Sep 24 |
| Natural UK Ltd | 44 | 1 | Full credit requested, awaiting response from supplier | Jul-24 |
| RMS Imaging LTD | 35 | 2 | No valid PO, requistioner has been chased, awaiting a response. | Aug 24 & Sep 24 |
| Treherne Care Services Ltd | 24 | 1 | Invoice disputed, the Local Authority is the lead provider for the package of care, the patient was admitted to hospital and 24 hr care provided but no approval was sought. | Sep-24 |
| B Braun | 22 | 1 | Initial delay due to the PO being raised to the incorrect supplier, issue resolved but there is a shortfall on the PO. The requisitioner is investigating as an additional requisition should have been raised. | Aug-24 |
| Abbott Medical Ltd | 21 | 2 | Price query raised; supplier has been asked for a part credit | Jun 24 |
| Johnson & Johnson Medical Ltd | 14 | 1 | Awaiting part credit from the supplier, once received the invoice can be paid | Jul 24 |
| Stryker UK Ltd | 14 | 1 | Invoice in price query, chased procurement to see if any resolution | Aug-24 |
| Vantive Ltd | 12 | 1 | Invoice has been queried numerous times with the supplier, as yet no response has been received | Apr-24 |
| Becton Dickson UK Ltd | 12 | 1 | Requisitioner states goods have not been received, supplier has been contacted to request a proof of delivery. Company is unable to provide PoD due to the length of time. Refer to management for advice | Sep-22 |

## Appendix 2 - Approved Single Tender Waivers >£25K between 1st January – 31st March 2025

| Ref No. | Date of Financial Approval | Area | Name of Supplier | Description | Rationale | Value £000s | Supported By Procurement | Procurement Advice | Breached OJEU |
|---|---|---|---|---|---|---|---|---|---|
| 2024/2025-1495 | 15/01/2025 | IHC West (Secondary Care - YG) | Fannin | Currently we use a suction device to capture all waste product thus reducing any infection risk and also reducing any further manual handling risks/tasks. Device is now obsolete; no further items can replace it the company have told us. For some time Stryker Neptune has been the monopoly market for this product but we have now found an alternative product by VacSax which is primarily exactly the same, it is cheaper, much lighter than the previous machine (further reducing any manual handling risks by twisting and stretching) and also the company support and service has been superior to Stryker. The item is essential to the surgical procedure however it would be beneficial to the board having a cheaper alternative. Unfortunately, I have been re-directed down this route via Charlie Pritchard as the Ireceptical by VacSax is not on the UK framework and it was recommended I put it through an ewaiver form. | Follow on from previous waiver | £44,820.00 | Accept | This waiver request is to facilitate a commitment agreement between BCUHB and Fannin UK Ltd for the free of charge placement of a Vacsax iReceptal surgical suction management system in YG Theatres. BCUHB must commit to purchase a minimum of 600 manifolds per annum for use with the system over an agreed 3-year period. The price per manifold is £24.90 (ex VAT) and therefore the total spend committed across the 3-year period is £44,820.00 (ex VAT). For comparison, the renewal proposal from the incumbent provider was £29.50 (ex VAT) per manifold, equating to £53,100.00 (ex VAT) across the same 3-year term.<br><br>The device used currently is no longer serviceable and this alternative product has been identified as a new market offering. As a new product, the iReceptal manifolds are not currently available to purchase via any existing frameworks. Given the cost-saving opportunity and urgent need for a replacement device, a single tender waiver has been recommended on this occasion. Procurement will add this product to a future workplan to review the market position and establish a compliant procurement route ahead of this agreement expiring to avoid any recurring waivers. | No |

| Ref No. | Date of Financial Approval | Area | Name of Supplier | Description | Rationale | Value £000s | Supported By Procurement | Procurement Advice | Breached OJEU |
|---|---|---|---|---|---|---|---|---|---|
| 2024/2025-1518 | 20/01/2025 | IHC Centre (Secondary Care - YGC) | Leica Microsystems | 3-year Service contract for the 2 microscopes sited in Ophthalmology Theatres Abergele. | Maintenance | £47,100.00 | Accept | Procurement support this Waiver request due to the Sole Supplier nature of the requirement. Leica are deemed the Original Engineering Manufacturer and therefore must carry out the Service and Maintenance of these items to ensure operational compliance in line with the item specifications.<br><br>The Health Board are unable to replace these items due to Capital Funding pressures and require a fully comprehensive cover package from the OEM to ensure continued operationally.<br><br>Sam Hughes, Assistant Procurement Business Manager- 20/01/2025 | Np |
| 2024/2025-1529 | 04/02/2025 | Charitable Funds | Day Break Medical | Ellex Tango Reflex Yag/SLT Laser with Yag Vitreolysis capability | Other (please specify) - £12,995 discount on purchase | £40,000.00 | Accept | Procurement accepts this waiver request as this is for the purchase of equipment that is already in situ on a rental basis. Clinical preference is to remain with this equipment and the supplier has offered the Health Board a discounted price to purchase the loaned device outright. Charitable funding has been allocated to enable this. A direct purchase is therefore the only option to progress this due to the equipment already being in situ on a rental agreement. | No |

| Ref No. | Date of Financial Approval | Area | Name of Supplier | Description | Rationale | Value £000s | Supported By Procurement | Procurement Advice | Breached OJEU |
|---|---|---|---|---|---|---|---|---|---|
| 2024/2025-1532 | 17/02/2025 | Women's Services | Lon Solutions | Baby Tagging Alarm System | Other (please specify) - BCUHB are currently with provider Lon Solutions for their Baby Tagging Security System across the 3 x sites Maternity and Neonatal units. It would cost too much to implement an alternative solution which would outweigh any savings potential with a new supplier. | £42,819.00 | Accept | Procurement supports this waiver on the basis of sole supplier. The baby tagging system is a closed protocol system already in place with Lon Solutions and no other suppliers would be able to interact with or maintain the system.<br><br>Last year's single year maintenance contract was below quote thresholds and as such was exercised via MutliQuote to approach the market. In that instance no other suppliers returned quotes due to the closed protocol nature of the system.<br><br>Waiver is being sought to put in place a longer-term maintenance contract for BCU alongside additional server upgrade works to the closed protocol system. | No |
| 2024/2025-1533 | 18/02/2025 | IHC Centre (Secondary Care - YGC) | NANOG Dental Implant Team | To provide diagnostic Cone Beam CT scan for oral, maxillofacial and Orthodontic patients requiring CT images | Interim arrangement pending tender | £29,618.00 | Accept | Procurement supports this waiver on the basis that this is an interim arrangement to ensure continuity of service whilst a tender exercise is to be undertaken for future.<br><br>Emma Burns - Procurement Business Manager | No |

| Ref No. | Date of Financial Approval | Area | Name of Supplier | Description | Rationale | Value £000s | Supported By Procurement | Procurement Advice | Breached OJEU |
|---|---|---|---|---|---|---|---|---|---|
| 2024/2025-1534 | 17/02/2025 | Corporate | New Medica | Completion of care pathways for cataract procedures beyond April 2025 | Follow-up work from previous open competition procurement | £985,000.00 | Accept | Procurement support this waiver on the basis of continuity of care for patients. A recent sourcing exercise was performed using the NWSSP framework agreement and New Medica provided the best value option and were awarded the contract at that time. This is a continuation of that service - Emma Burns, Procurement Business Manager | Yes |

| Ref No. | Date of Financial Approval | Area | Name of Supplier | Description | Rationale | Value £000s | Supported By Procurement | Procurement Advice | Breached OJEU |
|---|---|---|---|---|---|---|---|---|---|
| 2024/2025-1537 | 10/03/2025 | Capital | CRL Surveys | Specialist Concrete Structure surveying and report provision. | Other (please specify) - Recommendation from external Structural Engineer consultant, due to the specialist and critical nature of the survey work. | £35,795.00 | Accept | Procurement supports the waiver due to the specialist nature of the works required.<br><br>BCUHB have obtained independent advice from external consultant Ramboll (appointed via SBS framework) in relation to the redevelopment works at the Royal Alex Hospital which advises the appointment of CRL as contractors to undertake specialist structural work to the existing listed building on site at the Royal Alex.<br><br>Due to the specialist nature very few suppliers are able to complete the works required. Ramboll have previously worked with CRL on other projects and are confident that they have the skills and expertise to undertake the works and to support keeping the RAH development on schedule.<br><br>Failure to undertake these would impact upon the overall redevelopment programme of works.<br>An assessment on value has been conducted by Ramboll | No |

| Ref No. | Date of Financial Approval | Area | Name of Supplier | Description | Rationale | Value £000s | Supported By Procurement | Procurement Advice | Breached OJEU |
|---|---|---|---|---|---|---|---|---|---|
| 2024/2025-1538 | 03/03/2025 | Secondary Care - Managed Clinical Support | Leica Biosystems | Maintenance of Leica Scanscopes for Cellular Pathology | Maintenance | £41,659.64 | Accept | NWSSP Procurement support the use of a waiver process for this requirement due to the sole supplier nature of this maintenance agreement. Leica are the OEM for this equipment and therefore possess the necessary skills and qualifications to carry out this maintenance in line with the requirement.<br><br>This contract term also allows NWSSP Procurement the ability to review spend with this supplier and look to implement a compliant process that covers a longer term across a number of departments. | No |
| 2024/2025-1541 | 12/03/2025 | Corporate | Better Care | LMS, Training and content for ePMA | Genuinely one provider | £82,436.00 | Accept | Sole supplier - Better Care are the current provider of the ePMA system (BCU-MIN-54633). System has been developed by Better Care and therefore no other supplier would have the knowledge or expertise to deliver training and supporting content. | No |

| Ref No. | Date of Financial Approval | Area | Name of Supplier | Description | Rationale | Value £000s | Supported By Procurement | Procurement Advice | Breached OJEU |
|---|---|---|---|---|---|---|---|---|---|
| 2024/2025-1542 | 18/03/2025 | Corporate | ID MEDICAL | Implementation of rapid dermatology clinics at alternative sites across the Heath Board footprint, where room capacity has been identified. Weekend and extended weekday clinic hours to maximise throughput. This initiative will take place over a concentrated six-week period, from the week commencing 25th February 2025 to 31st March 2025, with the objective of clearing approximately 1,000 urgent patient cases. Due to the increased throughput in a shortened timeframe, there may be a requirement for the provider to support additional Inflammatory Nurse Led Clinic's to avoid overwhelming Health Board services and pro-longing patient waits for follow up appointments. | Other (please specify) - We are currently in an active contract with this provider, who has agreed to deliver additional sessions before the end of March. This arrangement is necessary to create additional capacity to treat patients at risk of breaching the 104-week waiting time target. Engaging an alternative provider at this stage would not be feasible within the required timeframe, as it would introduce delays and operational disruptions. Therefore, a Single Tender Waiver is requested to ensure continuity of service and compliance with patient waiting time targets. | £200,000.00 | Accept | Procurement supports the following waiver, a tender exercise (BCU-MIN-56710) was undertaken to appoint the dermatology requirement to ID Medical. The Health Board have completed a contract change notice for the requirement and are only looking to extend the scope of the service and not the total value of the contract, a VEAT notice is not required. The Framework utilised does allow for direct award, however this is on a ranked basis where ID medical are not the ranked 1 provider. Engaging an alternative provider would pose a clinical risk and would not deliver the appropriate course of action for the Health Board. | No |

| Ref No. | Date of Financial Approval | Area | Name of Supplier | Description | Rationale | Value £000s | Supported By Procurement | Procurement Advice | Breached OJEU |
|---|---|---|---|---|---|---|---|---|---|
| 2024/2025-1543 | 13/03/2025 | Secondary Care - Managed Clinical Support | J F HUNT POWER LTD / J F HUNT FUELS LTD | Hire of a Specialist High Energy Power Generator and fuel deliveries - to power the mobile PET-CT scanning unit. After Covid crisis - the generator use / hire was extended due to the need to provide additional MRI scanning capacity on a mobile unit as well. The generator is required ongoing to power the displaced PET-Scanner - this service is crucial as part of a 10-day Cancer Scanning pathway commissioned nationally by JCC (formerly WHSSC) - (BCUHB being the North Wales provider).<br><br>A separate business case was made to seek capital to provide a fixed power point from the mains supply at YGC (and move the mobile scanner there) - however this has been excluded due to the lack of power available at the site (and unlikely to be so for the duration of this e-waiver). All other location options with suitable mains supply have been excluded with capital estates. The generator supplied is specialist in nature - and works well - we are seeking to extend the use by not having to Tender - the current supplier is a national market leader in specialist generators - and most likely only suitable supplier based on the previous waiver / quotes received during end of the Covid period. | Follow on from previous waiver | £295,000.00 | Accept | Procurement support this waiver as this relates to an existing generator on hire at YGC and has previously been waivered.<br><br>A new procurement process to comply with SFIs would have significant impact upon the CT scanning service on site as any new contractor would have to install their own generator resulting in downtime of service.<br><br>Additionally the installation & removal of old generator would cost the health board.<br><br>Having discussed this requirement with the end users Procurement are content this should be the final waiver whilst planning takes place for the works which will remove the requirement going forward. | Yes |

## Appendix 3 - Approved Single Quote Waivers >£25K between 1st January – 31st March 2025

| Ref No. | Date of Financial Approval | Area | Name of Supplier | Description | Rationale | Value £000s | Supported By Procurement | Procurement Advice |
|---|---|---|---|---|---|---|---|---|
| 2024/2025-1521 | 02/01/2025 | IHC East (Area East) | Probo Medical | Replacement X-porte scan engine for the Sonosite X-porte s/n 049KCH | Compatibility Issue (e.g. warranty cover clause or specific equipment) | £11,379.00 | Accept | Probo Medical are the contracted maintenance provider for this device. This repair is not within scope of the maintenance contract, therefore this is an additional charge. This repair must, however, be completed by Probo as any third-party involvement with the device would jeopardise the maintenance agreement. We are therefore unable to compete the spend on this occasion. |
| 2024/2025-1526 | 04/02/2025 | IHC East (Area East) | S-MED | SOMNOtouch RESP Add-on Device | Compatibility Issue (e.g., warranty cover clause or specific equipment) | £13,360.00 | Accept | Procurement supports this waiver request as this purchase is for additional equipment for use with an existing system. Alternatives cannot be considered for standardisation, training and compatibility reasons. It is therefore not possible to compete the spend on this occasion and a waiver is the appropriate route. |
| 2024/2025-1527 | 11/02/2025 | IHC West (Secondary Care - YG) | Securitas Technology | Rental, Support and maintenance of on-site paging system at Ysbyty Gwynedd Bangor to cover the period 1st March 2025 to 30th May 2025 pending the migration to the new Multitone paging system and payment of invoices on time | Genuinely one provider | £7,696.62 | Accept | Procurement supports this waiver as an interim arrangement to ensure continuity of service whilst the new paging system is implemented |
| 2024/2025-1536 | 20/03/2025 | IHC Centre (Secondary Care - YGC) | Royal National Institute for the Blind | Provision of an Eye Clinical Liaison Officer full time with an extension to current contract until 31st March 2024 to support the Ophthalmic patients with sight loss. Crucial to the service and within the recommendations of the Royal College of Ophthalmologist guidelines for AMD | Genuinely one provider | £24,290.00 | Accept | Previous Waivers include 2023/2024-1340, 2024/2025-1515, 2023/2024-1252. Procurement have worked with the department to develop the specification requirement but have not been in a position to publish the tender. A further extension is required to allow the service to continue whilst the tender exercise is underway. |

| Ref No. | Date of Financial Approval | Area | Name of Supplier | Description | Rationale | Value £000s | Supported By Procurement | Procurement Advice |
|---|---|---|---|---|---|---|---|---|
| 2024/2025-1544 | 13/03/2025 | Secondary Care - Managed Clinical Support | Siemens | Max Wi-D Wireless Detector | Compatibility Issue (e.g. warranty cover clause or specific equipment) | £7,500.00 | Accept | Procurement supports this waiver request as there is a current maintenance contract in place for this equipment with this provider. The new detector is being offered at a discounted rate as a result of this. Alternatives cannot be considered as they would not be compatible with the equipment, therefore it is not possible to compete the spend on this occasion. |

| | |
|---|---|
| **Teitl adroddiad:**<br>***Report title:*** | **Conformance Report: Q1 2025/26** |
| **Adrodd i:**<br>***Report to:*** | Audit Committee |
| **Dyddiad y Cyfarfod:**<br>***Date of Meeting:*** | Tuesday, 19 August 2025 |
| **Crynodeb Gweithredol:**<br><br>***Executive Summary:*** | This conformance report provides an update to the Committee on areas that relate to regulatory compliance or assurance and good practice expectations.<br><br>The areas covered in this report are:<br><br>• **Purchase orders that are non-compliant with SFI's (April to June 2025)**<br><br>This data set relates to orders being raised after the invoice has been received.<br><br>Non-compliance for the period is 181 in April, 273 in May and 239 in June 2025. The total 693 breaches during quarter 1 (Q1) is an improvement compared to 758 in Q1 2024-25. A significant proportion of the orders are for known expenditure such as out of are treatment, utilities charges, external contracts, and contractual clinical services, however, the variable nature of the volume means that retrospective orders are produced.<br><br>The Health Board's Oracle users are regularly reminded of the 'No PO No Pay' policy and that all staff must have approval before committing to expenditure.<br><br>An approved purchase order (PO) exemption list is now been issued and forms part of the updated No Purchase Order No Pay Policy on behalf of NHS Wales.<br><br>NHS Wales Shared Services Partnership (NWSSP) have worked with the Health Board to implement a new process involving 'File Notes' to capture and record instances of procurement spend outside of the SFIs/Scheme of Reservation and Delegation (SoRD).<br><br>During Quarter 1, the number of file notes approved was 10 with a total contract value of £0.1m.<br><br>• **Single Waivers (April to June 2025)**<br><br>The number of waivers issued year to date has significantly decreased compared to this period last year.<br><br>Single Tenders – 5 approved in Q1, compared to 7 last year.<br><br>Single Quote – 3 approved in Q1, compared to 1 last year.<br><br>• **Receivables and conformance with payroll procedures**<br><br>The Health Board has procedures in place to ensure that balances owed to the Health Board are invoiced promptly. Escalation procedures are in place to ensure that debtors are collected in a timely manner or highlighted for further action. |

As at 30th June 2025, there were 3,277 outstanding invoices, totalling £12.1m, of which 568 invoices, totalling £5.2m were less than 30 days old.

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

For the period April to June 2025 there were 124 staff overpayments, with a gross value of £0.272m, comparable to 163 and £0.413m in the previous Financial Year. Failure to complete forms on time remains the main cause of overpayments (116 cases). Staff overpayment breaches are included in service/area monthly management reports and discussed as part of the budget monitoring process in order to improve future compliance.

As at 30th June 2025 the balance outstanding was £1.061m, compared to £1.222m at 30th June 2024.

- **Payables and conformance with Public Sector Payment Policy (PSPP)**

  The Health Board aims to ensure that all balances are paid within 30 days of receipt of a valid payable invoice. Best Practice (by number) is set at 95%. The 2025-26 year-to-date achievement for non-NHS invoices by number is 97%.

- **Losses and special payments**

  Losses and special payments should be exceptional in nature. The Health Board must administer losses in accordance with procedures set out by Welsh Government. Individual losses in excess of £50,000 require approval from the Welsh Government (£1,000,000 in the case of negligence claims).

  Clinical negligence claims account for the largest element of loss. Amounts in excess of £25,000 can be claimed from the Welsh Risk Pool Service in accordance with the risk pooling arrangements in place for NHS Wales. However, as the Welsh Risk Pool is funded from the NHS Wales healthcare budget these costs are still met by NHS Wales.

  Clinical negligence claims are managed by Legal and Risk Services and there were 356 active claims at the end of June 2025. Of these 186 matters were assessed as either probable or certain of settlement with a cumulative estimated value of £216m (before reimbursement from the Welsh Risk Pool).

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

  As at 30th June 2025 the number of claims outstanding is 12. This shows a reduction of 48 in the quarter.

- **Chairs Action in Quarter 1 2025/26**
  There were no Chairs actions in relation to financial compliance during the period.

| | |
|---|---|
| | • **Contract Procurement Review Update**<br>In total 16 finance procedures have been reviewed and updated over the last year and 4 new procedures have been written, approved and implemented. One policy remains outstanding, this has been reviewed and updated and will be circulated for wider consultation prior to being presented for approval.<br><br>Contract Register – Health Board staff are working in partnership with an external software solutions company to create a pan-BCU document and records management system for contracts. This is currently with the external company and is at the development stage using Microsoft SharePoint as the basis for the system. The use of SharePoint will allow for future internal maintenance and support without the need for significant additional upkeep costs. |
| **Argymhellion:**<br><br>***Recommendations:*** | The Audit Committee is asked to:<br>1. To note and discuss the below elements of performance<br>• Purchase orders that are non-compliant with SFI's<br>• Single Waivers<br>• Receivables and conformance with payroll procedures<br>• Payables and conformance with Public Sector Payment Policy (PSPP)<br>• Welsh Risk Pool Penalties – Learning from Events Report<br>• Contract Procurement Review Update<br>2. Approve the Losses and Special Payments (April to June 2025) |
| **Arweinydd Gweithredol:**<br>***Executive Lead:*** | Russel Caldicott, Interim Executive Director of Finance |
| **Awdur yr Adroddiad:**<br>***Report Author:*** | Denise Roberts, Head of Capital, Business Improvement and Compliance |

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

| | | | | |
|---|---|---|---|---|
| **Lefel sicrwydd:**<br><br>***Assurance level:*** | Arwyddocaol<br>*Significant*<br>☐ | Derbyniol<br>*Acceptable*<br>☒ | Rhannol<br>*Partial*<br>☐ | Dim Sicrwydd<br>*No Assurance*<br>☐ |
| | Lefel uchel o hyder/tystiolaeth o ran darparu'r mecanweithiau / amcanion presennol<br><br>*High level of confidence/evidence in delivery of existing mechanisms/objectives* | Lefel gyffredinol o hyder/tystiolaeth o ran darparu'r mecanweithiau / amcanion presennol<br><br>*General confidence / evidence in delivery of existing mechanisms / objectives* | Rhywfaint o hyder/tystiolaeth o ran darparu'r mecanweithiau / amcanion presennol<br><br>*Some confidence / evidence in delivery of existing mechanisms / objectives* | Dim hyder/tystiolaeth o ran y ddarpariaeth<br><br>*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:**<br><br>***Link to Strategic Objective(s):*** | Standing Orders, Standing Financial Instructions and the Scheme of Reservation and Delegation are designed to ensure that expenditure is committed in line with stipulated governance and incurred on the intended purpose. |
| **Goblygiadau rheoleiddio a lleol:**<br>***Regulatory and legal implications:*** | Areas of identified non-conformance highlight risk of failing to meet regulatory and legal requirements, and expected good practice. Mitigating actions are designed to manage highlighted risks effectively. |
| **Yn unol â WP7, a oedd EqlA yn angenrheidiol ac a gafodd ei gynnal?**<br>***In accordance with WP7 has an EqlA been identified as necessary and undertaken?*** | Not applicable |
| **Yn unol â WP68, a oedd SEIA yn angenrheidiol ac a gafodd ei gynnal?**<br>***In accordance with WP68, has an SEIA identified as necessary been undertaken?*** | Not applicable |
| **Manylion am risgiau sy'n gysylltiedig â phwnc a chwmpas y papur hwn, gan gynnwys risgiau newydd (croesgyfeirio at y BAF a'r CRR)**<br><br>***Details of risks associated with the subject and scope of this paper, including new risks( cross reference to the BAF and CRR)*** | BAF: 2.3 & CRR 24-05 – Delivery of the Annual Financial Plan. |
| **Goblygiadau ariannol o ganlyniad i roi'r *argymhellion ar waith***<br>***Financial implications as a result of implementing the recommendations*** | Management of financial risk of not achieving value for money. |
| **Goblygiadau gweithlu o ganlyniad i roi'r argymhellion ar waith**<br>***Workforce implications as a result of implementing the recommendations*** | None |
| **Adborth, ymateb a chrynodeb dilynol ar ôl ymgynghori**<br>***Feedback, response, and follow up summary following consultation*** | Not applicable |
| **Cysylltiadau â risgiau BAF:**<br>(neu gysylltiadau â'r Gofrestr Risg Gorfforaethol)<br>***Links to BAF risks:***<br>*(or links to the Corporate Risk Register)* | BAF: 2.3 & CRR 24-05 – Delivery of the Annual Financial Plan. |
| **Rheswm dros gyflwyno adroddiad i fwrdd cyfrinachol (lle bo'n berthnasol)**<br>***Reason for submission of report to confidential board (where relevant)*** | Not applicable |
| **Camau Nesaf:**<br>**Gweithredu argymhellion**<br>***Next Steps:***<br>***Implementation of recommendations***<br>• ***The report is for noting and, in the case of losses and special payments, approval*** | |
| **Rhestr o Atodiadau:**<br>***List of Appendices:***<br>1. Appendix 1: Conformance Report – Quarter 1 (April to June 2025)<br>2. Appendix 2: Approved Single Tender Waivers between 1st April – 30th June 2025<br>3. Appendix 3: Approved Single Quote Waivers between 1st April – 30th June 2025 | |

**Appendix 1: Conformance Report – Quarter 1 (April to June 2025).**

**Section 1 - Conformance with Procurement Procedures**

**a) SFI requirements**

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

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

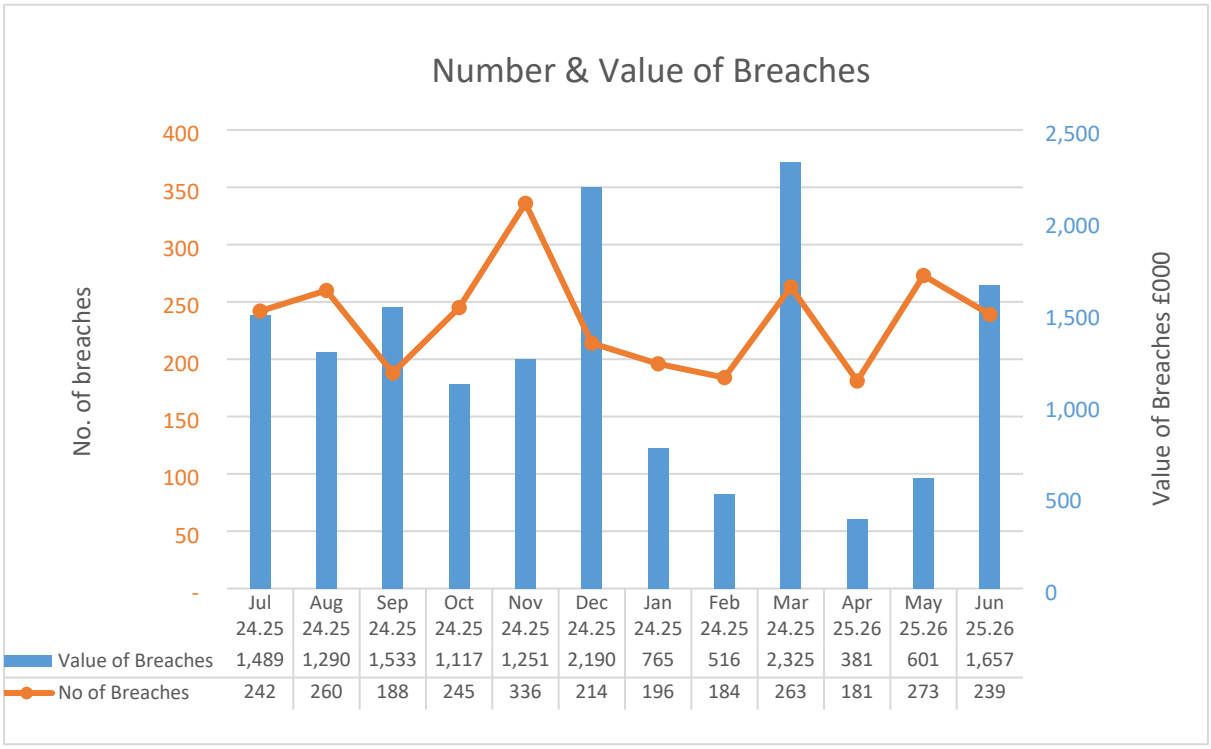
*Exemptions apply (see SFIs)

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

**b) Purchase Orders**

The use of a formal purchase order system is a key control to ensure expenditure is only committed following proper approval and all committed expenditure is recorded. The trend in the graph below shows that there has been a 27% decrease in the value of Purchase Order breaches in quarter 1 (Q1), with 693 breaches reported with a value of £2.6m. During the same period last Financial Year, the number of breaches were 758 with a value of £2.9m.

The value and number of breaches between July 2024 and June 2025 are detailed below:



Of the 'No PO (Purchase Order) No Pay' breaches, the 5 individual orders with the highest value for Q1 are as follows:

| Division | Month of Breach | Item Description | PO Amount £000's |
|---|---|---|---|
| Mental Health & LDS | Jun-25 | OOA PLACEMENTS OF WEST MH PATIENTS | 364 |
| Health Community East | Jun-25 | PERITONEAL DIALYSIS PATIENT VISITS - VANTIVE | 151 |
| Health Community West | Jun-25 | INSOURCING ENDOSCOPY FOR INVOICE 6912203 | 118 |
| Health Community East | May-25 | 2 MONTHS OF DAILY ROYAL MAIL COLLECTIONS FOR WEEKLY INVOICES | 114 |
| Health Community East | Jun-25 | 2 MONTHS OF DAILY ROYAL MAIL COLLECTIONS FOR WEEKLY INVOICES | 97 |

The Divisions with the highest number of PO breaches have been listed below (£'000s):

| Division | Jul-24 | Aug-24 | Sep-24 | Oct-24 | Nov-24 | Dec-24 | Jan-25 | Feb-25 | Mar-25 | Apr-25 | May-25 | Jun-25 | YTD |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| East | 75 | 86 | 64 | 76 | 94 | 55 | 68 | 57 | 66 | 77 | 87 | 67 | 231 |
| Centre | 57 | 126 | 40 | 74 | 108 | 63 | 54 | 43 | 80 | 45 | 76 | 101 | 222 |
| West | 62 | 93 | 40 | 80 | 87 | 75 | 37 | 47 | 68 | 53 | 59 | 57 | 169 |
| Regional Services | 17 | 36 | 25 | 22 | 33 | 20 | 34 | 18 | 36 | 10 | 35 | 21 | 66 |
| Mental Health & LDS | 26 | 35 | 17 | 25 | 31 | 20 | 14 | 26 | 11 | 11 | 22 | 17 | 50 |

| | 2024-25 | | | 2025-26 |
|---|---|---|---|---|
| **Expenditure Type** | **Q2** | **Q3** | **Q4** | **Q1** |
| Pay (Agency, Fees etc) | 279,110 | 307,865 | 393,806 | 233,105 |
| Managed Practices | 136,041 | 115,372 | 42,796 | 39,166 |
| Non-Pay | 3,896,810 | 4,134,814 | 3,179,579 | 2,365,783 |
| **Total** | **4,311,961** | **4,558,051** | **3,606,181** | **2,638,054** |

Divisions have been reminded of the SFI requirements and to take action to ensure future breaches do not re-occur. An approved purchase order (PO) exemption list is now been issued and forms part of the updated No Purchase Order No Pay Policy on behalf of NHS Wales.

The Health Board's Oracle users are regularly reminded of the 'No PO No Pay' policy and that all staff must have approval before committing to expenditure. Reminder bulletins on procurement rules are issued in procurement communications.

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

NHS Wales Shared Services Partnership (NWSSP) have worked with the Health Board to implement a new process involving 'File Notes' to capture and record instances of procurement spend outside of the SFIs/Scheme of Reservation and Delegation (SoRD).

During Quarter 1, the number of file notes approved was 10 with a total contract value of £3.3m. The table below provides detail for each file note:

| FILE NOTE REFERENCE NO: | NAME OF SUPPLIER | DESCRIPTION OF GOODS OR SERVICES REQUIRED | REASON FOR BREACH | DEPARTMENT | CONTRACT PERIOD | TOTAL CONTRACT VALUE |
|---|---|---|---|---|---|---|
| 2526-004-FN-BCU | PERINATAL INSTITUTE | RENEWAL FOR GAP LICENCE | EXTENDED WITHOUT APPROPRIATE AUTHORISATION | IT | 12 MONTHS | £5,625.00 |
| 2526-006-FN-BCU | MOSTYN HOUSE MEDICAL CENTRE | GENERAL PRACTITIONER HOURS TO THE ACADEMY FOR DR DEWI GOULDEN EDUCATION AND TRAINING TIME UNDER THE GP+ PROGRAMME FOR 2024/25 | EXTENDED IN EXCESS OF SFI ALLOWABLE LIMITS | PRIMARY AND COMMUNITY CARE | 12 MONTHS | £6,300.00 |
| 2526-010-FN-BCU | HEALTH EDGE SOLUTIONS LTD | HESSDA SILVER SLA (SERVICE LEVEL AGREEMENT)-WREXHAM | COMPETITION NOT SOUGHT IN ACCORDANCE WITH SFIS | IT | 12 MONTHS | £13,413.16 |
| 2526-012-FN-BCU | KIT LOG LTD | MONTHLY SUBSCRIPTION RENEWAL, PAPERTRAIL 30TH APRIL 2025 - APRIL 2026 | COMPETITION NOT SOUGHT IN ACCORDANCE WITH SFIS | IT | 12 MONTHS | £12,000.00 |
| 2526-032-FN-BCU | MICROCLEAN LTD | MICRONCLEAN CALL OFF ORDER FINANCIAL YEAR 25/26 | COMPETITION NOT SOUGHT IN ACCORDANCE WITH SFIS | PHARMACY | 12 MONTHS | £25,000.00 |
| 2526-041-FN-BCU | WINNCARE PAC LTD TA WINNCARE | ORDER OF MATRESSES AV111 AVON PRESSURE REDUCING MATRESS | COMPETITION NOT SOUGHT IN ACCORDANCE WITH SFIS | NURSING | ONE OFF | £6,000.00 |
| 2526-042-FN-BCU | SIEMENS HEALTHCARE LTD | DICOM CONNECTIONS | COMPETITION NOT SOUGHT IN ACCORDANCE WITH SFIS | RADIOLOGY | ONE OFF | £11,738.00 |
| 2526-046-FN-BCU | ELECTRONIC POINT OF CARE | EPOC MONITOR SERVER MAINTENANCE | COMPETITION NOT SOUGHT IN ACCORDANCE WITH SFIS | IT | 24 MONTHS | £38,377.50 |
| 2526-052-FN-BCU | KSD VOICE LTD | PROVISION OF SPECIALIST CISCO UNIFOED COMMUNICATIONS SUPPORT | EXTENDED IN EXCESS OF SFI ALLOWABLE LIMITS | IT | ONE OFF | £6,000.00 |
| 2526-078-FN-BCU | INTENSIVE CARE NATIONAL AUDIT & RESEARCH CENTER | CASE MIX PROGRAMME ANNUAL SUBSCRIPTION | COMPETITION NOT SOUGHT IN ACCORDANCE WITH SFIS | CRITIAL CARE | 12 MONTHS | £5,837.96 |

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

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

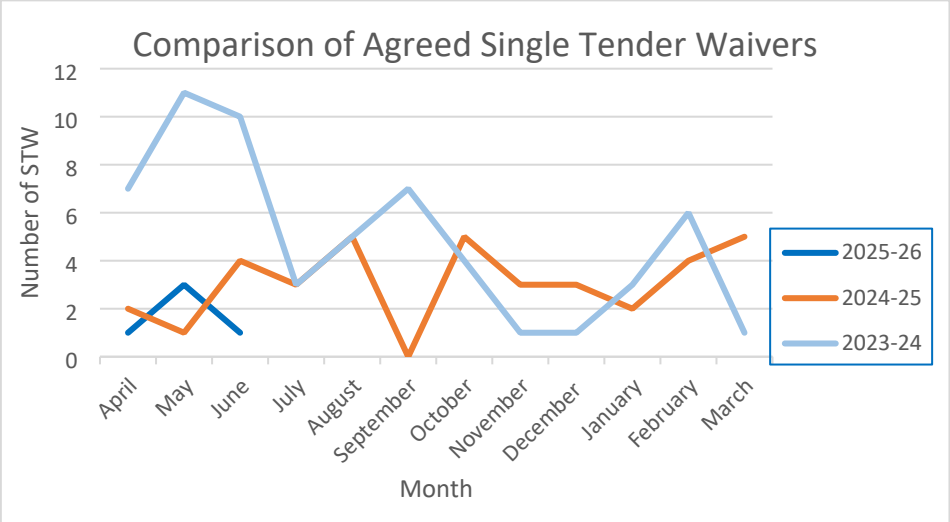
- Follow-up work where a provider has already undertaken initial work in the same area (and where the initial work was awarded from open competition);
- A technical compatibility issue which needs to be met, e.g., specific equipment required, or compliance with a warranty cover clause;
- A need to retain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

**The table below provides a summary of waiver activity for the year and the comparator data of last year.**

| Single Tender Waiver | 2024-25 Q1 | 2024-25 FYE | 2025-26 Q1 |
|---|---|---|---|
| Waivers Issued | 11 | 44 | 8 |
| Waivers Approved | 7 | 37 | 5 |
| Value of Approved Waivers | £0.3m | £4.6m | £0.3m |
| Waivers approval above EU Threshold | 0 | 3 | 1 |
| Cancelled Waivers | 2 | 8 | 2 |

The number of approved waivers has decreased significantly in comparison to the same period last year.

The chart below provides a monthly profile of the approvals to waive tender requirements during 2025-26, compared with 2024-25 and 2023-24. Further information is detailed in **Appendix 1**.



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

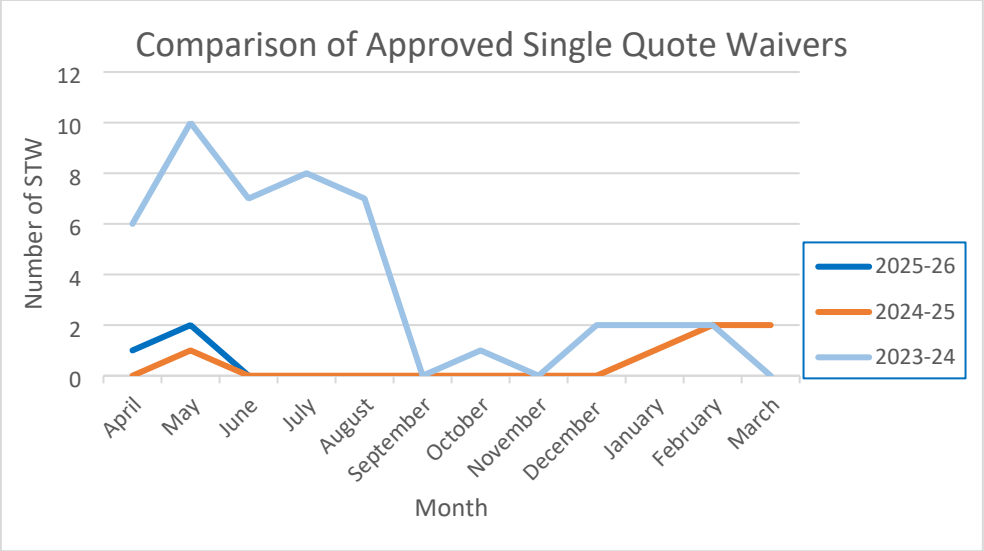
It is normal practice to obtain three quotes. Where this is not possible, then a single quote waiver should be obtained and approved ahead of expenditure being committed.

**The table below provides a summary of waiver activity for the year and the comparator data of last year.**

| **Single Quote Waiver** | **2024-25 Q1** | **2024-25 FYE** | **2025-26 Q1** |
|---|---|---|---|
| Waivers Issued | 17 | 60 | 13 |
| Waivers Approved | 1 | 6 | 3 |
| Value of Approved Waivers | £0.01m | £0.07m | £0.03m |
| Cancelled Waivers | 0 | 0 | 1 |

The number of approved waivers is consistent compared to the same period last year.

The chart below provides a summary of the approvals to waive quote requirements for 2025-26, compared with 2024-25 and 2023-24. Further information is detailed in **Appendix 2**.



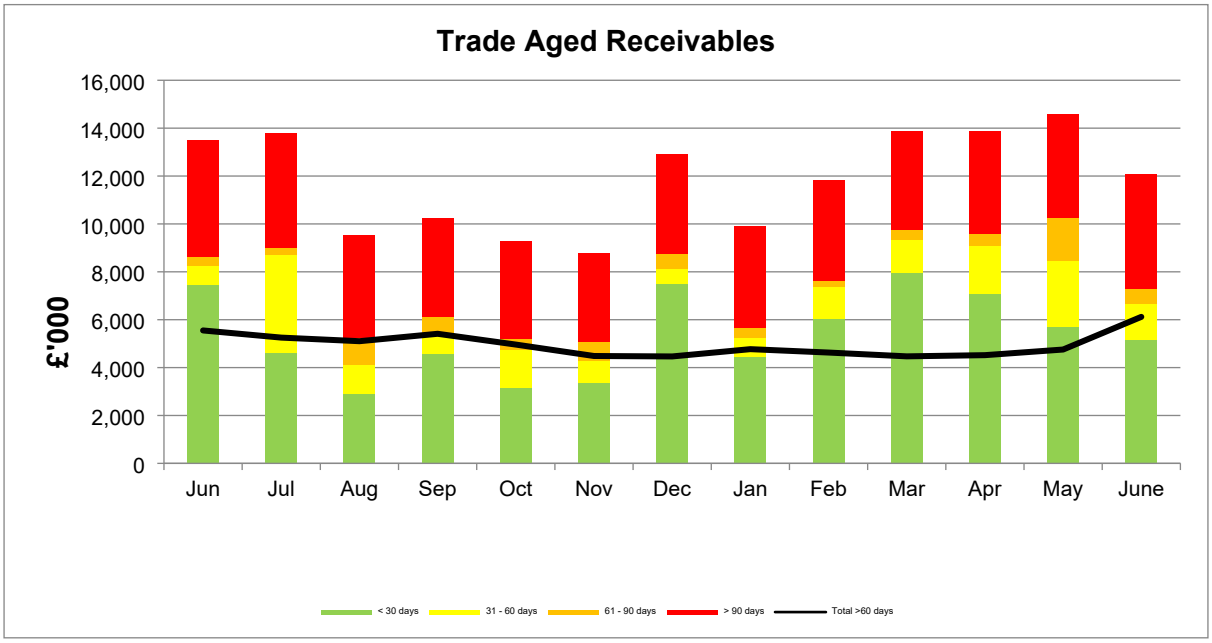
## Section 2 – Receivables and Conformance with Payroll Procedures

### a) Overview of Balances Owed

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

As at 30th June 2025, there were 3,277 outstanding invoices, totalling £12.1m, of which 568 invoices, totalling £5.2m were less than 30 days old.

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




**Provisions for bad and doubtful debts**

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

**Receivable balances over £10,000 and in excess of 6 months old as at 30th June 2025**

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

| Customer | £000's | Number of Invoices | Analysis and Further Action | Date Debt Raised |
|---|---|---|---|---|
| The Walton Centre | 202 | 10 | All queries were responded to by the Income Team. The Walton Centre is in dispute with BCU that will need to be resolved before the debt is cleared. | Jul 23 to Jul 24 |
| NHS Cheshire and Merseyside ICB | 141 | 6 | Charges were queried by the debtor. BCU has responded with evidence to support the charge in November 2024, last chased July 2025. | Oct 23 to Jul 24 |
| University Hospital Southampton NHS Foundation Trust | 183 | 1 | Invoice credited July 2025 due to incorrect value. Amended invoice has been raised. | Sep-24 |
| ST Helens & Knowsley Hospitals NHS Trust | 97 | 1 | Minimal response from debtor dispute chasing. Details have been forwarded to North West Lead Employer Deanery. | Sep-22 |
| Salary Overpayment | 39 | 1 | Discussions ongoing between BCU Senior Workforce colleagues and Union Representative. | Dec-23 |
| Overseas Patient | 28 | 1 | Debt has been referred to CCI. | Sep-22 |
| NHS South West London ICB | 35 | 2 | Accounts Receivable Team discussing with ICB due to confusion over payment. Problem arose during transition from CCG to ICB. Original invoice has been credited and replacement invoiced raised to ICB which remains outstanding. Additional Invoice in relation to LAC currently under discussion with Income Team. | Jan 23 to Oct 24 |
| Overseas Patient | 20 | 1 | This debt has been referred to CCI. | Aug-22 |
| SMT Ireland Limited | 20 | 1 | Continuing to chase with minimal response. Under review for referral CCI. | Jul-24 |
| NHS Greater Manchester ICB | 17 | 1 | Ongoing query in discussion between ICB and Income Team. | Oct-23 |
| Salary Overpayment | 16 | 1 | Discussions ongoing between BCU Senior Workforce colleagues. Awaiting further information from the employee. | Feb-22 |
| Overseas Patient | 14 | 1 | Invoice placed on hold until such time that the outcome of Asylum is confirmed. | Jul-24 |
| Salary Overpayment | 12 | 1 | This debt has been referred to CCI. | Apr-24 |
| Salary Overpayment | 10 | 1 | Awaiting further information from employee regarding affordability. Once received, an appropriate repayment plan will be proposed. | Feb-24 |

| Customer | £000's | Number of Invoices | Analysis and Further Action | Date Debt Raised |
|---|---|---|---|---|
| Salary Overpayment | 10 | 1 | Debt has been referred to CCI. | Sep-24 |
| Private Patient | 10 | 1 | Invoice raised for charge for inpatient treatment has been referred to the patient's insurance company. Accounts Receivable are working with insurance to obtain payment, contract restraints are not making it possible to refer to CCI. | Oct-20 |
| NHS GP Practice | 58 | 1 | Practice have confirmed that outstanding invoices will be paid following receipt of payment from BCU. | Mar-24 |
| NHS GP Practice | 21 | 1 | Practice have confirmed that outstanding invoices will be paid following receipt of payment from BCU. | Dec-24 |
| University of Manchester School of Medical Sciences | 81 | 4 | Payment agreed August 2025. | Oct 24 to Dec 24 |
| Nutricia LTD | 57 | 1 | Accounts Receivable Team continue to chase. | Dec-24 |
| NHS Shropshire Telford and Wrekin ICB | 11 | 1 | Invoice consistently being chased by Accounts Receivable with minimal response. ICB have confirmed that invoice is on hold for validation. | Oct-24 |
| Salary Overpayment | 17 | 1 | Accounts Receivable Team liaising with Service and Workforce colleagues. Employee is working to reduce overpayment. | Dec-24 |
| Salary Overpayment | 11 | 1 | This debt has been referred to CCI. Regular payments are being made. | Nov-21 |
| Moderna Tx | 16 | 1 | Accounts Receivable Team continue to chase. Reminder letters have been emailed and posted. Service is in contact with supplier. | Sep-24 |
| Q1 Total | 1,583 | 49 | | |
| **2024-25** | | | | |
| Q4 Total | 1,513 | 41 | | |
| Q3 Total | 1,230 | 40 | | |
| Q2 Total | 1,061 | 38 | | |
| Movement in current quarter | 70 | 8 | | |

- *St David's Hospice - Agreed repayment plan over a 3-year period.*

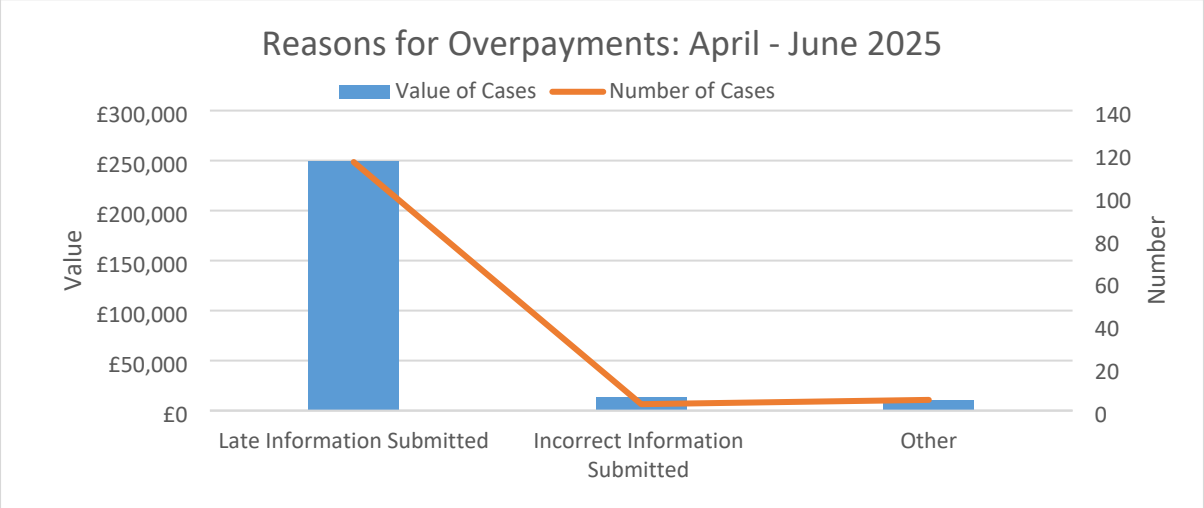
### b) Staff Overpayments

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

| | 2024-25 Q1 | 2024-25 FYE | 2025-26 Q1 |
|---|---|---|---|
| **Number of Salary Overpayments** | 163 | 514 | 124 |
| **Value of Salary Overpayments** | £0.413m | £1.272m | £0.272m |

For the period April to June 2025 there were 124 staff overpayments, with a gross value of £0.272m, comparable to 163 and £0.413m in the previous Financial Year.

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




The Establishment Control (EC) team support an establishment control leaver management process.

The specific actions undertaken by the team are:

- Where an Establishment Control request details that a member of staff is leaving, the EC team send a leavers reminder e-mail. This reminds the manager to ensure they action the leaver form and consider items such as an exit questionnaire;
- There is a monthly review of EC requests which details a staff member is leaving. The team compare the details of the staff member noted on the EC request with the ESR Leavers Report and follow up the action with the EC requestor regarding why the team member hasn't moved departments or been terminated;
- The EC Team produces a monthly ESR Leavers Report, which is compared to the ESR Change Event Log by Division. This highlights the number of leavers terminated in ESR after the leaving date and is shared with Division for their information and action.

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

It should be noted that overpayments as a result of internal process failures can affect the individual's universal credits, requiring the Health Board to write off the difference to ensure individuals income are not negatively affected.

***Staff Overpayment Repayments***

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

As at 30th June 2025 the balance outstanding was £1.061m (31st March 2025 £1.078m). The debt, by collection stage, is detailed below:

| | No. of Cases | % of Total Outstanding | Value of Total Outstanding |
|---|---|---|---|
| **Agreed Instalment Plans** | 256 | 37% | £0.407m |
| **Collection Agents** | 283 | 41% | £0.417m |
| **In Dispute or Under Review** | 68 | 10% | £0.109m |
| **Reminder Stage** | 48 | 7% | £0.076m |
| **Invoice Stage** | 34 | 5% | £0.052m |

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

The extremely aged debts are there because either:

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

NHS Wales Shared Services Partnership has approved and issued an All Wales overpayment procedure that should strengthen the Health Boards current governance and processes on recovering salary overpayments. The procedure is due to progress to the People and Culture Committee for endorsement.

**Section 3 - Conformance with Losses and Special Payments Procedures**

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

The losses and special payments table below provides an overview of the losses incurred to June 2025. Clinical negligence claims account for the largest element of loss. Amounts in excess of £25,000 can be claimed from the Welsh Risk Pool Service in accordance with the risk pooling arrangements in place for NHS Wales. However, as the Welsh Risk Pool is funded from the NHS Wales healthcare budget these costs are still met by NHS Wales.

In common with the rest of the NHS, the Health Board has experienced an increase in the volume of claim activity within recent years and the table below provides information in relation to clinical negligence claims. Clinical negligence claims are managed by Legal and Risk Services and there were 356 active claims at the end of June 2025. Of these 186 matters were assessed as either probable or certain of settlement with a cumulative estimated value of £216m (before reimbursement from the Welsh Risk Pool). The table below shows the age profile of these claims.

48% of the caseload (170 matters) relate to claims in the early stages and whilst a significant number of these will be successfully defended, there are ongoing financial challenges. However, they are an indicator of future quality and require ongoing monitoring to ensure that any lessons are identified and actioned.

| Year claim registered | No of claims |
|---|---|
| 2025/26 | 14 |
| 2024/25 | 88 |
| 2023/24 | 64 |
| 2022/23 | 58 |
| 2021/22 | 39 |
| 2020/21 | 38 |
| 2019/20 | 27 |
| 2018/19 | 13 |
| 2017/18 | 2 |
| 2016/17 | 3 |
| 2015/16 | 3 |
| 2014/15 | 2 |
| 2013/14 | 0 |
| 2011/12 | 1 |
| 2010/11 | 1 |
| 2009/10 | 2 |
| 2008/09 | 1 |
| **Total claims** | **356** |

**Losses and Special Payments**

| | Q2 24/25<br>£ | Q3 24/25<br>£ | Q4 24/25<br>£ | Q1 25/26<br>£ | Latest quarter analysis and further action |
|---|---|---|---|---|---|
| **Medical Negligence** | | | | | |
| Gross cost | 4,811,287 | 7,453,235 | 6,497,793 | 6,104,839 | Payments were made on 160 cases, of which 10 came under the Redress Scheme. |
| WRPS Reclaim | -4,260,545 | -6,676,066 | -5,764,116 | -5,280,925 | |
| Net Cost | 550,742 | 777,169 | 733,677 | 823,914 | |
| **Personal Injury** | | | | | |
| Gross cost | 81,719 | 44,898 | 80,174 | 297,831 | Payments were made on 52 cases. |
| WRPS Reclaim | -984 | 0 | 0 | -209,528 | |
| Net cost | 80,195 | 44,898 | 80,174 | 88,303 | |
| **Loss of cash** | 0 | 320 | 0 | 0 | No loss of cash was reported in Q1 |
| **Debtors written off** | 41,440 | -54 | 107.146 | 0 | No debtors write offs have been processed in Q1 |
| **Loss or damage to equipment, property and stock** | 55,447 | 110,970 | 98,152 | 87,841 | Relates to the loss of Pharmacy stock due to damage, breakages or expiry and obsolete stock written off. There are plans in place to improve this performance through introducing Pharmacy Automated Vending machines and aligning controls across the Health Board. |
| **Ex-gratia payments** | 20,156 | 5,448 | 12,907 | 50,541 | Relates to 12 payments for loss/damage of patient's property, 3 employment tribunal and 3 ombudsman payments for delayed and unsatisfactory treatment and 1 payment for compensation relating to a data breach. |
| **VERS Payments** | 0 | 0 | 0 | 0 | All payments are approved by the Remuneration Committee. |
| **Total** | **747,980** | **938,751** | **1,032,056** | **1,050,599** | |

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

**Section 4 – Welsh Risk Pool Penalties – Learning from Events Report**

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

WRP can levy a penalty of between £2,500 to £25,000 per case, which is recharged to divisions where the LFER or evidence is late. 8 penalties have been applied this year to date costing the Health Board £20,000. The total number of penalties during 2024-25 was 66 at a cost to the Health Board of £165,000.

The Health Board has implemented a new process, approved by the Executive Team in December 2024. As part of the process, data is provided to divisions on a weekly basis to support local recovery of overdue submissions in real time.

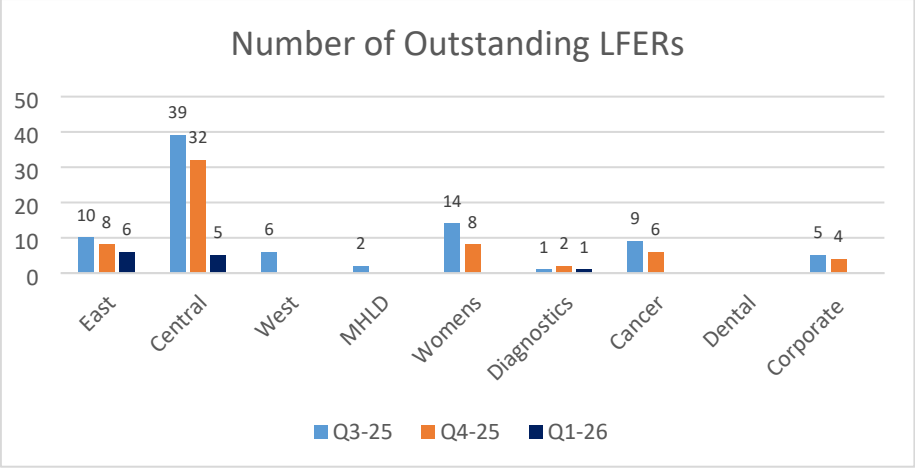
Legal Services hold a bi-weekly meeting to support and scrutinise the division's recovery efforts and performance is reported regularly to the WRP. All divisions have now embedded LFER monitoring into their governance structures.

As at 30th June 2025 the total number of outstanding LFERs was 12 (31st March 2025, 60).

The overdue LFERs, by category and division, are detailed below:

| IHC/Division | Claims | Claims Deferred | Redress | Redress Deferred | Total |
|---|---|---|---|---|---|
| East | 2 | 3 | 1 | 0 | 6 |
| Central | 2 | 2 | 0 | 1 | 5 |
| West | 0 | 0 | 0 | 0 | 0 |
| MHLD | 0 | 0 | 0 | 0 | 0 |
| Womens | 0 | 0 | 0 | 0 | 0 |
| Diagnostics | 1 | 0 | 0 | 0 | 1 |
| Cancer | 0 | 0 | 0 | 0 | 0 |
| Dental | 0 | 0 | 0 | 0 | 0 |
| Estates | 0 | 0 | 0 | 0 | 0 |
| **Total** | **5** | **5** | **1** | **1** | **12** |

The chart below provides a summary of the outstanding LFER's per quarter:



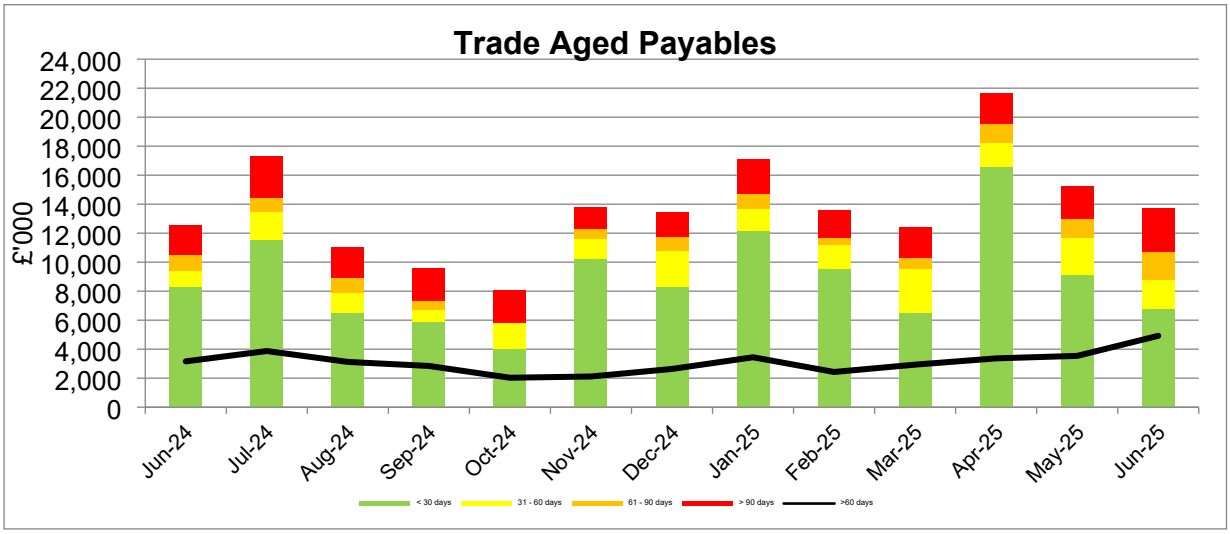
## Section 5 - Conformance with Payable Procedures

### PSPP Conformance

The Health Board aims to ensure that all balances are paid within a reasonable timeframe (or received for receivables), mainly within 30 days of receipt of a valid payable invoice (or issue of a receivables invoice). Best Practice of 95% (by number) is set for non-NHS invoices at 95%. The year-to-date achievement for non-NHS invoices by number is 97%.

### High Value (£10,000 plus) Exceptions

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




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

**Payable balances over 6 months old and over £10,000 as at 30th June 2025**

| Supplier | £000's | No of Invoices | Analysis and further action | Invoice Date |
|---|---|---|---|---|
| CHS Healthcare Software Ltd | 76 | 1 | Insufficient value on PO, awaiting PO approval for additional requisition | Nov-24 |
| Flintshire County Council | 51 | 1 | Additional PO has been raised, requisitioner has been asked to receipt | Dec-24 |
| Medtronic Ltd | 45 | 3 | Duplicate invoices, supplier has been contacted requesting credits | Mar 23, Feb 24 & Dec 24 |
| Natrual UK Ltd | 44 | 1 | Full credit requested, awaiting response from supplier | Jul-24 |
| RMS Imaging LTD | 35 | 2 | AP asked to review previous invoices, possible matching issue and shortfall on PO | Aug 24 & Sep 24 |
| Treherne Care Services Ltd | 37 | 2 | Invoice disputed, the Local Authority is the lead provider for the package of care, the patient was admitted to hospital and 24 hr care provided but no approval was sought. | Sep & Oct 24 |
| Vantive Ltd | 36 | 3 | Invoice has been queried numerous times with the supplier, as yet no response has been received | Apr, Nov & Dec 24 |
| Pintec Solutions Ltd | 25 | 1 | Emailed end user as the PO has not been receipted, requested reason for non-payment | Nov-24 |
| Abbott Medical Ltd | 21 | 2 | Price query raised; supplier has been asked for a part credit | Jun 24 |
| Becton Dickson UK Ltd | 12 | 1 | Requisitioner states goods have not been received, supplier has been contacted to request a proof of delivery. Company is unable to provide PoD due to the length of time. Refer to management for advice | Sep-22 |
| Liaison Financial Services Ltd | 10 | 1 | Aged invoice recently received, forwarded to approver to establish if the invoice is valid and if a PO will be raised | Oct-24 |
| Stryker UK Ltd | 10 | 1 | Awaiting credit from supplier | Nov-24 |

**Appendix 2 - Approved Single Tender Waivers >£25K between 1st April – 30th June 2025**

| Ref No. | Date of Financial Approval | Area | Name of Supplier | Description | Rationale | Value £000s | Supported By Procurement | Procurement Advice | Breached FTS |
|---|---|---|---|---|---|---|---|---|---|
| 2024/2025-1548 | 01/04/2025 | Secondary Care - Managed Clinical Support | Ibex Medical Analytics Ltd | Subscription renewal for Ibex Prostate Artificial Intelligence software application (awaiting All-Wales digital pathology procurement. | Interim arrangement pending tender | £28,434.07 | Accept | Procurement supports this waiver as an interim arrangement whilst the All-Wales digital pathology procurement is been complete. NHS Executive are providing the funding via the Welsh Government transformation fund. | No |
| 2025/2026-1554 | 02/05/2025 | Secondary Care - Managed Clinical Support | Haemonetics | Renewal of licence and maintenance support for blood dispensing hardware and software interfaces. Procurement strategy document attached and existing service quote + 5%. No other option to procure as required compatibility with LIMS and LIMS 2.0 interfaces and existing hardware. | Compatibility Issue (e.g., warranty cover clause or specific equipment) | £65,112.50 | Accept | Procurement supports this e-waiver on the basis of compatibility with the future All Wales LIMS System. There is no available public sector framework for this product and therefore, in order to ensure that there is a transfusion system in place to align with LIMS go live dates there is no other option than to support an ewaiver. | No |

| Ref No. | Date of Financial Approval | Area | Name of Supplier | Description | Rationale | Value £000s | Supported By Procurement | Procurement Advice | Breached FTS |
|---|---|---|---|---|---|---|---|---|---|
| 2025/2026-1555 | 09/05/2025 | Estates and Facilities | Static Systems Group Ltd | This STW is to cover for the first year of maintenance on the newly upgraded fire alarm system at the Ysbyty Gwynedd site as part of the warranty agreement. | Maintenance | £55,000.00 | Accept | Procurement supports this waiver on the basis that Static Systems is the installer, manufacturer and maintainer of this closed protocol fire alarm system at Ysbyty Gwynedd following an upgrade. The waiver request pertains to services covered under the manufacturer's 12-month warranty, which commenced following the fire alarm system upgrade completed last year. The supplier is the sole authorised provider for this closed protocol system, and no alternative vendors are permitted to perform warranty-related services or system modifications. Engaging any third party would risk voiding the warranty and compromising system integrity. Therefore, the waiver is justified on the basis of sole source supply. Approval of this waiver will allow the manufacturer or their authorised representative to carry out the necessary work in accordance with the warranty terms, ensuring continuity of service and compliance with warranty conditions. | No |

| Ref No. | Date of Financial Approval | Area | Name of Supplier | Description | Rationale | Value £000s | Supported By Procurement | Procurement Advice | Breached FTS |
|---|---|---|---|---|---|---|---|---|---|
| 2025/2026-1556 | 13/05/2025 | Secondary Care - Managed Clinical Support | Checkit | Connected Automated Monitoring Plus (CAM+) Peace of Mind Annual Subscription for service critical temperature monitoring and systems support | Compatibility Issue (e.g., warranty cover clause or specific equipment) | £46,777.61 | Accept | Procurement Services support this waiver request due to the sole supplier nature of the requirement. Checkit are to be deemed as the sole supplier and using a third-party supplier would lead to potential compatibility issues.<br><br>Following discussion with the department, it has been advised that this 12-month period will allow time for Procurement Services to align Checkit Maintenance agreements across the Health Board, with the aim to consolidate spend and initiate a longer-term agreement for potential cost and efficiency savings.<br><br>Sam Hughes- APBM<br>14/05/2025 | No |
| 2025/2026-1564 | 17/06/2025 | Secondary Care - Managed Clinical Support | Leica Biosystems | Renal of GT450 digital scanning solution to be compatible with All Wales Digital Cellular Pathology Group. 24 Month Lease period. | Compatibility Issue (e.g., warranty cover clause or specific equipment) | £119,425.92 | Accept | Follow on from waiver 601. Only Leica can provide and service this equipment as it is required to be compatible with the existing Histology equipment. This is pending the completion of an All Wales solution which has been delayed pending approval of a business case by Welsh Government. It is expected that this contract will take two years to complete once the Business Case has been approved. On this basis, Procurement Services supports this waiver. | Yes |

**Appendix 3 - Approved Single Quote Waivers >£25K between 1st April – 30th June 2025**

| Ref No. | Date of Financial Approval | Area | Name of Supplier | Description | Rationale | Value £000s | Supported By Procurement | Procurement Advice |
|---|---|---|---|---|---|---|---|---|
| 2024/2025-1550 | 06/05/2025 | IHC Centre (Secondary Care - YGC) | HICOM TECHNOLOGY LTD | 6 Month contract extension and Data migration from Diabetes Management System. 2 development days | Maintenance | £5,500.00 | Accept | Procurement supports this waiver as an interim arrangement to ensure continuity of service and access to historical patient data to continue to manage ongoing patient management. This is also required to ensure the historical data is transferred internally so no further system contract would be required in future. |
| 2025/2026-1553 | 15/04/2025 | Secondary Care - Managed Clinical Support | Bracco | Maintenance of radiology injectors and co2 insufflators | Maintenance | £11,794.00 | Accept | This request is fully supported. There is no alternative service provider due to the specialist nature of the equipment. Bracco are not currently included on the NHS Supply Chain framework so only option is direct award.<br><br>Helen Conners - Category Officer, Maintenance Team |
| 2025/2026-1557 | 20/05/2025 | IHC East (Area East) | Checkit Europe Ltd | Annual support contract for temperature monitoring system as detailed in quote Q-08490 (attached) | Genuinely one provider | £13,820.55 | Accept | Procurement Services support this waiver request due to the sole supplier nature of the requirement. Checkit are to be deemed as the sole supplier and using a third-party supplier would lead to potential compatibility issues.<br><br>Following discussion with the department, it has been advised that this 12-month period will allow time for Procurement Services to align Checkit Maintenance agreements across the Health Board, with the aim to consolidate spend and initiate a longer-term agreement for potential cost and efficiency savings.<br><br>Sam Hughes- APBM |

| | |
|---|---|
| **Teitl adroddiad:**<br><br>***Report title:*** | Internal Audit Progress Report 23 April – 31 July 2025 |
| **Adrodd i:**<br><br>***Report to:*** | Audit Committee |
| **Dyddiad y Cyfarfod:**<br><br>***Date of Meeting:*** | 19 August 2025 |
| **Crynodeb Gweithredol:**<br><br>***Executive Summary:*** | <u>Progress report</u><br>The progress report is produced in accordance with:<br>• the requirements as set out within *Global Internal Audit Standard 11.3: Communicating Results*.<br>• the *Welsh Government NHS Wales Audit Committee Handbook – Section 4.5 Reviewing internal audit assignment reports.*<br>The progress report summarises thirteen reviews finalised since the last Committee meeting in May 2025, with the recorded assurance as follows:<br>• Reasonable assurance – five<br>• Limited assurance – five<br>• Unsatisfactory assurance - one<br>• Assurance rating not applied – two<br>The report also includes information on draft reports issued and work in progress as well as a request for the Committee to approve amendments to the 2025/26 internal audit plan. |
| **Argymhellion:**<br><br>***Recommendations:*** | The Committee is asked to:<br><br>**Progress report**<br>• Receive the progress report.<br>**Plan**<br>• Approve the following amendments to the internal audit plan for 2025/26:<br>o Removal from the plan:<br>▪ Skills and Capabilities (BCU-2526-14).<br>▪ Productivity and Efficiency (BCU-2526-18).<br>▪ Capital Systems (BCU-SSU-2526-33).<br>▪ Wrexham Maelor Engineering Infrastructure Programme (BCU-SSU-2526-34).<br>o Additions to the plan:<br>▪ Adult and Older Persons Mental Health Unit at Ysbyty Glan Clwyd (BCU-SSU-2526-39).<br>▪ Contract management and procurement – Digital Data and Technology (DDaT) (BCU-2526-37).<br>▪ Contract management and procurement – Executive and Director corporate functions (BCU-2526-38). |
| **Arweinydd Gweithredol:**<br><br>***Executive Lead:*** | Director of Corporate Governance |
| **Awdur yr Adroddiad:** | Dave Harries, Head of Internal Audit, CMIIA<br>Nicola Jones, Deputy Head of Internal Audit, CMIIA |

| | | | | |
|---|---|---|---|---|
| ***Report Author:*** | | | | |
| **Pwrpas yr adroddiad:**<br>***Purpose of report:*** | I'w Nodi<br>*For Noting*<br>☒ | I Benderfynu arno<br>*For Decision*<br>☒ | Am sicrwydd<br>*For Assurance*<br>☒ | |
| **Lefel sicrwydd:**<br><br>***Assurance level:*** | Arwyddocaol<br>*Significant*<br>☐<br>Lefel uchel o hyder/tystiolaeth o ran darparu'r mecanweithiau / amcanion presennol<br><br>*High level of confidence/evidence in delivery of existing mechanisms/objectives* | Derbyniol<br>*Acceptable*<br>☐<br>Lefel gyffredinol o hyder/tystiolaeth o ran darparu'r mecanweithiau / amcanion presennol<br><br>*General confidence / evidence in delivery of existing mechanisms / objectives* | Rhannol<br>*Partial*<br>☐<br>Rhywfaint o hyder/tystiolaeth o ran darparu'r mecanweithiau / amcanion presennol<br><br>*Some confidence / evidence in delivery of existing mechanisms / objectives* | Dim Sicrwydd<br>*No Assurance*<br>☐<br>Dim hyder/tystiolaeth o ran y ddarpariaeth<br><br>*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:**<br><br>***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.<br>The Health Board assurance ratings above differ from those agreed across NHS Wales for internal audit opinions and therefore the assurance level has intentionally been left blank. | |
| **Cyswllt ag Amcan/Amcanion Strategol:**<br><br>***Link to Strategic Objective(s):*** | N/A other than those relating to individual audit reviews / recommendations. |
| **Goblygiadau rheoleiddio a lleol:**<br><br>***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 EqlA yn angenrheidiol ac a gafodd ei gynnal?**<br><br>***In accordance with WP7 has an EqlA been identified as necessary and undertaken?*** | The Equality duty is not applicable.<br>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?**<br><br>***In accordance with WP68, has an SEIA identified as necessary been undertaken?*** | The Socio-Economic duty is not applicable.<br>This progress report is required per the Welsh Government NHS Wales Audit Committee Handbook – Section 4.5 Reviewing internal audit assignment reports. |
| **Manylion am risgiau sy'n gysylltiedig â phwnc a chwmpas y papur hwn, gan gynnwys risgiau newydd (croesgyfeirio at y BAF a'r CRR)**<br><br>***Details of risks associated with the subject and scope of this paper, including new risks (cross reference to the BAF and CRR)*** | N/A other than those relating to individual audit reviews/recommendations. |
| **Goblygiadau ariannol o ganlyniad i roi'r *argymhellion ar waith*** | The progress report may record issues/risks, identified as part of a specific review, which has financial implications for the Health Board. |

| | |
|---|---|
| ***Financial implications as a result of implementing the recommendations*** | |
| **Goblygiadau gweithlu o ganlyniad i roi'r argymhellion ar waith**<br><br>***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**<br><br>***Feedback, response, and follow up summary following consultation*** | The Progress Report is produced independently of management.<br>The Progress report shared with the Director of Corporate Governance. |
| **Cysylltiadau â risgiau BAF:**<br>(neu gysylltiadau â'r Gofrestr Risg Gorfforaethol)<br><br>***Links to BAF risks:***<br>*(or links to the Corporate Risk Register)* | N/A other than those relating to individual audit reviews. |
| **Rheswm dros gyflwyno adroddiad i fwrdd cyfrinachol (lle bo'n berthnasol)**<br><br>***Reason for submission of report to confidential board (where relevant)*** | N/A |
| **Camau Nesaf:**<br>**Gweithredu argymhellion**<br><br>***Next Steps:***<br>***Implementation of recommendations***<br><br>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:**<br><br>***List of Appendices:***<br>• Appendix 1: Progress report<br>• Appendix 2: Orthopaedic Surgical Hub Llandudno Hospital<br>• Appendix 3: Waiting List Initiative Payments – IHC Centre<br>• Appendix 4: Effective Governance - Cancer Services<br>• Appendix 5: Effective Governance - IHC East<br>• Appendix 6: Performance Management Framework and Reporting | |

# Internal Audit Progress Report

## Audit Committee

## 24 April to 31 July 2025

### Betsi Cadwaladr University Health Board

Contents




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

## Introduction

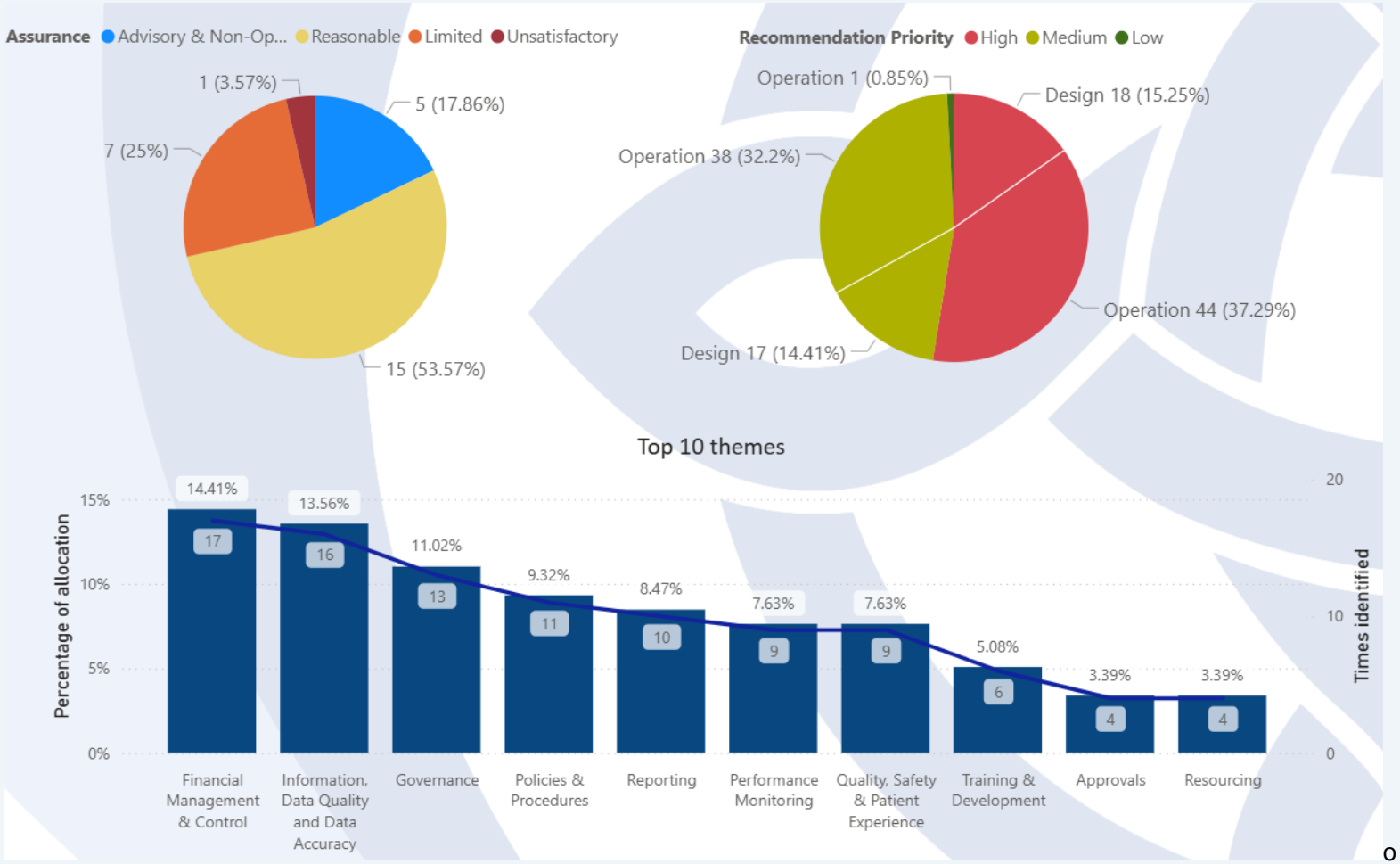
This progress report provides an update to the Audit Committee in respect of the assurances, key issues, and progress against the Internal Audit (IA) Plans for 2024/25 and 2025/26.

## Reports Issued

Since the last progress report, fourteen reviews have been issued as final (twelve 2024/25, two 2025/26).

The image below details final report ratings to date for 2024/25, recommendations by priority and themes identified. This shows the key themes of recommendations relate to Financial Management & Control, Information, Data Quality and Data Accuracy, and Governance. Please refer to table 7 for theme definitions.

Image 1: Extract from the NHS Wales tracker for Betsi Cadwaladr University Health Board as of 31 July 2025 – 2024/25 overview




o

# Executive Summaries

| | | |
|---|---|---|
| Standing Financial Instructions – Procurement follow up | BCU-2425-28 | May 2025 |
| Report opinion: | Reasonable |  |

## Purpose

The scope of the audit was to review progress and delivery of the twenty-four actions identified in the *Independent Review of Betsi Cadwaladr University Health Board Contract Procurement Management* issued on 29 January 2024. We have reviewed the work undertaken by Finance, Procurement Services, and the Programme Management Office.

## Overview

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

- Two actions have not been completed within the specified timescales, and no revised delivery deadline has been set.
- We are unable to verify all actions reported as complete due to incomplete evidence / supporting documents.
- Conformance Reports are not presented to the Audit Committee at the frequency stipulated in the Committee Cycle of Business.
- A small number of purchase orders have been issued and noted as being sent to *#N/A* or -. The Health Board should receive assurance from NWSSP Procurement Services where this has been applied.
- There is a lack of clarity where post titles / positions are not defined in the Scheme of Reservation and Delegation (SoRD).

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

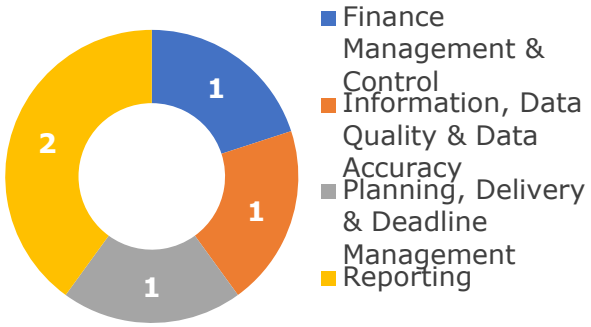
## Scope & Assurance Summary

| Objectives (The objectives and associated assurance ratings are not necessarily given equal weighting when formulating the overall audit opinion.) | | Related Findings | Assurance |
|---|---|---|---|
| 1 | Progress against delivery of the twenty-four recommended actions identified in the Contract Procurement Management review is in line with plans agreed by the Health Board. | 1 | **Reasonable** |
| 2 | There is evidence to support delivery of agreed actions, and, where applicable, changes have been embedded into processes. | 2, 3, 4, 5 | **Reasonable** |
| 3 | The Health Board and relevant Committees are provided with sufficient information to be assured on the progress and delivery of the Independent Review recommendations. | - | **Substantial** |

## Management Actions

| - | 5 |
|---|---|
| High Priority | Medium Priority |

## Themes




## Risk Types

Quality or Safety Issues

Financial Loss

| | | |
|---|---|---|
| Waiting List Initiatives – IHC Centre | BCU-2425-34 | May 2025 |
| Report opinion: | Limited |  |

## Purpose

To review arrangements in the Integrated Health Community (IHC) Centre for identifying, agreeing and approving Waiting List Initiative (WLIs) payments.

## Overview

The Amendment to the National Consultant Contract in Wales includes a section on WLI sessions as follows:

*2.36 Waiting List Initiatives work may be requested by the employer to be carried out in addition to the Consultant's contracted sessions.*

*2.37 These additional sessions will be voluntary.*

*2.38 Such sessions may be undertaken in uncontracted time.*

WLI is an additional clinic or list undertaken outside of core contracted hours to alleviate or reduce patient waiting times. It must have been identified and approved to deliver the Health Board's planned care activity or to address specific activity and funding allocated by Welsh Government.

WLI work is temporary and voluntary - it does not form part of the Consultant job plan and must be undertaken in uncontracted time.

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

- There is no standard operating procedure within the Health Board to ensure standardisation and equity across all its services. We were advised local procedures were in place but received no evidence to support this assertion.
- We were unable to verify actual WLI activity reviewed to the majority of job plans as the job plans had not been agreed and we therefore could not verify that WLI activity was undertaken outside of a contracted session.
- We noted on some approved claims that WLI activity was undertaken on Supporting Professional Activity (SPA) session, with the displaced SPA then undertaken at another time. We are unclear how this complies with paragraph 2.38 of the National Contract.

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

## Scope & Assurance Summary

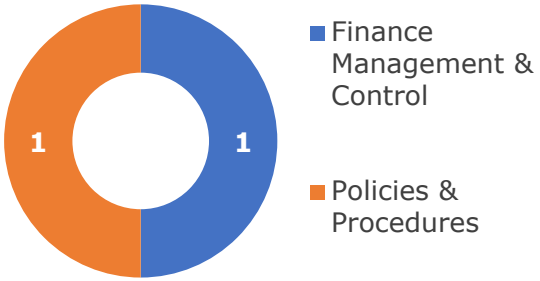
| Objectives (The objectives and associated assurance ratings are not necessarily given equal weighting when formulating the overall audit opinion.) | | Related Findings | Assurance |
|---|---|---|---|
| 1 | There is a current WLI procedure in place that is available for all staff that align with the Amendment to the National Consultant Contract in Wales. | 1 | Unsatisfactory |
| 2 | WLI activity is only commissioned and agreed to be undertaken in uncontracted time. | 2 | Limited |

### Management Actions

2 — High Priority

\- — Medium Priority

### Themes




### Risk Types

Quality or Safety Issues

Financial Loss

| | | |
|---|---|---|
| Partnerships, Engagement and Communications | BCU-2425-26 | May 2025 |
| Report opinion: | Limited |  |

### Purpose

To review the management arrangements, progress and delivery of actions from the Partnerships, Engagement and Communication Strategy (2022-25), the Listening to Citizens, Patients, Staff, and Partners Independent Review, and Health Board Annual Delivery Plan (relevant objectives).

### Overview

We have concluded limited assurance on this area. We recognise that a lot of work has been undertaken by the team to improve engagement and communication, however there are still a number of matters requiring management attention, which include:

- Not all improvement actions have been delivered within the specified timescales. No delivery deadlines have been set for the Independent Review recommendations.
- We were unable to fully verify the status of 4/10 completed actions in our review sample due to the robustness of evidence provided.

- Staff resources – issues found include no Standard Operating Procedure (SOP) in place outlining the engagement process and requirements, some published resources require updating, 2/7 Engagement Toolkit resources require the use of personal email addresses to access.
- We were unable to verify the robustness of delivery / implementation oversight due to limited forum minutes provided for review.
- There is no consistent benefits realisation process in place to review and monitor benefits / improvements post-implementation.
- No assurance regarding the implementation progress / delivery of the PEC Strategy or Listening to Citizens Independent Review was provided to the Board or its Committees between January 2024 and March 2025. Updated action plans / comprehensive updates were not submitted for Board / Committee scrutiny during this period.

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

## Scope & Assurance Summary

| Objectives (The objectives and associated assurance ratings are not necessarily given equal weighting when formulating the overall audit opinion.) | | Related Findings | Assurance |
|---|---|---|---|
| 1 | There are effective processes in place to monitor, manage and support implementation of the key elements stated in the Strategy, Health Board Three Year Plan (partnership and engagement references) and recommendations from the independent report. | 1 | **Reasonable** |
| 2 | There is progress in delivery of the strategy elements, and evidence of improvements to date. Where these have not been delivered, there is evidence that these have been subject to discussion / change and, where appropriate, are included in future plans. | 2, 3, 4 | **Limited** |
| 3 | The effectiveness of actions taken above have/are being measured to demonstrate whether anticipated benefits are being achieved. | 5 | **Limited** |
| 4 | There are robust governance arrangements in place to ensure that delivery of the Strategy, plan and recommendations from the independent report are subject to Health Board oversight and scrutiny, and assurance of progress is provided to the Board and / or relevant Committees. | 6 | **Limited** |

Management Actions

Themes

Risk Types

| 4 | 2 |
|---|---|
| High Priority | Medium Priority |


Quality or Safety Issues

Public Perception & Reputational Risk

| Effective governance: Cancer Services | BCU-2425-31 | May 2025 |
|---|---|---|
| Report opinion: | Limited |  |

## Purpose

To review the effectiveness of the governance arrangements within Cancer Services.

## Overview

We have concluded limited assurance on this area. Whilst there is evidence of appropriate governance and reporting structure, financial governance and risk management processes, there are immediate improvements needed to improve some areas of governance. The significant matters requiring management attention are:

- We are unable to evidence regular review of Cancer Pathway Performance information at the Senior Leadership Team meetings for January and February 2025 with March 2025 showing presentation at one meeting but not another despite this being a standard agenda item for the meeting.
- There is regular reporting of financial performance however the service is forecasting an overspend position at year end which is a breach of Standing Financial Instruction 5.2.2 "….and delegated budget holders must not exceed the budgetary total or virement limits set by the Board". At the time of our review the service was not forecast to achieve its set savings target.
- The service is not progressing or monitoring tier 2/3 clinical audits however we recognise this has been identified as a risk area and subject to focus in 25/26.
- The number of open/overdue incidents is a cause for concern.
- There are no formal arrangements in place to ensure staff are aware of 'speak up safely' or how to follow the 'whistleblowing' route, to ensure staff concerns can be raised effectively.

We found that the service had embedded risk management processes that are in line with the Health Board's risk strategy concerning an established risk register and a regular review of risks.

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

## Scope & Assurance Summary

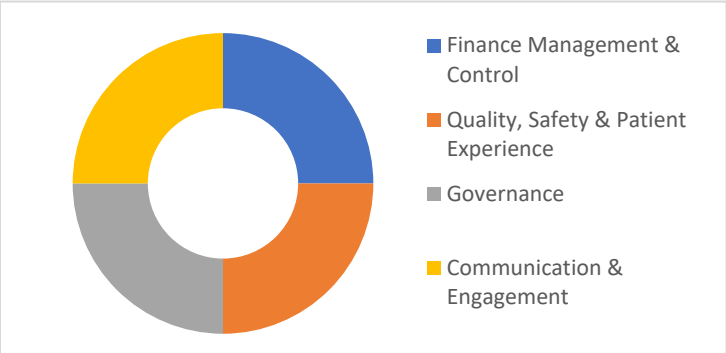
| Objectives (The objectives and associated assurance ratings are not necessarily given equal weighting when formulating the overall audit opinion.) | | Related Findings | Assurance |
|---|---|---|---|
| 1 | There is an appropriate governance and reporting structure in place within the service to provide assurance on services and ensure oversight of all areas of responsibility. | 1 | **Limited** |
| 2 | There are appropriate financial governance arrangements in place to manage budgets, with regular review of savings and budgets. Where services are not operating within agreed budgetary allocation, appropriate actions and monitoring arrangements are in place. | 2 | **Limited** |
| 3 | The service is progressing and monitoring tier 2/3 clinical audits and contributing to tier 1 audits as required, with processes in place to share details of lessons learnt. | 3 | **Unsatisfactory** |
| 4 | Complaints, concerns, incidents and staff concerns (via Speak Up Safely) are investigated, reviewed, and responded to in a timely manner. Learning from these is captured and reviewed / shared as appropriate. | 4 | **Limited** |
| 5 | Risk management processes are embedded throughout the service and are in line with the risk strategy in terms of risk registers and regular review of risks. | - | **Substantial** |

### Management Actions

**4** High Priority

**-** Medium Priority

### Themes




### Risk Types

Quality or Safety Issues

Legal & Regulatory Non-Compliance

| | | |
|---|---|---|
| Effective governance: Integrated Health Community - East | BCU-2425-30 | June 2025 |
| Report opinion: | Limited |  |

## Purpose

To review the effectiveness of the governance arrangements within the East Integrated Health Community (IHC).

## Overview

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

- There are established governance structures in place, however a review of key group papers shows low attendance at meetings. This is recognised by the IHC.
- There is regular reporting of financial performance however the IHC is forecasting an overspend position at year end which is a breach of Standing Financial Instruction 5.2.2 "….and delegated budget holders must not exceed the budgetary total or virement limits set by the Board". At the time of our review the service was not forecast to achieve its set savings target. There are also a number of Accountability Letters that have not been signed by budget holders.
- The Clinical Effectiveness Group is not meeting on a regular basis, we are therefore unable to confirm there is effective oversight and monitoring of clinical audit.
- The increasing number of incidents is a cause for concern and management should put arrangements in place to close open and overdue incidents.
- Several risks are overdue for review and require updating.

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

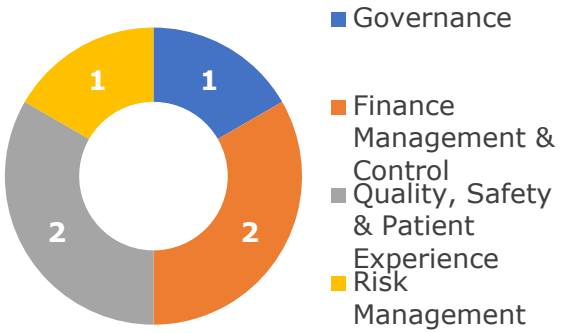
## Scope & Assurance Summary

| Objectives (The objectives and associated assurance ratings are not necessarily given equal weighting when formulating the overall audit opinion.) | | Related Findings | Assurance |
|---|---|---|---|
| 1 | There is an appropriate governance and reporting structure in place within the service to provide assurance on services and ensure oversight of all areas of responsibility. | 1 | **Reasonable** |
| 2 | There are appropriate financial governance arrangements in place to manage budgets, with regular review of savings and budgets. Where services are not operating within agreed budgetary allocation, appropriate actions and monitoring arrangements are in place. | 2 | **Limited** |
| 3 | The IHC is progressing and monitoring tier 2/3 clinical audits and contributing to tier 1 audits as required, with processes in place to share details of lessons learnt. | 3 | **Unsatisfactory** |
| 4 | Complaints, concerns, incidents and staff concerns (via Speak Up Safely) are investigated, reviewed, and responded to in a timely manner. Learning from these is captured and reviewed / shared as appropriate. | 4 | **Reasonable** |
| 5 | Risk management processes are embedded throughout the service and are in line with the risk strategy in terms of risk registers and regular review of risks. | - | **Reasonable** |

## Management Actions

| 3 | 3 |
|---|---|
| High Priority | Medium Priority |

## Themes




## Risk Types

Legal & Regulatory Non-Compliance

Financial Loss

Quality or Safety Issues

| Grievance Management | BCU-2425-19 | June 2025 |
|---|---|---|
| Report opinion: | Reasonable |  |

## Purpose

To provide assurance on the effectiveness and efficiency of the process to manage grievance cases within the Health Board.

## Overview

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

- Information on employee relations is reported locally and via the People & Culture Committee, however this is for disciplinary cases and does not include grievance case information / data. Reporting should be revisited to ensure the Health Board is sighted on all areas of employee relations.
- Whilst there is informal feedback from those involved in the grievance process, there is no documented learning from cases, or analysis, to identify potential themes and take appropriate action i.e. where there may be opportunity to provide additional training / awareness on areas of concern to management.

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

## Scope & Assurance Summary

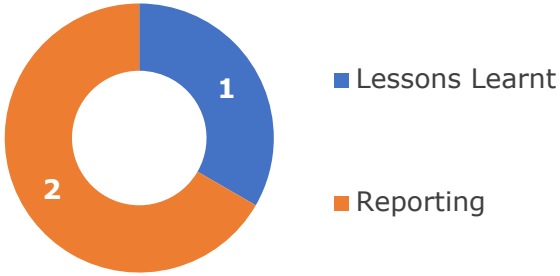
| | Objectives | Related Findings | Assurance |
|---|---|---|---|
| 1 | Information on the process to raise a grievance, and key people to contact, is available to staff and provides them with clear steps and guidance. | - | **Substantial** |
| 2 | Formal grievances are recorded, monitored, and reported within the Health Board. Where delays are identified these are escalated / actioned as required. | 1 | **Reasonable** |
| 3 | Grievances are promptly investigated, with accurate records created and retained. Key steps of the process are completed in line with the Policy and without unreasonable delay. | - | **Reasonable** |
| 4 | Designated contacts responsible for grievance cases are aware of their responsibilities and have received appropriate training to deal with grievances. | - | **Substantial** |
| 5 | There is an analysis of grievance cases, including satisfaction and feedback of the employees and managers involved in the process, allowing trends or themes to be identified, follow up action to be monitored and regular sharing of learning. | 2,3 | **Limited** |

### Management Actions

**1** High Priority

**2** Medium Priority

### Themes




### Risk Types

Financial Loss

Legal & Regulatory Non-Compliance

| | | |
|---|---|---|
| Duty of Quality | BCU-2425-10 | June 2025 |
| Report opinion: | Limited |  |

### Purpose

To provide assurance that the Health Board is implementing the requirements of the Duty of Quality (the Duty), which came into force on 1 April 2023. The Duty aims to improve the quality of healthcare services and the health outcomes for people in Wales.

### Overview

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

- A Quality Regulatory Policy, which is designed to ensure compliance with the Duty of Quality by defining roles and responsibilities, is drafted but has not yet been finalised and issued to staff.
- The Quality Management System (QMS) is due to be rolled out to areas across the Health Board, however there is no guide available for staff to ensure this is utilised effectively.
- There is limited information available on Duty of Quality training for staff, and no evidence of a training needs analysis and subsequent monitoring of training.

Full details of matters arising are detailed within the Findings & Agreed Action Plan. We recognise that work is ongoing to develop several areas relating to ensuring the Duty is considered in decision making:

- Development of the Quality Impact Assessment.
- Revision in Board and Committee paper templates.

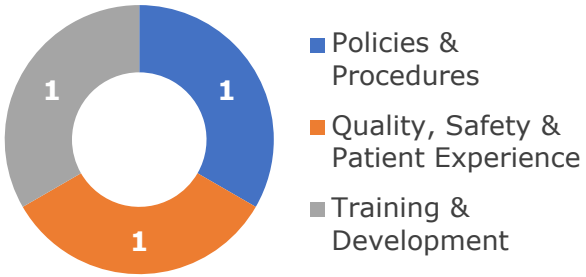
## Scope & Assurance Summary

| Objectives (The objectives and associated assurance ratings are not necessarily given equal weighting when formulating the overall audit opinion.) | | Related Findings | Assurance |
|---|---|---|---|
| 1 | The Health Board has robust governance, reporting and escalation mechanisms for oversight of the Duty. | - | **Substantial** |
| 2 | There are clear policies and procedures covering the requirements of the Duty and the related Welsh Government guidance. | 1 | **Reasonable** |
| 3 | There is Board-wide training and ongoing support to help staff meet the requirements of the Duty. | 2 | **Reasonable** |
| 4 | The Health Board's Quality Management System supports compliance with the Duty. | 3 | **Reasonable** |
| 5 | The Health Board has embedded the Duty into strategic decision-making and across all aspects of the Board's activities. | - | **Reasonable** |

### Management Actions

| - | 3 |
|---|---|
| High Priority | Medium Priority |

### Themes




### Risk Types

Legal & Regulatory Non-Compliance

Quality or Safety Issues

| Budgetary Control | BCU-2425-27 | June 2025 |
|---|---|---|
| Report opinion: | Reasonable |  |

## Purpose

To review whether the Health Board has effective controls in place to manage its financial budgets, including delegation and information available to budget holders.

## Overview

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

- Although 90% of Accountability Letters have been signed, and those who have not signed have been subject to follow-up by Finance, there is no further escalation or consequence for those officers who do not sign these, despite this being a requirement of Standing Financial Instructions.
- There is a procedure for the sign-off of journal entries over £100k, however this is not applied consistently across finance teams.
- There is guidance in place for budget holders, and in the absence of ESR mandatory training (which is being revised), training is available and delivered by finance, however attendance for this is not monitored effectively.

Full details of matters arising are detailed within the Findings & Agreed Action Plan. We recognise that work is ongoing to publish the new Budgetary Control Procedure.

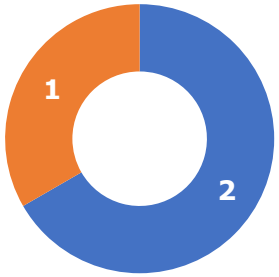
## Scope & Assurance Summary

| Objectives | The objectives and associated assurance ratings are not necessarily given equal weighting when formulating the overall audit opinion. | Related Findings | Assurance |
|---|---|---|---|
| 1 | Procedures are available to staff, are up-to-date and reflect current working practices. | - | **Reasonable** |
| 2 | Accountability Letters have been completed and signed by all Budget Holders and Managers for 2024/25 in line with Standing Financial Instruction 5.2.1 and 5.2.6. | 1 | **Reasonable** |
| 3 | The delegated limits recorded in the E-Financials hierarchy are in line with current Scheme of Reservation and Delegation. | - | **N/A** |
| 4 | Manual and automatic accrual entries are correct and subject to effective scrutiny. | - | **Reasonable** |
| 5 | Journal entries are subject to appropriate segregation of duties and scrutiny. | 2 | **Reasonable** |
| 6 | A Budget Virement Policy exists and is complied with at all times. | - | **Substantial** |
| 7 | The reporting of the month end financial position to the Health Board is complete and accurate in line with the General Ledger. Any manual adjustments made are underpinned by evidence to support the change(s). | - | **Substantial** |
| 8 | Budget holders and managers have received appropriate training enabling them to manage their delegated budgets. | 3 | **Reasonable** |

## Management Actions

| - | 3 |
|---|---|
| High Priority | Medium Priority |

## Themes




## Risk Types

Financial Loss

| | | |
|---|---|---|
| Performance Management Framework and reporting | BCU-2425-31 | July 2025 |
| Report opinion: | Limited |  |

## Purpose

To review the implementation of, and confirm that, the Integrated Performance Framework (IPF) 2023-25 is operating as expected.

## Overview

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

- We have been unable to corroborate that the Substructure for integrated performance reporting, as detailed in every performance report since May 2024, is operating as presented.
- We have not been provided with evidence underpinning the identification of local performance measures reported in addition to the national measures – we are unclear whether the local measures focus on areas of greatest risk.
- We have been unable to evidence any outcomes of performance meetings between operational services and the executive; consequently we are unable to provide assurance that corrective actions are formally communicated/set for services to improve performance where this is below expected measures.

Elements of good practice could be seen within the directorates through the operational accountability/service performance reports being presented at the directorate finance and performance meetings.

Full details of matters arising are detailed within the Findings & Agreed Action Plan. The following opportunities for enhancement have been identified that do not impact the overall opinion and are highlighted for management information:

- IHC/Directorate specific Performance Reports detail local performance against the national measure only; the reports could be enhanced to include the Health Board overall measure also as we found instances where the local position was better than the reported Health Board position. Where this is the case, learning could be identified for sharing across the Health Board which may support the attainment of overall improved performance.

## Scope & Assurance Summary

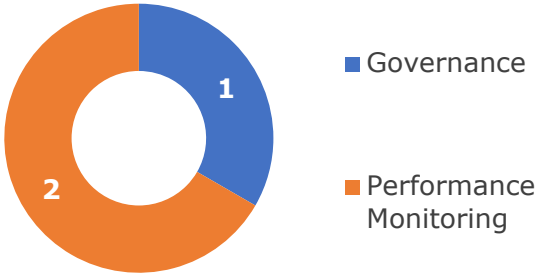
| Objectives | | Related Findings | Assurance |
|---|---|---|---|
| 1 | There is a governance structure with mechanisms for regular monitoring and escalation in place | 1 | **Limited** |
| 2 | There is evidence to support reported performance data and narrative. | 2 | **Limited** |
| 3 | Arrangements are in place within the operational management structure where operational leaders and Executive scrutinise and hold to account areas of poor performance, evidence this and review whether expected remedial action is implemented and improved performance to the service user | 3 | **Limited** |

### Management Actions

3 — High Priority

\- — Medium Priority

### Themes




### Risk Types

Quality or Safety Issues

| | | |
|---|---|---|
| Waste Management | BCU-2425-33 | June 2025 |
| Report opinion: | Reasonable |  |

### Purpose

To review the Health Board's compliance with WHTM 07-01 Welsh Health Technical Memorandum Safe and sustainable management of healthcare waste and ascertain how it is preparing for implementation of the Waste Separation Requirements (Wales) Regulations 2023 in April 2026.

### Overview

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

- Some areas of non-compliance were identified during site visits, such as a build-up of waste / equipment.
- A systematic approach is not followed for the verification of invoices, to ensure both accuracy and legitimacy of amounts being claimed.

- Recycling / waste data has been produced; however, this has not been analysed/reviewed to consider whether waste across the Health Board can be reduced and if any improvements can be made.
- The Spill and Environmental Emergency Procedures have not been communicated to all relevant staff.
- Progress on the implementation of Waste Separation Requirements (Wales) Regulations 2023 and associated risks / implications are not reported regularly to the Strategic Infection Prevention Group (SIPG), and we are unsighted if there is assurance provided to the Health Board via its Committees.
- There are several concerns relating to implementation of the new waste separation requirements, however there is no documented risk on the Estates risk register relating to this.

Full details of matters arising are detailed within the Findings and Agreed Action Plan. We have not raised findings relating to the following:

- The Waste Management Policy is out of date; however, it has been reviewed and is awaiting sign off (Objective 1).
- Management should consider more frequent contractor meetings for the Waste Electrical and Electronic Equipment (WEEE) contract following the current retender exercise (Objective 4).
- Management ensures both waste related incidents that remain open are subject to management oversight and corrective action/lesson learnt documented as soon as possible (Objective 5).

## Scope & Assurance Summary

| Objectives | | Related Findings | Assurance |
|---|---|---|---|
| 1 | There are appropriate policies and procedures in place that address waste management issues. | - | **Reasonable** |
| 2 | There is an appropriate governance structure in place, with clearly defined accountability, reporting and approval processes. | 1 | **Reasonable** |
| 3 | There is assurance that waste contracts (including national arrangements) have been appropriately procured, ensuring compliance with legislation and providing value for money to the Health Board. | - | **Reasonable** |
| 4 | Operational practice in key areas is in line with the Health Board's policy and procedures, and relevant legislation. | 2,3 | **Reasonable** |
| 5 | Adequate arrangements are in place to record, monitor and report waste management activities. | 4, 5 | **Reasonable** |
| 6 | Initiatives and actions are in place to support the achievement of agreed / mandatory targets and to prepare for implementation of Waste Separation Requirements (Wales) Regulations 2023 in April 2026. | 6 | **Reasonable** |

## Management Actions

| - | 6 |
|---|---|
| High Priority | Medium Priority |

## Themes


## Risk Types

Financial Loss

Legal & Regulatory Non-Compliance

Quality or Safety Issues

| Orthopaedic Surgical Hub Llandudno Hospital | BCU-SSU-2425-17 | July 2025 |
|---|---|---|
| Report opinion: | Unsatisfactory |  |

### Purpose

The audit focused on the delivery and management arrangements in place to progress the development of an Orthopaedic Surgical Hub at Llandudno Hospital. This was the second audit undertaken of the project and it had been commissioned in accordance with the agreed provision (and associated funding) provided within the approved Business Justification Case (BJC) Integrated Audit Assurance Plan. The previous audit undertaken in 2023/24 determined limited assurance.

### Overview

We have concluded **unsatisfactory assurance** at the current review.

The project had been subject to further prolongation since the last audit undertaken in early 2024. The current estimated completion date was reported as January 2026, a further 11 months delay. noting the project was originally envisaged as being completed within 12 months.

Delays have been attributed to several factors, including design co-ordination, delays in ordering/procuring materials along with issues of procured components not meeting the tolerances required for the build.

The project was forecasting an anticipated overspend of approximately £1.6m over the approved budgeted allocation, with no contingency remaining at the time of the current review.

Quality issues were observed both with regard to the delivery of the scheme and the robustness of the quality assurance regime in place.

The key findings requiring management attention include the need to:

- address a number of High priority recommendations arising from the previous audit.
- evaluate the procurement strategy applied (and the delivery of the scheme as a whole).
- ensure the regularity of the Project Board meetings (which forms one of the key pillars of the Project Governance arrangements).
- maintain agreed improvements to project progress reporting to the Board/Executive level.
- address 'Gateway Review' outstanding recommendations detailed as 'Critical'.
- provide qualitative explanations to support reported VAT and equipment cost calculations,
- apply Project Bank Account requirements which remain outstanding or provide approved rationale for non-implementation.
- review the approval process for changes/variations ensuring compliance with Standing Orders/SFI's.
- address site inspection arrangements and preparation for commissioning.

## Scope & Assurance Summary

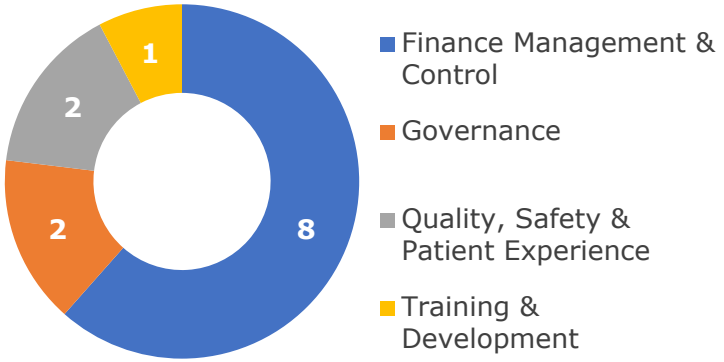
| | Objectives | Related Findings | Assurance |
|---|---|---|---|
| 1 | Validation of Management Action - Assurance that previously agreed actions had been appropriately actioned by management | - | **Limited** |
| 2 | Project Performance - Consideration of performance against project objectives (e.g. time, cost, benefits, critical success factors etc.). | 1,2 | **Unsatisfactory** |
| 3 | Project Governance - Assurance that appropriate governance arrangements were in place for the current project phase. | 3,4,5 | **Unsatisfactory** |
| 4 | Financial Management - Adequate cost control and reporting systems are operated, both internally and by the External Cost Adviser. Assessment of the ongoing arrangements for the review of risk and associated management of contingency funds. | 6,7,8 | **Limited** |
| 5 | Validation of Costs - To ensure adequate processes and procedures are in place to ensure that the contractor is correctly reimbursed in accordance with the contract. This will include a review of the internal and contractual change control mechanisms are applied at the project. | 9 | **Limited** |
| 6 | Site progress - Assurance that the site supervisor and contractor have appropriate monitoring and reporting arrangements in place to manage progress on site. | 10,11,12 | **Unsatisfactory** |
| 7 | Equipping - To ensure that the equipping process is aligned with the key construction delivery timetable, and that there are appropriate management and reporting arrangements in place to ensure its co-ordination. | 13 | **Limited** |

## Management Actions

**11** High Priority

**2** Medium Priority

## Themes




## Risk Types

Financial Loss

Legal & Regulatory Non-Compliance

Quality or Safety Issues

| | | |
|---|---|---|
| Standards of Business Conduct: Follow up | BCU-2425-22 | June 2025 |
| Report opinion: | Not Applicable | - |

## Purpose

This audit originates from the 2024/25 internal audit plan, agreed with management, and approved by the Audit Committee. The objective of this follow-up review is to assess the implementation of the management actions that were agreed upon to mitigate the risks highlighted in the 2023/24 Standards of Business Conduct – Declarations of Interest, Gifts and Hospitality (BCU-2324-21) audit report. This report concluded with a limited assurance rating. By conducting this review, we seek to ensure that the risks and issues of significance identified have been adequately addressed.

## Overview

One (1) of the agreed actions have been closed as per table below:

| | High | Medium | Low | **Total** |
|---|---|---|---|---|
| Closed | 1 | - | - | **1** |
| Partially Implemented | 2 | 1 | - | **3** |
| Outstanding | 3 | - | - | **3** |
| **Total** | **6** | **1** | **-** | **7** |

The findings are based on our review of evidence provided by the Head of Corporate Governance and information available in the public domain. As detailed below, we were unable to verify the effectiveness of some of the key controls in place as source data, including notification logs, declaration data, ESR upload data, evidence of data reconciliation, Board Member declarations, were not provided for review.

We observed good progress in some areas, such as the updating of the Standards of Business Conduct Policy and development of additional guidance material to support staff and management, however some of the issues of significance identified in our 2023/24 review remain outstanding. These include, but are not limited to, the following:

- Approval of declarations.
- Accuracy / transparency of the published Board Member Register of Declarations of Interest.
- Frequency of reporting to Audit Committee.
- Data quality / accuracy and validity.
- Approval and timeliness of Gifts, Hospitality, and Sponsored Events declarations.

Whilst we recognise the Corporate Governance Directorate are responsible for maintaining, operating and reporting on declarations of interest/gifts and hospitality, accountability for compliance rests with all operational directors/leads and employees. The Director of Corporate Governance may wish to consider re-establishing a forum of Corporate Governance Leads and use this forum as the vehicle for sharing and embedding key governance expectations throughout the clinical directorates/divisions and all corporate functions.

| | | |
|---|---|---|
| Falls Management: Follow up | BCU-2526-22 | June 2025 |
| Report opinion: | Not Applicable | - |

## Purpose

The overall objective of this audit is to provide the Health Board with assurance regarding the implementation of the agreed management actions from the Falls Management (BCU-2324-05) review that was reported as part of our 2023/24 work programme.

## Overview

The scope of this follow-up review does not aim to provide assurance against the full review scope and objective of the original review. The 'follow-up review opinion' provides an assurance level against the implementation of the agreed action plan.

As part of our testing, we visited wards at three acute hospitals and three community hospitals, reviewing a sample of thirty-six Falls and Bone Health Multifactorial Assessments (FBHMA).

Objectives of the area under review:

1. Appropriate progress has been made with the implementation of the agreed management actions within the agreed timescales.

2. Adequate evidence is available to support the level of progress that has been made.

3. The actions implemented have effectively addressed the issues highlighted during the original audit.

The table below illustrates the status of the agreed actions. A significant amount of work has been undertaken to address the actions raised. It is noted that work is ongoing to ensure some actions are fully implemented.

| | High | Medium | Low | **Total** |
|---|---|---|---|---|
| Closed | 3 | 1 | - | **4** |
| Partially Implemented | 7 | - | - | **7** |
| Outstanding | - | - | - | **-** |
| **Total** | **10** | **1** | **-** | **11** |

Falls Data: Comparing April-December 2023/24 to the same period in 2024/25, the overall number of falls decreased by 5.8%, and falls causing moderate harm and above decreased by 29.2%.

Training and Documentation: Improvements have been made in falls training and the quality of risk assessments. However, some areas still lack sufficient information to fully understand patients' needs.

Governance and Learning: The Health Board continues to implement strategies to identify themes, trends, and lessons learned from falls incidents. However, there are still issues with the completion of SWARM documents following falls.

Therapist Assessments: There is a potential issue affecting staff understanding of patients' needs as Health Board Therapists use a separate electronic system for recording patient management, which is not currently accessible to nursing staff.

## Work in Progress Summary

The following draft reports have been issued:

Table 1: Draft Reports issued

| Review | Status | Date draft report issued | Date management response due |
|---|---|---|---|
| Corporate Legislative Compliance - Civil Contingencies Act 2004 | Draft report issued. | 30 July 2025 | 29 August 2025 |

The following reviews are currently in progress:

Table 2: Reviews in progress

| Review | Status | Draft report due |
|---|---|---|
| Public Health: Prevention and Early intervention – Grant funded activity | Fieldwork started. | September 2025 |

| Review | Status | Draft report due |
|---|---|---|
| Value and Sustainability - improvements and savings delivery | Fieldwork started. | September 2025 |
| Patient Experience | Draft report prepared. | August 2025 |
| Learning – Regulatory reporting | Fieldwork started. | September 2025 |
| Complaints | Fieldwork started. | August 2025 |
| Community Services | Fieldwork started. | September 2025 |
| Primary Medical Care | Fieldwork started. | September 2025 |

## Follow-up

The Corporate Governance Directorate provide Internal Audit with details of actions agreed as closed by Executives and provide relevant evidence to support closure. We have reviewed 59 recommendations submitted to us during the period, with the outcomes noted in the table below.

Table 3 – Status of follow-up actions submitted for closure

| Recommendation - category by submission | Number of recommendations | Closed | Partially closed | Outstanding |
|---|---|---|---|---|
| Submitted for 1st review | 24 | 17 (71%) | 5 (21%) | 2 (8%) |
| Submitted for 2nd review (following previous feedback by Audit) | 33 | 20 (61%) | 9 (27%) | 4 (12%) |
| Submitted for 3rd review (following previous feedback by Audit | 2 | 2 (100%) | - | - |
| **TOTALS** | **59** | **39 (66%)** | **14 (24%)** | **6 (10%)** |

## Contingency/Health Board support/Advice

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

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

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

## Delivering the plan

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

The Audit Committee is requested to approve the following changes to the audit plan.

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

| Audit Title | Reason for requesting deferral / removal from plan / adding to the plan |
|---|---|
| Skills and Capabilities (BCU-2526-14) | Due to resource limitations with Digital Data and Technology (DDaT) when the review was to take place coupled with the impact delaying this review would have on the delivery at other NHS Wales organisations internal audit plans it was agreed with the Director of Corporate Governance, subject to Audit Committee approval, that this review be deferred and included in the planning for the 2026/27 internal audit plan.<br><br>**Recommendation: This review is deferred to be included in risk planning for the 2026/27 plan.** |
| Productivity and Efficiency (BCU-2526-18) | On the 29 April 2025 the Cabinet Secretary for Health and Social Care published the *Report by the External Ministerial Advisory Group on NHS Wales Performance and Productivity* including the response from Welsh Government that included requirement placed on the Health Board to implement. Undertaking a review as planned, which would cut-across the themes and actions from the report, does not allow the Health Board sufficient time to progress the recommendations, with some actions stipulating a timeline of six months.<br><br>**Recommendation: This review is deferred to be included in risk planning for the 2026/27 plan.** |
| Capital Systems (BCU-SSU-2526-33) | At a risk planning meeting with the Director of Environment and Estates, the Director advised that he needed to review the current process and undertaking any review now would not add value as we would be identifying matters which management were already aware of.<br><br>**Recommendation: This review is deferred to be included in risk planning for the 2026/27 plan.** |
| Wrexham Maelor Engineering Infrastructure Programme (BCU-SSU-2526-34) | This scheme has been subject to several downgrading's and the Director of the Environment and Estates has advised that the current plan is to review the scheme again; the materiality of the risk has reduced as the original scheme is being progressed in smaller stages. |

| Audit Title | Reason for requesting deferral / removal from plan / adding to the plan |
|---|---|
| | **Recommendation: This review is deferred to be included in risk planning for the 2026/27 plan.** |
| Adult and Older Persons Mental Health Unit at Ysbyty Glan Clwyd (BCU-SSU-2526-39) | The Health Board has recently received notification of increased funding for this scheme. This is a major capital development and there is a requirement for the business case to include funding for the integrated audit and assurance plans (IAAP) that underpin the major capital internal audit reviews with review funding included in the overall capital allocation.<br><br>Noting the recent review of a capital scheme, governance and control of capital schemes is considered high risk requiring internal audit review through the scheme's various stages.<br><br>**Recommendation: This review is added to the 2025/26 internal audit plan.** |
| Contract management and procurement – Digital Data and Technology (DDaT) (BCU-2526-37) | The Head of Internal Audit met with the Director of Corporate Governance and Executive Director of Finance to discuss the risks identified concerning procurement within DDaT. Building on the review of Procurement undertaken under Special Measures, it was agreed that a review be undertaken, subject to Audit Committee approval.<br><br>**Recommendation: This review is added to the 2025/26 internal audit plan.** |
| Contract management and procurement – Executive and Director corporate functions (BCU-2526-38) | The Head of Internal Audit met the Chief Executive to discuss this proposed review following increased risk awareness in the procurement of goods and services by some corporate functions. Building on the review of Procurement undertaken under Special Measures, the Chief Executive agreed that a review be undertaken, subject to Audit Committee approval.<br><br>**Recommendation: This review is added to the 2025/26 internal audit plan.** |

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

For 2025/26, two reports have been issued as final, with one missing the response timeline; table 5 will be updated for the next progress report to reflect the 2025/26 performance position.

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

Table 5: Performance Indicators

| Indicator | Status | Actual | Target | Red | Amber | Green |
|---|---|---|---|---|---|---|
| Report turnaround: time from fieldwork completion to draft reporting [10 days] | Green | 96% | 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 | 79% | 80% | v>20% | 10%<v<20% | v<10% |
| Report turnaround: time from management response to issue of final report [10 days] | Green | 100% | 80% | v>20% | 10%<v<20% | v<10% |

Table 6: Core Plan 2025/26

| Planned output | Outline timing | Status | Assurance (including draft report assurance opinions) |
|---|---|---|---|
| 1. Risk Management and Board Assurance Framework (Assurance) | January-March 2026 | | |
| 2. Follow up | June 2025-March 2026 | Ongoing. | |
| 3. Corporate Legislative Compliance - Civil Contingencies Act 2004 (Assurance) | June/July 2025 | Draft report issued. | |
| 4. Standards of Business Conduct (Assurance) | October-December 2025 | | |
| 5. Executive and Operational Leadership Team Governance (Assurance) | January-March 2026 | | |
| 6. Public Health: Prevention and Early intervention – Grant funded activity (Assurance) | July/August 2025 | Work in progress. | |
| 7. Value and Sustainability - improvements and savings delivery (Assurance) | July-September 2025 | Work in progress. | |
| 8. Budgetary Control and Financial Reporting (Assurance) | November/December 2025 | | |
| 9. Budget Setting (All Wales review) (Assurance) | TBC | | |
| 10. Patient Experience (Assurance) | July-September 2025 | Report prepared - in QA | |

| Planned output | Outline timing | Status | Assurance (including draft report assurance opinions) |
|---|---|---|---|
| | | process. | |
| 11. Learning (Assurance) | July/August 2025 | Work in progress. | |
| 12. Outpatient Transformation (Assurance) | July-September 2025 | Planning. | |
| 13. Complaints (Assurance) | July-September 2025 | Work in progress. | |
| 14. Skills and Capabilities (Assurance) | | Recommended for deferment. | - |
| 15. Delivering successful change and benefits realisation (Assurance) | August/September 2025 | | |
| 16. Non-Digital Data and Technology (DDaT) controlled IT (Assurance) | October-December 2025 | | |
| 17. Community Services (Assurance) | July-September 2025 | Work in progress. | |
| 18. Productivity and Efficiency (Assurance) | July-September 2025 | Recommended for deferment. | - |
| 19. Planned Care (Assurance) | October-December 2025 | Planning. | |
| 20. Urgent Emergency Care (Assurance) | October-December 2025 | | |
| 21. Primary Dental Care (Assurance) | October-December 2025 | | |
| 22. Primary Medical Care (Assurance) | July-September 2025 | Work in progress. | |
| 23. Workforce Planning (Assurance) | January-March 2026 | | |
| 24. Compassionate Leadership (Assurance) | October-December 2025 | Planning. | |
| 25. Speaking Up Safely (Assurance) | September 2025 | Planning. | |
| 26. On-call arrangements (Assurance) | September 2025 | Planning. | |

| Planned output | Outline timing | Status | Assurance (including draft report assurance opinions) |
|---|---|---|---|
| 27. Consultant Job Planning follow up | August/September 2025 | Brief agreed. | |
| 28. NICE guidance compliance (Assurance) | October-December 2025 | Planning. | |
| 29. Agency utilisation (Assurance) | January-March 2026 | | |
| 30. Tertiary Care services (Assurance) | October-December 2025 | | |
| 31. Estate Management (Assurance) | October-December 2025 | Brief issued. | |
| 32. Statutory Compliance: Asbestos Management (Assurance) | January-March 2026 | | |
| 33. Capital Systems (Assurance) | | Recommended for deferment. | - |
| 34. Wrexham Maelor Hospital Engineering Infrastructure Programme (Assurance) | | Recommended for deferment. | - |
| 35. Integrated Regional Care Fund (IRCF) Projects (Assurance) | October-December 2025 | | |
| 36. Falls Management follow up | May/June 2025 | Final report issued. | Assurance not applicable |
| 37. Contract management and procurement – Digital Data and Technology (Advisory) | June 2025 | Final report issued. | Advisory |
| 38. Contract management and procurement – Executive and Director corporate functions (Assurance) | August/September 2025 | Brief agreed. | |
| 39. Adult and Older Persons Mental Health Unit at Ysbyty Glan Clwyd (Assurance) | TBC | | |

## Themes and definitions

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

| Reference | Theme | Definition / Examples |
|---|---|---|
| 1 | Approvals | The internal control framework for securing approvals is ineffective.<br>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.<br>Information is not communicated clearly internally within teams, or externally with partners, for a or wider stakeholders.<br>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.<br>Contractual documentation has not been executed in a timely manner.<br>The contract is not being applied as intended. |
| 4 | Cyber Security | There is no strategy for maintaining cyber security and/ or it is deficient.<br>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.<br>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:<br>• Absence of key roles and associated responsibilities to provide good governance.<br>• Ineffective accountability and reporting structures with the absence of key scrutiny groups/ committees.<br>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. |

| Reference | Theme | Definition / Examples |
|---|---|---|
| | | There is limited/ no guidance on the expected arrangements for data and information management.<br>Insufficient records are maintained and/ or there are key gaps that would impact decision making.<br>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.<br>Lessons learnt are not regularly shared/ reviewed within the organisation.<br>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.<br>The systems are ineffective in capturing the required information to manage performance.<br>Performance information is not monitored and/ or shared.<br>Corrective action to address performance issues is not determined or is ineffective. |
| 10 | Physical Security | There is no strategy/ plan to maintain physical security.<br>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.<br>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.<br>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.<br>Defined reporting does not provide adequate information to support robust assurance, escalation and risk management.<br>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. |

| Reference | Theme | Definition / Examples |
|---|---|---|
| 14 | Resourcing | Organisational planning and management approaches do not incorporate consideration of demand and capacity.<br>Demand and capacity inadequately considered.<br>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.<br>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.<br>The strategy is not an effective tool in achieving organisational objectives. |
| 17 | Training & Development | There is no defined strategy for training and development.<br>Training needs have not been identified.<br>There is no plan in place to address identified training needs. |

# Appendix A

## Assurance Opinion

| | | |
|---|---|---|
|  | **Substantial** | Few matters require attention and are compliance or advisory in nature.<br>**Low impact** on residual risk exposure. |
|  | **Reasonable** | Some matters require management attention in control design or compliance.<br>**Low to moderate impact** on residual risk exposure until resolved. |
|  | **Limited** | More significant matters require management attention.<br>**Moderate impact** on residual risk exposure until resolved. |
|  | **Unsatisfactory** | Action is required to address the whole control framework in this area.<br>**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.<br>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]

# Orthopaedic Surgical Hub Llandudno Hospital

## Final Internal Audit Report

## 2024/25

## Betsi Cadwaladr University Health Board

Unsatisfactory Assurance

**Contents**



| | |
|---|---|
| **Review Reference** | BCU-SSU--2425-17 |
| **Fieldwork** | January – April 2025 |
| **Executive Sign Off** | 29th July 2025 |
| **Audit Committee** | August 2025 |
| **Executive Lead** | Russ Caldicott, Executive Director of Finance |
| **Audit Team** | Huw Richards, Head of Internal Audit |
| | Paul Stocker, Audit Manager |

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

# Executive Summary

## Purpose

The audit focused on the delivery and management arrangements in place to progress the development of an Orthopaedic Surgical Hub at Llandudno Hospital. This was the second audit undertaken of the project and it had been commissioned in accordance with the agreed provision (and associated funding) provided within the approved Business Justification Case (BJC) Integrated Audit Assurance Plan. The previous audit undertaken in 2023/24 determined **limited assurance**.

## Overview

We have concluded **unsatisfactory assurance** at the current review.

The project had been subject to further prolongation since the last audit undertaken in early 2024. The current estimated completion date was reported as January 2026, a further 11 months delay. noting the project was originally envisaged as being completed within 12 months.

Delays have been attributed to several factors, including design co-ordination, delays in ordering/procuring materials along with issues of procured components not meeting the tolerances required for the build.

The project was forecasting an anticipated overspend of approximately £1.6m over the approved budgeted allocation, with no contingency remaining at the time of the current review.

Quality issues were observed both with regard to the delivery of the scheme and the robustness of the quality assurance regime in place.

The key findings requiring management attention include the need to:

- address a number of High priority recommendations arising from the previous audit.
- evaluate the procurement strategy applied (and the delivery of the scheme as a whole).
- ensure the regularity of the Project Board meetings (which forms one of the key pillars of the Project Governance arrangements).
- maintain agreed improvements to project progress reporting to the Board/Executive level.
- address 'Gateway Review' outstanding recommendations detailed as 'Critical'.
- provide qualitative explanations to support reported VAT and equipment cost calculations,
- apply Project Bank Account requirements which remain outstanding or provide approved rationale for non-implementation.
- review the approval process for changes/variations ensuring compliance with Standing Orders/SFI's.
- address site inspection arrangements and preparation for commissioning.

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

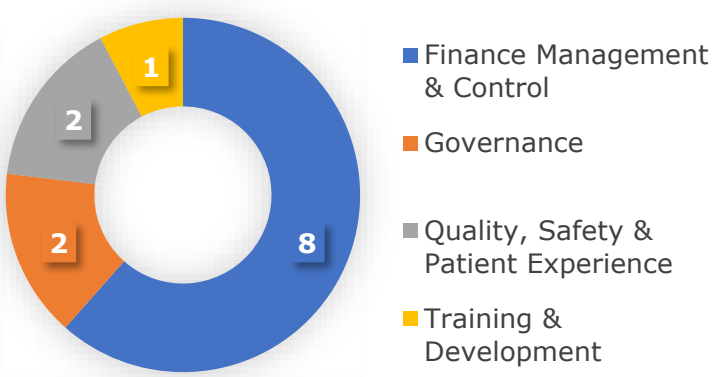
## Scope & Assurance Summary

| Objectives | The objectives and associated assurance ratings are not necessarily given equal weighting when formulating the overall audit opinion. | Related Findings | Assurance |
|---|---|---|---|
| 1 | Validation of Management Action - Assurance that previously agreed actions had been appropriately actioned by management | - | **Limited** |
| 2 | Project Performance - Consideration of performance against project objectives (e.g. time, cost, benefits, critical success factors etc.). | 1,2 | **Unsatisfactory** |
| 3 | Project Governance - Assurance that appropriate governance arrangements were in place for the current project phase. | 3,4,5 | **Unsatisfactory** |
| 4 | Financial Management - Adequate cost control and reporting systems are operated, both internally and by the External Cost Adviser. Assessment of the ongoing arrangements for the review of risk and associated management of contingency funds. | 6,7,8 | **Limited** |
| 5 | Validation of Costs - To ensure adequate processes and procedures are in place to ensure that the contractor is correctly reimbursed in accordance with the contract. This will include a review of the internal and contractual change control mechanisms are applied at the project. | 9 | **Limited** |
| 6 | Site progress - Assurance that the site supervisor and contractor have appropriate monitoring and reporting arrangements in place to manage progress on site. | 10,11,12 | **Unsatisfactory** |
| 7 | Equipping - To ensure that the equipping process is aligned with the key construction delivery timetable, and that there are appropriate management and reporting arrangements in place to ensure its co-ordination. | 13 | **Limited** |

## Management Actions

| 11 | 2 |
|---|---|
| High Priority | Medium Priority |

## Themes




## Risk Types

Financial Loss

Legal & Regulatory Non-Compliance

Quality or Safety Issues

Choose an item.

# Orthopaedic Surgical Hub Llandudno Hospital – At a Glance

## Cost

The latest cost report (Nr.12 March 2025) as reproduced in Table 1 estimated a variance of (£1.673m), against the original forecast cost. The project contingency had been fully exhausted with 45% of the programme remaining.

***Table 1***

| Financial Summary as at Project Cost Report Nr.12 March 2025 | | | |
|---|---|---|---|
| | **Budget** | **Forecast** | **Variance** |
| Main works contract sum | £9,215,280.00 | £9,215,280.00 | £0.00 |
| Priority works contract sum | £1,371,740.50 | £1,371,740.50 | £0.00 |
| Enabling works contract sum | £5,782,764.00 | £5,782,764.00 | £0.00 |
| Scottish Power | £186,000.00 | £186,000.00 | £0.00 |
| Architect (Contract Administrators) Instructions | | £2,519,889.70 | £2,519,889.70 |
| Extension of Time – loss and expense | | £279,827.68 | £279,827.68 |
| **Forecast Target Cost** | **£16,555,784.50** | **£19,355,501.88** | **£2,799,717.38** |
| Health Board Fees | £1,480,521.39 | £1,764,145.93 | £283,624.54 |
| Non-works costs | £341,570.88 | £441,570.88 | £100,000.00 |
| Equipment | £3,480,000.00 | £3,565,864.57 | £85,864.57 |
| Contingency- Risk Register | £1,676,123.00 | £0.00 | -£1,676,123.00 |
| **Sub Total** | **£23,533,999.77** | **£25,127,083.26** | **£1,593,083.49** |
| VAT | £4,706,799.95 | £5,025,416.65 | £318,616.70 |
| Less abatement HB Fees | -£296,104.28 | -£352,829.19 | -£56,724.91 |
| Less abatement works costs | £0.00 | -£182,093.93 | -£182,093.93 |
| **Forecast Total Cost** | **£27,944,695.45** | **£29,617,576.79** | **£1,672,881.35** |

## Time

At the time of the previous audit the original anticipated operational date had been revised from November 2024 to a contract end date of 25th February 2025., Due to ongoing and emerging delays the latest accepted Programme (rev.06 issued January 2025) had a revised completion date of 19th January 2026, significantly further delaying delivery of the project.

## Quality

Issues of quality have been identified both in respect of the overall assurance and testing regime in place and with regards to delivery of the project. These are further explored within findings under the heading 'Site Progress'.

# Findings & Agreed Action Plan

**Objective 1:** Validation of Management Actions | **Limited**

## Overview / Summary of Observations

A copy of the latest version of the audit tracker maintained by BCU Corporate Governance was obtained, it was noted that the majority of the recommendations had been listed as actioned (13/17) with a further (4/17) noted as agreed but not yet actioned.

On reviewing the status of the recommendations and the supporting evidence as provided the following was determined in respect of the status of recommendations agreed within the 2023/24 audit report (finalised September 2024). Details of each of these are available to view in Appendix A, and can be summarised as follows:

| | Complete | Outstanding | Closed - Superseded | **Total** |
|---|---|---|---|---|
| High | 5 | 4 | - | **9** |
| Medium | 7 | 1 | - | **8** |
| **Total** | **12** | **5** | **-** | **17** |

Recognising of the seventeen recommendations made at the initial review, twelve (70%) have been implemented, and noting four (44%) of the High Priority issues identified remained outstanding. Limited assurance has therefore been determined in respect of the follow up actions taken by management to address the previously agreed recommendations.

| **Objective 2:** Project Performance | **Unsatisfactory** |
|---|---|

## Overview / Summary of Observations

### Time

When considering the procurement/contract route for this Project, traditional routes for a project of this size/nature e.g. Design for Life were discussed and discounted by the UHB due to the predicted impact on the required delivery programme i.e. delivery within a condensed timeframe.

Utilising existing contractor frameworks for design and construction and accessing other already established frameworks in order to mitigate costs and achieve the desired programme were presented as the preferred contract strategy.

At the time of the previous audit, the original anticipated operational date had been revised from November 2024 to a contract end date 25th February 2025. Due to ongoing and emerging delays the latest accepted Programme (rev.06 issued January 2025) had a revised completion date of 19th January 2026, significantly further delaying delivery of the project. Several reasons were put forward for the delays including:

- Coordination issues between the main contractor and subcontractor. The Health Board's advisers believe this had contributed to poor progress on site.
- Design co-ordination issues between Architectural and Structural drawings resulting in demolitions being paused within X-Ray, while the structural engineer attended site to review. This had also impacted progress on the groundworks.
- Design co-ordination issues between the steel frame and the setting out information had resulted in certain parts of the steel frame having to be returned to the fabricator and amended off-site.

The separate work package for the enabling works was currently working to rev03 and was reported to be on track as per the latest PM report (March 2026).

The main contractor had been requested to demonstrate the interdependency between the main works and 'Power On' date as shown in the enabling works, with a revised programme to illustrate the same. The UHB have advised that discussions were ongoing with the Supply Chain Partner, Advisers and SES and ultimately WG to identify ways to expedite aspects of the project to bring forward the operational date of the facility.

### Cost

The latest cost report (Nr.12 March 2025) estimated a variance of (£1.673m), against the original forecast cost. However, noting the delays to date it would be anticipated that costs may rise further, potentially including inflationary pressures for materials and equipment, staff costs for the additional time period, and extension of time allowances (EOT) which, at the time of the current review, had been assessed at £279k.

The project contingency had been fully exhausted, with the latest PM report (11/04/2025) recording that the additional contingency figure held by WG would be required. Assuming maintenance of the January 2026 completion date there is 45% of the programme remaining with limited contingency provisions.

### Quality

Several issues had been identified, including some of those noted under the 'Time' element, further considerations in respect of quality are raised elsewhere within this report under the 'Site Progress' objective, including the inspection regime and Health & Safety issues.

It should be noted that the latest PM report noted that *'the installation of containment, ductwork, pipework etc. had proceeded at risk on site, at the contractor's discretion. A formal notification identifying this risk was issued by Gleeds, this will be updated to reflect the further works that are now proceeding without a signed off WS4 design'.*

Recognising the prolongation of the project programme, the cost escalation and quality issues reported, unsatisfactory assurance had been determined in respect of project performance

| Key Findings | | Risk & Impact | Agreed Management Action |
|---|---|---|---|
| 1 | **Procurement/Contract Strategy**<br><br>The project is being delivered utilising the JCT Standard Building Contract Without Quantities (2016). To date, the project has experienced significant performance issues, including delays, cost uncertainty, and difficulties in managing scope changes. These issues suggest that the form of contract may not be optimally aligned with the complexity and risk profile of the project.<br><br>It is acknowledged that as part of original efforts to expedite the project to meet WG expectations it was decided that a JCT Contract without quantities would offer the best solution.<br><br>The UHB may wish to undertake a formal review of its choice of contract strategy, specifically the suitability of the JCT Standard Building Contract Without Quantities (2016) for complex or evolving project environments. The review could assess whether an alternative form would provide better mechanisms for collaborative risk management, cost control, and programme certainty.<br><br>The findings of this (and a wider evaluation of the project delivery would help mitigate these issues on future projects. | Limited flexibility for change management, minimal incentivisation for contractor performance, and reduced visibility of cost forecasting—all of which may be contributing factors to the project's poor performance. | **Agreed Action:**<br><br>Each specific project within the annual Capital Programme shall be subject to a documented delivery strategy including the project specifics, phasing/decant plan, design strategy, procurement strategy, risk management strategy and shall be used as part of the contract selection criteria. The strategy for each project shall be presented to the Director of Environment and Estates for agreement prior to inclusion in the business case. This shall be part of the business case (Commercial Case) and shall document the contract adopted and the benefits and risks.<br><br>The approach undertaken with regards to Llandudno will not be progressed for future developments, with contracts awarded based on financial ceilings.<br><br>*LOH: Contract executed so limited opportunity to change other than specific terms and such is unlikely to be accepted by the contractor.* |
| | | | **Expected Evidence of Implementation:**<br><br>Contract award controlled through Standing Orders, Scheme of Reservation & Delegation and Standing Financial Instructions (governance of the Health Board) with sign off by the Executive Director of Finance for future contract award. |
| | | **High Priority** | **Officer: Director of Corporate Governance & Executive Director of Finance**<br><br>**Target Implementation Date:**<br><br>**October 2025** |
| | **Theme:** Finance Management & Control | Control Operation | |

| Key Findings | | Risk & Impact | Agreed Management Action |
|---|---|---|---|
| 2 | **Design delays**<br><br>Prior to going out to tender the UHB engaged a design team to achieve a RIBA Stage 4 level of design to ensure that wherever possible the contractor had sufficient design information during the tender stage to provide a full cost assessment. However noting the nature of the project, it was agreed that a level of further design work would be required by the successful contractor for the project to proceed.<br><br>When the Works packages were assigned to the successful bidders the UHB design team were not novated across to the appointed contractor who wished to engage their own Mechanical & Engineering (M&E) design team. It is understood however that the UHB has maintained the services of their design team to provide support during the project.<br><br>The Project to date has suffered from significant delays, some of which are attributable to design considerations, of note are the following extracts from update reports (Highlight reports and Project Manager's Reports for February and March 2025), showing a timeline of design delay issues:<br><br>• The WS4 (design) submission received in February (2025) was incomplete. The contractor was informed of this in February, following a formal notification sent in January.<br>• Design review held on 14 February; further submissions received on 17 and 19 February. Comments from the client and design team issued on 5 March; contractor comments received on 7 March and addressed by 10 March.<br>• No revised WS4 submission was received, leading to escalation on 27–28 March. The contractor returned the comment tracker on 31 | Unresolved design issues or outstanding requests for information (RFIs), impacting the delivery of the project. | **Agreed Action:**<br><br>The design strategy included in Action 1 above will be used to assess the core packages to be employer or contractor designed and include:<br><br>1. Who undertake what design packages.<br>2. The design stages.<br>3. Design transfer/novation arrangements.<br>4. Design warranty or professional indemnity arrangements.<br>5. Roles and responsibilities under the contract and for the retained team.<br>6. Coordination and technical submission arrangements and design variance obligations/restrictions.<br><br>The criteria may vary according to the specific project. Each project shall, at the earliest opportunity, include an integrated programme for all stages to post-occupation evaluation to the design strategy.<br><br>The design development, programme and risks shall be reviewed monthly and reported with escalation and mitigation.<br><br>*LOH: Continue to report and review monthly with escalations and mitigations.* |

| | | | |
|---|---|---|---|
| | March, requesting clarifications. No resubmission date is confirmed. Installation of containment, ductwork, and pipework is proceeding at the contractor's risk. Gleeds issued a formal risk notification, which will be updated to reflect ongoing works without approved WS4 design.<br><br>The above issues would suggest either a poor design solution, poor design development and co-ordination or lack of readiness to proceed to the market. The reasons for the design issues arising at the scheme should be formally assessed to determine any key responsibilities and associated performance and/or contract mechanisms to address the same. | | **Expected Evidence of Implementation:**<br><br>Agreement to a working design supported as compliant for environment for treatment of these patients, supported through NWSSP colleagues and Welsh Government. |
| | | **High Priority** | **Officer: Director of Environment and Estates**<br><br>**Target Implementation Date:**<br><br>**August 2025** |
| | **Theme:** Finance Management & Control | Control Operation | |

| **Objective 3:** Project Governance | **Unsatisfactory** |
|---|---|

## Overview / Summary of Observations

A Project Execution Plan (PEP) was developed and updated to Version 2.0 in December 2024. The document outlined the processes and procedures for project administration, including the roles and responsibilities of key staff, as well as oversight provided by Programme and Project Boards. The collective governance framework was visually represented within a Project Organisational Structure.

The role of Senior Responsible Officer (SRO) for the Project was previously held by the Executive Director of Transformation and Strategic Planning, but following staff changes and a revised Governance Structure developed in February 2025 the role of SRO had been taken over by the Executive Director of Finance. Since the last audit the role of Programme Director had also been subject to a change, with a new Director in post since August 2024.

Other changes to the management of the Project included a new UHB Senior Project Manager assuming responsibility in March 2025.

A number of forums/meetings had been established including the Project Board, Monthly Project Progress meetings, along with commercial meetings.

However, the changes in key project leadership roles and responsibilities and Project Board structure/meetings, have occurred against a background of a Project that is beset with issues affecting time, quality and cost. The failure to hold Project Board Meetings for two consecutive months in 2025 is particularly concerning and is one of the limiting factors as regards overall assurance for this objective.

Whilst the Project initiation Document (PID) was revised to reflect a new governance structure in late 2024, changes since necessitate that this be revised again.

| Key Findings | | Risk & Impact | Agreed Management Action |
|---|---|---|---|
| 3 | **Project Board meetings**<br><br>The minutes from the January 2025 Project Board meeting could not be accessed due to a technical issue with the recording software. It was confirmed that the minutes were not recoverable.<br><br>Additionally, no Project Board meetings were held in February or March 2025. The organisation had advised that meetings were expected to resume in April 2025.<br><br>The Project Board's Terms of Reference required meetings to be held monthly. Given the status of the project in relation to Time, Cost, and Quality parameters, this lapse in governance and oversight during a critical phase is of particular concern. | Lack of oversight and governance of the project – with Time, Quality and Cost not subject to reporting and/or scrutiny. | **Agreed Action:**<br><br>Board meetings were not undertaken following the Senior Responsible Officer Executive Director leaving the Health Board. These meetings have re-commenced and evidence can be provided as required to confirm this to be the case.<br><br>**Expected Evidence of Implementation:**<br><br>Minutes of the meetings |

| | | | |
|---|---|---|---|
| | | **High Priority** | **Officer: Executive Director of Finance**<br>**Target Implementation Date:**<br>**Implemented April 2025 onwards** |
| | **Theme:** Governance | Control Operation | |
| 4 | **Project reporting**<br>The previous audit of the project recommended that management ensure that regular project updates be provided to the various UHB groups and committees. Management had reported that this had been actioned with bi-monthly reports provided to the Executive Management. However except for a December 2024 report, no further reports or updates to the Board or Exec Management in respect of the Project were identified. | The Board and or Executive Management are not kept appraised of Project progress- lack of oversight | **Agreed Action:**<br>Project status report presented through a development session of the Executive and further an update and report on progress was presented to the July 2025 Executive, with a verbal update on the wider positioning in regard to the development.<br>**Expected Evidence of Implementation:**<br>Report to Executive (formal and informal) |
| | | **High Priority** | **Officer: Executive Director of Finance**<br>**Target Implementation Date: Implemented** |
| | **Theme:** Governance | Control Operation | |
| 5 | **SRO Formal Acceptance**<br>The Gateway review undertaken in July 2024 made a number of recommendations, these were followed up in November 2024 with findings reported within an Assurance of Action Plan Document.<br>This follow up report noted that "*two key outstanding issues which require action are the agreement of delegations to the SRO including spending authorities, and the formal appointment letter for the SRO setting out roles, responsibilities and delegations".* The Gateway team assessed this as being 'critical', 'address now'.<br>Since the report was published the role of SRO has transferred to another UHB Exec Director but no evidence was provided to | Non-compliance with Capital Procedure Manual and failure to address Gateway Formal recommendation. | **Agreed Action:**<br>A standard approach to appointment of SRO within the Health Board will be formally ratified by the Health Board, covering areas such as:<br>1. The roles and responsibilities of the SRO.<br>2. Project specific delegations and authorities.<br>*3.* Requesting counter signature of the SRO accepting the duties and appointment and confirming they have capacity to undertake the role.<br>**Expected Evidence of Implementation:**<br>Ratified approach to appointment of SRO agreed through the Executive to cover appointment and duties. |

| | | | |
|---|---|---|---|
| | our audit review that this outstanding recommendation had been addressed for the role of SRO either before or after the change of incumbent. | **High Priority** | **Officer: Director of Corporate Governance**<br>**Target Implementation Date:**<br>**October 2025** |
| | **Theme:** Governance | Control Operation | |

| **Objective 4:** Financial Management | **Limited** |
|---|---|

## Overview / Summary of Observations

The UHB had established Capital Procedures through its Capital Projects Manual, although noting these were last updated in December 2020.

The Project Board had been provided with monthly cost reports produced by the UHB's external Cost Advisers. The provision of the cost reports was supplemented by the monthly Project Highlight reports which serve to complement the cost information with more qualitative updates that illustrate the challenges and opportunities that the cost position presents.

The UHB had prepared and provided Welsh Government (WG) with the required Project Progress Reports. During the review period, reports for September 2024 and January 2025 were noted and these were found to include copies of the latest cost reports and project highlight reports, reflecting those reported internally. Appropriate narrative being recorded to appraise WG of project progress and risks.

A Project Risk Register was maintained and shared as an agenda item at Project Board and Project Progress meetings. The risk register template follows the Welsh Government Design for Life: Building for Wales template. Moving into the Construction stage, the risk register had been updated to include six main sections, however, the project's contingency had been fully exhausted and no longer sufficient to meet materialising project risks The issue of costs in respect of the project has been noted in cost reports provided by the UHB's advisers with the March 2025 recording that report noting that *"as previously reported the risk relating to not receiving firm costs from the contractor has been realised and the contingency figure held by Welsh Government will need to be considered".*

Project delays have also resulted in adverse cashflow management in respect of the UHB's utilisation of its Capital Resource Limit (CRL) for 2024/25. The projected outturn as reported at month 11(2024/25) for this project being £11.356m against the forecast outturn for the year of £23m as recorded at month 1(2024/25). Welsh Government had been kept informed of the slippage in line with its requirements as outlined within the NHS Wales Infrastructure Guidance. The Month 12 report for the BCU Capital Investment Group noted that All Wales funding be re-provided through brokerage for the 2025/26 financial year.

| Key Findings | | Risk & Impact | Agreed Management Action |
|---|---|---|---|
| 6 | **Project VAT calculations**<br><br>At BJC (January 2024), the recoverable VAT for the Project was estimated at £257,392, all attributable to fees, as assessed at the time. However, by July 2024, an additional £910,000 in potential VAT recovery was identified and reported contributing to a revised forecasted total cost of £27,034,255 against the approved budget of £27,944,695. This reduction in the forecast was attributed to an applied 9.88% abatement to the works element.<br><br>This revised VAT figure, representing a potential saving of £910,000, was later reassessed by the VAT advisers and by February 2025, Cost Report No. 10 confirmed that this entire £910,000 VAT abatement on the Main Works had been re-evaluated and ultimately removed. There remains a lack of | Inaccurate VAT assessments on this scale skews potentially impacting project planning and assumptions. | **Agreed Action:**<br><br>The Standing orders, Scheme of Reservation and Delegation and Standing Orders will require for each major project professional recoverable VAT advice to be sought for the conclusion of each project decision gateway to validate any assumptions included within the cost plan. For instance, SOC, OBC, FBC and final account.<br><br>*Amendments to the Standing Financial Instructions, Scheme of Delegation and Standing Orders of the Health Board will be updated to require the Capital Accountant to agree through expert advice from the Health Boards VAT adviser will be sought to inform any to update the VAT position to be procured.* |

| | | | |
|---|---|---|---|
| | transparency and reporting for the significant changes in the VAT assumptions made to date. | | **Expected Evidence of Implementation:**<br>Revised SFI, SO & Scheme of Reservation and Delegation includes requirement for Vat advice on all major capital projects |
| | | **High Priority** | **Officer: Director of Corporate Governance & Executive Director of Finance**<br>**Target Implementation Date: October 2025** |
| | **Theme:** Finance Management & Control | Control Operation | |
| 7 | **Capital Projects Manual**<br>The Capital Projects Manual and its Addendum were last updated in December 2020 (Version 11). Since then, several changes have occurred that are not incorporated into the current version. As a key resource for managing capital expenditure, the manual should reflect the most current guidance and requirements to remain an effective and relevant reference tool. | Outdated guidance available with risk of non-compliance with either best practice or in keeping with current regulations/requirements | **Agreed Action:**<br>The current Capital Projects Manual shall be reviewed by the Director of Environment and Estates in conjunction with the Health Boards Capital Accountant |
| | | | **Expected Evidence of Implementation:**<br>Revised Capital Projects Manual |
| | | **Medium Priority** | **Officer: Director of Environment & Estates**<br>**Target Implementation Date: March 2026** |
| | **Theme:** Finance Management & Control | Control Operation | |

| | | | |
|---|---|---|---|
| 8 | **Changes approvals**<br><br>The Project has been subject to several Contract Administrator Instructions (CAI), a sample of three with values greater than £150k were reviewed for appropriate approval.<br><br>The UHB Capital Procedure Manual (2020) notes that variations/changes in excess of £150k are to be approved by the Executive Director of Finance and the SRO.<br><br>Copies of signed approvals for the sample CAI's was requested but have not been provided. Additionally, the review could not identify discussion of these changes in the minutes of Project Board meetings for the period concerned. | Non-compliance with SO's/SFIs, WG requirements. | **Agreed Action:**<br><br>The Director of Environment and Estates will investigate why the Health Board has not complied with the requirements of the Capital Procedure manual, with all approvals moving forwards compliant with the governance of the Health Board. |
| | | | **Expected Evidence of Implementation:**<br><br>Report to Executive on the non-compliance and rationale to the Executive for the three awards and assurances over continued compliance with the manual moving forwards. This may change following updating of the manual as referred to earlier. |
| | | **High Priority** | **Officer: Director of Environment and Estates**<br><br>**Target Implementation Date: October 2025** |
| | **Theme:** Finance Management & Control | Control Operation | |

| **Objective 5:** Validation of costs and contractual payments | **Limited** |
|---|---|

### Overview / Summary of Observations

Recognising the JCT Standard Form Building Contract Without Quantities applied at this scheme, interim payments are based on agreed rates, with monthly payments determined within the cashflow forecast. This had been revised during the project to reflect changes to the programme with regards to overall timescale.

Fieldwork testing of the December 2024 interim valuation noted that the UHB's Contract Administrator had prepared the valuation and interim certificate in accordance with the contract, and payment had been appropriately authorised. However, the valuation included a reduced (3%) retention figure compared to that specified within the formal conditions of contract i.e. 5%. The UHB's advisers indicated that the figure of 5% retention figure had been subsequently challenged by the main contractor and one of its main subcontractors and it had been subsequently agreed to revise the project retention to the lower figure of 3%.

At the time of the audit fieldwork, the Project Bank Account had still not been established (as recommended at the previous audit). The management action therefore remains open and in conjunction with the finding as regards approval of the revised retention figure, **limited** assurance has been determined.

| Key Findings | | Risk & Impact | Agreed Management Action |
|---|---|---|---|
| 9 | **Retention figure**<br>Noting that the agreed 5% contract retention has subsequently been reduced to reflect the Main and sub-contractors' requirements. Noting the key change in the agreed contract conditions and award criteria, formal Project Board scrutiny/challenge and approval of the same was not evidenced. | Reduced oversight and loss of control of key decision making | **Agreed Action:**<br>The process for movement on retention values will be documented in the revised Scheme of Reservation and Delegation. |
| | | | **Expected Evidence of Implementation:**<br>Reference to delegation route for decisions on retentions to be referenced within the Scheme of Reservation and Delegation |
| | | **High Priority** | **Officer: Director of Corporate Governance and Executive Director of Finance** |
| | **Theme:** Finance Management & Control | Control Operation | **Target Implementation Date: October 2025** |

| **Objective 6:** Site Progress | | Unsatisfactory |
|---|---|---|

**Overview / Summary of Observations**

A site visit was conducted on 17th February 2025, accompanied by the UHB's Senior Project Manager and the main contractor's Site Manager.

During the visit, it was observed that site access from the hospital side was restricted via access-controlled doors, which could only be operated by the main contractor's workforce. As a result, hospital staff and patients were excluded from the area.

The client had appointed independent Health & Safety Consultants, who were initially conducting monthly site inspections, with findings documented in Site Safety Inspection Reports. These reports were shared at the Project Progress Meetings. Following concerns raised by the client and issues identified by the Health & Safety Consultants during inspections, the frequency of visits was increased to weekly. Subsequent reports indicated that the required improvements were implemented.

The client had also appointed two Clerks of Works to the Project, one specialising in electrical and the other mechanical and engineering disciplines.

The Clerks of Works maintained records of their site visits. Evidence was provided confirming that issues identified during these visits were communicated at Project Progress Meetings and followed up via email correspondence with the client's advisers and the main contractor.

The Clerks of Works did note however concerns regarding the maintaining of records which would form part of the programme of commissioning to be undertaken prior to project completion.

| | Key Findings | Risk & Impact | Agreed Management Action |
|---|---|---|---|
| 10 | **Inspecting Regime RIBA Stage 5**<br><br>The RIBA 2020 Plan of Work notes that *"It is crucial that it is clear who is to inspect Construction Quality, so that the client can be sure the building will be delivered in line with the requirements of the Building Contract".*<br><br>As this is a JCT contract, the organisation opted to fulfil the traditional Clerk of Works function using internal staff. Two specialist roles were assigned to cover Electrical and Mechanical & Engineering aspects of the project.<br><br>However, it was noted that there is an assurance gap relating to the inspection of the general construction elements of the build. The RIBA Plan of Work 2020 recommends that *inspections should be carried out by individuals with experience in similar construction* | Inspection regime not adequately covering all aspects of the project – quality of work issues may go unchallenged. | **Agreed Action:**<br><br>When a NEC suite contract is used, there is a contractual requirement for the use of Supervisors to routinely inspect and report upon the works. When a JCT suite contract is used, BCUHB shall appoint equivalent appointments for Clerk of Works to inspect and report upon the works. Both approaches provide assurance relating to the works with the reports passed to the Project Manager for inclusion in the monthly progress report.<br><br>*LOH: The appointment of a building Clerk of Works in unlikely to benefit the scheme at this stage. However, BCUHB to request the architect undertakes site inspections and reports on compliance with their design. M&E inspections to continue.* |

| | | | |
|---|---|---|---|
| | *technologies.* The absence of dedicated oversight in this area raises concerns regarding the adequacy of assurance over the broader construction works. | | **Expected Evidence of Implementation:**<br>Instruction to architect from Director of Environment and Estates, with resultant reports presented through Project Board as part of the Estates update. |
| | | **High Priority** | **Officer: Director of Environment and Estates**<br>**Target Implementation Date: September 2025** |
| | **Theme:** Quality, Safety & Patient Experience | Control Design | |
| 11 | **Inspection restrictions**<br>It was noted from conversations with the respective Clerks of Works that they did not enjoy unfettered access to the site as they were not in possession of the appropriate Construction Site Safety Certification (CSCS) to allow unaccompanied visits. As a result, visits now depend on the availability of the main contractor, with Clerk of Works personnel requiring accompaniment by main contractor employees. | Site inspections not able to be conducted unannounced – restricted access with ramifications for the robustness of the inspection regime. | **Agreed Action:**<br>BCUHB staff responsible for site visits shall be required to attain the appropriate CSCS accreditation commensurate with their role. This shall be deemed an essential qualification to the satisfactory execution of their duties.<br>*LOH: Staff to be requested to obtain CSCS accreditation if their role requires it.* |
| | | | **Expected Evidence of Implementation:**<br>Sharing on enrolment details in course and accreditation in estates updates to project Board |
| | | **Medium Priority** | **Officer: Director of Environment and Estates**<br>**Target Implementation Date: December 2025** |
| | **Theme:** Training & Development | Control Design | |
| 12 | **Commissioning Programme**<br>The Clerks of Works noted that they had concerns over the programme of commissioning, this view is supported by the latest Project Manager's report which notes under | Robustness of this quality assurance process compromised with potential for cascading | **Agreed Action:**<br>At the outset of the project adequate time shall be allowed for commissioning, witnessing and validation according to the specific requirements of the project |

| | | | |
|---|---|---|---|
| | the key risk/issues section that *A detailed commissioning programme needs to be developed with input from the BCUHB / NWSSP teams. This needs to demonstrate the interdependency between both the Main and Enabling Works programmes.* The report provides further background as to the issues and engagement to date.<br><br>A formal commissioning programme was requested in Contract Administrator's Instruction (CAI) 113 issued on 13th January 2025. The first iteration that was received on 11th February did not provide sufficient detail and this was notified to the contractor, along with examples of commissioning programmes from other projects, to demonstrate the required level of detail. A revised commissioning programme is awaited.<br><br>Whilst noting the above concerns as raised about commissioning it is understood that the UHB are seeking to condense the commissioning process to achieve a handover of patient areas ahead of the revised completion date. Given difficulties to date this would require careful consideration and planning, with potential risks assessed and included within the Project Risk register with potential costings for any mitigation required. | failures, higher costs, and operational inefficiencies. | including the appointment of a Commissioning Manager.<br><br>*LOH: A commissioning manager has been appointed and integrated programme for agreement and adoption by stakeholders is being developed.*<br><br>**Expected Evidence of Implementation:**<br><br>Commissioning programme to be presented to Project Board and Executive for endorsement |
| | | **High Priority** | **Officer: Director of Environment and Estates**<br><br>**Target Implementation Date: October 2025** |
| | **Theme:** Finance Management & Control | Control Design | |

| **Objective 7:** Equipping | **Limited** |
|---|---|

## Overview / Summary of Observations

Procurement for the project is managed by NWSSP Procurement, led by two Procurement Managers. Clinical items are largely sourced via catalogue, while more complex and high-value items are procured through framework agreements.

Design sheets, maintained electronically by the UHB's architects, detail equipment requirements for each room and are securely stored with restricted access. Due to programme delays, some procured items—particularly electronic devices—are being temporarily deployed at the existing orthopaedic facility at Abergele Hospital to ensure they are suitably assessed for Electro-Bio Medical Engineering (EBME) safety, compliance, and calibration checks.

Project Highlight Reports reviewed confirmed that procurement and supply issues have been actively communicated. The November 2024 report noted outstanding orders for long-lead items, with focused resolution meetings planned for December.

In parallel, a proactive review was underway to identify existing equipment at Abergele Hospital suitable for transfer to Llandudno. Spreadsheets detail items to be repurposed, with site visits and discussions held with clinical teams and EBME to ensure continued viability and manufacturer support.

While this reuse strategy should help reduce overall spend, the January 2025 cost report still reflects the original estimated equipment budget, with a slight increase of £85k. The rationale for this uplift is unclear and is addressed separately under the "Validation of Costs" section of this report.

| | Key Findings | Risk & Impact | Agreed Management Action |
|---|---|---|---|
| 13 | **Equipment budget**<br><br>The Project has an equipment budget of £3.4m and the outturn figure has remained as such despite, the work going on to reuse existing equipment where possible, it would be anticipated that this would feed into projected savings. However, the outturn has instead recently increased by £85k with no narrative explaining the reason for this increase.<br><br>It is not clear at the present time what the eventual equipment expenditure will be, given the above, and issues over the ordering and supply of equipment, with possible financial and availability ramifications.<br><br>The ongoing design issues (and absence of formal sign off) could also adversely impact on the final equipment schedules, budget and ultimately the outturn costs. | Equipment budget estimated outturn figure does not reflect possible risks/opportunities. | **Agreed Action:**<br><br>A genuine pre-estimate of equipment and costs shall be undertaken at key stages using the signed-off C-Sheets and Room Data Sheets and if not prepared by the Cost Manager, shall be reviewed by the CM. An audit of the equipment approved as required, equipment ordered and equipment delivered shall be undertaken as appropriate.<br><br>*LOH: A review to validate the budget cost and equipment required, ordered and delivered was commenced in July 2025. A report will be presented at the August Board.* |

| | | | |
|---|---|---|---|
| | | | **Expected Evidence of Implementation:**<br>Expenditure on Equipment compared to original plan to be presented to Project Board and escalated as required. |
| | | **High Priority** | **Officer: Director of Environment and Estates**<br>**Target Implementation Date: September 2025** |
| | **Theme:** Finance Management & Control | Control Operation | |

# Appendix A – Validation of Management Action

## Recommendations agreed at the 2023/24 audit

| Orthopaedic Surgical Hub Llandudno Hospital (September 2024) | | | | Previously providing  | |
|---|---|---|---|---|---|
| **Ref** | **Area** | **Previously agreed Action** | **Current Status** | **Revised Responsibility & Timescale** | **Priority Rating** |
| 1.1 | Project Delays | The contractual issues on the main works contract have now been resolved and contract signed. | Actioned | Head of Capital Development - complete | **High** |
| 2.1 | Project Governance | The UHB have introduced formal minute taking in respect of the Programme Board and Project Board meetings from Apr-24 (evidence provided but outside of review timeline). | Actioned | Project Director – April 2024 | **Medium** |
| 2.2 | Project Governance | Verbal updates will be by exception only going forward, however written highlight reports now provided at all meetings re: Capital Update and Overall Programme Update (evidence provided but outside of review timeline. | Actioned | Project Director May 2024 | **Medium** |
| 2.3 | Project Governance | The UHB have introduced formal minute taking in respect of the monthly Programme Board meetings from May-24 onwards (evidence provided but outside of review timeline). Minutes are agreed and reviewed in each project board and stored in a central repository. | Actioned | Project Director May 2024 | **Medium** |
| 3.1 | Project Governance | The PEP is to be updated to reflect current project status and the | Actioned | Head of Capital Development – August 2024 | **Medium** |

| Orthopaedic Surgical Hub Llandudno Hospital (September 2024) | | | Previously providing  | | |
|---|---|---|---|---|---|
| **Ref** | **Area** | **Previously agreed Action** | **Current Status** | **Revised Responsibility & Timescale** | **Priority Rating** |
| | | governance refresh agreed following Gateway review. | | | |
| 4.1 | Tender Evaluation | The HB received two submissions for the main contract works which allowed commercial comparison between Complete Head of Capital Development Orthopaedic Surgical Hub Llandudno Hospital Final Internal Audit Report 20 both contractors. Contractors were vetted both on technical and commercial criteria. The appointed contractor scored highest on both commercial and technical. This allowed the cost advisors confirm value for money. KPI meetings arranged for October 2024. | Actioned | Head of Capital Development - Complete | **High** |
| 4.2 | Tender Evaluation | On submission and award of the tender the risk register was reviewed and adjusted in line with tender submission. The relevant risks were maintained, closed risks were omitted / reduced. Value for money covered in 4.1. To be covered during October 2024 KPI review. | Not actioned – further supporting evidence required. | Head of Capital Development - Complete | **High** |
| 4.3 | Financial Management | Discussions to take place with DoF/Deputy DoF to discuss most appropriate approval route. | Actioned | Head of Capital Development – August 2024 | **High** |
| 4.4 | Financial Management | 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. | Not actioned – see current finding (8). | Senior Project Manager<br><br>September 2024 | **High** |

| Orthopaedic Surgical Hub Llandudno Hospital (September 2024) | | | Previously providing  | | |
|---|---|---|---|---|---|
| **Ref** | **Area** | **Previously agreed Action** | **Current Status** | **Revised Responsibility & Timescale** | **Priority Rating** |
| 4.5 | Tender Evaluation | Agree, sufficient time should be allowed within business case preparation to provide fully tendered at Complete Head of Capital Development Orthopaedic Surgical Hub Llandudno Hospital Final Internal Audit Report 21 submission stage. Due to the time constraints this was not feasible within this scheme. | Implemented – for future projects | Head of Capital Development - Complete | **Medium** |
| 4.6 | Financial Management | The amount required from the WG held contingency was reported at Project Board, PFIG and WG meetings following the enabling works tender receipt. Any changes to this requirement will be reported through project board risks recorded on the risk register and highlighted through the cost reports. PPR report are provided direct to WG provided regular updates | Actioned | Head of Capital Development - Complete | **Medium** |
| 5.1 | Financial Management | 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. | Outstanding project bank account not in place. | Head of Capital Development – Late 2024 | **High** |
| 6.1 | Financial Management | Regular updates/presentations have been provided to the Executive Team following requests from the CEO. As a key deliverable within our Special Measures Framework, monthly updates are provided via the governance route or the Annual Plan | Actioned | Programme Director<br><br>Complete | **High** |
| 7.1 | Contractual Appointments | UHB advised actioned – Detail as per 7.2 | Not actioned – unclear that information as provided addresses this. | Head of Capital Development - Complete | **High** |

| Orthopaedic Surgical Hub Llandudno Hospital (September 2024) | | | | Previously providing  | |
|---|---|---|---|---|---|
| **Ref** | **Area** | **Previously agreed Action** | **Current Status** | **Revised Responsibility & Timescale** | **Priority Rating** |
| 7.2 | Contractual Appointments | However, the design team, cost advisors and CDM advisors are all from the health board local design team frameworks. The external PM was appointed on the SBS framework as supported by procurement. | Not actioned – main tenet of recommendation has not been addressed. | Head of Capital Development - Complete | **Medium** |
| 7.3 | Contractual Appointments | The initial works packages were under £7m, however this procurement plan changed during the design stage that led to contract values over £7m. For future health board framework inception forms to be used. | Actioned | Head of Capital Development - Complete | **High** |
| 7.4 | Contractual Appointments | Cost Advisor are instructed to prepare contract prior to pre-start meeting. | Implemented – for future projects | Head of Capital Development - Complete | **Medium** |
| 8.1 | Design | 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 | Not actioned – no evidence provided to support this, also noting ongoing design issues. | Senior Project Manager – August 2024 | **Low** |
| 9.1 | Planning | Condition tracker to be requested from Architect and submitted as appendices to highlight report. | Actioned | Senior Project Manager – September 2024 | **Low** |

# Appendix B

## Assurance Opinion

| | | |
|---|---|---|
|  | **Substantial** | Few matters require attention and are compliance or advisory in nature.<br>**Low impact** on residual risk exposure. |
|  | **Reasonable** | Some matters require management attention in control design or compliance.<br>**Low to moderate impact** on residual risk exposure until resolved. |
|  | **Limited** | More significant matters require management attention.<br>**Moderate impact** on residual risk exposure until resolved. |
|  | **Unsatisfactory** | Action is required to address the whole control framework in this area.<br>**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.<br>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]

# Waiting List Initiative payments – IHC Centre

## Final Internal Audit Report

## 2024/25

## Betsi Cadwaladr University Health Board

Limited Assurance

**Contents**



| | |
|---|---|
| Review Reference | BCU-2425-34 |
| Fieldwork | February-March 2025 |
| Executive Sign Off | 2 May 2025 |
| Audit Committee | June 2025 |
| Executive Lead | Tehmeena Ajmal, Chief Operating Officer |
| Audit Team | Dave Harries, Head of Internal Audit<br>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 in the Integrated Health Community (IHC) Centre for identifying, agreeing and approving Waiting List Initiative (WLIs) payments.

## Overview

The Amendment to the National Consultant Contract in Wales includes a section on WLI sessions as follows:

*2.36 Waiting List Initiatives work may be requested by the employer to be carried out in addition to the Consultant's contracted sessions.*

*2.37 These additional sessions will be voluntary.*

*2.38 Such sessions may be undertaken in uncontracted time.*

WLI is an additional clinic or list undertaken outside of core contracted hours to alleviate or reduce patient waiting times. It must have been identified and approved to deliver the Health Board's planned care activity or to address specific activity and funding allocated by Welsh Government.

WLI work is temporary and voluntary - it does not form part of the Consultant job plan and must be undertaken in uncontracted time.

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

- There is no standard operating procedure within the Health Board to ensure standardisation and equity across all its services. We were advised local procedures were in place but received no evidence to support this assertion.
- We were unable to verify actual WLI activity reviewed to the majority of job plans as the job plans had not been agreed and we therefore could not verify that WLI activity was undertaken outside of a contracted session.
- We noted on some approved claims that WLI activity was undertaken on Supporting Professional Activity (SPA) session, with the displaced SPA then undertaken at another time. We are unclear how this complies with paragraph 2.38 of the National Contract.

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

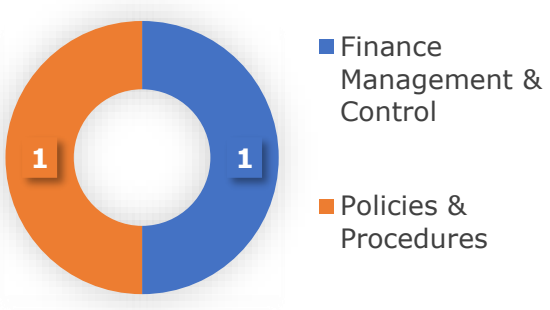
## Scope & Assurance Summary

| Objectives (The objectives and associated assurance ratings are not necessarily given equal weighting when formulating the overall audit opinion.) | | Related Findings | Assurance |
|---|---|---|---|
| 1 | There is a current WLI procedure in place that is available for all staff that align with the Amendment to the National Consultant Contract in Wales. | 1 | **Unsatisfactory** |
| 2 | WLI activity is only commissioned and agreed to be undertaken in uncontracted time. | 2 | **Limited** |

## Management Actions

| 2 | 0 |
|---|---|
| High Priority | Medium Priority |

## Themes




## Risk Types

Quality or Safety Issues

Financial Loss

# At a Glance:

## Health Board Waiting List Initiative payments for April to November 2024

| Health Board Cost Centre | Number of claims paid | Gross Cost £ |
|---|---|---|
| 050 Diagnostics & Specialist Clinical Support (HX80) L5 | 307 | 1,061,105.99 |
| **050 Ysbyty Glan Clwyd (HX21) L5** | **444** | **441,986.33** |
| 050 Ysbyty Maelor Wrexham (HX41) L5 | 424 | 324,257.19 |
| 050 WF & OD Executive (YX31) L5 | 629 | 290,350.34 |
| 050 Ysbyty Gwynedd (HX01) L5 | 479 | 262,509.03 |
| 050 East Area (AX41) L5 | 166 | 79,127.97 |
| 050 Womens (HX78) L5 | 253 | 75,749.73 |
| 050 Central Area (AX21) L5 | 135 | 55,804.35 |
| 050 West Area (AX01) L5 | 95 | 52,002.93 |
| 050 Cancer Services (HX97) L5 | 10 | 6,866.59 |
| 050 Regional Specialist Services (MX16) L5 | 15 | 3,472.56 |
| 050 Dental: CDS (CDSZ) L5 | 16 | 1,306.23 |
| 050 West Area MHLD (MX13) L5 | 7 | 644.96 |
| **Total** | **2,980** | **2,655,184.20** |

## Payments by Position – Ysbyty Glan Clwyd

| Position Title | Number of claims paid | Gross Cost £ |
|---|---|---|
| Consultant | 325 | 393,855.40 |
| Locum Fixed Term Consultant | 30 | 30,724.06 |
| Registered Nurse | 26 | 5,110.82 |
| Ad-Hoc Locum Consultant | 2 | 2,883.40 |
| Specialty Doctor (2021 contract) | 2 | 2,323.92 |
| Healthcare Assistant | 20 | 1,898.59 |
| Ward/Unit Manager | 6 | 1,693.17 |
| Specialist Grade (2021 contract) | 1 | 1,562.52 |
| Assistant Practitioner Nursing | 6 | 881.74 |
| Deputy Ward/Unit Manager | 5 | 729.65 |
| Senior Healthcare Assistant | 6 | 316.12 |
| Advanced Nurse Practitioner | 15 | 6.94 |
| **Total** | **444** | **441,986.33** |

# Findings & Agreed Action Plan

| **Objective 1:** There is a current WLI procedure in place that is available for all staff that align with the Amendment to the National Consultant Contract in Wales. | **Unsatisfactory** |
|---|---|

**Overview / Summary of Observations**

There is no Health Board Standard Operating Procedure currently published to support both Operational Managers and the Consultant to ensure compliance with the requirements relating to Waiting List Initiative sessions, as detailed within the *Amendment to the National Consultant Contract in Wales*.

We were advised by operational management for both Medical and Surgical specialities that a procedure was followed but received no evidence to corroborate this.

| | Key Findings | Risk & Impact | Agreed Management Action |
|---|---|---|---|
| 1 | **Health Board Procedure**<br><br>The Health Board has no Procedure detailing the planning, authorising, recording and monitoring of Waiting List Initiative (WLI) work in relation to medical and dental staff.<br><br>*We have noted Cardiff and Vale University Health Board have published a dedicated procedure that could be used as a template for developing one in the Health Board (Reference: Waiting List Initiative Procedure - Medical & Dental Staff UHB 515).* | Inability to demonstrate compliance with the requirements set out in the Amendment to the National Consultant Contract in Wales. | **Agreed Action:**<br><br>The Health Board develop, in partnership, and ratify a Waiting List Initiative Procedure to ensure Waiting List Initiative sessions are applied consistently and subject to effective scrutiny and approval across the Health Board, eliminating any inconsistent practice that may be in place with localised, undocumented procedures.<br><br>The Central IHC, on behalf of the Chief Operating Officer, will lead the development of a BCUHB Waiting List Initiative Procedure.<br><br>**Who: Central IHC Director Target date: 31st July 2025**<br><br>**Expected Evidence of Implementation:**<br><br>An agreed Health Board wide Waiting List Initiative Procedure. |
| | | **High Priority** | **Officer: Chief Operating Officer**<br><br>**Date: 01/05/2025** |
| | **Theme:** Policies & Procedures | Control Design | |

| **Objective 2:** WLI activity is only commissioned and agreed to be undertaken in uncontracted time. | **Limited** |
|---|---|

**Overview / Summary of Observations**

We reviewed a sample of ten highest paid Consultants by Waiting List Initiative (WLI) sessions (forty session claims) for the period April to November 2024 at Ysbyty Glan Clwyd.

The review of evidence provided to us by operational management, and compared to job plans obtained from the Office of the Medical Director, found:

- All claims had been signed by operational management to confirm the WLI claims and approve payment, although we noted some were dated as being undertaken in November 2023 but only processed in April 2024.
- Only two (20%) Consultants had agreed and locked-down job plans (totalling six paid WLI sessions); we were unable to verify these claims as it was unclear which week the sessions were being claimed in relation to the job plan and/or whether the Consultant was on annual leave.
- Eighty (80%) Consultants did not have agreed, locked-down job plans; we did not verify the claims paid back to the job plan sessions as they have not been agreed between the Consultant and operational management.
- On claim forms submitted, we noted a small number recorded replacing Supporting Professional Activity (SPA) sessions at an alternative date and are unclear how by requesting and agreeing with the Consultant to undertake a WLI session in an SPA session management can demonstrate compliance with section 2.38 *"Such sessions may be undertaken in uncontracted time"* of *The Amendment to the National Consultant Contract in Wales*.
- Actual WLI activity was consistent with that planned except for one session where management were unable to confirm the number of patients who attended.

| | Key Findings | Risk & Impact | Agreed Management Action |
|---|---|---|---|
| 2 | **WLI Payments**<br><br>We have been unable to verify the WLI claims made and approved comply in full with the requirements of the *National Consultant Contract in Wales.*<br><br>Eighty percent (80%) of the Consultants in our sample do not have agreed and locked-down job plans to verify the completion of WLI sessions are undertaken in uncontracted time. | Non-compliance with the Amendment to the National Consultant Contract in Wales. | **Agreed Action:**<br><br>Action 1. The procedure (above) and agreement of WLI sessions /claim forms to include confirmation that WLI activity complies with requirements of the Consultant Contract. This is a field that will be included in the new BCUHB electronic form to be used to monitor WLI compliance.<br><br>**Who: Head of Business Systems; Target date: 31st May 2025**<br><br>*Action 2.* Supported by the agreed management actions following the Consultant Job Planning Internal Audit report in January 2025, we will ensure an improvement to enable completion of annual job plans to 80% within each year and sustain every year thereafter.<br><br>**Who: IHCs, MH&LD, Diagnostic and Women's Medical Directors Target date: March 2026** |

| | | | |
|---|---|---|---|
| | | | *Action 3.* BCUHB must clarify its interpretation of section 2.38 of the *contract which states* - Such sessions **may** be undertaken in uncontracted time. This will bring clarity to the process, managers involved and clinicians and standardisation in terms of how this is interpreted across specialties. For example, some specialities / IHC interpret uncontracted sessions to include SPA while others do not, as revealed in this audit.<br><br>**Who: Deputy Medical Director**<br>**Target date: 31st June 2025**<br><br>Action 4. Whilst the procedure is under development, additional controls will be implemented to ensure agreed WLI activity is undertaken in uncontracted time noting the need for clarification from action 3. The new electronic form will capture confirmation that the activity is being performed in uncontracted time which will be audited by operational and medical leadership teams.<br><br>**Who: Head of Business Systems Target date: 31st May 2025** |
| | | | **Expected Evidence of Implementation:**<br><br>Data to evidence that consultants have agreed and locked down job plans.<br><br>Sample of WLI claim forms and corresponding job plans (to confirm undertaken in uncontracted time) and / or evidence that this is confirmed at the point of WLI payment approval. |
| | | **High Priority** | **Officer: Executive Medical Director**<br><br>**Date: 01/05/2025** |
| | **Theme:** Financial Management & Control | Control Operation | |

# Appendix A

## Assurance Opinion

| | | |
|---|---|---|
|  | **Substantial** | Few matters require attention and are compliance or advisory in nature.<br>**Low impact** on residual risk exposure. |
|  | **Reasonable** | Some matters require management attention in control design or compliance.<br>**Low to moderate impact** on residual risk exposure until resolved. |
|  | **Limited** | More significant matters require management attention.<br>**Moderate impact** on residual risk exposure until resolved. |
|  | **Unsatisfactory** | Action is required to address the whole control framework in this area.<br>**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.<br>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
Partneriaeth Cydwasanaethau
Gwasanaethau Archwilio a Sicrwydd
Shared Services Partnership
Audit and Assurance Services

# Effective Governance - Cancer Services

## Final Internal Audit Report 2024/25

## Betsi Cadwaladr University Health Board

Limited Assurance

**Contents**



| | |
|---|---|
| Review Reference | BCU-2425-31 |
| Fieldwork | February 2025 – March 2025 |
| Executive Sign Off | May 2025 |
| Audit Committee | June 2025 |
| Executive Lead | Tehmeena Ajmal, Interim Chief Operating Officer |
| Audit Team | Dave Harries, Head of Internal Audit |
| | Nicola Jones, Deputy Head of Internal Audit |
| | Ossama Lotfy, Principal Auditor |

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

# Executive Summary

## Purpose

To review the effectiveness of the governance arrangements within Cancer Services.

## Overview

We have concluded limited assurance on this area. Whilst there is evidence of appropriate governance and reporting structure, financial governance and risk management processes, there are immediate improvements needed to improve some areas of governance. The significant matters requiring management attention are:

- We are unable to evidence regular review of Cancer Pathway Performance information at the Senior Leadership Team meetings for January and February 2025 with March 2025 showing presentation at one meeting but not another despite this being a standard agenda item for the meeting.
- There is regular reporting of financial performance however the service is forecasting an overspend position at year end which is a breach of Standing Financial Instruction 5.2.2 "….and delegated budget holders must not exceed the budgetary total or virement limits set by the Board". At the time of our review the service was not forecast to achieve its set savings target.
- The service is not progressing or monitoring tier 2/3 clinical audits however we recognise this has been identified as a risk area and subject to focus in 25/26.
- The number of open/overdue incidents is a cause for concern.
- There are no formal arrangements in place to ensure staff are aware of 'speak up safely' or how to follow the 'whistleblowing' route, to ensure staff concerns can be raised effectively.

We found that the service had embedded risk management processes that are in line with the Health Board's risk strategy concerning an established risk register and a regular review of risks.

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

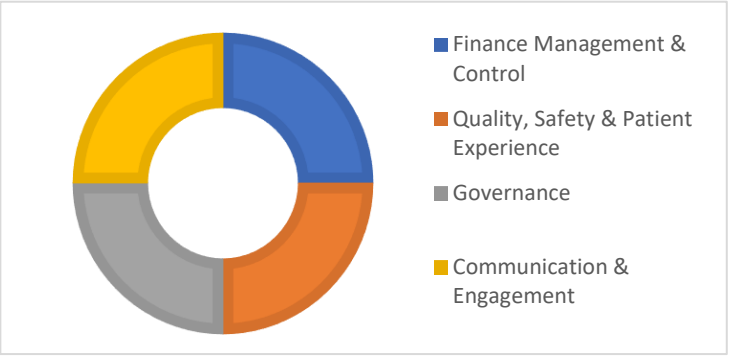
## Scope & Assurance Summary

| Objectives (The objectives and associated assurance ratings are not necessarily given equal weighting when formulating the overall audit opinion.) | | Related Findings | Assurance |
|---|---|---|---|
| 1 | There is an appropriate governance and reporting structure in place within the service to provide assurance on services and ensure oversight of all areas of responsibility. | 1 | **Limited** |
| 2 | There are appropriate financial governance arrangements in place to manage budgets, with regular review of savings and budgets. Where services are not operating within agreed budgetary allocation, appropriate actions and monitoring arrangements are in place. | 2 | **Limited** |
| 3 | The service is progressing and monitoring tier 2/3 clinical audits and contributing to tier 1 audits as required, with processes in place to share details of lessons learnt. | 3 | **Unsatisfactory** |
| 4 | Complaints, concerns, incidents and staff concerns (via Speak Up Safely) are investigated, reviewed, and responded to in a timely manner. Learning from these is captured and reviewed / shared as appropriate. | 4 | **Limited** |
| 5 | Risk management processes are embedded throughout the service and are in line with the risk strategy in terms of risk registers and regular review of risks. | - | **Substantial** |

## Management Actions

| 4 | - |
|---|---|
| High Priority | Medium Priority |

## Themes




## Risk Types

Quality or Safety Issues

Legal & Regulatory Non-Compliance

# Findings & Agreed Action Plan

| **Objective 1:** There is an appropriate governance and reporting structure in place within the service to provide assurance on services and ensure oversight of all areas of responsibility. Reporting includes ward to board assurance, audit results, ward accreditation information and monitoring of actions resulting from external reviews such as Healthcare Inspectorate Wales and Audit Wales. | **Limited** |
|---|---|

There is an up-to-date management structure, which describes the senior management triumvirate and their direct deputies including responsibilities held by all of them. This also includes the roles of the wider Senior Leadership Team (SLT).

The Senior Leadership Team meet as a minimum monthly although we were advised they aim to meet fortnightly to discuss matters. The Terms of Reference including cycle of business were approved at SLT meeting in November 2024. This includes the remit of the SLT, including that they are *"accountable for all aspects of safe delivery of the divisions services"*. There is a standard agenda for each meeting covering a range of areas, including performance, finance and service issues. We reviewed minutes of meetings for January, February and March 2025, with the minutes evidencing that meetings are well attended and quorate. There are details of discussion across standard agenda items, however it is noted that there was no update provided on Cancer Pathway Performance at the January and February 2025 meetings with meetings in March 2025 recording presentation at one (17 March 2025) but not at 31 March 2025 despite it being noted as an Agenda Item.

We reviewed the presentation by the service to the Health Board's Performance, Finance and Information Governance Committee on 29 October 2024 (Item PF24.110b) where the service reported "Performance in August remained at 52.5%; this is below trajectory and below the threshold for de-escalation (4 months at 55%+)". We note from the Health Board meeting 27 March 2025 Item 25/60 that "Cancer: Performance remains fragile with a rate of 51% at the end of February 2025. Performance remains below plan and is not expected to attain the Welsh Government ask of a 70% delivery by March 2025. (Corporate Risk 24-11 Planned Care)" Our review of the SLT minutes for January to March 2025 inclusive identified limited minuted actions how the SLT was to improve performance.

There is a Patient Safety and Quality Group (PSQG) for the services, with the Terms of Reference stating that the Group meets monthly, and its remit is *"To oversee the quality and safety aspects of the business of the Cancer Division. Its focus is on ensuring the quality and safety of the service provided to patients and covers activities including patient safety and quality, patient experience and risk management. The Group will seek assurance from other groups ensuring the triangulation of assurances and evidence of learning".* We reviewed minutes of the Group meetings for January and March 2025 (meeting not quorate in February and was subsequently cancelled). These included discussions on regular agenda items such as risk register, Concerns / Incidents & Patient Experience, Infection Prevention, Safeguarding and Performance Safety Quality Reporting.

There is a Service Delivery Group (SDG) meeting, which includes the Performance, Finance and Information Governance Committee (PFIG), where finance and performance data is presented. We are advised that performance is also briefly discussed at the fortnightly SLT, however this is centred around escalation and/or areas of concern. Areas of low performance are escalated to the Operational Leadership Team.

In terms of monitoring of actions from external reviews, we are advised Healthcare Inspectorate Wales (HIW) had completed an inspection in radiotherapy in January 2025 and results will be monitored via the PSQG. Management advised informal feedback had been received verbally however a report will not be available for two months, so we are unable to confirm the oversight via the PSQG is operating effectively.

| Key Findings | Risk & Impact | Agreed Management Action |
|---|---|---|

| | | | |
|---|---|---|---|
| 1 | **Governance arrangements**<br><br>The Terms of Reference (ToR) for the Senior Leadership Team sets out the remit of the group, and there is a standing agenda item which includes all areas for discussion at each meeting.<br><br>A review of the minutes for January, February and March 2025 meetings show that whilst most areas on the agenda are discussed within the *PFIG Update – Performance, Finance, Information Governance* item, there was no update provided on Cancer Pathway Performance at the January and February meetings. We also noted through reports to the Health Board and Committee that performance is not at a level it should be but found minutes did not record specific action to improve on performance. | The service is unable to demonstrate formal and appropriate oversight of performance. | **Agreed Action:**<br><br>It is noted that PFIG updates to the SLT on the Cancer Pathway performance were not provided during January and February meetings due to annual leave of the cancer network lead. An update was presented at the 17th March 2025 meeting evidenced in the minutes.<br>PFIG updates on the cancer pathway performance will continue to be provided as a standing agenda item to SLT with contingency arrangements in place to ensure cover during leave.<br><br>**Expected Evidence of Implementation:**<br><br>Minutes / agenda of the SLT including updates on all matters of performance with actions noted to recover and improve the reported position. |
| | | **High Priority** | **Officer: Divisional General Manager**<br><br>**Date: June 2025** |
| | **Theme:** Governance | Control Operation | |

| **Objective 2:** There are appropriate financial governance arrangements in place to manage budgets, with regular review of savings and budgets. Where services are not operating within agreed budgetary allocation, appropriate actions and monitoring arrangements are in place. | **Limited** |
|---|---|

The service financial information and position are reported at the monthly Performance, Finance and Information Governance meetings. More detailed scrutiny is undertaken monthly by each budget holder and Finance; however we were advised these meetings are not recorded.

We reviewed the finance report for Month 10 (January 2025) as presented to the Health Board Performance, Finance and Information Governance Committee on 25 February 2025 which reported Cancer Services spend at £58.1m against a cumulative budget allocation of £56.7m - £1.4m overspent (2.5%)

Reported savings target for the service is set at £1.6m with forecast deliver of £1.2m resulting in a £400k predicted under delivery of this. Noting the service is £1.4m overspent at month 10, it is unclear whether the savings identified are having a positive impact on the overall position.

Accountability letters are signed electronically, and the division does not keep a record of these. However, the September 2024 finance report included an update on the completion of assurance statements which was at 100% for the service, and Budget Manager training has been undertaken by 83% of the required staff.

| Key Findings | | Risk & Impact | Agreed Management Action |
|---|---|---|---|
| 2 | **Delivering financial balance** | Non-compliance | **Agreed Action:** |

| | | | |
|---|---|---|---|
| | There is regular reporting of financial performance however the service is forecasting an overspend position at year end and is not forecast to achieve its set savings target. | with requirements of Standing Financial Instruction 5.2.2. | The division took further actions in respect of grip and control of expenditure, with cost reductions & control actions aligned to the control total target issued by the health board being met and exceeded. Further action re delivery of CRES savings resulting achieving an over recovery of targets of £2k. However, it is recognised that a final £1m deficit remains against budget allocated and therefore non-compliant with requirements of Standing Financial Instruction 5.2.2<br>The overspend is represented by Drug related expenditure and commissioning contracts aligned to demonstratable growth. These issues have been escalated & reported through the health board and the various committees such as Execs & PFIG.<br><br>Actions<br>An Oncology business case has been presented with final approval at board pending May 25 to secure recurrent budget.<br>A further business case is ongoing to address further cost pressures linked to demand, activity, quality & governance pan BCU.<br>Ensure working focus groups such as SACT improvement etc are documented as reports for information or minuted through attendance at PFIG or SLT to demonstrate ongoing improvement for patient safety, quality, efficiencies and finance. |
| | | | **Expected Evidence of Implementation:**<br>The grip and control of expenditure is evident through Minutes / agenda of the SLT through to PFIG to operational leaders who are accountable for respective cost centres. |
| | | **High Priority** | **Officer: Divisional General Manager**<br>**Date: March 2026** |
| | **Theme:** Finance Management & Control | Control Operation | |

| **Objective 3:** The service is progressing and monitoring tier 2/3 clinical audits and contributing to tier 1 audits as required, with processes in place to share details of lessons learnt. | **Unsatisfactory** |
|---|---|

Clinical audit is a vital process aimed at ensuring healthcare is delivered in line with established standards.

We are advised that due to the absence of a Clinical Director, the service is not progressing or monitoring tier 2/3 clinical audits. We note this gap has been identified and will be reviewed by the Senior Leadership Team during 2025/26.

Management provided an example of recent National Bowel Cancer Audit (NBOCA) to show evidence of participation at National Tier 1 audits. The Service also co-ordinate submission of the responses to these audits and we were sighted a recent National Oesophago-Gastric Cancer Audit

(NOGCA) as an example.

| | Key Findings | Risk & Impact | Agreed Management Action |
|---|---|---|---|
| 3 | **Clinical Audit**<br>Management advised that due to absence of Clinical Director, the service is not progressing or monitoring tier 2/3 clinical audits. A gap is identified and will therefore be reviewed by the SLT during 25/26. | Audits are not progressing, impacting the ability for the directorate to assess and improve the quality of patient care and outcomes. | **Agreed Action:**<br>Level 3 audits within radiotherapy are in their infancy and this is a piece of work that we are addressing following the HIW visit. We have asked an SAS Dr to support the mortality reviews with the Clinical Lead for Radiotherapy which addresses in part level 2 audits<br>Cancer SLT have also fed back that the Health Board needs to invest in a Chief Clinical Information Officer.<br><br>Oncology is currently reliant on locum and agency medics who have no SPAs in their job plans only DCCs resulting in limited capacity.<br><br>The clinical Leads will focus on creating roles with Clinical Audit responsibilities within Consultant Job Plans as we continue to recruit into vacancies on a substantive basis. |
| | | | **Expected Evidence of Implementation:**<br>Evidence that clinical audits are being progressed at all levels, including a programme of clinical audits across the service. |
| | | **High Priority** | **Officer: Oncology Clinical Lead**<br>**Date: March 2026** |
| | **Theme:** Quality, Safety & Patient Experience | Control Design | |

| **Objective 4:** Complaints, concerns, incidents and staff concerns (via Speak Up Safely) are investigated, reviewed, and responded to in a timely manner. Learning from these is captured and reviewed / shared as appropriate. | **Limited** |
|---|---|

**Complaints / concerns / incidents**

The position of complaints, concerns, incidents, ombudsman etc. is reported at the monthly Patient Safety and Quality Group (PSQG). Themes of concerns and incidents usually include waiting times to see a consultant, delays to commence Systemic Anti-Cancer Therapy (SACT) treatment, communication, lack of follow up, lack of empathy and attitude of clinicians.

Open complaints and incidents are discussed weekly by Head of Nursing, Patient Safety Team and Complaints Team to identify any delays in responding within the given timescale. The Cancer Governance Facilitator attends the Concerns Hub daily. The Senior Leadership Team meetings take place on a fortnightly basis and regular update is given by the Governance Facilitator and/or Head of Nursing, on Patient Safety & Quality,

including Incidents/Concerns – Severe/Catastrophic.

Lessons learned are actioned and shared within the Cancer Services Team and shared widely by the Patient Safety team if appropriate. They can also be uploaded on SharePoint for everyone to view.

Figures as quoted within the Patient Safety Group Meeting / March 2025 (reporting on data 01/01/2025 - 10/03/2025), were as follows:

*"Position and themes including catastrophic/severe incidents*

*Cancer Services have currently 195 open incidents with 154 overdue. Incidents under management review – 34. This is slightly misleading as the status must be changed to management review if the incident handler requires to be updated or progress notes entered onto the incident. 13 incidents are under investigation and 7 awaiting closure. We are managing the backlog of overdue incidents and have reduced these from 500 to where we are today. Further focused work is ongoing.*

*Complaints*

*4 complaints remain open. 1 is overdue due to availability for a meeting with the complainant which took place on 20th February, 2025. The investigation report is now being drafted following the meeting. 3 are within the timescale and the investigation reports are being drafted".*

**Staff concerns / Speak Up Safely**

Through our review, we found no evidence of routine review of any staff complaints being considered in the papers we received but recognise there may not be any active at the time of our review.

| Key Findings | | Risk & Impact | Agreed Management Action |
|---|---|---|---|
| 4 | **Open / Overdue Incidents**<br>As of March 2025, the service has 195 open incidents, with 154 of these overdue. | Incidents are not managed efficiently.<br>Potential of repeat incidents occurring. | **Agreed Action:**<br>The number of incidents since March has decreased significantly to 98. This is due to an agreed action of discussing and encouraging the investigating and closing of incidents in a timely manner through discussions at the daily Patient Safety Huddle, weekly e-mail reminders to incident handlers by the Patient Safety team and by further monitoring through the monthly PSQG Meeting. |
| | | | **Expected Evidence of Implementation:**<br>Evidence of a reduction in overdue incidents (i.e. reporting to PQSG) |
| | | **High Priority** | **Officer: Head of Nursing**<br>**Date: October 2026** |
| | **Theme:** Quality, Safety & Patient Experience | Control Operation | |

| **Objective 5:** Risk management processes are embedded throughout the service and are in line with the risk strategy in terms of risk registers and regular review of risks. | **Substantial** |
|---|---|

The division holds one risk register on the Datix system. The Division's Risk Lead (Deputy Divisional General Manager) is responsible for maintaining the risk register and ensuring all elements are completed.

The Risk Lead meets with the Head of Nursing and Cancer Governance Officer weekly to provide any updates. The team then meet monthly where the risk register is reviewed in more detail – the Regional Risk Manager, from the Corporate Risk Management Team, is invited to these meetings to provide guidance. Any changes to the risk register (removal, change of score, addition, etc) is discussed at the monthly Patient Safety and Quality Group (PSQG). The cycle of business of the PSQG includes a more detailed review of the risk register once a quarter to enable further scrutiny and discussion.

A Risk Governance Audit conducted by the Corporate Risk Team aims to provide Directorates and Services with a better understanding of how well they embed the Risk Framework and Risk Management Procedures, thus providing an overall understanding of how robust local risk governance arrangements are.

The following were the highlights of the December 2024 audit:

- Risk maturity rating was "Advanced" (94%);
- All mandatory fields were complete (100%);
- 100% of risks are correctly formatted and descriptions are correct;
- 82% of action plans are up to date. We were advised that the two outstanding have since been removed from the open list and will be discussed at the next PSQG for consideration of closure;
- 90% of relevant staff have completed risk management training, which is provided by the Risk Management team.

# Appendix A

## Assurance Opinion

| | |
|---|---|
|  **Substantial** | Few matters require attention and are compliance or advisory in nature.<br>**Low impact** on residual risk exposure. |
|  **Reasonable** | Some matters require management attention in control design or compliance.<br>**Low to moderate impact** on residual risk exposure until resolved. |
|  **Limited** | More significant matters require management attention.<br>**Moderate impact** on residual risk exposure until resolved. |
|  **Unsatisfactory** | Action is required to address the whole control framework in this area.<br>**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.<br>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 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]

# Effective Governance – Integrated Health Community - East

## Final Internal Audit Report

## 2024/25

## Betsi Cadwaladr University Health Board

Limited Assurance

**Contents**



| | |
|---|---|
| **Review Reference** | BCU-2425-30 |
| **Fieldwork** | March 2025 – April 2025 |
| **Executive Sign Off** | June 2025 |
| **Audit Committee** | August 2025 |
| **Executive Lead** | Tehmeena Ajmal, Chief Operating Officer |
| **Audit Team** | Dave Harries, Head of Internal Audit |
| | Nicola Jones, Deputy Head of Internal Audit |
| | Ossama Lotfy, Principal Auditor |

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

# Executive Summary

## Purpose

To assess the effectiveness of the governance arrangements within the East Integrated Health Community (IHC).

## Overview

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

- There are established governance structures in place, however a review of key group papers shows low attendance at meetings. This is recognised by the IHC.
- There is regular reporting of financial performance however the IHC is forecasting an overspend position at year end which is a breach of Standing Financial Instruction 5.2.2 "….and delegated budget holders must not exceed the budgetary total or virement limits set by the Board". At the time of our review the service was not forecast to achieve its set savings target. There are also a number of Accountability Letters that have not been signed by budget holders.
- The Clinical Effectiveness Group is not meeting on a regular basis, we are therefore unable to confirm there is effective oversight and monitoring of clinical audit.
- The increasing number of incidents is a cause for concern and management should put arrangements in place to close open and overdue incidents.
- Several risks are overdue for review and require updating.

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

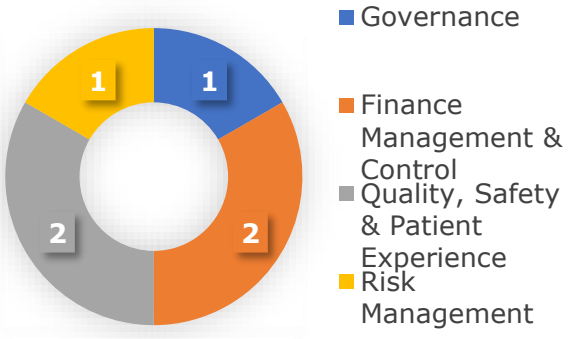
## Scope & Assurance Summary

| Objectives (The objectives and associated assurance ratings are not necessarily given equal weighting when formulating the overall audit opinion.) | | Related Findings | Assurance |
|---|---|---|---|
| 1 | There is an appropriate governance and reporting structure in place within the IHC to provide assurance on services and ensure oversight of all areas of responsibility. | 1 | **Reasonable** |
| 2 | There are appropriate financial governance arrangements in place to manage the financial position, with regular review of savings and financial position. Where services are not operating within the agreed budgetary allocation, appropriate actions and monitoring arrangements are in place. | 2,3 | **Limited** |
| 3 | The IHC is progressing and monitoring tier 2/3 clinical audits and contributing to tier 1 audits as required, with processes in place to share details of lessons learnt. | 4 | **Unsatisfactory** |
| 4 | Complaints, concerns, incidents and staff concerns (via Speak Out Safely) are investigated, reviewed, and responded to in a timely manner. Learning from these is captured and reviewed / shared as appropriate. | 5 | **Reasonable** |
| 5 | Risk management processes are embedded throughout the IHC and are in line with the risk strategy in terms of risk registers and regular review of risks. | 6 | **Reasonable** |

### Management Actions

| 3 | 3 |
|---|---|
| High Priority | Medium Priority |

### Themes




### Risk Types

Legal & Regulatory Non-Compliance

Financial Loss

Quality or Safety Issues

## Findings & Agreed Action Plan

| **Objective 1:** There is an appropriate governance and reporting structure in place within the IHC to provide assurance on services and ensure oversight of all areas of responsibility. Reporting includes ward to board assurance, audit results, ward accreditation information and monitoring of actions resulting from external reviews such as Healthcare Inspectorate Wales and Audit Wales. | **Reasonable** |
|---|---|

There is an up-to-date management structure, which sets out roles and reporting within the IHC. The IHC Director reports to the Chief Operating Officer (COO). There is a Senior Leadership Team (SLT) in place, which has four Service Delivery Groups reporting to it – Service Quality, Service Finance & Performance, Service Transformation and Service People & Culture. The IHC structure, SLT and Service Delivery Groups are clearly defined and depict all areas of responsibilities allocated to the Senior Team.

The Senior Leadership Team meet monthly, with standard agenda items including Chair's reports from key meetings and discuss operational issues. Actions of the meetings are captured and monitored.

We reviewed the Cycle of Business and Terms of Reference (ToR), agenda and minutes for key meetings and identified the following:

- Whilst Terms of References are all in a standard format, identification of both the Chair and Vice Chair was not recorded in the ToR of the SLT.
- Minutes of the Quality Delivery Group meeting held on 26 November 2024 recorded that low attendance has been noted with acknowledgement that the Senior Leadership Team are reviewing all IHC Meetings to avoid duplication.
- Minutes of the Finance & Performance meeting held on 27 November 2024 noted that it was not quorate, however the group decided to proceed and any items for approval were to be escalated to SLT for a decision.
- Minutes of the People and Culture Meeting on 15 October 2024 show poor attendance with five (5) Apologies recorded and twenty-three (23) Non-Attendees/No Apologies Noted.

EAST IHC provide reports to Quality, Safety and Experience Committee (QSE) and Board as part of the 'Improving Quality Report' which is presented by the Executive Director of Nursing and Midwifery.

We are advised that Ward Accreditation Programmes / visits that feed into ward to board assurance, have been on hold for some time, which is a pan BCU decision, with a new methodology to be launched in 2025/26. In the meantime, we were provided with evidence that supportive visits are being undertaken for all wards where delivery of care is observed.

Reporting arrangements for Quality Regulation in terms of reviews i.e. Healthcare Inspectorate Wales, Care Inspectorate Wales and Public Services Ombudsman for Wales are reported to the Health Boards Regulatory Assurance Group (RAG) on a monthly basis with exception reporting up to the Executive Delivery Group.

| | Key Findings | Risk & Impact | Agreed Management Action |
|---|---|---|---|
| 1 | **Governance**<br>East IHC have established the required governance structure in-line with that approved by the Health Board. We reviewed Terms of Reference, cycles of business and minutes for several group meetings, identifying the following gaps:<br>• Identification of both the Chair and Vice Chair was not recorded in the ToR of the Senior Leadership Team (SLT).<br>• Minutes of the Quality Delivery Group meeting held on 26 November 2024 recorded that low attendance has been noted with acknowledgement that the Senior Leadership Team are reviewing all IHC Meetings to avoid duplication.<br>• Minutes of the Finance & Performance meeting held on 27 November 2024 noted that it was not quorate however group decided to proceed and any items for approval to be escalated to SLT for a decision.<br>• Minutes of the People and Culture Meeting on 15 October 2024 show poor attendance with (5) Apologies recorded and (23) Non-Attendees/No Apologies Noted. | Potential risk of:<br>Low attendance meetings could result in ineffective oversight / scrutiny at key meetings. | **Agreed Action:**<br>Review Terms of Reference in line with updated SORD and Foundations for the Future.<br>**Expected Evidence of Implementation:**<br>Updated version of SLT TOR.<br>Minutes of meetings evidencing appropriate attendance in line with agreed ToRs. |
| | | **Medium Priority** | **Officer: IHC Director (East)**<br>**Target Implementation Date: September 2025** |
| | **Theme:** Governance | Control Operation | |

| | |
|---|---|
| **Objective 2:** There are appropriate financial governance arrangements in place to manage the financial position, with regular review of savings and financial position. Where services are not operating within the agreed budgetary allocation, appropriate actions and monitoring arrangements are in place. | **Limited** |

Financial performance and position are reported at the Finance and Performance sub-board. Terms of Reference (ToR) and Operating Arrangements for this state the purpose is "*…to undertake a detailed review of the EIHC financial and performance management position and forecasts, to consider significant financial issues and performance issues and to make decisions on these matters on behalf of the EIHC SLT relating to those budgets delegated by the Executive Team to the EIHC SLT".*

Meetings of the EIHC F&P are held monthly and is accountable to the Performance Finance and Information Governance Committee, and to EIHC SLT. Meeting minutes from September, October and November 2024 evidence discussions on financial matters as outlined in the group ToR. Whilst the November meeting was not quorate, the group proceeded, escalating items for approval to SLT for a decision.

All East IHC Directorates submit performance scorecards, detailing financial positions, efficiency savings and actions being taken to address financial pressures. Budget holders receive monthly finance statements, and each directorate has a monthly finance meeting with IHC Directors where their financial position and delivery of savings plans against the target is discussed, together with actions and support to help improve the financial position and savings delivery.

We reviewed the finance report for Month 10 (January 2025) as presented to the Health Board Performance, Finance and Information Governance Committee on 25 February 2025, which reported IHC East spend at £402.0m against a cumulative budget allocation of £381.4m - £20.6m overspent. Reported savings target for the IHC is set at £11.2m with a forecast delivery of £10.3m, resulting in a £0.9m predicted under delivery of this.

There are a number of accountability letters that have not been signed for 2024/25; out of 89 letters issued, sixty-five (73%) have been accepted, twenty (22%) have not had a response and four (5%) are outstanding with a reason.

| Key Findings | | Risk & Impact | Agreed Management Action |
|---|---|---|---|
| 2 | **Accountability Letters**<br>A number of IHC East accountability letters for 2024/25 have not been signed, as required by Standing Financial Instructions.<br>Out of a total of 89 letters, 73% (65) have been accepted, 23% (20) have had no response and 4% (4) are outstanding with a valid reason noted (not confirmed). | Potential risk of:<br>Breach of Standing Financial Instructions. | **Agreed Action:**<br>Sign accountability letters.<br><br>**Expected Evidence of Implementation:**<br>Accountability Letters should be signed in accordance with Health Board SFIs. |
| | | **High Priority** | |
| | **Theme:** Finance Management & Control | Control Operation | **Officer: IHC Director (East)**<br>**Target Implementation Date: July 2025** |
| 3 | **Delivering financial balance** | Potential risk of: | **Agreed Action:**<br>Review forecast year end position with finance team. |

| | | | |
|---|---|---|---|
| | There is regular reporting of financial performance however the service is forecasting an overspend position at year end and is not forecast to achieve its set savings target | Non-compliance with requirements of Standing Financial Instruction 5.2.2. | **Expected Evidence of Implementation:**<br>The grip and control of expenditure is evident through Minutes / agenda of the SLT through to PFIG to operational leaders who are accountable for respective cost centres. |
| | | **High Priority** | **Officer: IHC Director (East)** |
| | **Theme:** Finance Management & Control | Control Operation | **Target Implementation Date: September 2025** |

**Objective 3:** The IHC is progressing and monitoring tier 2/3 clinical audits and contributing to tier 1 audits as required, with processes in place to share details of lessons learnt. **Unsatisfactory**

Clinical audit is a vital process aimed at ensuring healthcare is delivered in line with established standards. Clinical Audit activity within the IHC is reviewed through the East Clinical Effectiveness Group (ECEG), which reports into the East IHC Service Delivery Quality Group (SDQG) on monthly basis.

The ECEG Terms of Reference (ToR) states that it will identify clinical risk and drive improvements via oversight and review of National and local clinical audits and ensure that arrangements for clinical audits are operating effectively to improve quality, safety and clinical outcomes across the East IHC.

We are advised that Tier 1 audits are reported at ECEG meetings, however we were only provided with minutes of the meeting held on 22 October 2024, which stated that apologies were sent from the Clinical Audit Lead and that an updated report will be shared at the next meeting. We requested minutes for the meetings in November 2024 and December 2024; we were advised these did not take place. We are unable to confirm there is appropriate reporting of Tier 1 audits. We are also advised that Tier 2 and 3 audits are not regularly monitored or reviewed, therefore we could not ascertain how lessons learnt are shared throughout the IHC or within the Health Board.

| Key Findings | | Risk & Impact | Agreed Management Action |
|---|---|---|---|
| 4 | **Clinical Audit**<br>Tier 1 audits are reported via the East Clinical Effectiveness Group; however we were not able to evidence this. We are advised that Tier 2 and 3 audits are not regularly monitored or reviewed, therefore we could not ascertain how lessons learnt are shared throughout the IHC or within the Health Board. | Potential risk of:<br>Audits are not progressing, impacting the ability for the directorate to assess and improve the quality of patient care and outcomes. | **Agreed Action:**<br>Develop implementation plan with owners for monitoring and review.<br>**Expected Evidence of Implementation:**<br>Agendas and minutes of regular ECEG meetings, including reporting on Tier 1 audits.<br>Evidence of Tier 2 and 3 audits being monitored regularly and reported to the ECEG. |

| | | | |
|---|---|---|---|
| | | **High Priority** | **Officer: IHC Director (East) & IHC Director of Nursing (East)**<br>**Target Implementation Date: September 2025** |
| | **Theme:** Quality, Safety & Patient Experience | Control Design | |

**Objective 4:** Complaints, concerns, incidents and staff concerns (via Speak Out Safely) are investigated, reviewed, and responded to in a timely manner. Learning from these is captured and reviewed / shared as appropriate. **Reasonable**

**Complaints/concerns / incidents**

Complaints, concerns and incidents are shared locally via the East IHC Patient Quality and Safety Group (PQSG), which reports monthly to the IHC Quality Delivery Group (QDG) in line with the reporting structure.

We reviewed minutes of the QDG meeting held on 26th November 2024, attendance of the meeting was low, which was noted, and we are advised the Senior Leadership Team (SLT) are reviewing all IHC Meetings to avoid duplication. A report was submitted from the East IHC PSQG which included update on incidents and complaints figures.

The number of open complaints for February and March 2025 is as follows:

| | >30 days | <=30 days | Total | % within timescales |
|---|---|---|---|---|
| February 2025 | 8 | 52 | 60 | 87% |
| March 2025 | 12 | 51 | 63 | 81% |

As at March 2025, the IHC is responding to complaints within the 75% target compliance, and in comparison, to other areas across the Health Board:

| IHC/Service | <=30 Days | >30 Days | Total | (%) |
|---|---|---|---|---|
| Cancer Services | 1 | 3 | 4 | 25.00% |
| Corporate Services | 4 | 1 | 5 | 80.00% |
| Diagnostics and Specialist Clinical Support Services | 5 | 2 | 7 | 71.43% |
| IHC Central | 39 | 16 | 55 | 70.91% |
| IHC East | 51 | 12 | 63 | 80.95% |
| IHC West | 43 | 2 | 45 | 95.56% |
| Mental Health and Learning Disabilities | 11 | 0 | 11 | 100.00% |
| Midwifery and Women's Services | 16 | 11 | 27 | 59.26% |
| **Total** | **170** | **47** | **217** | 78.34% |

*Integrated Quality Report May 2025. The data provided by the patient experience team notes there has been a consistent increased number of complaints received across the board.

Learning from complaints is shared via the East IHC Integrated Concerns Operational Group (EICOG) and Quality Delivery Group (QDG), and the Executive Delivery Group for Quality (EQDG). We were provided with agendas for each of the meetings, which evidence learning.

The number of open incidents for February and March 2025 were as follows:

| | New incidents | Management review | Under investigation | Awaiting closure | Closed | Rejected |
|---|---|---|---|---|---|---|
| February 2025 | 38 | 61 | 3 | 13 | 739 | 20 |
| March 2025 | 171 | 125 | 20 | 69 | 484 | 13 |

From the data it can be seen that the number of new incidents as of March 2025 has risen to 171 from 38 in February 2025. Also the number of closed incidents has dropped to 484 from 739 for the same period.

**Staff concerns / Speak Up Safely**

All processes and procedures relating to staff are held on the Health Board intranet page 'Speaking Up Safely - supporting staff to raise concerns'. We have been advised that staff concerns were "Nil" for February and March 2025.

| Key Findings | | Risk & Impact | Agreed Management Action |
|---|---|---|---|
| 5 | **Open / Closed Incidents**<br>The number of incidents is a cause for concern and management should put arrangements in place to close open and overdue incidents. The number of new incidents as of March 2025 has risen to 171 from 38 in February 2025. Also the number of closed incidents has dropped to 484 from 739 for the same periods. | Potential risk of:<br>Potential of repeat incidents recurring, impacting on patient safety. | **Agreed Action:**<br>Develop and agree recovery plan.<br>**Expected Evidence of Implementation:**<br>Evidence of a plan / arrangements in place to close open and overdue incidents. |
| | | **Medium Priority** | **Officer: IHC Director of Nursing (East)**<br>**Target Implementation Date: September 2025** |
| | **Theme:** Quality, Safety & Patient Experience | Control Operation | |

**Objective 5:** Risk management processes are embedded throughout the IHC and are in line with the risk strategy in terms of risk registers and regular review of risks. **Reasonable**

The IHC has established a risk management process that reports to the Quality Delivery Group (QDG), where risk management is a standard agenda item. Within the IHC, a Risk Management Group oversees both operational and strategic risk management across healthcare services. Although a Terms of Reference (ToR) document outlines its purpose and monthly meeting schedule, it lacks issue and review dates, making it unclear if it remains current. Additional meetings may be scheduled by the Chair or Deputy Chair if necessary.

The Risk Management Group reports by exception to the IHC Performance and Finance Group and the Executive Risk Management Group. Recent meeting papers from 20 December 2024, alongside minutes from 15 November, 18 October, and 20 September, cover topics such as risk register updates, overdue risks, and risk escalation.

The November 2024 minutes show that East IHC manages 163 risks, 121 of which are active and under review across three tiers. There are 42 non-live risks that require updates within four weeks, with 21 exceeding this timeframe. Additionally, 26 live risks are overdue, with 7 more than four weeks behind. Teams have been urged to review and update these accordingly.

All directorates submit monthly risk reports to the IHC, with a consolidated triple-A report submitted to the QDG. Risks requiring escalation proceed through structured tiers before reaching the wider Health Board Risk Management Group. Staff can access resources via the Health Board’s intranet, including the Risk Management Framework and training materials.

| Key Findings | | Risk & Impact | Agreed Management Action |
|---|---|---|---|
| 6 | **Review of risks**<br><br>Risk Management processes are embedded throughout the IHC, and the risk registers reviewed were in line with Risk Management Procedures, however there are a number of risks that are overdue and require updating. | Potential risk of:<br><br>Inadequate review of risks may increase the probability of occurrence and the potential negative consequences that may arise. | **Agreed Action:**<br><br>Review and update risks at IHC and portfolio levels.<br><br>**Expected Evidence of Implementation:**<br><br>Risk register with all risks reviewed / updated. |
| | | **Medium Priority** | **Officer: IHC Director (East)**<br><br>**Target Implementation Date: September 2025** |
| | **Theme:** Risk Management | Control Operation | |

# Appendix A

## Assurance Opinion

| | |
|---|---|
|  **Substantial** | Few matters require attention and are compliance or advisory in nature.<br>**Low impact** on residual risk exposure. |
|  **Reasonable** | Some matters require management attention in control design or compliance.<br>**Low to moderate impact** on residual risk exposure until resolved. |
|  **Limited** | More significant matters require management attention.<br>**Moderate impact** on residual risk exposure until resolved. |
|  **Unsatisfactory** | Action is required to address the whole control framework in this area.<br>**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.<br>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 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 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
Partneriaeth Cydwasanaethau
Gwasanaethau Archwilio a Sicrwydd
Shared Services Partnership
Audit and Assurance Services

# Performance Management Framework and Reporting

# Final Internal Audit Report

## 2024/25

## Betsi Cadwaladr University Health Board/NHS Trust

Limited Assurance

**Contents**



| | |
|---|---|
| **Review Reference** | BCUHB-2425-25 |
| **Fieldwork** | February – April 2025 |
| **Executive Sign Off** | 11 July 2025 |
| **Audit Committee** | August 2025 |
| **Executive Lead** | Stephen Powell, Director of Performance and Commissioning |
| **Audit Team** | David Harries, Head of Internal Audit |
| | Nicola Jones, Deputy Head of Internal Audit |
| | Patrick Williams, Principal Auditor |

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

# Executive Summary

## Purpose

To review the implementation of, and confirm that, the Integrated Performance Framework (IPF) 2023-25 is operating as expected.

## Overview

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

- We have been unable to corroborate that the Substructure for integrated performance reporting, as detailed in every performance report since May 2024, is operating as presented.
- We have not been provided with evidence underpinning the identification of local performance measures reported in addition to the national measures – we are unclear whether the local measures focus on areas of greatest risk.
- We have been unable to evidence any outcomes of performance meetings between operational services and the executive; consequently, we are unable to provide assurance that corrective actions are formally communicated/set for services to improve performance where this is below expected measures.

Elements of good practice could be seen within the directorates through the operational accountability/service performance reports being presented at the directorate finance and performance meetings.

Full details of matters arising are detailed within the Findings & Agreed Action Plan. The following opportunities for enhancement have been identified that do not impact the overall opinion and are highlighted for management information:

- IHC/Directorate specific Performance Reports detail local performance against the national measure only; the reports could be enhanced to include the Health Board overall measure also as we found instances where the local position was better than the reported Health Board position. Where this is the case, learning could be identified for sharing across the Health Board which may support the attainment of overall improved performance.

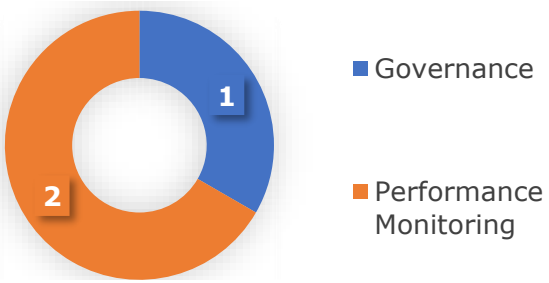
## Scope & Assurance Summary

| Objectives | | Related Findings | Assurance |
|---|---|---|---|
| 1 | There is a governance structure with mechanisms for regular monitoring and escalation in place | 1 | **Limited** |
| 2 | There is evidence to support reported performance data and narrative. | 2 | **Limited** |
| 3 | Arrangements are in place within the operational management structure where operational leaders and Executive scrutinise and hold to account areas of poor performance, evidence this and review whether expected remedial action is implemented and improved performance to the service user | 3 | **Limited** |

## Management Actions

| 3 | 0 |
|---|---|
| High Priority | Medium Priority |

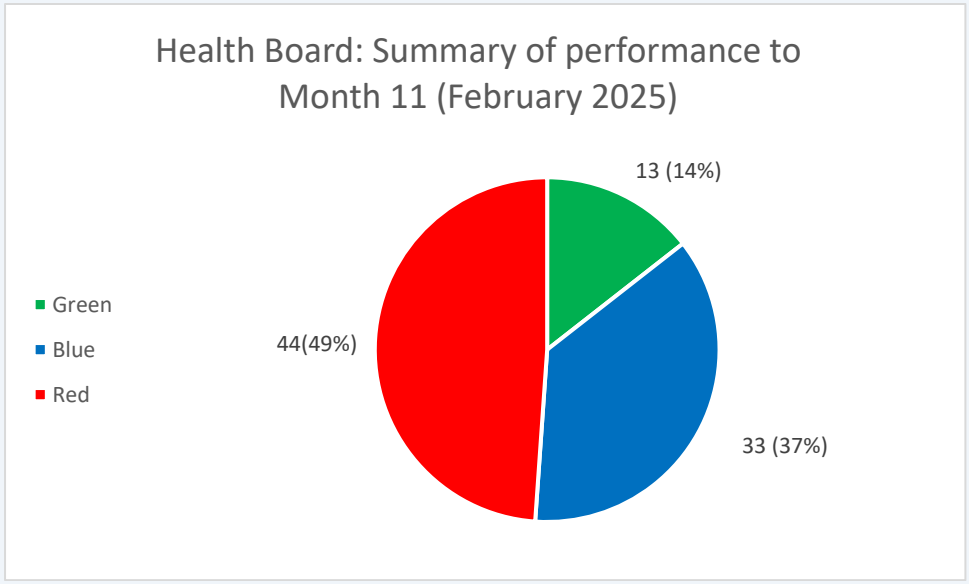
## Themes

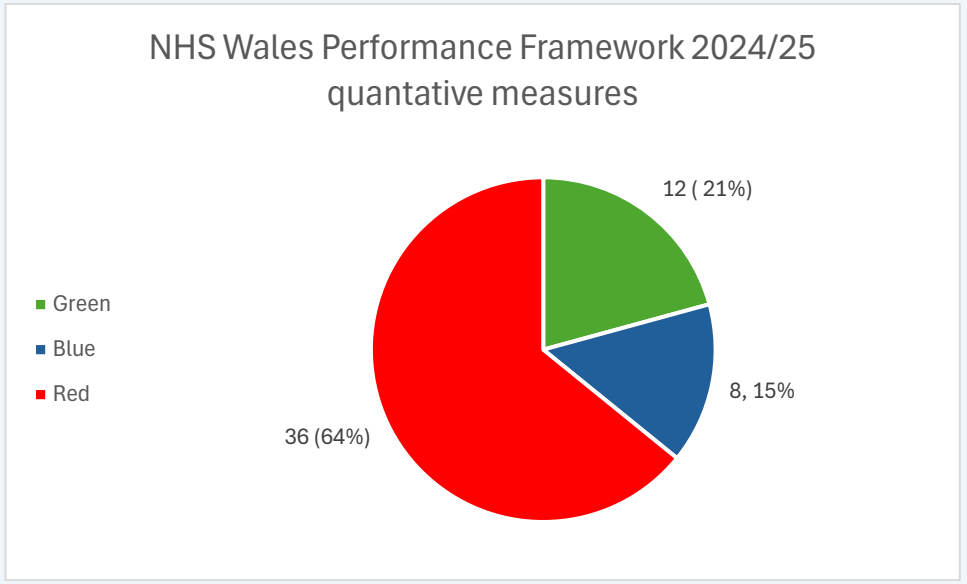



## Risk Types

Quality or Safety Issues

The following is a summary of the performance for Month 11 (February 2025) derived from the integrated performance report submitted to the Health Board on March 27, 2025. We have extracted the performance data related to 54 quantitative measures from the NHS Wales Performance Framework for the 2024/25.




Red - The latest available data point indicates that performance is worse than the target.
Blue - It is inappropriate, or not possible, to rate available data against any available target.
Green - The latest available data point indicates that performance is at, or better than the target.

# Findings & Agreed Action Plan

| **Objective 1:** There is a governance structure with mechanisms for regular monitoring and escalation in place. | **Limited** |
|---|---|

The performance measures in the NHS Wales Performance Framework for 2024-2025 reflect the National Programme areas as outlined in the NHS Wales Planning Framework 2024-2027; the 2024/25 revision consists of 54 quantitative measures.

In alignment with the Integrated Performance Reporting & Governance Superstructure, these metrics are presented to the Health Board, Quality Safety and Experience Committee (QSE) and the Performance, Finance and Information Governance (PFIG) Committees through an Integrated Performance Report that merges performance data from the NHS Wales Performance Framework with local metrics.

At the Health Board meeting on the 30 May 2024 the integrated performance report included a specific section on the reporting governance structure which depicts a Governance Superstructure and Governance Substructure. We confirmed that the Integrated Performance Report is being presented at the relevant Committee and Health Board in accordance with the Governance Superstructure.

The Integrated Performance Executive Delivery Group meets monthly and our review of minutes and papers indicate discussions are held by the four domains noted below, coupled with updates on escalated areas.

- People and Culture
- Quality and Patient Experience
- Operational Delivery & Effectiveness
- Financial Performance

Through our review of papers, whilst we can evidence East and Centre Integrated Health Communities (IHCs) and Mental Health & LDS (MHLD) reviewing performance it is unclear that the entire Substructure is operating as detailed. [West IHC did not responding to our request].

| | Key Findings | Risk & Impact | Agreed Management Action |
|---|---|---|---|
| 1 | Governance<br><br>Through the review of the Executive Delivery Group Minutes and reports received from two IHCs and MHLD we have not been able to confirm that *Decision and Action Logs from substructure* or *Integrated Performance Scorecards* feed into the Integrated Performance Executive Delivery Group or that performance translates down to *Individual PADRs*. | Lack of oversight of performance form the Directorates. | **Agreed Action:**<br><br>The Integrated Performance Framework to be fully implemented during quarter 2 of 2025/26. This will entail monthly meetings with the larger management structures delivering patient care. The reporting hierarchy will ensure "ward to board" assurance reporting.<br><br>**Expected Evidence of Implementation:**<br><br>During quarter 2 including action log and escalation of key issues. |

| | | | |
|---|---|---|---|
| | | **High Priority** | **Officer: Director of Performance & Commissioning**<br>**Date: by 30th Sept 2025** |
| | **Theme:** Governance | Control Design | |

| **Objective 2:** There is evidence to support reported performance data and narrative. | **Limited** |
|---|---|

The Integrated Performance Report provides the Committees and Health Board with performance data and narrative information. This encompasses an integrated performance escalation report, overall summary of performance, and a detailed breakdown of the All-Wales NHS Performance Dashboard. The report encompasses 90 performance measurements, including the NHS Wales performance framework quantitative measures and local metrics. A summary of the findings can be found in the additional information section above.

We conducted a review of the Integrated Performance Report to verify that all the quantitative measures of the NHS Wales performance framework were being measured within the Health Board. Through cross-referencing, we were able to ascertain that all quantitative measures were being evaluated accordingly gathered across four key domains.

We note the following after reviewing the report:

- 36 (64%) of the NHS Wales performance framework quantitative measures indicate that performance is worse than the target.
- Key domain two "Our Access & Activity Performance", out of the 37 quantitative measures 32 (86%) indicate that performance is worse than the target measures, with 23 being linked to the NHS Wales performance framework.
- All 90 performance/measures are linked to the appropriate committees for oversight.
- 25 of the NHS Wales performance quantitative measures are linked to the Corporate Risk Register.

We attempted to ascertain how the local metrics were formulated; we reached out to the Director of Performance and Commissioning and the Deputy Director of Performance on two occasions but received no response to our request.

We conducted a review of four operational performance reports to determine the level of monitoring and scrutiny. Out of the four responses, we received data from three operational areas. Monthly performance reports were presented at finance and performance meetings in these three areas, providing an overview of the service's contribution to the national KPI Performance Framework, as well as other locally identified metrics.

| **Key Findings** | | **Risk & Impact** | **Agreed Management Action** |
|---|---|---|---|
| 2 | Performance | | **Agreed Action:** |

| | | | |
|---|---|---|---|
| | We have been unable to verify the source and rationale underpinning the identification and reporting of local performance metrics that are included in addition to the national measures. Consequently, we are unclear that the highest risk local matters are being reported for scrutiny and assurance. | The Health Board may not be sighted on areas or poor performance as the local measures are not focused on the areas of highest risk to it achieving its Strategic Objectives. | Local performance indicators and escalations are created where a services performance is showing early signs of distress or consistently failing a target.<br><br>Whilst outside of the NHS Wales performance framework it is essential to identify areas that need further scrutiny and assurance as the NHS Wales performance framework cannot cover all delivery of the NHS.<br><br>The Performance Team working with the relevant Service Lead, will include the source and rationale underpinning any local metrics.<br><br>**Expected Evidence of Implementation:**<br><br>The rationale for the inclusion of local measures is evident and reported on for the Health Board to be assured that they relate to areas of greatest risk. |
| | | **High Priority** | **Officer: Director of Performance & Commissioning**<br><br>**Date: by 30th September 2025** |
| | **Theme:** Performance Monitoring | Control Operation | |

| **Objective 3:** Arrangements are in place within the operational management structure where operational leaders and Executive scrutinise and hold to account areas of poor performance, evidence this and review whether expected remedial action is implemented and improved performance to the service user. | **Limited** |
|---|---|

The Integrated Performance Reporting and Governance Superstructure encompasses Executive-led Directorate Level Integrated Performance Reviews that are scheduled to occur biannually, as well as Directorate Led Integrated Performance Reviews that are to be conducted on a monthly basis.

We received PowerPoint presentations for the last round of Executive-led Directorate Level Integrated Performance Reviews, which were delivered to an executive panel (not minuted) between May 2024 and August 2024. We were informed that no such reviews have been conducted since then. Consequently, we have been unable to observe directorates being held consistently accountable for areas needing improvement.

Upon reviewing our sample at the operational level, we were able to observe accountability/service performance reports being presented at the Divisional finance and performance meetings. These provide an opportunity for the service leads to speak directly with the Directors and provide them with an overview of service performance for assurance and an escalation route. However, we could not confirm that all directorates are holding areas accountable for performance below expected measures. This makes it challenging to demonstrate how staff are held accountable for lack of improvement in performance through the Health Board's governance processes.

| Key Findings | | Risk & Impact | Agreed Management Action |
|---|---|---|---|
| 3 | Performance Accountability<br><br>Whilst we note executive accountability meetings take place and accountability/service performance reports produced; these are not operating consistently as expected.<br><br>We were unable to confirm the outcomes of performance meetings as we did not receive any minutes/evidence of specific actions set to address the required improvement in performance. | Lack of accountability for performance.<br><br>No improvements in performance, impacting on patient quality and safety. | **Agreed Action:**<br><br>Finding accepted.<br><br>The Health Board is in the process of setting up monthly meetings with IHCs and pan BCU patient facing services. Initial meetings have been held in quarter 1 with monthly meeting to be diarised during quarter 2 to run monthly from September onwards. |
| | | | **Expected Evidence of Implementation:**<br><br>Executive-led Directorate Level Integrated Performance Reviews, for both Clinical facing and all corporate support services are undertaken on a consistent basis in line with the governance Super/Sub structure.<br><br>Evidence of outcomes from these reviews are retained enabling review whether the set actions have been implemented and made a difference. |
| | | **High Priority** | **Officer: Director of Performance & Commissioning**<br><br>**Date: by 30th September 2025** |
| | **Theme:** Performance Monitoring | Control Operation | |

# Appendix A

## Assurance Opinion

| | | |
|---|---|---|
|  | **Substantial** | Few matters require attention and are compliance or advisory in nature.<br>**Low impact** on residual risk exposure. |
|  | **Reasonable** | Some matters require management attention in control design or compliance.<br>**Low to moderate impact** on residual risk exposure until resolved. |
|  | **Limited** | More significant matters require management attention.<br>**Moderate impact** on residual risk exposure until resolved. |
|  | **Unsatisfactory** | Action is required to address the whole control framework in this area.<br>**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.<br>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/NHS Trust 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/NHS Trust. 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
Partneriaeth Cydwasanaethau
Gwasanaethau Archwilio a Sicrwydd
Shared Services Partnership
Audit and Assurance Services

Archwilio Cymru
Audit Wales

# Audit Committee Update – Betsi Cadwaladr University Health Board

Date issued: August 2025

Document reference: 4960A2025

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

The Auditor General has a wide range of audit and related functions, including auditing the accounts of Welsh NHS bodies, and reporting on the economy, efficiency, and effectiveness with which those organisations have used their resources. The Auditor General undertakes his work using staff and other resources provided by the Wales Audit Office, which is a statutory board established for that purpose and to monitor and advise the Auditor General.

Audit Wales is the non-statutory collective name for the Auditor General for Wales and the Wales Audit Office, which are separate legal entities each with their own legal functions as described above. Audit Wales is not a legal entity and itself does not have any 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, the Wales Audit Office and, where applicable, the appointed auditor are relevant third parties. Any enquiries regarding disclosure or re-use of this document should be sent to Audit Wales at infoofficer@audit.wales.

# Contents

## Audit Committee update

# About this document

1 This document provides the Audit Committee with an update on our current and planned accounts and performance audit work at Betsi Cadwaladr University Health Board. We presented our most recent Audit Plan to the committee on 3 March 2025.

2 We also provide additional information on:

- Other relevant examinations and studies published by the Audit General.
- Relevant corporate documents published by Audit Wales (e.g. fee schemes, annual plans, annual reports), as well as details of any consultations underway.

3 Details of future and past Good Practice Exchange (GPX) events are available on our website.

# Accounts audit update

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

Exhibit 1 – Accounts audit work

| Area of work | Executive Lead | Focus of the work | Current status | Planned date for consideration |
|---|---|---|---|---|
| **Audit of Accounts 2024-25** | Russell Caldicott, Executive Director of Finance | Audit of Financial Statements Report including the Opinion on the Financial Statements. | Completed<br><br>. | June 2025 |

# 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 |
|---|---|---|---|---|
| **Planned Care** | Executive Medical Director | This work follows on from the national report on tackling the planned care backlog. It considers:<br>• the extent that health boards have achieved Welsh Government targets for recovering planned care services;<br>• the efficacy of local plans and activity to recover waiting lists; and<br>• Use of the additional Welsh Government financial allocations to improve waiting lists. | Completed | August 2025 |
| **All Wales thematic work on Urgent and Emergency Care** | Chief Operating Officer | This work examines different aspects of the urgent and emergency care system in three parts:<br>• Part One: Flow out of hospital.<br>• Part Two: accessing urgent and emergency care. | Part One: Completed<br><br>Part Two: In clearance | July 2024<br><br>October 2025 |

| Area of work | Executive Lead | Focus of the work | Current status | Planned date for consideration |
|---|---|---|---|---|
| **Use of the strategic financial assistance provided by the Welsh Government for the period October 2020 onwards** | Executive Director of Finance and Corporate Resources | This audit will encompass a high-level examination of the Health Board's arrangements for using the additional £297m financial assistance provided by the Welsh Government as part of the targeted intervention package announced in October 2020. | Drafting | October 2025 |
| **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. | Fieldwork | October / December 2025 |
| **Structured Assessment 2025 - core** | Director of Corporate Governance / Board Secretary | This work will review the following core areas:<br>• Board and committee effectiveness, cohesion, and transparency.<br>• Corporate systems of assurance.<br>• Corporate planning arrangements.<br>• Corporate financial planning arrangements.<br>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. | Planning | December 2025 |

| Area of work | Executive Lead | Focus of the work | Current status | Planned date for consideration |
|---|---|---|---|---|
| **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. | Planning | December 2025 |
| **Thematic review of cancer services** | To be confirmed | Following on from our recent review of the national leadership arrangements for cancer services, this work will consider:<br>• The progress NHS bodies are making towards achieving Welsh Government targets and quality standards for cancer services;<br>• The efficacy of local plans and associated actions to recover cancer waiting lists; and<br>• Use of the additional Welsh Government financial allocations to improve cancer services. | Not yet started | April 2026 |
| **Structured Assessment - deep dive review of the arrangements to manage estates** | Executive Director of Finance and Corporate Resources | This work will examine the effectiveness of corporate arrangements to manage the Health Board's estate with a particular focus on how NHS bodies are prioritising resources to meet strategic priorities whilst also ensuring the current estate remains fit for purpose. | Planning | April 2026 |

# Other relevant publications

6 Exhibit 3 provides information on other relevant examinations and studies published by the Auditor General in the last six months. The links to the reports on our website are provided. The reports highlighted in **bold** have been published since the last committee update.

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

| Title | Publication date |
|---|---|
| **Temporary Accommodation, long-term crisis?** | **July 2025** |
| Cost Savings Arrangements: A Checklist for NHS Board Members | June 2025 |
| The Wales Infrastructure Investment Strategy | May 2025 |
| No time to lose: Lessons from our work under the Well-being of Future Generations Act | April 2025 |
| The Biodiversity and Resilience of Ecosystems Duty | March 2025 |
| Addressing workforce challenges in NHS Wales | February 2025 |

# Additional information

7 Exhibit 4 provides information on corporate documents recently published by Audit Wales. Links to the documents on our website are provided. There are no relevant Audit Wales consultations currently underway.

**Exhibit 4 – Audit Wales corporate documents**

| Title | Publication Date |
|---|---|
| Annual Report and Accounts 2024-25 | June 2025 |
| Annual Plan 2025-26 | April 2025 |


Audit Wales

1 Capital Quarter

Tyndall Street Cardiff, CF10 4BZ

Tel: 029 2032 0500

Fax: 029 2032 0600

Textphone: 029 2032 0660

E-mail: info@audit.wales

Website: www.audit.wales

We welcome correspondence and telephone calls in Welsh and English.
Rydym yn croesawu gohebiaeth a galwadau ffôn yn Gymraeg a Saesneg.

Archwilio Cymru
Audit Wales

# Tackling the Planned Care Challenges – Betsi Cadwaladr University Health Board

Date issued: May 2025

Document reference: 4664A2025

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

The Auditor General has a wide range of audit and related functions, including auditing the accounts of Welsh NHS bodies, and reporting to the Senedd on the economy, efficiency, and effectiveness with which those organisations have used their resources. The Auditor General undertakes his work using staff and other resources provided by the Wales Audit Office, which is a statutory board established for that purpose and to monitor and advise the Auditor General.

Audit Wales is the non-statutory collective name for the Auditor General for Wales and the Wales Audit Office, which are separate legal entities each with their own legal functions as described above. Audit Wales is not a legal entity and itself does not have any functions.



In the event of receiving a request for information to which this document may be relevant, attention is drawn to the Code of Practice issued under section 45 of the Freedom of Information Act 2000. The section 45 Code sets out the practice in the handling of requests that is expected of public authorities, including consultation with relevant third parties. In relation to this document, the Auditor General for Wales and the Wales Audit Office are relevant third parties. Any enquiries regarding disclosure or re-use of this document should be sent to 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.

# Contents

# Summary report

## About this report

1 This report sets out the findings of work on planned care recovery that we have undertaken at Betsi Cadwaladr University Health Board (the Health Board) to examine the progress it is making in tackling its planned care challenges and reducing its waiting list backlog. The work has been undertaken to help 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 the efficient, effective, and economic use of its resources. Our work was delivered in accordance with INTOSAI[1] audit standards. This report excludes any examination of waits relating to cancer diagnosis and treatment, which are the subject of a separate examination by the Auditor General.

2 Tackling the planned care waiting list backlog is one of the biggest challenges facing the NHS in Wales. NHS waiting time targets in Wales have not been met for many years and the COVID-19 pandemic made an already challenging situation considerably worse as planned care services were initially postponed and then slowly re-started to allow the NHS to focus its attention on dealing with those seriously ill with the virus. Since the onset of the pandemic, the overall size of the NHS waiting list has grown significantly and at the end of February 2025 there were 614,150 individual patients waiting for treatment.

3 In April 2022, the Welsh Government published its Programme for Transforming and Modernising Planned Care and Reducing Waiting Lists in Wales. The programme includes £170 million recurring funding to support planned care recovery, together with an additional £15 million funding per year over four years to support planned care transformation. Welsh Government subsequently allocated a further £50 million between September 2024 and October 2024 to reduce the longest waiting times[2]. The programme includes specific targets and Ministerial priorities:

- that no one should wait longer than a year for their first outpatient appointment by the end of 2022 (**target date revised to December 2023**[3]);
- to eliminate the number of people waiting longer than two years in most specialties by March 2023 (**target date revised to March 2024**);
- people should receive diagnostic testing and reporting within eight weeks and therapy interventions within 14 weeks by Spring 2024; and

[1] INTOSAI is the International Organization of Supreme Audit Institutions

[2] Health Secretary response to latest NHS Wales performance data. The £50 million additional allocation comprised £28 million in September and £22 million in October 2024.

[3] Health Boards did not achieve the original targets for first outpatient appointment and number of people waiting longer than two years for treatment. As a result, the Welsh Government agreed to set interim targets (**in bold**, above).

- to eliminate the number of people waiting longer than one year in most specialties by Spring 2025.

4 In May 2022, the Auditor General for Wales published a commentary on "Tackling the Planned Care Backlog in Wales" which estimated that it could take up to seven years for the overall waiting list in Wales to return to pre-pandemic level. The commentary highlighted key areas for action, including:

- having strong and aligned local leadership to deliver the national vision for recovering planned care services;
- having a renewed focus on system efficiencies and new technologies;
- building and protecting planned care capacity; and
- communicating effectively with patients who are waiting for treatment and having systems in place to manage the clinical risks to those patients while they are waiting.

5 Our work has considered the progress Heath Board is making in tackling its planned care challenges and reducing its waiting list backlog, with a specific focus on:

- action that the Health Board has taken to tackle the planned care backlog;
- waiting list performance; and
- understanding and overcoming the barriers to improvement.

6 We undertook our work between October 2024 and February 2025. The methods we used are summarised in **Appendices 1 and 2**. **Appendix 3** provides some additional data analysis on planned care services and **Appendix 4** contains the Health Board's response to any recommendations arising from our work.

7 The Health Board is currently at Level 5 escalation under the NHS Wales escalation and oversight framework and it continues to rely on significant additional non-recurrent strategic funding allocation. Its financial position has a direct bearing on the affordability, sustainability and recovery of planned care services.

# Key facts

**£114.5m** the amount of additional funding the Health Board has received from Welsh Government between 2022-23 and 2024-25 to support planned care improvement.

**199,249** the overall size of the waiting list at February 2025.

**103%** the percentage growth in the overall waiting list between April 2019 and February 2025.

**29,553** the number of patient pathways waiting more than 1 year for their first outpatient appointment at February 2025 against a national target of zero waiting. The number of 1 year waits for an outpatient appointment has increased by 22%, since April 2022.

**8,304** the number of patient pathways waiting more than 2 years for treatment at February 2025 against a national target of zero waiting. The number of 2-year waits has reduced by 53% since April 2022.

**62%** the percentage diagnostic test waits that are within 8 weeks at February 2025 against a national target of 100%. The number of ‘over 8 weeks’ diagnostic waits has increased by 23% since April 2022.

**89%** the percentage of therapy waits that are within 14 weeks at February 2025 against a national target of 100%. The Health Board has achieved an 73% reduction of ‘over 14 weeks’ therapy waits since April 2022.

**54,096** number waiting more than one year for treatment at February 2025 against a national target of zero for most specialties by Spring 2025. This has increased by 30% since April 2022.

# Key messages

## Overall conclusion

8 Overall, we found that **there are significant numbers of long patient waits indicating that the action the Health Board is taking to address this is not having the necessary overall effect. It needs to improve service efficiency, develop sustainable planned care improvements to meet growing demand, and strengthen reporting of harm that occurs as a result of a delay.**

## Key findings

### Action that the Health Board is taking to tackle the planned care challenge

- Whilst the Health Board has set out plans for securing short-term waiting list improvements, it has yet to sufficiently describe actions needed to secure more sustainable improvements to planned care services.
- Despite a clear structure, the Health Board's Planned Care Program Board lacks delegated decision-making authority to set direction and allocate resources. It needs to strengthen how it uses business cases to drive improvement initiatives and link these cases effectively to an agreed planned care improvement programme. Lack of continuity of senior planned care leadership has been detrimental to improvement.
- The Health Board has received a total of £114.5 million in additional Welsh Government funding. However, this has been allocated primarily towards short-term reactive solutions without investment in longer term service transformation.
- Whilst the Health Board has begun to implement the Getting It Right First Time (GIRFT[4]) recommendations, there remain opportunities to improve efficiencies, particularly in relation to improving utilisation of theatres and outpatient services to improve efficiency and productivity.
- The Health Board is making effective use of day surgery, with 83% of elective surgery performed as day case, the highest in Wales.
- The Health Board has been slow to implement the Welsh Government's Promote, Prevent and Prepare policy fully. Reporting on the incidence of harm associated with planned care waits needs to be improved.

[4] Getting It Right First Time (GIRFT) is a programme that aims to improve the quality and efficiency of hospital care.

## Waiting list performance – Is the action taken resulting in improvement?

- In overall terms, the continued growing backlog of people waiting to be treated presents a substantial problem for the Health Board. The size of the waiting list has increased from 98,190 in April 2019 to 199,249 treatment pathways in February 2025.
- The Health Board has not met the recent national planned care recovery targets:
  - The number waiting over a year for their first outpatient appointment has increased from 24,265 patient pathways in April 2022 to 29,553 in February 2025.
  - The number waiting over 2 years for treatment has reduced from 17,500 patient pathways in April 2022 to 8,304 on February 2025.
  - The Health Board did not meet the target of increasing the speed of diagnostic testing and reporting to eight weeks and 14 weeks for therapy interventions by Spring 2024. In February 2025, there remained 10,067 patients waiting over 8 weeks for diagnostics and 1,565 patients waiting for therapies over 14 weeks.

## Barriers to improvement

- There are a number of barriers to further planned care improvement. These include growing service demand, capacity to support service transformation and absence of clinical leadership. The Health Board recognises these challenges but has not yet developed an overarching strategy to address these. Initiatives which aim to address immediate capacity challenges are relatively new and short term in nature. Further work is required to develop sustainable and transformative solutions to ensure the Health Board does not continue to face the same or greater challenges in future.

# Recommendations

9 We have set out recommendations arising from this audit in **Exhibit 1**. The Health Board's is currently developing its management response.

**Exhibit 1: recommendations**

| Recommendations |
| --- |
| **Planning**<br>R1 Over and above the commitments signalled within its annual plans, the Health Board should develop a detailed Planned Care improvement plan. This should aim to both design and deliver sustainable planned care services in the medium to longer term and to take advantage of opportunities for further regional working. The plan should be costed, with realistic but challenging milestones within it. **(Exhibit 2)** |
| **Demand and capacity**<br>R2 The Health Board should ensure that its demand and capacity modelling approach is consistently applied across the organisation and its specialties and used to inform short-term service capacity planning and longer-term service design. This should consider continued growth or expected changes in population demand for planned care services **(Exhibit 2).** |
| **Programme governance and programme business cases**<br>R3 The Health Board should strengthen its Planned Care Programme Board to ensure it has the authority to set direction and deliver both transformational change and short-term capacity improvement by:<br>3.1 Strengthening the Programme Board's delegated authority arrangements to ensure it is the primary forum for all transformational and short-term capacity improvement funding **(Exhibit 3).**<br>3.2 Developing a clear planned care improvement programme for delivery, monitoring and associated accountability **(Exhibit 3).**<br>3.3 Improving training for planned care business case development to ensure quality of business cases and timely approval **(Exhibit 3).**<br>3.4 Prepare business cases earlier in the year or cyclically to align with a multi-year planned care programme to avoid implementation delays **(Exhibit 3).** |

**Recommendations**

**Programme Board clinical leadership**

R4 The Health Board should review and strengthen its Planned Care Programme Board leadership arrangements by:

- 4.1 Developing a clear remit, authority and accountability for the role of the Clinical Director of Planned Care **(Exhibit 3).**
- 4.2 Appointing clinical leads for all specialties to the Programme Board to support the development of integrated speciality plans **(Exhibit 3).**

**Risk management**

R5 The Health Board should review and update the Planned Care risk register to ensure controls are effective and that the overall risk levels start to reduce in the next 6 months **(Exhibit 3).**

**Monitoring impact of additional funding**

R6 The Health Board should strengthen its monitoring of the use and impact of the additional Welsh Government planned care funding **(Paragraph 24).**

**Recommendations**

**Efficiency and productivity**

R7 Our work has identified there are opportunities for further efficiency and productivity improvements. The Health Board should:

- 7.1 Ensure there is clear monitoring and reporting on the completion of recommendations arising from the Getting it Right First Time (GIRFT) reviews **(Exhibit 6).**
- 7.2 Develop enhanced measures to reduce the number of short notice surgical cancellations **(Exhibit 6).**
- 7.3 Improve the recording accuracy of surgical cancellation reasons to enable the Health Board to understand and address the root cause of surgical cancellations **(Exhibit 6).**
- 7.4 Develop and implement a plan to improve theatre utilisation rates across the Health Board, with realistic improvement trajectories, with the aim of achieving the GIRFT recommendation of 85% **(Exhibit 6).**
- 7.5 Develop and rollout approaches to increase the use of "virtual" outpatient appointments, where clinically appropriate **(Exhibit 6).**
- 7.6 Develop job planning policy and guidance **(Exhibit 6).**
- 7.7 Ensure job plans are completed annually, utilising team-based job planning where it is appropriate to align consultant capacity to meet service demand **(Exhibit 6).**
- 7.8 Roll out pooled waiting lists across the Health Board particularly focusing on challenged services to ensure it treats its patients in turn **(Exhibit 6).**

**Promote, Prevent and Prepare for Planned Care policy**

R8 The Health Board complete the establishment of the 'Promote, Prevent and Prepare (3P's) for Planned Care' contact centre and ensure it covers all specialties **(Exhibit 7)**.

**Recommendations**

**Risk of harm**

R9 In order to strengthen its arrangements for managing the clinical risks associated with long waits, the Health Board should:

- 9.1 Develop and implement a consistent methodology for assessing the risk of harm to patients caused by long waits across specialties **(Exhibit 7).**
- 9.2 Develop a routine report to be presented at the Quality and Safety Committee that effectively reports risks and actual incidents of harm resulting from delays in access to treatment **(Exhibit 7).**
- 9.3 Develop and implement clinical plans for all challenged services to ensure higher risk patients are prioritised **(Exhibit 7).**

# Detailed report

## Action that the Health Board is taking to tackle the planned care challenge

10 We considered whether the Health Board is effectively planning and delivering planned care improvement, is appropriately utilising and monitoring the impact of Welsh Government funding and is supporting patients who are at most risk of harm as a result of a delay.

11 We found that **the Health Board's Annual Delivery Plan describes actions for planned care, however these are short-term in nature and lack detail on how successful delivery will be measured. The absence of a dedicated and costed, longer-term plan for planned care recovery means the Health Board has not determined the action needed to deliver more sustainable improvements to planned care services**.

### Planned care improvement plans and the programme to deliver them

12 It is important that the Health Board has a clear plan for tackling the waiting list backlog and delivering sustainable planned care improvement. We considered whether the Health Board has:

- clear, realistic and costed improvement plans for planned care that align with the national recovery plan ambitions and Ministerial priorities; and
- appropriate programme management arrangements to support planned care improvement, supported by clear accountabilities and clinical leadership and reporting to committees and the Board.

#### Planned care improvement plans

13 We found that **the Health Board has appropriately set out its short-term planned care improvement initiatives in its 2025-28 Integrated Medium-Term Plan. However, there is a notable absence of a dedicated short and longer-term plan that supports waiting list recovery and the development of efficient and sustainable planned care services. This is likely to affect the pace of improvement.**

14 The findings that underpin this conclusion are summarised in **Exhibit 2**.

**Exhibit 2: the Health Board's approach to planned care improvement planning**

| Audit question | Yes / No / Partially | Comments |
|---|---|---|
| Has the Health Board developed a clear plan to support planned care recovery? | **No** | The Health Board's Annual Plan 2024-25 sets out the priorities for planned care. However, this is overly short-term focussed and lacks the necessary detail on longer-term sustainable planned care services. The Health Board has included planned care improvement requirements for 2025 onwards in its 2025-2028 three-year plan. This sets out six planned care workstreams that focus on short-term improvements and some limited pathway improvements. This includes workstreams on referral management, waiting list management, and outpatient, pre-operative and theatre efficiencies, and development of specialty level improvement plans. At present however, there is no stand-alone planned care recovery plan aligned to a clinical strategy. As a result, there is insufficient planning detail to address growing demand and reshaping services so that they are financially affordable **(Recommendation 1).** |
| Is the approach for delivering planned care improvement costed and affordable? | **No** | The Annual Plan 2024-25 provides a financial plan for the organisation and sets out the Health Board's over-arching financial position. However, there is no costed planned care plan or route-map to financially sustainable services. This creates a lack of transparency on the affordability of current planned care service delivery **(Recommendation 1).** In the absence of a costed planned care improvement plan, the Health Board relies on short-term business cases which are of varying quality and additional Welsh Government funding. |
| Are the Health Board's planned care priorities appropriately aligned to the national planned care recovery plan and Ministerial priorities? | **Yes** | The Annual Plan 2024-25 and the more recently developed 2025-2028 three year plan are both sufficiently aligned to the ministerial priorities and the national 'transforming and modernising planned care and reducing NHS waiting lists' recovery plan. |

| Audit question | Yes / No / Partially | Comments |
|---|---|---|
| Has the Health Board set out realistic yet challenging targets and milestones for planned care? | **Partially** | The Health Board has developed improvement trajectories and system indicators aligned to Welsh Government escalation requirements. The improvement trajectories focus on eliminating the number of patients waiting more than 104 weeks. While the Health Board has made ongoing progress by increasing capacity, it is unlikely to meet this target. The Health Board's targets for addressing the growing number of patients waiting more one year are not credible based on growing demand and deteriorating performance. |
| Are the Health Board's planned care priorities informed by analysis and modelling of capacity and demand? | **Partially** | The Health Board's approach to capacity and demand modelling has focused on improving the quality of waiting list data to assess current and future demand. This analysis has been undertaken by the data performance and planning workstream but has not been rolled out across the organisation and all specialties. Further work is needed to understand core capacity and plan for additional capacity to meet immediate and longer-term requirements. **(Recommendation 2)** |
| Has the Health Board set out how it will transform its clinical service models to make them more sustainable in the future? | **No** | The Health Board has not set out how it will transform its clinical service models to make them more sustainable in the future. As outlined in its 2025-28 three-year plan, the Health Board intends to develop clinical services in line with its 10-year strategy and clinical services plan. This work will be commencing in 2026. |
| Are plans for planned care improvements aligned to other key corporate plans such as the IMTP and plans for workforce, digital and estates? | **Partially** | The 2025-28 three-year plan outlines some limited digital, workforce and estates initiatives that will help improve some aspects of planned care service delivery, such as the new orthopaedic facility in Llandudno. However, the plan does not contain the level of detail needed for wider enabling services to support sustainable planned care service development. |

Source: Audit Wales fieldwork

## Planned care programme delivery and oversight

15 We found that **the current planned care programme arrangements are not effective in delivering planned care improvements. The Programme Board lacks authority and direction and there is insufficient clinical leadership and engagement. The absence of a standalone plan for planned care recovery and transformation compounds the issue**.

16 The findings that have led us to this conclusion are summarised in **Exhibit 3**.

**Exhibit 3: the Health Board's approach to the programme management of planned care improvement**

| Audit question | Yes / No / Partially | Comments |
|---|---|---|
| Does the Health Board have a clear and appropriately resourced improvement programme to support planned care recovery? | **No** | The Health Board's Planned Care Programme Board has a clear structure. However, over the last year, the arrangements have lacked sufficient delegated decision-making authority to set direction and allocate resources. It is working in an environment where funding decisions can by-pass the Programme Board, with funding directly provided to the Health Board's Integrated Healthcare Communities. Consequently, the Programme Board has served as a discussion forum without being sufficiently able to provide leadership and direction needed to facilitate change **(Recommendation 3.1).** The Programme Board has lacked clarity on its programme of work due to the absence of an agreed overarching plan. Consequently, the draft terms of reference have been developed in isolation, and do not provide clarity of purpose. Members have raised issues regarding unclear reporting structures. There is no forward work programme to provide adequate assurance on overall progress delivery beyond updates from individual work streams. (**Recommendation 3.2).**<br>Over the last year, the Programme Board has presented several business cases to the Executive team for approval. These cases have varied in quality, resulting in some not being approved. As some of these business cases for new initiatives are developed during the year, the lack of approval can delay implementation, impacting the timeliness of improvement. The Health Board needs to both:<br>• strengthen its training approach for the development of planned care business cases (**Recommendation 3.3**);<br>• prepare business cases much earlier in the year, or ideally on an ongoing cycle linked to a multi-year planned care programme (**Recommendation 3.4**). |

| Audit question | Yes / No / Partially | Comments |
|---|---|---|
| Is planned care recovery supported by clearly defined operational accountabilities and effective clinical leadership? | **No** | There has been a lack of continuity of senior leadership for planned care over the last year. This has seen responsibility move from the Integrated Healthcare Community Director (East) to the Executive Medical Director, then to the Executive Director of Finance in summer of 2024 then to the newly appointed Chief Operating Officer. In addition, in March 2025, the Health Board's Assistant Director for planned care left. There is an urgent need to review Planned Care Programme Board leadership arrangements (**Recommendation 4**).<br>The Heath Board appointed a Clinical Director for Planned Care in October 2024, however, there is limited clarity on this role or remit **(Recommendation 4.1).**<br>Our work also suggests that given the longstanding absence of clinical strategy, that there is a real need for substantive speciality level clinical leads. These leads need to build consensus through the development of integrated specialty plans and drive efficient and affordable pathway changes to sustainably meet growing demand (**Recommendation 4.2**). |
| Has the Health Board undertaken a risk assessment to understand the issues that could prevent delivery of planned care improvement aims? | **Partially** | The planned care workstreams identify and report risks to the Programme Board, through a risk register. Higher rated risks are effectively escalated to the Executive Team to approve actions to address the risks. The Health Board also identifies planned care risks in the corporate risk register. However, the risk rating has not changed in the last twelve months and remains above risk appetite indicating current controls are not effective. The Health Board needs to ensure that the actions it is taking to address risks are effectively evaluated and monitored and appropriately challenge the impact of actions taken **(Recommendation 5).** |
| Is performance on planned care recovery routinely reported to the appropriate committee/s and to the board? | **Partially** | Planned care performance is reported to the Board and Performance, Finance and Information Governance Committee. However, with the significant increase in demand and the deterioration in performance, oversight and challenge will need to be strengthened. This will ensure better outcomes and allow for a thorough evaluation of the measures implemented to improve performance. |

Source: Audit Wales fieldwork

## Utilisation of additional Welsh Government funding

17 We have looked at the Health Board's use of the additional planned care allocation that it has received from the Welsh Government. This section considers:

- the overall amount of additional planned care funding the Health Board has received from Welsh Government over the last three years;
- how the Health Board spent the money; and
- the Health Board's arrangements for overseeing how it has spent additional funding.

### Use of additional funding

18 We found that **since 2022-23 the Health Board has received a total of £114.5 million in additional Welsh Government funding. The Health Board is directing its additional Welsh Government funding towards tackling extremely long waits. There is limited use of the funding to support specialty level service transformation**.

19 To support planned care recovery over and above existing funding, the Health Board received a total additional Welsh Government allocation of £114.5 million between 2022-23 and 2024-25 (**Exhibit 4**).

**Exhibit 4: the Welsh Government's allocation to the Health Board to support planned care improvement**

| Financial year | Annual allocation (£m) |
|---|---|
| 2022-23 | 38.4 |
| 2023-24 | 34.3 |
| 2024-25 | 34.5 |
| Additional in-year Welsh Government allocation | 7.3[5] |
| **Total allocated** | **114.5** |

Source: Health Board financial self-assessment returns

20 The Health Board can appropriately account for the Welsh Government planned care funding it has received. We reviewed the use of the funding in 2023-24 in greater detail (**Exhibit 5**). During that year, the Health Board predominantly used the funding on short-term initiatives rather than service transformation to enable lasting improvement. It used £18.2 million or 64% of total funding allocation on insourcing and outsourcing activity to increase capacity in the short-term.

[5] In December 2024, Welsh Government allocated a further £7.3 million in non-recurrent funding to reduce some of the longest planned care waits in the Health Board.

21 The Health Board continued to adopt the short-term funding model throughout 2024-25. While this will have contributed to limiting further growth in very long waits, it is not providing the sustainable solution needed.

**Exhibit 5: use of the 2023-24 Welsh Government additional financial allocation, Betsi Cadwaladr University Health Board**

| | Performance improvement funding (£m) | Transformation fund (£m) |
|---|---|---|
| Mixed specialty insourcing (general surgery, ENT, urology, minor operations and pre-operative assessment) | 1.5 | |
| Dermatology contract extension | 0.3 | |
| Orthopaedics outsourcing | 2.7 | |
| Ophthalmology outsourcing | 2.3 | |
| Radiology recovery plan | 4.6 | |
| Endoscopy insourcing | 5.9 | |
| Planned care corporate capacity | 0.7 | |
| Stage 4 efficiencies | 0.6 | |
| Waiting list initiatives | 1.6 | 3.8 |
| Regional treatment centre closure | 0.2 | |
| Orthopaedic planned care sessions | 0.5 | |
| Validation and booking | 0.4 | |
| Insourcing internal support costs | 1.2 | |
| Additional activity - primary & secondary care drugs | | 3.2 |
| Abergele high volume low complexity orthopaedics | | 0.2 |
| Funding as a commissioner[6] | 4.5 | |
| **Total allocated** | **27.0** | **7.2** |

Source: Health Board self-assessment returns

[6] This includes specialised services commissioning of £2.85 million and commissioning £1.6 million of planned care services from NHS England.

### Monitoring impact of additional funding

22 We have considered the extent that Health Board oversees the use of the Welsh Government planned care financial allocations. We found that the **Health Board has reasonable arrangements to oversee the use of the additional Welsh Government planned care financial allocation, we have not seen evidence of monitoring its expected impact**.

23 The Planned Care Programme Board receives a financial report which provides a breakdown of planned spend for individual schemes from the sustainability fund, including any revised forecasts. The report indicates where planned spend is subject to further business case approval.

24 The Health Board also provides reports on proposed allocation of planned care funding at the Performance Finance and Information Governance Committee. While this reporting includes cost estimates, we have not seen any evidence of a more detailed monitoring whether the proposed investments have delivered the expected improvements **(Recommendation 6).**

## Operational management of planned care

25 Alongside the well-planned use of additional funding, health boards' ability to secure meaningful and sustainable planned care improvements will be dependent on them optimising their routine operational arrangements for planned care. In this section we consider the actions the Health Board is taking:

- to maximise its use of existing resources; and
- to protect and increase its planned care capacity.

### Maximising the use of existing resources

26 We have examined some opportunities that exist for the Health Board to improve efficiency and productivity, and the actions it is taking to maximise the use of its existing resources. We found **that the Health Board is starting to implement the Getting it Right First Time recommendations and while it has been effective in its use of day case surgery, there remains significant opportunity to improve efficiency.**

27 **Exhibit 6** identifies efficiency and productivity opportunities that could help maximise the use of existing resources within the Health Board to support planned care improvements.

**Exhibit 6: efficiency and productivity opportunities**

| Opportunity area | Audit findings |
|---|---|
| Responding to Getting it Right First time (GIRFT) reports | The Health Board have received reviews on general surgery, ophthalmology, orthopaedics, urology, gynaecology and operating theatre reviews. It has made variable progress in responding to GIRFT reviews, however the pace of delivery needs to improve particularly in relation to ophthalmology and orthopaedics. Whilst GIRFT was a specific workstream reporting into the Planned Care Programme Board, this has now ceased. Responsibility for implementing the recommendations is delegated to individual services. Consequently, there is now a loss of central reporting and assurance to the Planned Care Programme Board on progress in implementing GIRFT recommendations (**Recommendation 7.1**). |
| Arrangements for measuring and managing productivity of services | The Health Board has established an Elective Optimisation Programme. This oversees key performance metrics and a number of projects to review and monitor performance and standardise policies and procedures.<br>Task and finish groups have been established with clear aims and performance measures these include:<br>• Theatre dashboard – to monitor theatre utilisation including late starts and early finishes, high flow lists[7] and surgical cancellations.<br>• Policies and procedures – to review policies, standardise and implement best practice across to the Health Board.<br>• Reviewing all sub-speciality pathways to ensure standardised way of working.<br>• Reviewing demand against current capacity to meet future demand.<br>Our analysis of efficiency data below and in **Appendix 3** indicates there remain significant opportunities for improvement in efficiency. |

[7] Delivering High Flow Lists - Getting it Right First Time Guidance for Health Bodies

| Opportunity area | Audit findings |
| --- | --- |
| Reducing the number of cancelled operations | The Health Board, through its Elective Optimisation Programme has begun to scrutinise the high volume of surgical cancellations. **Exhibit 20** shows the total number of cancellations almost reached 4,700 for the 12-month period to February 2025 **(Recommendation 7.2)**. This is the highest of all Welsh health boards. **Exhibits 21** shows the cancellation reasons with "other" being the highest category recorded. This approach to recording cancellations does not assist the Health Board in understanding and addressing the underlying causes of short-term cancellations. The Health Board should prioritise accuracy in reporting to ensure the actions it plans to take are effective and resources allocated appropriately. **(Recommendation 7.3)** |
| Improving operating theatre utilisation | Whilst the Health Board has strengthened its arrangements for monitoring theatre utilisation, these are yet to improve performance. The Elective Optimisation Programme group is responsible for overseeing theatre utilisation through monitoring of the Theatre Dashboard metrics. The GIRFT target for theatre utilisation stands at 85%. The Health Board's integrated performance report indicates that monthly performance varies between 74% and 67% in the last twelve months with no meaningful improvement. Key contributors affecting theatre utilisation are late and early finishes which have remained significantly above GIRFT targets. **(Recommendation 7.4)** |
| Making use of "virtual" outpatient appointments | Virtual outpatient appointments can have a positive impact in reducing the need for travel and the risk of healthcare acquired infections. The Health Board recognises the variance in take up and engagement across services post-Covid and the risk of not being able to meet the target of increasing the volume of virtual appointments. **Exhibit 19** shows that virtual appointments are not well adopted by the Health Board, currently the lowest in Wales at 12.2% of all outpatient appointments in the 12-month period to February 2025. **(Recommendation 7.5)** |

| Opportunity area | Audit findings |
|---|---|
| Reducing non-attendance at outpatient appointments | The Health Board is working to reduce non-attendance at outpatient appointments. The Health Board introduced its Patient Access to Planned Care Policy in January 2025. This sets out implications for non-attendance and policy exceptions. Weekly reporting and escalation to Access Meetings ensures oversight of "Did Not Attend" (DNA) rates. The Health Board is developing standardised operating procedures (SOPs) for the management, monitoring and reporting of DNAs supported by a move to a centralised management of booking services. **Exhibit 18** shows some recent improvement in outpatient "did not attend" rates to around 5.5% of total outpatient clinic activity. This equates to around 38,400 lost patient appointments in the most recent 12-month period to February 2025 representing a lost opportunity cost of around £5.8 million. |
| Making more use of day case surgery | The Health Board is performing effectively in its use of day case surgery. **Exhibit 22** indicates that the 83% of the Health Board's elective surgery is day case and is positively the highest in Wales. |
| Effective consultant job-planning | The Health Board does not have effective consultant job-planning arrangements. At the time of our review there was no agreed Job planning policy in place **(Recommendation 7.6**). A recent internal audit report in January 2025 indicated compliance with Welsh Government requirements[8] for annual job plan review is at 66% against a target of 90%. **(Recommendation 7.7).** |
| Pooled lists within a Health Board speciality to ensure it treats its patients in turn | There is limited evidence to demonstrate the use of pooled lists by the Health Board, noting some progress in dermatology. The Health Board has identified that it needs to fully roll out the Welsh Admin Portal to enable it to effectively manage and pool waiting lists across Integrated Healthcare Communities. **(Recommendation 7.8).** |

Source: Audit Wales fieldwork including analysis of NHS Wales data and Health Board self-assessment and data returns

[8] National consultant contract in Wales

## Protecting and increasing planned care capacity

28 We examined the actions that the Health Board is taking to protect planned care capacity by separating out elective and emergency activity. We also looked at the actions the Health Board is taking to increase its planned care capacity.

29 We found that **the Health Board is taking measures to protect its elective capacity, but it needs to do more. Whilst it has secured additional capacity through insourcing, outsourcing and waiting list initiatives, these measures are unsustainable in the longer term.**

30 The Health Board has had some success protecting planned care capacity from wider service pressures in a small number of areas. This is particularly notable where services are physically separated from the major hospital sites. This includes orthopaedics and ophthalmology services in Abergele Hospital and surgical services in Llandudno General Hospital. As highlighted previously, the reasonably high level of day-case surgery also helps to protect planned care services from wider unscheduled care and medical pressures. Nevertheless, short-term surgical cancellation data indicates that the Health Board cancels operations because of unscheduled care pressures and wider capacity issues in hospitals.

31 To further protect services, the Health Board is planning a new elective orthopaedic hub at Llandudno General Hospital. The aim of this initiative is to reduce pressure on planned care services from unscheduled emergency care and reduce waiting times for this challenged service. The Health Board has secured £29.4 million additional Welsh Government capital funding in November 2023. While work is progressing on this facility, it is delayed and the original ambition to open in early 2025 has not been met. It is now unlikely that this will be achieved by the end of 2025.

32 The Health Board is insourcing and outsourcing services as a means to increase planned care capacity to help meet its short-term needs. In 2023-24, the Health Board spent £6.8 million on insourcing and outsourcing contracts for six key specialties, primarily for orthopaedics and ophthalmology with a further £5.9 million allocated to endoscopy diagnostics and £4.6 million on radiology recovery. The Health Board allocated £3.8 million to transform planned care services however it is not clear which initiatives were implemented from this additional funding. The Health Board continues to utilise premium weekend working to increase capacity in the short-term. This is neither financially sustainable nor is it an effective means of improving efficiency and risks reducing staff resilience.

## Managing clinical risk and harm associated with long planned care waits

33 Long patient waits increases the risk of preventable irreversible harm. Patients' health may deteriorate while waiting, they may be waiting in pain and with anxiety and uncertainty not knowing when they will finally receive treatment. They may also not be able to work or support or care for others while they are waiting. We considered whether the Health Board has sound arrangements to:

- identify, manage, and report on clinical risk and harm associated with long waits; and
- effectively communicating with patients who are on a waiting list and to manage potential inequalities in access to care.

34 We found that **the Health Board is starting to take action to implement the Welsh Government's Promote, Prevent and Prepare policy, but is yet to be fully rolled out across all specialties. Overall engagement in the implementation of the policy needs to increase with strengthened reporting on actual harm resulting from delays.**

35 The findings which have led us to this conclusion are summarised in **Exhibit 7**.

**Exhibit 7: the Health Board's approach to managing clinical risks and communicating with patients on waiting lists**

| Audit question | Yes / No / Partially | Comments |
|---|---|---|
| Has the Health Board implemented the first phase of the Welsh Government's Promote, Prevent and Prepare for Planned Care policy[9]? | **Partially** | The Health Board has been slow to implement the first phase of Welsh Government's Promote, Prevent and Prepare policy (3Ps). Its "Self-Care While You Prepare" service is currently only available to patients in four specialties: general surgery, orthopaedics, ophthalmology and dermatology. The Health Board has experienced delays in recruiting clinical and administrative staff to effectively meet demand and manage risk of harm resulting from delays. The Health Board needs to complete its recruitment and ensure the service covers all specialties **(Recommendation 8).** |

[9] Promote, Prevent and Prepare for Planned care policy to ensure that support and information is easily accessible to those waiting for appointments and interventions

| Audit question | Yes / No / Partially | Comments |
|---|---|---|
| Is the Health Board assessing the risk to patients waiting the longest? | **Partially** | The Health Board uses the DATIX system to record clinical risk resulting from a delay in treatment. However, there is no consistent methodology throughout specialties to assess risk and inform reporting on the risk of harm or instances of recorded harm **(Recommendation 9.1)**. |
| Is the Health Board capturing and reporting evidence of harm resulting from waiting list delays and is reporting on it to the Quality and Safety Committee? | **No** | We found insufficient arrangements for routinely reporting clinical risks associated with waiting list delays to the Board and its committees. Despite the largest waiting list and some of the longest waits in Wales, there have been no reports to the Quality, Safety and Experience Committee regarding patient harm as a result of delayed treatment **(Recommendation 9.2).** |
| Is the Health Board effectively balancing the tension between eliminating long waits and managing clinical risks in its approach to prioritising patients? | **No** | The Health Board's primary focus is eliminating long waiting lists. The Health Board should ensure the development of clinical plans for all challenged services to ensure higher risk patients are prioritised appropriately **(Recommendation 9.3)** |
| Does the Health Board monitor and record how many patients are leaving planned care waiting lists in favour of private treatment? | **No** | The Health Board does not have a mechanism for monitoring and recording the number of patients leaving planned care waiting lists in favour of private treatment. |

Source: Audit Wales fieldwork

# Waiting list performance – Is the action taken resulting in improvement?

36 We analysed current 'Referral to Treatment'[10] waiting list performance and trends to determine whether the Health Board is:

- reducing the overall levels of waits; and
- meeting Ministerial priorities and Welsh Government national targets.

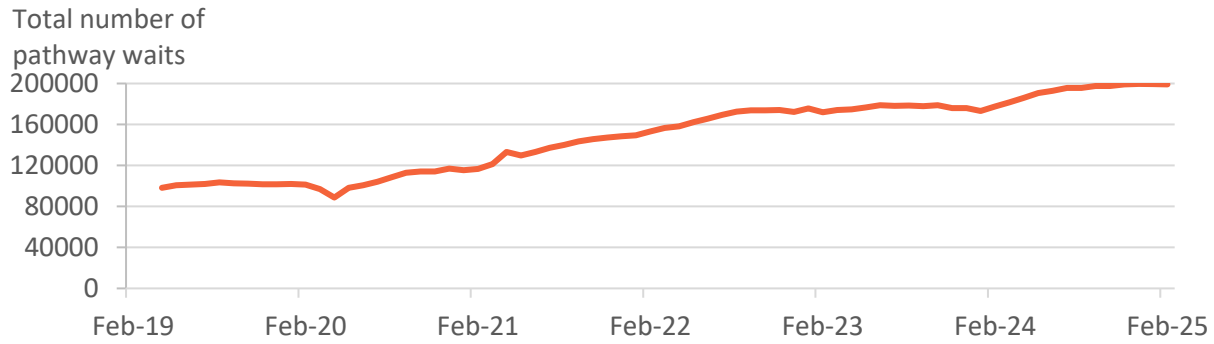
37 We found that **the Health Board has increasing numbers of waits and at the same time is not meeting Welsh Government performance targets. The growing number numbers of patients waiting over a year for treatment is of significant concern**.

## The scale of the waiting list

38 Across Wales, the scale and extent of waits substantially increased following the Covid-19 pandemic. We have looked at these changes in terms of the overall size of the waiting list. We have also considered both the volume of waits for diagnostics and therapy services and trends in referral rates. We found that **the continued growing backlog of people waiting to be treated presents an increasing and significant challenge for the Health Board. There are now nearly 200,000 open treatment pathways[11].**

39 **Exhibit 8** shows the overall trend of planned care waits for the Health Board since April 2019. This shows an increase in the size of the waiting list from 98,190 in April 2019 to 199,249 treatment pathways in February 2025. The action that the Health Board is taking to reduce the overall numbers of people waiting is not resulting in sufficient impact.

**Exhibit 8: Planned care waiting list size, Betsi Cadwaladr University Health Board**

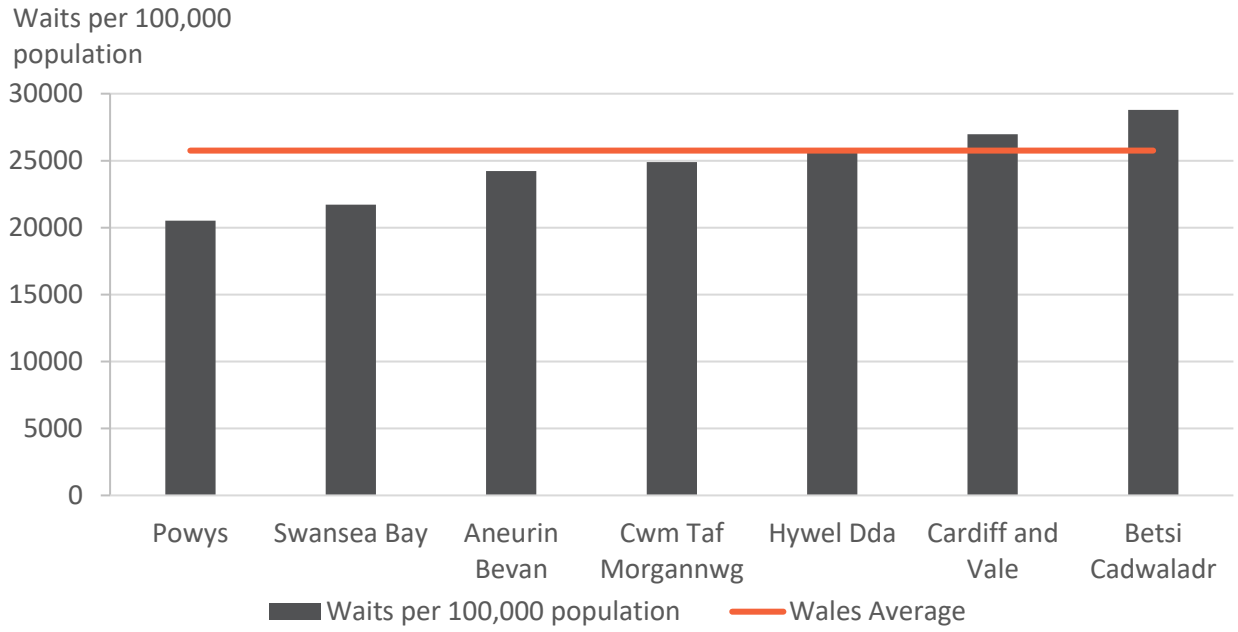



Source: Welsh Government, Stats Wales

[10] Referral to Treatment is how the NHS records the timeliness of planned care. It starts when a Health Board receives a referral and finishes when it has treated the patient. During that patient pathway, the NHS records distinct stages, including new outpatient appointment, diagnostic, follow up appointment or therapeutic intervention and treatment.

40 **Exhibit 9** provides a comparative picture of the volume of waits across Wales. It shows that the Health Board has a higher proportion of waits compared with other health boards in Wales.

**Exhibit 9: Waits per 100,000 population, by health board of residence, February 2025**




Source: Welsh Government, Stats Wales. Note: Powys data is for December 2024.

## Performance against national targets/priorities

41 We looked at the progress that the Health Board is making against the Welsh Government's aims[12]. These are:

- No one waiting longer than a year for their first outpatient appointment by the end of 2022 (**target date revised to December 2023**[13]).
- Eliminate the number of people waiting longer than two years in most specialties by March 2023 (**target date revised to March 2024**[6]).
- Increase the speed of diagnostic testing and reporting to eight weeks and 14 weeks for therapy interventions by Spring 2024.
- Eliminate the number of people waiting longer than one year in most specialties by Spring 2025.

[12] We have not included the Welsh Government performance on Cancer services as this is outside the scope of this review.

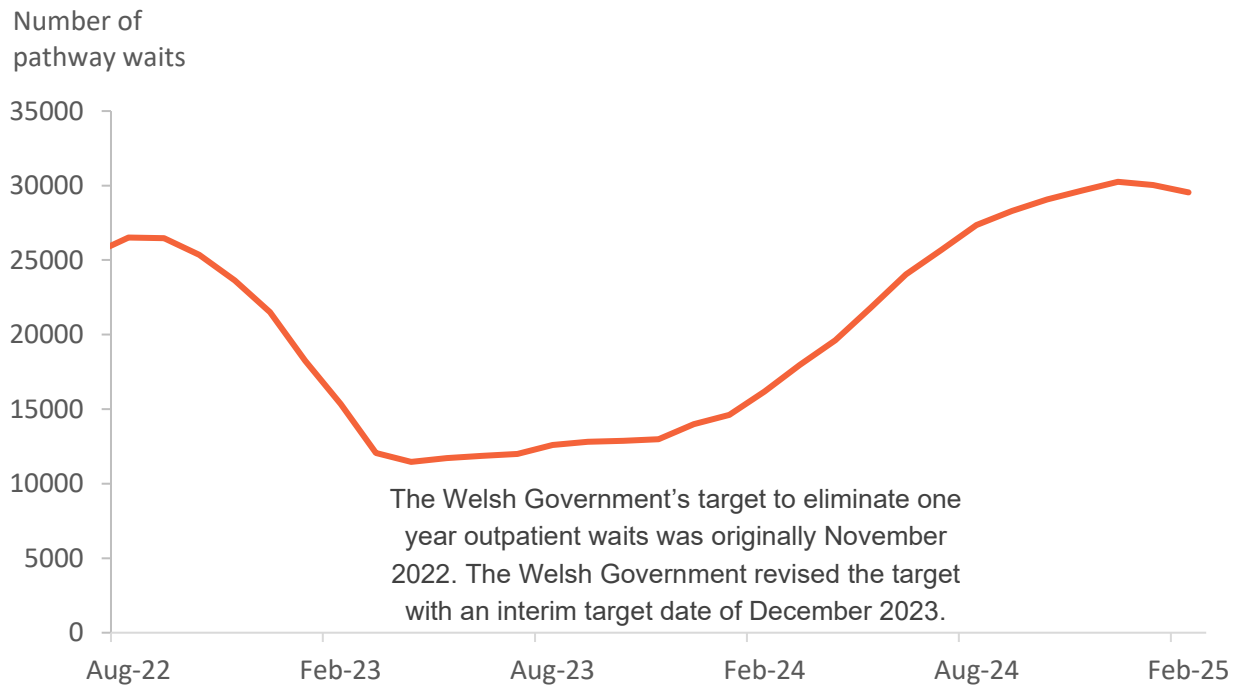
[13] Health boards did not meet the original targets for first outpatient appointment and number of people waiting longer than two years. As a result, the Welsh Government agreed to set interim targets (**in bold**, above).

42 We found that **the Health Board did not meet the Welsh Government's targets and despite making reasonably good progress initially performance has recently deteriorated.**

## No one waiting longer than a year for their first outpatient appointment

43 **Exhibit 10** shows Health Board waiting list performance for first (new) outpatient appointments. The Health Board failed to meet the revised December 2023 Welsh Government target to ensure no one waited more than a year for their new outpatient appointments. While initially improving, the Health Board did not achieve the Welsh Government's target to eliminate outpatient waits that are over a year. Performance substantially deteriorated during 2023 and 2024, and it is only recently starting to marginally improve.

**Exhibit 10: the number of first (new) outpatient appointments waits that are over a year since referral, Betsi Cadwaladr University Health Board**




Source: Welsh Government, Stats Wales

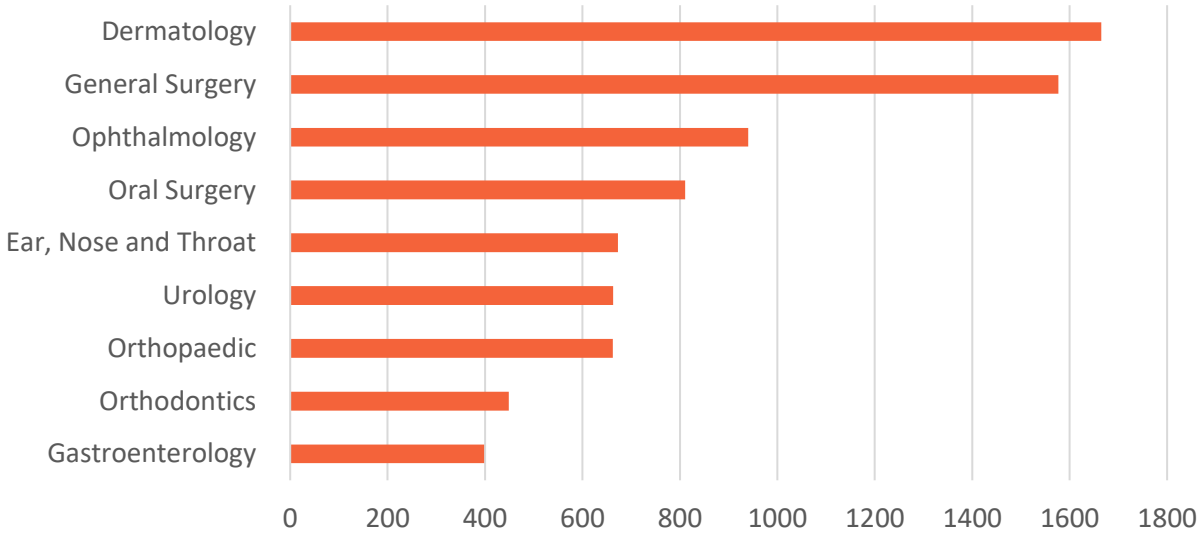
## Eliminate the number of pathways longer than two years in most specialties by March 2023

44 **Exhibit 11** shows that the Health Board did not meet the revised Welsh Government target to eliminate waits over 2 years by March 2024 and early performance improvement has not been maintained. Of those waits currently over 2 years, **Exhibit 12** shows that extreme waits are across a range specialties, but include dermatology, general surgery, ophthalmology and oral surgery.

**Exhibit 11: the number of planned care waits over 2 years, Betsi Cadwaladr University Health Board**


Source: Welsh Government, Stats Wales

**Exhibit 12: the number of planned care waits over 2 years by specialty as of February 2025, Betsi Cadwaladr University Health Board**

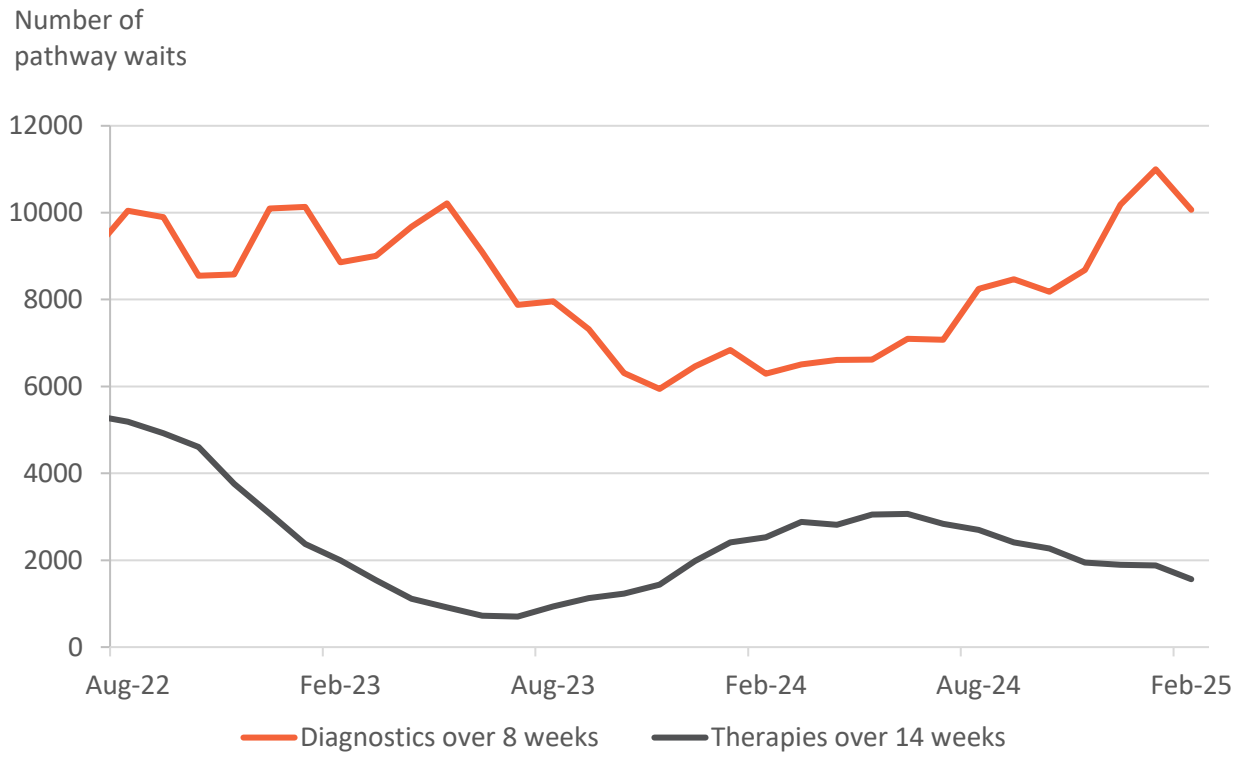



Source: Welsh Government, Stats Wales

## Increase the speed of diagnostic testing and reporting to eight weeks and 14 weeks for therapy interventions by Spring 2024

45 The Welsh Government sought to increase the speed of diagnostic testing and reporting to eight weeks and 14 weeks for therapy interventions by Spring 2024. The Health Board is not meeting its targets for therapy or diagnostic waits (**Exhibit 13**). Of its diagnostic services, diagnostic endoscopy and to an extent neurophysiology diagnostics are of greatest concern because of the volume and proportion of very long waits in these areas. Physiotherapy waits also appear to be a challenge for the Health Board.

**Exhibit 13: the number of diagnostic and therapy pathway waits that breach Welsh Government targets (Diagnostic waits is an 8-week target, therapies waits is a 14 week target), Betsi Cadwaladr University Health Board**

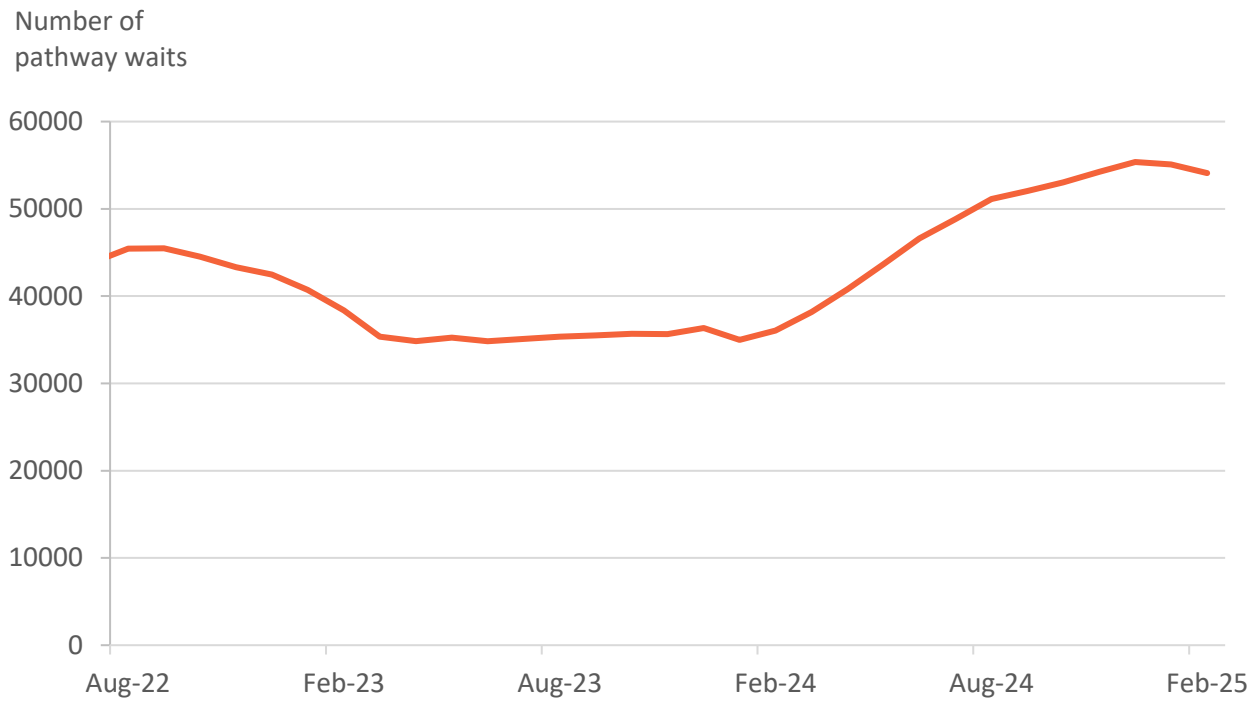



Source: Welsh Government, Stats Wales

## Eliminate the number of people waiting longer than one year in most specialties by Spring 2025

46 The Welsh Government's longer-term ambition was to eliminate waits over 1 year in most specialties by the Spring of 2025. **Exhibit 14** shows deterioration in performance in 2024 reaching the highest ever recorded level of one year waits at the Health Board in December 2024. The position has marginally improved since.

**Exhibit 14: the number of pathway waits that are over a year, Betsi Cadwaladr University Health Board**




Source: Welsh Government, Stats Wales

# Barriers to further improvement

47 We have considered the factors that are affecting the Heath Board's ability to tackle its waiting list backlog and secure sustainable improvements in planned care, together with actions that it is taking to address them.

48 We found that the Health Board recognises the barriers to improvement but is significantly affected by increasing service demand, capacity pressures and a lack of clinical leadership to drive change and recovery.

49 Our fieldwork has found challenges in the following areas:

- **Demand for planned care services** – There is significantly increasing demand for services. The Health Board is making some progress in reducing the number of extreme waits, however referral levels are increasing (**Exhibit 16, Page 39**). At the same time, our analysis of the levels of medical and surgical admissions indicates that service activity is slightly lower than 2019 levels (**Exhibit 17, Page 39**). This suggests an increasing gap between demand and supply which the Health Board must address.
- **Workforce capacity** – The Health Board has identified that staffing issues are a further challenge to delivery. This includes recruitment to key roles such as anaesthetists and some wider theatre staffing. This has contributed to difficulties optimising theatre capacity.
- **Capacity to support transformation** - The Health Board has deliberately focused on addressing immediate demand and reducing waiting lists without appropriate analysis of its core capacity. This alongside wider resourcing challenges is limiting opportunities for more long-term transformation work and the ultimate need to implement sustainable modernised services.
- **Clinical leadership –** The absence of a Medical Director and shortage of clinical leadership in the planned care programme, particularly for challenged services has impeded delivery progress.
- **Clinical strategy –** The Health Board does not have an overall clinical strategy and individual service plans for challenged services to support planned care recovery. As a result, the Health Board is adopting an ineffective reactive approach which lacks clarity and consistency across the Integrated Health Communities.

50 The Health Board has begun to take action to address some of these barriers. To address issues with theatre utilisation it has established the Elective Optimisation Programme to scrutinise performance and drive change, as described in **Exhibit 6.** The Health Board is also taking action to increase the use of the Abergele hospital for ophthalmology procedures.

51 The Health Board has recently identified short-term measures to address capacity issues in response to increased demand in dermatology including additional locum recruitment and the use of minor operation procedures at Connah's Quay Health Centre.

52 The actions the Health Board has taken, including the appointment of an Interim Medical Director are at their early stages and further work is required to ensure the Health Board does not continue to face the same or greater challenges in future.

# Appendix 1

## Audit methods

**Exhibit 15** sets out the methods we used to deliver this work. Our evidence is based on the information drawn from the methods below.

**Exhibit 15: audit methods**

| Element of audit methods | Description |
|---|---|
| Documents | We reviewed a range of documents, including:<br>• Planned care programme initiation document.<br>• Annual plan.<br>• Performance, Finance and Information Governance committee papers<br>• Planned care programme board papers<br>• Quality, Safety and Equality Committee papers<br>• Public Board meeting papers.<br>• Executive team papers<br>• GIRFT reviews<br>• Corporate risk register<br>• Planned care programme risk register<br>• Performance reports<br>• Terms of reference<br>• Internal audit reports |
| Self-assessment | We issued and then analysed a self-assessment completed by the Health Board. |
| Interviews | We interviewed the following:<br>• Interim Director of Finance – Senior Responsible Officer for planned care.<br>• Interim Chief Operating Officer<br>• Assistant Director for planned care.<br>• Integrated Health Community – Planned Care Director.<br>• Lead Clinical Director for planned care<br>• Outpatient Lead<br>• Finance Lead for planned care<br>• Quality, Safety and Equality Committee Chair |

| Element of audit methods | Description |
| --- | --- |
| | • Promote, Prevent, Prepare Lead |
| Observations | We observed the Planned Care Programme Board in December 2024. |
| Data analysis | We analysed key data on:<br>• waiting list performance;<br>• financial spend; and<br>• outpatient and inpatient efficiencies. |

# Appendix 2

## Audit criteria

Main audit question: **Is the Health Board effectively managing its planned care challenges?**

| Level 2 questions | Level 3 questions | Audit Criteria (what good looks like) |
|---|---|---|
| Is the Health Board's waiting list performance improving? | What is the scale of the challenge?<br>Is the Health Board meeting Welsh Government targets/ambitions? | The Health Board has:<br>• made progress reducing the overall number of referral to treatment waits for planned care services; and<br>• met Ministerial priorities and national targets that were set by the Welsh Government. |
| Does the Health Board have a clear plan and a programme of action to support planned care waiting list recovery? | Does the Health Board have a clear, realistic, and funded plan in place for planned care recovery?<br>Is there a clear programme structure to deliver planned care improvement? | The Health Board has:<br>• clear, realistic and funded plan in place for planned care recovery in the short and longer-term; and<br>• a programme structure that appropriately supports the delivery of the plan. |

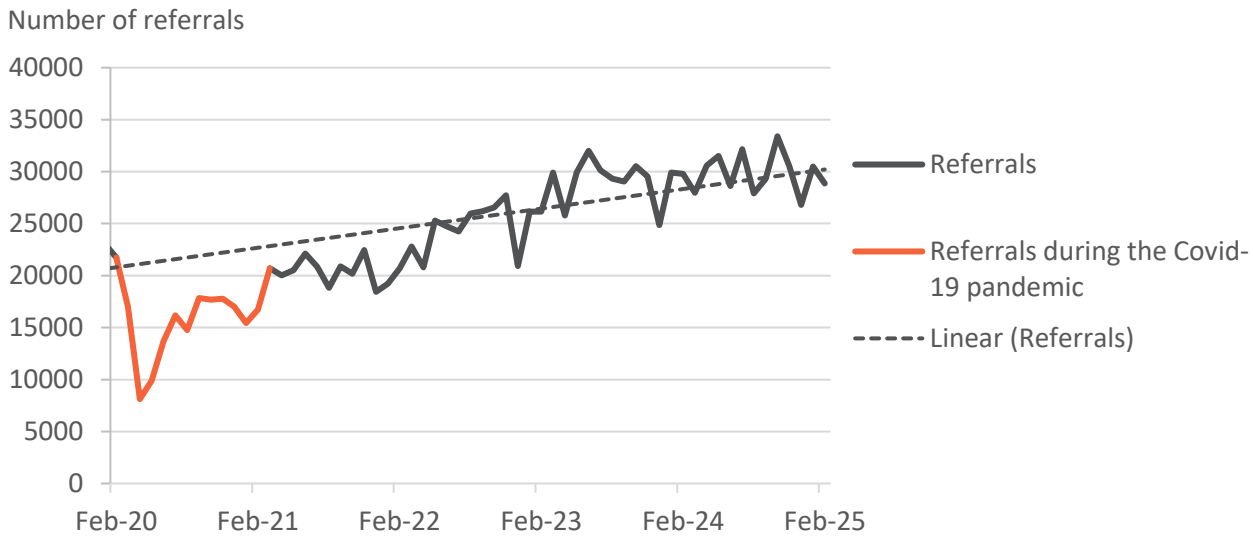
| Level 2 questions | Level 3 questions | Audit Criteria (what good looks like) |
|---|---|---|
| Is the Health Board maximising the impact of its funding to address the planned care backlog? | Is it clear what additional monies have been received by the Health Board?<br>Is it clear what the additional waiting list monies has been spent on?<br>Did the Health Board aim to use all the money on planned care improvement?<br>Can the Health Board clearly demonstrate that the money has resulted in performance improvement, enabled service efficiency and/or new ways of working?<br>Is the Health Board's overall financial position affecting its ability to deliver sustainable planned care recovery? | • There is sufficient evidence that the Health Board spent the money as intended by the Welsh Government (i.e. addressing waits and transforming services).<br>• The Health Board can clearly demonstrate that the spend has resulted in improvement.<br>• The Health Board's overall financial position is not affecting its ability to support planned care recovery. |
| Does the Health Board have effective operational management arrangements to drive improvement and | Is the Health Board improving its operational management of planned care services?<br>How does the Health Board capture information on clinical risk relating to long planned care waiting lists? | The Health Board is:<br>• improving the operational management of planned care services; and<br>• capturing information and managing clinical risks and harm related to long planned care waiting lists. |

| Level 2 questions | Level 3 questions | Audit Criteria (what good looks like) |
|---|---|---|
| management of clinical risks? | How does the Health Board capture information on clinical risk relating to long planned care waiting lists?<br>Is the Health Board sufficiently managing clinical risks resulting from delays to treatment?<br>Is the Health Board proactively ensuring clear routes of communication when patients are concerned that they are deteriorating? | The Health Board:<br>• has sound arrangements to identify, capturing, and report on clinical risk and harm associated with long waits;<br>• is proactively managing clinical risks resulting from delays to treatment and effectively communicating with patients. |
| Does the Health Board sufficiently understand barriers to improvement and what needs to be done to address them? | Does the Health Board understand the barriers it has experienced to improvement in planned care performance? (Capacity, funding, recruitment & retention, estates/use of facilities, commissioning external healthcare?)<br>What mechanisms and interventions have been put in place by the Health Board to address these barriers?<br>Is the Health Board learning and sharing good practice where things have gone well? | The Health Board has:<br>• identified its risk and barriers and acted on these to address long planned care waiting lists in the short-term and sustainable service models in the longer term.<br>• good arrangements for seeking good practice and sharing and applying learning to improve planned care services. |

# Appendix 3

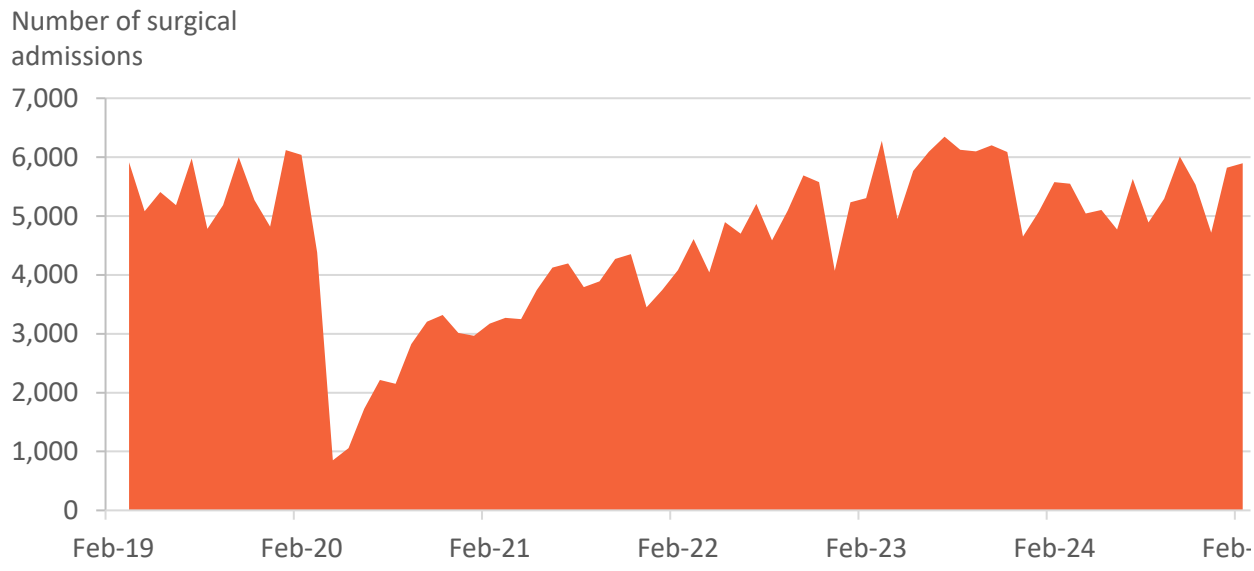
## Additional data analysis on planned care

**Exhibit 16: trend of monthly referrals to Betsi Cadwaladr University Health Board**




Source: Welsh Government, Stats Wales

**Exhibit 17: monthly elective medical and surgical admission levels, Betsi Cadwaladr University Health Board**

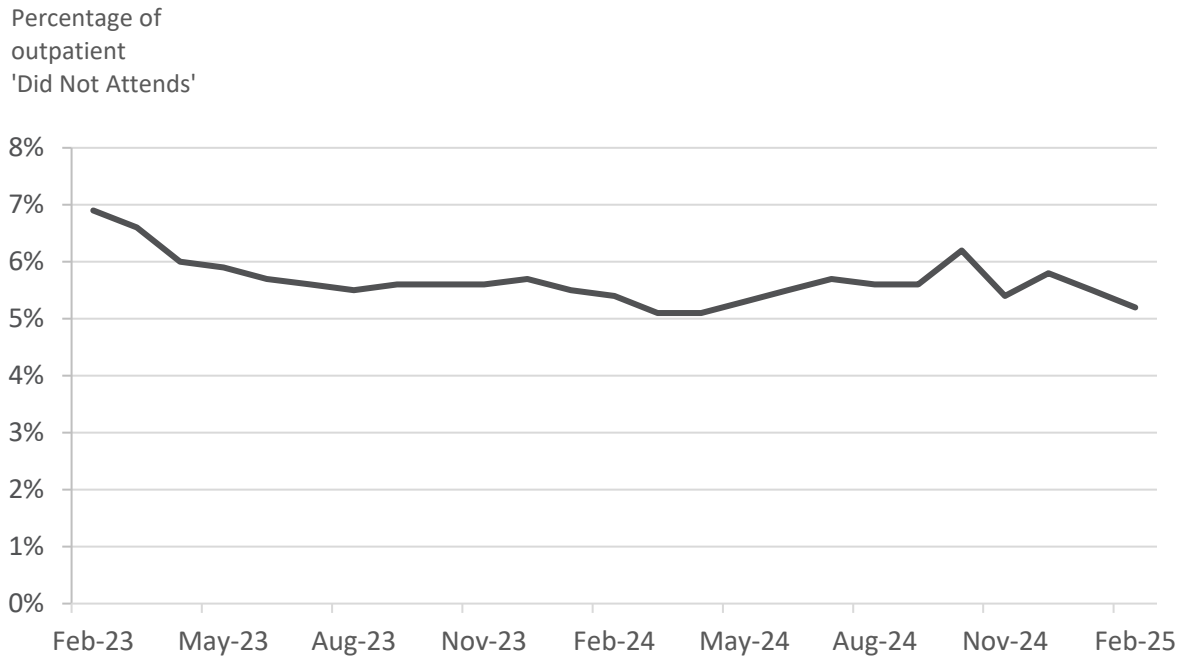



Source: Digital Health and Care Wales secondary care dashboard

**Outpatient services**

53 Outpatient appointments where a patient 'did not attend' is inefficient. **Exhibit 18** shows that the Health Board's 'Did Not Attends' is around 5.5% of total outpatient clinic activity. This equates to around 38,400 lost patient appointments in the most recent 12-month period to February 2025. It represents a lost opportunity cost of around £5.8 million (£150 per appointment[14]). If the Health Board could reduce its outpatient Did Not Attends by 20%, it could potentially save around £1.15 million.

**Exhibit 18: the number and percentage of outpatient 'Did Not Attends', Betsi Cadwaladr University Health Board**

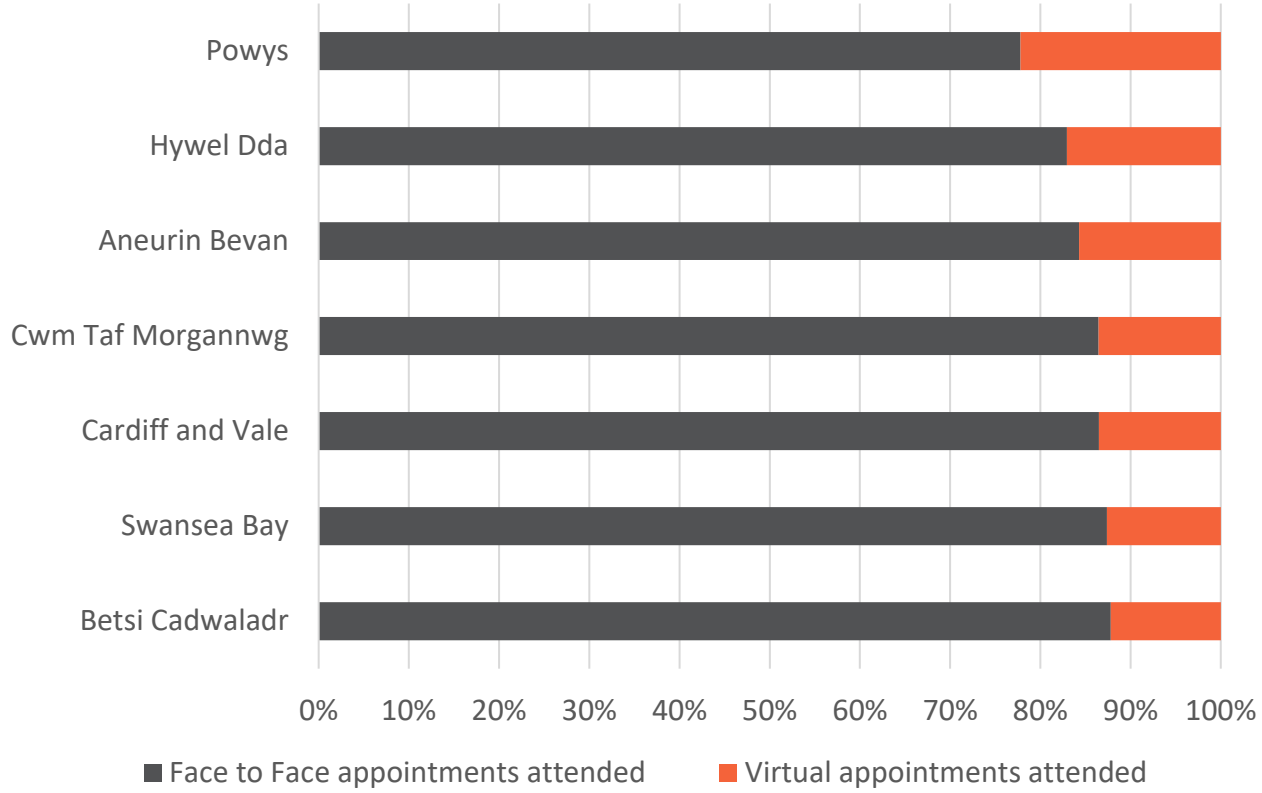



Source: Digital Health and Care Wales secondary care dashboard and datasets

54 NHS bodies can use virtual outpatient appointments for some but not all patients. **Exhibit 19** shows that the 'virtual' consultation approach is not well-adopted in most health boards and is the lowest in Betsi Cadwaladr University Health Board.

[14] We have adjusted the 2018 NHS England cost of an outpatient appointment (£120) by Bank of England CPI rates to estimate current average outpatient costs in 2024.

**Exhibit 19: proportion of outpatient attendances that are virtual appointments, from April 2024 to February 2025**

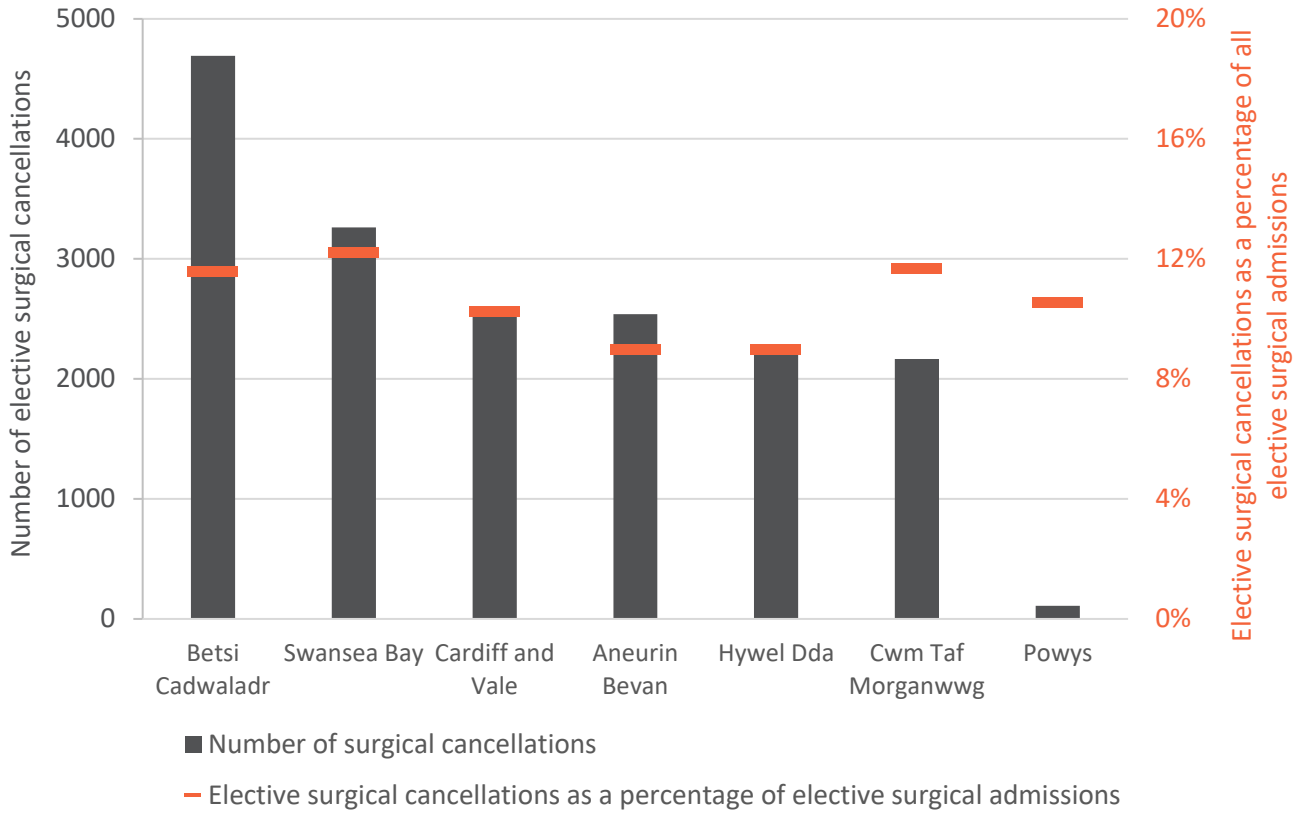



Source: Digital Health and Care Wales secondary care dashboard and datasets

### Surgical cancellations

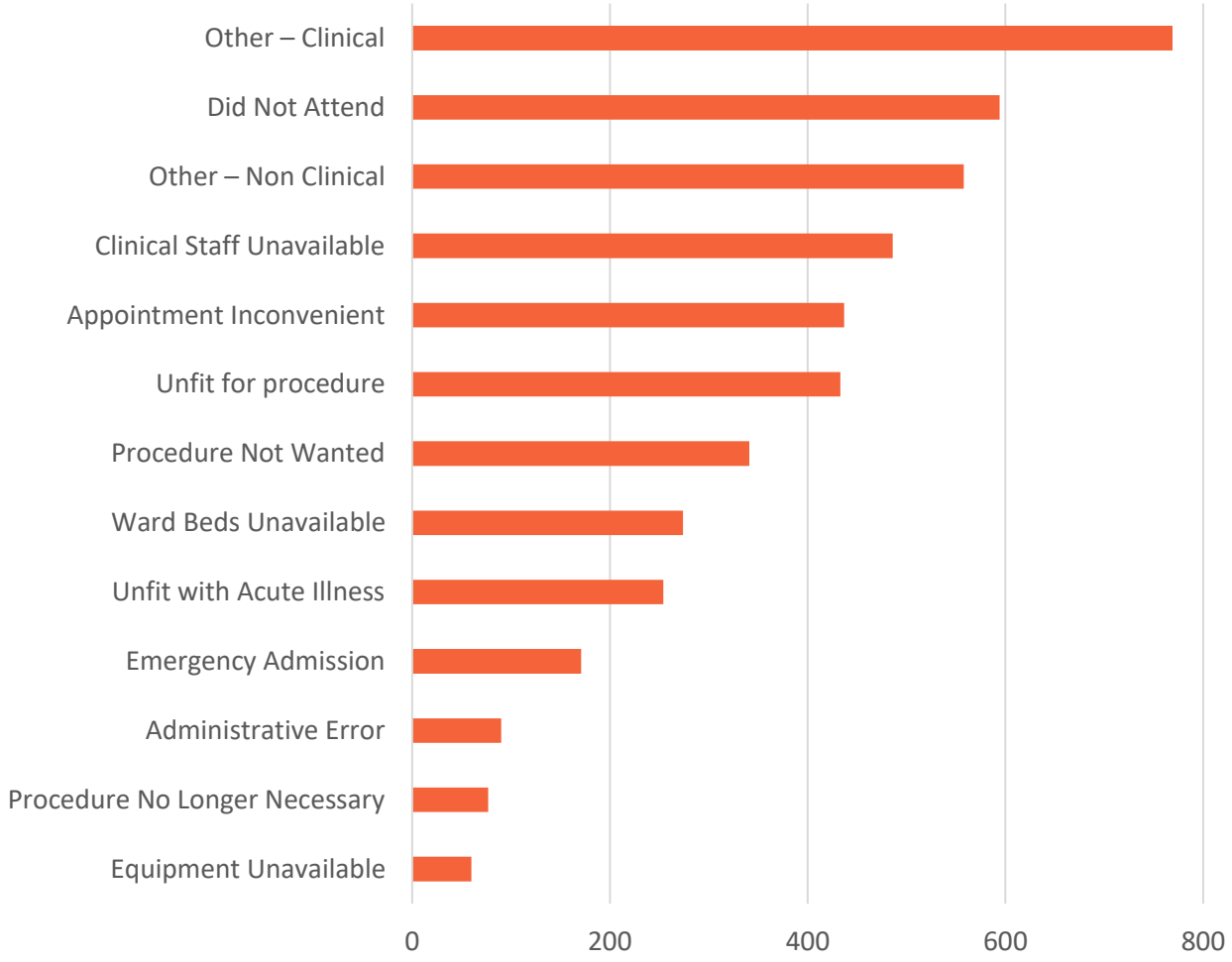
55 Short notice cancellations result in significant inefficiency because operating theatre sessions cannot be easily backfilled with other patients. The total number of surgical cancellations for the Health Board was almost 4,700 for the latest 12 month published data (March 2024 to February 2025) (**Exhibit 20**). **Exhibit 21** identifies the cancellation reasons.

**Exhibit 20: the number of short notice (within 24 hours) surgical cancellations alongside cancellations as a percentage of all elective surgical admissions, March 2024 to February 2025**




Source: Health Board submissions to the Welsh Government and Digital Health and Care Wales

**Exhibit 21: number of short notice (within 24 hours) surgical cancellations for the latest 12-month reporting period (March 2024 to February 2025), by reason, Betsi Cadwaladr University Health Board**

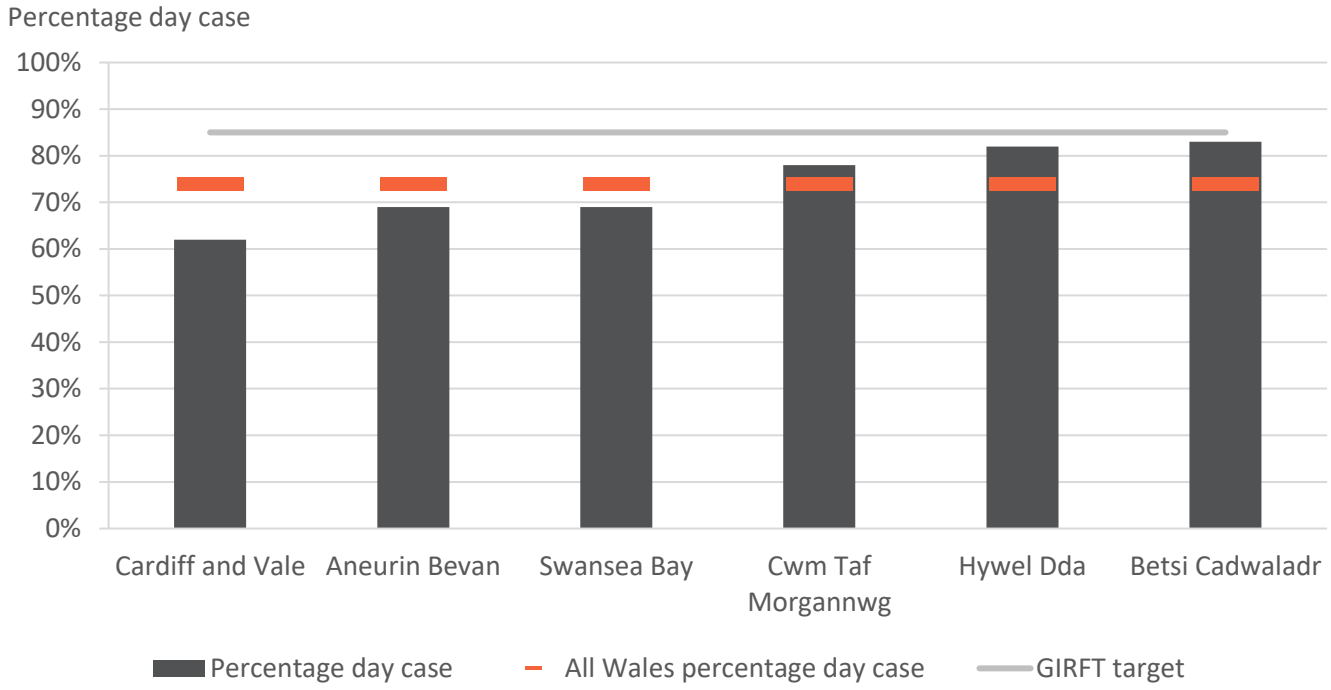



Source: Health Board submissions to the Welsh Government

**Day case surgery**

56 Day case surgery offers the potential for improved efficiency, lower costs, lower carbon footprint per patient[15] and a better patient experience when compared with inpatient services. Getting It Right First Time recommends that on average 85% of all elective[16] surgery should be day case[17]. Our analysis in **Exhibit 22** indicates that 83% of the Health Board's elective surgery is day case and positively is the highest in Wales.

**Exhibit 22: proportion of elective surgery undertaken by Health Boards as day case for the period April 2024 to February 2025**




Source: Digital Health and Care Wales secondary care dashboard and datasets

[15] Paper outlines GIRFT's 'unique position' in supporting the NHS drive for net zero carbon emissions - Getting It Right First Time - GIRFT

[16] Elective surgery is the type of surgery associated with a planned care patient pathway.

[17] Getting it Right First Time - Elective Recovery High Volume Low Complexity guidance for health systems


Audit Wales

Tel: 029 2032 0500

Fax: 029 2032 0600

Textphone: 029 2032 0660

E-mail: info@audit.wales

Website: www.audit.wales

We welcome correspondence and telephone calls in Welsh and English.
Rydym yn croesawu gohebiaeth a galwadau ffôn yn Gymraeg a Saesneg.

# The management response to audit recommendations

**Exhibit 23** below sets out the Health Board's response to our audit recommendations.

| Recommendation | Management response | Completion date | Responsible officer |
|---|---|---|---|
| **Planning**<br>R1 Over and above the commitments signalled within its annual plans, the Health Board should develop a detailed Planned Care improvement plan. This should aim to both design and deliver sustainable planned care services in the medium to longer term and to take advantage of opportunities for further regional working. The plan should be costed, with realistic but challenging milestones within it. (Exhibit 2) | The Health Board has identified Planned Care as a Major workstream (one of four) with the Chief Executive to Chair the Planned Care Project Board that will oversee delivery of the major program with 6 workstreams;<br><br>1- RTT Waiting List Management<br>2- Referral Management<br>3- Booking<br>4- Pre-operative and post operative effectiveness<br>5- Follow ups<br>6- Integrated Planned (Planned Care, Diagnostics & Cancer)<br><br>The Planned Care Board will oversee development and implementation of plans. | October 2025 | Executive Director of Transformation and Improvement |
| **Demand and capacity**<br>R2 The Health Board should ensure that its demand and capacity modelling approach is consistently applied across the organisation and its specialties and used to inform short-term | The Operational teams are (in conjunction with the Director of Performance) developing demand and capacity plans to support in year and future modelling of Integrated Medium Term Plans (IMTP). | December 2025 | Chief Operating Officer (COO) |

| Recommendation | Management response | Completion date | Responsible officer |
|---|---|---|---|
| service capacity planning and longer-term service design. This should consider continued growth or expected changes in population demand for planned care services **(Exhibit 2).** | | | |
| **Programme governance and programme business cases**<br>R3 The Health Board should strengthen its Planned Care Programme Board to ensure it has the authority to set direction and deliver both transformational change and short-term capacity improvement by:<br>3.1 Strengthening the Programme Board's delegated authority arrangements to ensure it is the primary forum for all transformational and short-term capacity improvement funding **(Exhibit 3).**<br>3.2 Developing a clear planned care | The Planned Care Board will oversee the development of Planned Care enhanced delivery in 2025/25 (see R1). It is of note that the Planned Care Programme Board is to be Chaired by the Chief Executive, with delivery of improvements through the Executive Director of Transformation and Delivery.<br><br>In addition, this Committee has Welsh Government membership and will oversee use of the Planned Care Fund totalling £34m.<br><br>3.1 to be reviewed in conjunction with the revisions to the Standing Orders and scheme of Reservation and Delegation | October 2025 Plan developed<br><br>October 2025 | Executive Director of Planning, Transformation and Improvement<br><br>Director of Corporate Governance |

| Recommendation | Management response | Completion date | Responsible officer |
|---|---|---|---|
| improvement programme for delivery, monitoring and associated accountability **(Exhibit 3).** | As noted previously | See above | See above |
| 3.3 Improving training for planned care business case development to ensure quality of business cases and timely approval **(Exhibit 3).** | Business Case development is being pursued within the Directorate for Transformation and Improvement, with a Business Case proforma under review. | January 2026 | Executive Director of Planning, Transformation and Improvement |
| 3.4 Prepare business cases earlier in the year or cyclically to align with a multi-year planned care programme to avoid implementation delays **(Exhibit 3).** | The Planning cycle will engage with the wider organisation as an ongoing as opposed to an annual process, this change key in determining the ability of the Health Board to prioritise resources for future financial years, aligning to Strategic Plans. | January 2026 | Executive Director of Planning, Transformation and Improvement |
| **Programme Board clinical leadership**<br>R4 The Health Board should review and strengthen its Planned Care Programme Board leadership arrangements by: | Programme Board formed and appointments / governance and oversight of the leadership with progress in regards to appointment of clinical leads continuing | | |

| Recommendation | Management response | Completion date | Responsible officer |
|---|---|---|---|
| 4.1 Developing a clear remit, authority and accountability for the role of the Clinical Director of Planned Care **(Exhibit 3).** | Clinical Director of Planned Care appointed and remit clarified within the Programme Boar. | August 2025 | Chief Executive Officer |
| 4.2 Appointing clinical leads for all specialties to the Programme Board to support the development of integrated speciality plans **(Exhibit 3).** | Progress made in appointments for Clinical leads, further appointments to be completed. | December 2025 | Chief Executive Officer |
| **Risk management**<br>R5 The Health Board should review and update the Planned Care risk register to ensure controls are effective and that the overall risk levels start to reduce in the next 6 months (Exhibit 3). | Planned Care Delivery is referenced within the Corporate Risk Register. A delivery Director appointed to monitor delivery and report on performance and operational delivery the responsibility of the Chief Operating Officer | October 2025 | Executive Director of Finance & Chief Operating Officer |
| **Monitoring impact of additional funding**<br>**R6** The Health Board should strengthen its monitoring of the use and impact of the additional | Planned Care Fund utilisation is reported within the Planned Care Program Board, with allocation and use supported through the Integrated Performance, Executive Delivery | Ongoing | Executive Director of Finance |

| Recommendation | Management response | Completion date | Responsible officer |
|---|---|---|---|
| Welsh Government planned care funding (Paragraph 24). | Group and the Performance, Finance and Information Governance Committee. | | |
| **Efficiency and productivity**<br>R7 Our work has identified there are opportunities for further efficiency and productivity improvements. The Health Board should: | The below improvements are contained within the overall planning. These workstreams referred to in section R1 will deliver against the specific elements listed below; | | |
| 7.1 Ensure there is clear monitoring and reporting on the completion of recommendations arising from the Getting it Right First Time (GIRFT) reviews **(Exhibit 6).** | Speciality demand and capacity plans to include reference to GIRFT and optimum levels of performance (access and quality of care) for our local population. This will feature within the demand and capacity modelling. | December 2025 | Chief Operating Officer |
| 7.2 Develop enhanced measures to reduce the number of short notice surgical cancellations **(Exhibit 6).** | Planned Care Programme Board to review utilisation of clinics in addition to factoring improvements into demand and capacity modelling. | October 2025 | Chief Operating Officer |
| 7.3 Improve the recording accuracy of surgical cancellation reasons to enable the Health Board to understand | Planned Care Programme Board to review utilisation of clinics in addition to factoring improvements into demand and capacity modelling. | October 2025 | Chief Operating Officer |

| Recommendation | | Management response | Completion date | Responsible officer |
|---|---|---|---|---|
| | and address the root cause of surgical cancellations **(Exhibit 6).** | | | |
| 7.4 | Develop and implement a plan to improve theatre utilisation rates across the Health Board, with realistic improvement trajectories, with the aim of achieving the GIRFT recommendation of 85% **(Exhibit 6).** | As above | November 2025 | Chief Operating Officer |
| 7.5 | Develop and rollout approaches to increase the use of "virtual" outpatient appointments, where clinically appropriate **(Exhibit 6).** | As above | November 2025 | Chief Operating Officer |
| 7.6 | Develop job planning policy and guidance **(Exhibit 6).** | Reporting to Planned Care Programme Board, the newly appointed Medical Director will lead in this area. | December 2025 | Medical Director |
| 7.7 | Ensure job plans are completed annually, utilising team-based job planning where it is appropriate to align | A rolling process of review will be put in place. | January 2026 | Medical Director |

| Recommendation | Management response | Completion date | Responsible officer |
|---|---|---|---|
| consultant capacity to meet service demand **(Exhibit 6).**<br>7.8 Roll out pooled waiting lists across the Health Board particularly focusing on challenged services to ensure it treats its patients in turn **(Exhibit 6).** | Treat in turn is a key element of delivery of improved access for routine patients waiting an extreme amount of time. Pooled lists for BCUHB and then booking based on treat in turn essential as we look to deliver improved access to our local population. Initially we would look to complete this during 2025/26. However, Foundations for the Future will support delivery through changing operational structures. | November 2025 | Chief Operating Officer |
| **Promote, Prevent and Prepare for Planned Care policy**<br>R8 The Health Board complete the establishment of the 'Promote, Prevent and Prepare (3P's) for Planned Care' contact centre and ensure it covers all specialties **(Exhibit 7).** | Work has progressed in regards to development of the '3P's' for the Health Board, the policy being developed at this time. Work to continue into 2025/26 and complete in the later quarter of the financial year. | November 2025 | Chief Operating Officer |
| **Risk of harm**<br>R9 In order to strengthen its arrangements for managing the clinical risks associated with long waits, the Health Board should: | | | |

| Recommendation | | Management response | Completion date | Responsible officer |
|---|---|---|---|---|
| 9.1 | Develop and implement a consistent methodology for assessing the risk of harm to patients caused by long waits across specialties **(Exhibit 7).** | This methodology is currently being worked on with the Clinical Executive of the Health Board. | October 2025 | Executive Director of Nursing |
| 9.2 | Develop a routine report to be presented at the Quality and Safety Committee that effectively reports risks and actual incidents of harm resulting from delays in access to treatment **(Exhibit 7).** | The Health Board reports routinely to the Quality, Health & Safety Committee matters. As above. | November 2025 | Executive Director of Nursing |
| 9.3 | Develop and implement clinical plans for all challenged services to ensure higher risk patients are prioritised **(Exhibit 7).** | Plans under development with a focus placed upon challenged specialities. | November 2025 | Chief Operating Officer |

| | | | | |
|---|---|---|---|---|
| **Teitl adroddiad:**<br><br>***Report title:*** | PUBLIC - Local Counter Fraud Service Q1 Report 2025/2026 | | | |
| **Adrodd i:**<br><br>***Report to:*** | Audit Committee | | | |
| **Dyddiad y Cyfarfod:**<br><br>***Date of Meeting:*** | Tuesday, 19 August 2025 | | | |
| **Crynodeb Gweithredol:**<br><br>***Executive Summary:*** | This report provides a Q1 2025/26 update on Local Counter Fraud Service activity.<br><br>Reactive Work: 17 cases were closed, with 27 remaining open at the end of the quarter. One complex case was referred to NHS CFS Wales. Sanctions included disciplinary action and civil recovery.<br><br>Proactive Work: Staff engagement increased significantly via intranet content and a successful counter fraud clinic at Wrexham Maelor Hospital. A review of travel expense claims is underway.<br><br>Training: Compliance remains high at 89%, with refreshed e-learning and in-person sessions delivered.<br><br>Staffing: Catherine McHarrie has been appointed to the Band 6 LCFS role, starting August 2025.<br><br>There are no financial implications to note. | | | |
| **Argymhellion:**<br><br>***Recommendations:*** | The Audit Committee is asked to consider and note the contents of the Q1 report. | | | |
| **Arweinydd Gweithredol:**<br><br>***Executive Lead:*** | Mr. Russell Caldicott – Interim Executive Director of Finance | | | |
| **Awdur yr Adroddiad:**<br><br>***Report Author:*** | Ms Danielle Kerr-Timmins – Head of Local Counter Fraud Service | | | |
| **Pwrpas yr adroddiad:**<br>***Purpose of report:*** | I'w Nodi<br>*For Noting*<br>☒ | I Benderfynu arno<br>*For Decision*<br>☐ | Am sicrwydd<br>*For Assurance*<br>☒ | |
| **Lefel sicrwydd:**<br><br>***Assurance level:*** | Arwyddocaol<br>*Significant*<br>☐<br>Lefel uchel o hyder/tystiolaeth o ran darparu'r mecanweithiau / amcanion presennol<br><br>*High level of confidence/evidence in delivery of existing mechanisms/objectives* | Derbyniol<br>*Acceptable*<br>☒<br>Lefel gyffredinol o hyder/tystiolaeth o ran darparu'r mecanweithiau / amcanion presennol<br><br>*General confidence / evidence in delivery of existing mechanisms / objectives* | Rhannol<br>*Partial*<br>☐<br>Rhywfaint o hyder/tystiolaeth o ran darparu'r mecanweithiau / amcanion presennol<br><br>*Some confidence / evidence in delivery of existing mechanisms / objectives* | Dim Sicrwydd<br>*No Assurance*<br>☐<br>Dim hyder/tystiolaeth o ran y ddarpariaeth<br><br>*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:**<br><br>***Link to Strategic Objective(s):*** | Building an Effective Organisation |
| **Goblygiadau rheoleiddio a lleol:**<br><br>***Regulatory and legal implications:*** | The progress against the Local Counter Fraud Service Workplan for 2025/26 will be reported to the Audit Committee and also to Welsh Government in the Counter Fraud Annual Report for 2025/26. |
| **Yn unol â WP7, a oedd EqIA yn angenrheidiol ac a gafodd ei gynnal?**<br><br>***In accordance with WP7 has an EqIA been identified as necessary and undertaken?*** | No<br><br>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.<br><br>Gweithdrefn ar gyfer Asesu Effaith ar Gydraddoldeb WP7<br><br>*WP7 Procedure for Equality Impact Assessments* |
| **Yn unol â WP68, a oedd SEIA yn angenrheidiol ac a gafodd ei gynnal?**<br><br>***In accordance with WP68, has an SEIA identified as necessary been undertaken?*** | No<br><br>Socio-economic Impact Assessment is not required to be carried out, as this report does not deal with Health Board's strategic decisions.<br><br>Gweithdrefn WP68 ar gyfer Asesu Effaith Economaidd-Gymdeithasol.<br><br>*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)**<br><br>***Details of risks associated with the subject and scope of this paper, including new risks( cross reference to the BAF and CRR)*** | The programme of Counter Fraud work targets the NHS Requirements of the UK Government Functional Standard 013 Counter Fraud (GovS013) from the Cabinet Office, to protect NHS financial resources from Fraud, Bribery and Corruption. |
| **Goblygiadau ariannol o ganlyniad i roi'r *argymhellion ar waith***<br><br>***Financial implications as a result of implementing the recommendations*** | No recommendations |
| **Goblygiadau gweithlu o ganlyniad i roi'r argymhellion ar waith** | No recommendations |

| | |
|---|---|
| ***Workforce implications as a result of implementing the recommendations*** | |
| **Adborth, ymateb a chrynodeb dilynol ar ôl ymgynghori**<br><br>***Feedback, response, and follow up summary following consultation*** | The paper has been subject to Executive review and sign off. |
| **Cysylltiadau â risgiau BAF:**<br>(neu gysylltiadau â'r Gofrestr Risg Gorfforaethol)<br><br>***Links to BAF risks:***<br>*(or links to the Corporate Risk Register)* | |
| **Rheswm dros gyflwyno adroddiad i fwrdd cyfrinachol (lle bo'n berthnasol)**<br><br>***Reason for submission of report to confidential board (where relevant)*** | N/A |
| ***Next Steps:***<br><br>The Committee is required to note the contents of the Q1 Local Counter Fraud Service Progress Report. | |
| ***List of Appendices:***<br><br>*Appendix A – Counter Fraud Progress Dashboard Q1 25/26* | |

***AUDIT COMMITTEE, 19th AUGUST 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, and any other relevant developments. The Committee is invited to review and note the contents of this report.

## 2. Reactive Counter Fraud Wok

### 2.1 Cases

| | Q3 24/25 | Q4 24/25 | Q1 25/26 |
|---|---|---|---|
| **Open Cases at close of Q** | 38 | 22 | 27 |
| **Cases closed during Q** | 16 | 8 | 17 |

Reactive counter fraud work is ongoing, with 27 open cases remaining at the end of Q1. Of these, 30% have shown significant progress since the last Audit Committee update. While this is below the team's expectations, progress was affected by a vacancy in the Band 6 LCFS post, which remained unfilled for approximately 11 weeks during the recruitment process.

During Q1, 17 cases were closed. A total of five sanctions were applied, including one disciplinary sanction in the form of a final written warning and a civil recovery of the funds lost. Additionally, declarations of interest were submitted in three of the cases.

One case was transferred to NHS Counter Fraud Service Wales and remains under investigation. The case relates to complex pharmaceutical fraud. BCUHB Chief Pharmacist is aware and in contact with CFS Wales.

NHS Counter Fraud Service Wales have three cases open (including the above) relating to BCUHB and closed three cases in Q1.

## 3. Proactive Counter Fraud Work

**Engagement:**

Engagement efforts continued during Q1, with several posts published on the intranet page and payslip messages to staff. These generated a significant increase in staff interaction, with site views rising from 235 in Q4 2024–25 to 1,644. The content included a mix of instructional and deterrent-focused articles, helping to ensure staff were not only informed of key updates but also understood their relevance, impact, and where to access further guidance on their responsibilities.

The first of this years 'Counter Fraud Clinics' took place at Wrexham Maelor Hospital. We were pleased to engage with 326 attendees, who received QR code cards and informative leaflets on how to report fraud, along with some handy giveaways like keyring torches, pens, and trolley coins. It was great to have meaningful conversations about fraud prevention within the NHS.

Partnership work continued in Q1, including a meeting with the Economic Crime Unit at North Wales Police to strengthen collaborative efforts, share intelligence, and explore opportunities for joint investigations and support on complex cases. This engagement aims to enhance the effectiveness of fraud prevention and enforcement activities through improved information sharing and coordinated action.

A summary report for all reactive and proactive work completed during Q1 has been provided in Appendix A.

**Training:**

Training compliance remains strong, with 89.08% of staff completing the mandatory e-learning. The fraud awareness e-learning package has been refreshed in response to staff feedback to improve clarity and relevance. Additionally, five in-person presentations were delivered to staff during the period. The main counter fraud awareness presentation is currently undergoing a substantial update to ensure it remains current, engaging, and better suited to staff needs.

**Proactive Exercises:**

In Q1, a local proactive exercise was launched to review travel expense claims across the organisation, with a focus on home-to-base mileage and high-value general mileage claims.

A full copy of the Local Proactive Exercise Report will be provided to the committee including recommendations once complete.

## 4. Other

Following the retirement of Graham Jones (Band 6 LCFS) in June. A competitive recruitment process took place which resulted in the successful appointment of Catherine McHarrie to the role. Catherine's expected start date is the 11th August 2025.

## 5. Other / Budgetary / Financial Implications

There are no budgetary implications associated with this paper.

## 6. 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

# Open Investigations – End of Q1 25-26

Cases Under Investigation

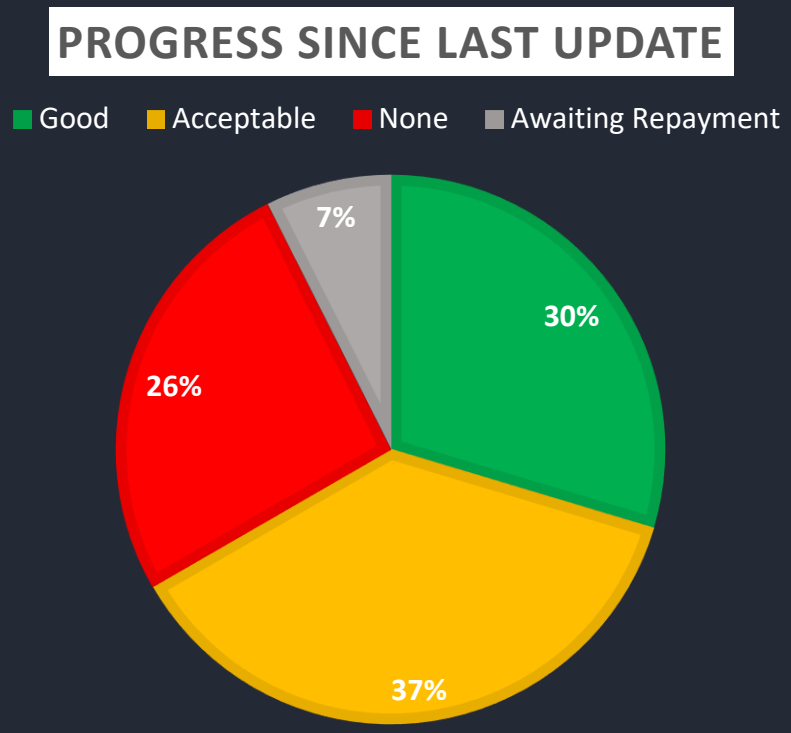
27

Referrals Received

15

Interviews Under Caution

0

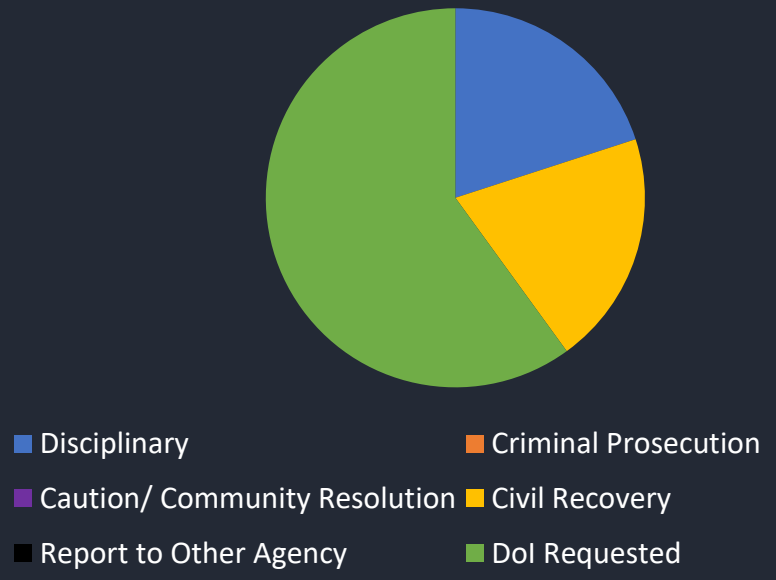



| Allegation Type | Number of Cases |
|---|---|
| Working Whist Sick | 5 |
| Secondary Employment | 2 |
| Procurement | 1 |
| Mandate Fraud / Phishing | 2 |
| Perscription/Pharmacy | 4 |
| Theft/Drug Dealing | 1 |
| Patient Fraud | 2 |
| Expenses/Timesheet/Leave | 6 |
| Recruitment Fraud | 1 |
| False Qualifications | 1 |
| Diversion of Funds | 1 |
| Private Patients | 1 |
| Total | 27 |

# Investigation Outcomes – Q1 25-26

| Cases Closed | Sanctions Applied | Loss Identified | Loss Recovered | Referred to other agency |
|---|---|---|---|---|
| 17 | 5 | £206.19 | £206.19 | 4 |

## SANCTIONS/OUTCOMES




Fraud Identified in
5.88%
Of Cases

Sanctions Applied in
5.88%
Of Cases

Average Days to Investigate
86

# Proactive Work – Q1 25-26

Training Compliance
89.08%

Risk Reviews
1

Presentations
5

Media Reports
12

System Weakness Reports Completed
0

Local Proactive Exercises Completed
0

Local Proactive Exercises in Progress
1

Engagement Events (People Seen)
326

| | |
|---|---|
| **Cyfarfod a dyddiad:**<br>**Meeting and date:** | Audit Committee |
| **Cyhoeddus neu Breifat:**<br>**Public or Private:** | Public |
| **Teitl yr Adroddiad**<br>**Report Title:** | Summary of business considered in private session to be reported in public |
| **Cyfarwyddwr Cyfrifol:**<br>**Responsible Director:** | Pam Wenger, Director of Corporate Governance |
| **Awdur yr Adroddiad**<br>**Report Author:** | Philippa Peake-Jones, Head of Corporate Affairs |
| **Craffu blaenorol:**<br>**Prior Scrutiny:** | None |
| **Atodiadau**<br>**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:

**8 May 2025**

- Local Counter Fraud Service Progress Report
- Policy Response: Bribery and Corruption
- Key Messages from Annual Accounts

- Draft Annual Accountability Report 2024/25
- Corporate Governance Code

**24 June 2025**

- Financial Annual Accounts 2024/25
- Annual Report 2024/25
- Head of Internal Audit Opinion & Annual Report 2024/25
- ISA 260 Audit of Financial Statements
- Local Counter Fraud Annual Report 2024/25

| | | | | |
|---|---|---|---|---|
| **Teitl adroddiad:**<br><br>***Report title:*** | **CORPORATE GOVERNANCE REPORT** | | | |
| **Adrodd i:**<br><br>***Report to:*** | Audit Committee | | | |
| **Dyddiad y Cyfarfod:**<br><br>***Date of Meeting:*** | Tuesday, 19 August 2025 | | | |
| **Crynodeb Gweithredol:**<br><br>***Executive Summary:*** | The objective of this report is to provide the Committee with an update on key Corporate Governance matters and to provide an update to the Committee on a range of corporate governance matters as well as assurance. | | | |
| **Argymhellion:**<br><br>***Recommendations:*** | Members are asked to:<br>• **APPROVE** the Audit Committee Cycle of Business 2025-2026<br>• **APPROVE** the Committee Annual Report | | | |
| **Arweinydd Gweithredol:**<br><br>***Executive Lead:*** | Pam Wenger – Director of Corporate Governance | | | |
| **Awdur yr Adroddiad:**<br><br>***Report Authors:*** | Philippa Peake-Jones – Head of Corporate Governance | | | |
| **Pwrpas yr adroddiad:**<br>***Purpose of report:*** | I'w Nodi<br>*For Noting*<br>☐ | I Benderfynu arno<br>*For Decision*<br>☒ | Am sicrwydd<br>*For Assurance*<br>☐ | |
| **Lefel sicrwydd:**<br><br>***Assurance level:*** | Arwyddocaol<br>*Significant*<br>☐<br>Lefel uchel o hyder/tystiolaeth o ran darparu'r mecanweithiau / amcanion presennol<br><br>*High level of confidence/evidence in delivery of existing mechanisms/objectives* | Derbyniol<br>*Acceptable*<br>☒<br>Lefel gyffredinol o hyder/tystiolaeth o ran darparu'r mecanweithiau / amcanion presennol<br><br>*General confidence / evidence in delivery of* | Rhannol<br>*Partial*<br>☐<br>Rhywfaint o hyder/tystiolaeth o ran darparu'r mecanweithiau / amcanion presennol<br><br>*Some confidence / evidence in delivery of* | Dim Sicrwydd<br>*No Assurance*<br>☐<br>Dim hyder/tystiolaeth o ran y ddarpariaeth<br><br>*No confidence / evidence in delivery* |

| | | | | |
|---|---|---|---|---|
| | | *existing mechanisms / objectives* | *existing mechanisms / objectives* | |

| | |
|---|---|
| **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:**<br><br>***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:**<br><br>***Link to Strategic Objective(s):*** | This work links to all strategic objectives of the Health Board as Corporate Governance is a key enabler for them. |
| **Goblygiadau rheoleiddio a lleol:**<br><br>***Regulatory and legal implications:*** | The Health Board is required to act according to its Standing Orders. This report contains information to allow the Health Board to conform to this.<br><br>It is essential that the Board has robust arrangements in place for Corporate Governance and failure to do so could have legal implications for the Health Board. |
| **Yn unol â WP7, a oedd EqlA yn angenrheidiol ac a gafodd ei gynnal?**<br><br>***In accordance with WP7 has an EqlA been identified as necessary and undertaken?*** | This is not applicable for this report. |
| **Yn unol â WP68, a oedd SEIA yn angenrheidiol ac a gafodd ei gynnal?**<br><br>***In accordance with WP68, has an SEIA identified as necessary been undertaken?*** | This is not applicable for this report. |
| **Manylion am risgiau sy'n gysylltiedig â phwnc a chwmpas y papur hwn, gan gynnwys risgiau newydd (croesgyfeirio at y BAF a'r CRR)**<br><br>***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***<br><br>***Financial implications as a result of implementing the recommendations*** | The effective management of Governance has the potential to leverage a positive financial dividend for the Health Board through better integration of risk management into business planning, decision-making and in shaping how care is delivered to our patients thus leading to enhanced quality and less waste |

| | |
|---|---|
| **Goblygiadau gweithlu o ganlyniad i roi'r argymhellion ar waith**<br><br>***Workforce implications as a result of implementing the recommendations*** | Failure to have effective Corporate Governance can impact adversely on the workforce. |
| **Adborth, ymateb a chrynodeb dilynol ar ôl ymgynghori**<br><br>***Feedback, response, and follow up summary following consultation*** | Not applicable |
| **Cysylltiadau â risgiau BAF:**<br>(neu gysylltiadau â'r Gofrestr Risg Gorfforaethol)<br><br>***Links to BAF risks:***<br>*(or links to the Corporate Risk Register)* | BAF24-01 Building an Effective and Accountable Organisation<br><br>CRR-16 – Leadership/Special Measures |
| **Rheswm dros gyflwyno adroddiad i fwrdd cyfrinachol (lle bo'n berthnasol)**<br><br>***Reason for submission of report to confidential board (where relevant)*** | Not applicable |
| ***Next Steps:***<br>• To continue to improve and report on Corporate Governance | |
| ***List of Appendices:***<br><br>**Appendix 1** The Audit Committee Cycle of Business 2025-2026<br>**Appendix 2** The Committee Annual Report | |

## CORPORATE GOVERNANCE REPORT

### 1. INTRODUCTION

The purpose of this report is to provide the Committee with an update on key corporate governance matters.

### 2. ANNUAL BUSINESS CYCLE 2025-26 (Formal, Informal and Board Development)

The Business Cycle for the Planning, Population Health and Partnerships Committee for 2025-26 is attached at **Appendix 1**

### 3. DRAFT COMMIITTEE ANNUAL REPORT

Under Standing Order 10.2.3, each Committee of the Board is required to submit an annual report "setting out its activities during the year and detailing the results of a review of its performance". This first annual report from the Planning, Population Health and Partnerships Committee details the activities and performance for the Committee for the reporting period 2024-2025.

### 4. COMMITTEE SELF ASSESSMENT

The results of the Committee Self-Assessment are available in Appendix 3 of the report.

### 5. RECOMMENDATIONS

Members are asked to:

- **APPROVE** the Planning, Population Health and Partnerships Cycle of Business 2025-2026;
- **APPROVE** the Committee Annual Report
- **NOTE** and **DISCUSS** the Committee Self-Assessment

# Betsi Cadwaladr University Health Board
# Audit Committee

Cycle of Business

(1 April 2025 – 31 March 2026)

Betsi Cadwaladr University Health Board should, on an annual basis, receive a cycle of business that identifies the items which will be regularly presented for consideration. The annual cycle is one of the key components in ensuring that the Health Board is effectively carrying out its role.

The Committee Cycle of Business covers the period 1 April 2025 to 31 March 2026.

The Committee Cycle of Business has been developed to help plan the management of Health Board matters and facilitate the management of agendas and Health Board business. The Annual Cycle of Business will be complemented by a “Non-Routine Board Business (Forward Work Plan)” for ‘one-off’ Ad-hoc items raised during the course of meetings.

The role of the Audit Committee is set out in the Terms of Reference which is available here: [Insert here]

| **Committee Chair** | **Independent Members** | **Executive Members** | **In Attendance** |
|---|---|---|---|
| Vacant<br><br>**Committee Vice Chair**<br>Urtha Felda | Rhian Watcyn Jones<br>Dyfed Jones | Russell Caldicott (Executive Director of Finance)<br>Pam Wenger (Director Corporate Governance) | Danielle Timmins (Head of Local Counter Fraud)<br>Sreeman Andole (Head Responsible for Clinical Audit)<br>Dave Harries (Head of Internal Audit)<br>Andrew Doughton (Representative of Auditor General – External Audit) |

# AUDIT COMMITTEE CYCLE OF BUSINESS 2025-26

| Item of Business | Executive Lead | Reporting period | Q1 | | | Q2 | | | Q3 | | | Q4 | | | 2026-27 | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | | April 2025 | May 2025 (Private) | June 2025 | July 2025 | Aug 2025 | Sep 2025 | Oct 2025 | Nov 2025 | Dec 2025 | Jan 2026 | Feb 2026 | Mar 2026 | April 2026 | May 2026 |
| **Preliminary Matters** | | | | | | | | | | | | | | | | |
| Minutes of the previous Board Meeting | Director of Corporate Governance | All Regular Meetings | ⚑ | | ⚑ | | ⚑ | | ⚑ | | ⚑ | | ⚑ | | ⚑ | |
| Action Log | Director of Corporate Governance | All Regular Meetings | ⚑ | | ⚑ | | ⚑ | | ⚑ | | ⚑ | | ⚑ | | ⚑ | |
| **Governance, Risk & Assurance** | | | | | | | | | | | | | | | | |
| Corporate Governance Report:<br>• Committee Cycle of Business<br>• Committee Terms of Reference<br>• Committee Annual Report<br>• Committee Self-Assessment<br>*(Going forward these documents will go to the Committee in March)* | Director of Corporate Governance | As Required | ⚑ | | | | | | | | | | | | | |
| Corporate Risk Register Report | Director of Corporate Governance | Quarterly | ⚑ | | ⚑ | | | | ⚑ | | | | ⚑ | | | |
| Board Assurance Framework Report | Director of Corporate Governance | Bi-Annually | ⚑ | | | | ⚑ | | | | ⚑ | | | | | |
| Update on Outstanding Audit Recommendations | Executives to present on a rolling basis | All Regular Meetings | ⚑ | | ⚑ | | ⚑ | | ⚑ | | ⚑ | | ⚑ | | ⚑ | |
| Statutory Compliance Report<br>• Welsh Health Circulars<br>• Ministerial Directions | Director of Corporate Governance | All Regular Meetings | ⚑ | | ⚑ | | ⚑ | | ⚑ | | ⚑ | | ⚑ | | ⚑ | |
| Standing Orders Reservation and Delegation of Powers | Director of Corporate Governance | Bi-Annually | | | | | ⚑ | | | | | | | | ⚑ | |
| Corporate Governance Code | Director of Corporate Governance | Annually | ⚑ | | | | | | | | | | | | | |
| Detail of Breaches of Standing Orders | Director of Corporate Governance | Annually | ⚑ | | | | | | ⚑ | | | | | | | |
| Declarations of Interest and Gifts & Hospitality Report | Director of Corporate Governance | Bi-Annually | ⚑ | | | | | | ⚑ | | | | | | ⚑ | |

| Item of Business | Executive Lead | Reporting period | Q1 | | | Q2 | | | Q3 | | | Q4 | | | 2026-27 | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | | April 2025 | May 2025 (Private) | June 2025 | July 2025 | Aug 2025 | Sep 2025 | Oct 2025 | Nov 2025 | Dec 2025 | Jan 2026 | Feb 2026 | Mar 2026 | April 2026 | May 2026 |
| Adoption of Corporate Policies<br>• TBC | Director of Corporate Governance | As Required | ⚑ | | ⚑ | | ⚑ | | ⚑ | | ⚑ | | ⚑ | | ⚑ | |
| **Finance** | | | | | | | | | | | | | | | | |
| Conformance Report | Executive Director of Finance | | ⚑ | | | | ⚑ | | ⚑ | | | | ⚑ | | | |
| Update on Annual Accounts | Executive Director of Finance | As Required | ⚑ | | | | | | | | | | | | | |
| **Internal Audit** | | | | | | | | | | | | | | | | |
| Internal Audit Progress Report | Head of Internal Audit | All Regular Meetings | ⚑ | | ⚑ | | ⚑ | | ⚑ | | ⚑ | | ⚑ | | ⚑ | |
| Internal Audit Plan 2025/26 | Head of Internal Audit | Annually | ⚑ | | | | | | | | | | | | | |
| Specific Internal Audit Reports as required | Executives invited to attend as required | As Required | ⚑ | | ⚑ | | ⚑ | | ⚑ | | ⚑ | | ⚑ | | ⚑ | |
| **External Audit** | | | | | | | | | | | | | | | | |
| External Audit Progress Report | Audit Wales | All Regular Meetings | ⚑ | | ⚑ | | ⚑ | | ⚑ | | ⚑ | | ⚑ | | ⚑ | |
| Final Accounts Memorandum | Audit Wales | Annually | ⚑ | | | | | | | | | | | | | |
| Annual Audit Letter | Audit Wales | Annually | ⚑ | | | | | | | | | | | | | |
| External Audit Plan 2025/26 | Audit Wales | Annually | ⚑ | | | | | | | | | | | | | |
| Structured Assessment | Audit Wales | Annually | | | | | | | | | | | ⚑ | | | |
| Specific External Audit Reports as required | Executives invited to attend as required | As Required | ⚑ | | ⚑ | | ⚑ | | ⚑ | | ⚑ | | ⚑ | | ⚑ | |
| **Counter Fraud** | | | | | | | | | | | | | | | | |
| Local Counter Fraud Service Progress Report | Executive Director of Finance | All Regular Meetings | ⚑ | | ⚑ | | ⚑ | | ⚑ | | ⚑ | | ⚑ | | ⚑ | |
| Local Counter Fraud Service Workplan 2025/26 | Executive Director of Finance | Annually | ⚑ | | | | | | | | | | | | | |
| **Financial Annual Accounts and Annual Report** | | | | | | | | | | | | | | | | |
| Financial Annual Accounts | Executive Director of Finance | Annually | Draft | ⚑ | ⚑ | | | | | | | | | | | ⚑ |
| Annual Report | Director of Corporate Governance | Annually | Draft | ⚑ | ⚑ | | | | | | | | | | | ⚑ |
| Annual Governance Statement | Director of Corporate Governance | Annually | Draft | ⚑ | ⚑ | | | | | | | | | | | ⚑ |
| Head of Internal Audit Opinion and Annual Report | Head of Internal Audit | Annually | | ⚑ | ⚑ | | | | | | | | | | | |
| ISA 260 Audit of Financial Statements | Audit Wales | Annually | | ⚑ | ⚑ | | | | | | | | | | | |

| Item of Business | Executive Lead | Reporting period | Q1 | | | Q2 | | | Q3 | | | Q4 | | | 2026-27 | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | | April 2025 | May 2025 (Private) | June 2025 | July 2025 | Aug 2025 | Sep 2025 | Oct 2025 | Nov 2025 | Dec 2025 | Jan 2026 | Feb 2026 | Mar 2026 | April 2026 | May 2026 |
| (include Enquiries of those charged with Governance) | | | | | | | | | | | | | | | | |
| Local Counter Fraud Annual Report | Executive Director of Finance | Annually | | ⚑ | ⚑ | | | | | | | | | | | |
| Procurement Annual Report | Executive Director of Finance | Annually | | ⚑ | ⚑ | | | | | | | | | | | |
| **For Information** | | | | | | | | | | | | | | | | |
| Summary of Business to be reported from Private | Director of Corporate Governance | All Regular Meetings | ⚑ | | ⚑ | | ⚑ | | ⚑ | | ⚑ | | ⚑ | | ⚑ | |
| Forward Work Plan | Director of Corporate Governance | All Regular Meetings | ⚑ | | ⚑ | | ⚑ | | ⚑ | | ⚑ | | ⚑ | | ⚑ | |
| Cycle of Business | Director of Corporate Governance | Annually | ⚑ | | | | | | | | | | | | | |
| **Closing Business** | | | | | | | | | | | | | | | | |
| Agree Items for Referral to Board / Other Committees | Chair | | ⚑ | | ⚑ | | ⚑ | | ⚑ | | ⚑ | | ⚑ | | ⚑ | |
| Review of meeting effectiveness | Chair | All Regular Meetings | ⚑ | | ⚑ | | ⚑ | | ⚑ | | ⚑ | | ⚑ | | ⚑ | |
| Date of the next meeting | Chair | All Regular Meetings | ⚑ | | ⚑ | | ⚑ | | ⚑ | | ⚑ | | ⚑ | | ⚑ | |
| Resolution to exclude the Press and Public | Chair | All Regular Meetings | ⚑ | | ⚑ | | ⚑ | | ⚑ | | ⚑ | | ⚑ | | ⚑ | |
| **Private Agenda** | | | | | | | | | | | | | | | | |
| Local Counter Fraud Service Progress Report (Private) | Executive Director of Finance | All Regular Meetings | ⚑ | | ⚑ | | ⚑ | | ⚑ | | ⚑ | | ⚑ | | ⚑ | |
| Counter Fraud Functional Standard Return | Executive Director of Finance | Annually | | ⚑ | | | | | | | | | | | | |

Bwrdd Iechyd Prifysgol
Betsi Cadwaladr
University Health Board

# AUDIT COMMITTEE

# Annual Report 2024-25

## FOREWORD

I am pleased to present the 2024-25 Annual Report of the BCUHB Audit Committee which outlines the activity for the period 1 April 2024 – 31 March 2025.

**Karen Balmer**
**Chair of the Audit Committee**

# AUDIT COMMITTEE Annual Report 2024 - 2025

## 1. Introduction

1.1 This report summarises the key areas of business activity undertaken by the Committee between 1 April 2024 and 31 March 2025 and highlights some of the key issues which the Committee intend to give further consideration to over the next 12 months.

1.2 The Committee's Annual 'Business Cycle' was reviewed on 12 September 2024 and was a key component in ensuring that the Committee effectively carried out its role during 2024 – 25.

1.3 This report reflects the Committee's key role in the development and monitoring of the Governance and Assurance framework with respect to the (activity/function).

## 2. Role and Responsibilities

2.1 The primary purpose of the Committee is to act on behalf of the Board to:

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

2.1.2 Independently monitor, review and report to the Board on the processes of governance, and where appropriate, facilitate and support, through its independence, the attainment of effective processes.

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

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

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

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

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

## 3. Agenda Planning Process

3.1 The Chair of the Committee, in conjunction with the Executive Lead and Meeting Secretary develops the final agenda for the Committee meetings.

3.2 The venue, location and other administrative arrangements are organised a year in advance where possible.

3.3 The secretariat for the meeting is provided by Laura Jones.

3.4 The agenda and papers are disseminated to Committee members prior to the date of the meeting. Where appropriate all papers are accompanied by a cover sheet which provides an executive summary and guidance to the Committee on the action required.

## 4. Operating Arrangements

4.1 Only very minor amendments were considered necessary in respect of the Terms of Reference and Operating arrangements for the Audit Committee.

4.2 The new Committee Cycle of Business for the Audit Committee is being presented for approval on 19 August 2025, however the agenda for each meeting is sufficiently flexible to allow the Committee to consider any emerging issues.

## 5. Membership, Frequency and Attendance

5.1 The Terms of reference of the Committee state that the Committee should consist of a minimum of three members of the Board.

5.2 During the year the Committee met on eight occasions with member attendance as follows:

| Name | (XX) Committee<br>(out of xx possible meetings) |
|---|---|
| Karen Balmer (Committee Chair) | Eight out of eight meetings |
| Urtha Felda | Six out of eight meetings |
| Rhian Watcyn Jones | Eight out of eight meetings |
| Dyfed Jones | Seven out of eight meetings |

5.3 The Committee requires the attendance of other Health Board Officers for advice, support and information routinely at meetings. It may also co-opt additional independent 'external' members from outside the organisation to provide specialist skills, knowledge and expertise.

## 6. Committee Activity

6.1 The Committee fulfilled its work plan for 2024-2025 covering a wide range of activity. This work can be summarised under the following headings;

a) Financial Annual Accounts 2023/24
b) Annual Report 2023/24
c) Head of Internal Audit Opinion and Annual Report 2023/24
d) ISA 260 Audit of Financial Statements
e) Local Counter Fraud Annual Report and Counter Fraud Functional Standard Return 2023/24
f) Progress against Outstanding Audit Recommendations
g) Update on Internal and External Audit Recommendations
h) Health Board Policies and Written Control Documents
i) Welsh Health Circulars and Ministerial Directions
j) Declarations of Interest and Gifts and Hospitality
k) Corporate Risks and Board Assurance Framework associated with the Committee
l) Scheme of Delegation
m) Standing Orders Reservations and Delegation of Powers
n) Conformance Report
o) External Audit Progress Report
p) Internal Audit Progress Report
q) Structured Assessment
r) Local Counter Fraud Progress Report

## 7. Key Achievements/Benefits:

7.1 As a reader you will see from this report what a successful and varied year the Audit Committee has had during 2024-25. Although detailed more fully above and within the Committee papers, some of the key highlights were:

- Successful establishment and operation of the Committee with full engagement from members and supporting officers.
- Enhanced reporting and assurance processes, particularly around:
  - Internal and external audit recommendations.
  - Policy management and compliance monitoring.
- Focused sessions on:
  - Counter Fraud
  - Procurement
  - Welsh Risk Pool
- Conducted a self-assessment using the Audit Committee Handbook.
- Identified areas of progress and opportunities for improvement.
- Covered a wide range of governance and assurance activities including:
  - Financial accounts and audit reports.
  - Risk management and control frameworks.
  - Policy and compliance oversight.
  - Fraud prevention
- Regular 'AAA Reports' submitted to the Board.
- Transparent publication of minutes and papers on the Health Board's website.

## 8. Key Challenges

8.1 As indicated earlier in the report a focus for the Committee in 2025 forward into 2026, will be the work which is underway to give assurance at a strategic level.

8.2 Finally, although these challenges remain, the Committee will continue to monitor activity and develop innovative ways to support new developments and opportunities.

## 9. Committee Effectiveness & Performance

9.1 The Committee regularly reviews its own performance by completing this report on an annual basis, reviewing the cycle of business which provides the Committee with the basis on which it will monitor its progress during the year and also provide clarity for all of those who contribute to the agenda as to the expectations of them.

9.2 A Committee effectiveness questionnaire will be issued again circa February 2026, the outcome of which will be reported to the Committee in respect of recommendations and subsequent actions in response to areas identified for improvement.

## 9. Reporting the Committee's Work

9.1 The Committee Chair reports the key issues discussed at each of its meetings by way of a 'AAA Report' to the Board.

9.2 These reports are supported by the relevant and more detailed Committee minutes. Committee papers, including minutes are routinely published on the Health Board's website.

## 10. Conclusion and way forward

10.1 The Committee is very grateful to all those involved in the work of the Committee for their support over the past 12 months, and for the constructive and positive way in which they have contributed to the activity.

10.2 The Committee will continue to ensure that it conducts its business in accordance with legislation and best practice.

10.3 It will provide the assurance that the Committee has in place the appropriate governance arrangements and resources to ensure success in achieving its objectives.

## 11. Further Information

Please visit the Health Board's websites for further information as outlined below:
Committees and Advisory Groups - Betsi Cadwaladr University Health Board

**Audit Committee – Non-Routine Committee Business Workplan**

(1 April 2024 – 31 March 2025)

This forward plan is only to be used for one-off Adhoc items that do not require inclusion as routine business on the Annual Committee Cycle of Business.

| Date of Request | Origin of Request | Requestor | Item Summary / Title | Nature of Request | Lead Officer | Executive Lead | Intended Meeting Date | Status |
|---|---|---|---|---|---|---|---|---|
| 16.01.25 | Audit Committee action AC25/05.4 | Audit Committee | Final Internal Audit Report on Consultant Job Planning | Progress and oversight to be monitored by the People and Culture Committee referring back to the Audit Committee in six months' time. | Sree Andole<br>Nick Graham | Pam Wenger | 19.08.25 | Going to P&C Comm 14.08.25 and will then come back to AC |
| 22.07.25 | Email from HSJ / Pam | Helen Stevens-Jones | Partnerships, Engagement and Communication Internal Audit Report | Update against progress on the Partnerships, Engagement and Communication Internal Audit Report | Helen Stevens-Jones | Helen Stevens-Jones | 21.10.25 | This has been deferred to Oct as HSJ on leave |
| 07.07.25 | Meeting with Pam re: Audit Committee | Pam Wenger | Risk Framework and Risk Procedures | Include Risk Framework and Risk Procedures under the CRR for October meeting. | Nesta Collingridge | Pam Wenger | 21.10.25 | This will be included on agenda in Oct |
| 21.07.25 | Action AC25/70.1 from Audit Committee 08.05.25 | Pam Wenger | Clinical Audit Plan | Clinical Audit Plan to go to QSE in July and come back to Audit Committee to confirm progress. | Joanne Shillingford | Sree Andole | 21.10.25 | This went to QSE in July, further work is required before it comes to AC |
| 29.07.25 | Action AC25/32.1 from Audit Committee | Pam Wenger | Information Governance and Records Management | A session on records management to take place with the Executive Committee and come back to the Committee as a substantive item. | Dylan Roberts | Pam Wenger | 21.10.25 | Pam will take this to EC |
| 12.09.24 | Action AC24/124.3 from Audit Committee | Audit Committee / Pam Wenger | June – Update on new process for policies<br><br>Email from GD 03.07.25 to confirm there has been a delay in confirming the approval routes for policies / procedures due to HB reporting structures) | Establish a long term review of the process for reviewing policies and procedures. | Glesni Driver | Pam Wenger | 21.10.25 | Further work required |
| 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<br><br>Email from PM 01.07.25 still in the procurement stage so report not due to be ready until end of August | A full evaluation report to be presented at Audit Committee – this was due to go to Jan / March but put forward for April meeting as the review will be commissioned externally. | Phil Meakin | Pam Wenger | 21.10.25 | Further work required |
| 04.03.25 | Suggested as part of discussion at meeting 04.03.25 | Pam Wenger | Standing Orders Reservation and Delegation of Powers | Full review of Standing Orders Reservation and Delegation of Powers | Philippa Peake-Jones | Pam Wenger | 19.08.25 | **CLOSED**<br>Going to Comm in Aug 25 |
| 12.06.25 | Email from PW / TA | Pam Wenger | Audit Wales Planned Care Report | Management response on the Planned Care report to be presented to the Committee. | Tehmeena Ajmal<br>Russell Caldicott | Tehmeena Ajmal<br>Russell Caldicott | 19.08.25 | **CLOSED**<br>Going to Comm in Aug 25 |
| 17.06.25 | Email from PW / RC | Pam Wenger | Historical Symphony Contract | Paper to be presented in private | Alison Bishop producing paper | Russell Caldicott | 19.08.25 | **CLOSED**<br>Going to Comm in Aug 25 |

| | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| 31.03.25 | Email from Danielle Timmins 31.03.25 | Danielle Timmins | Counter Fraud Annual Report | Counter Fraud Annual Report to go to Audit Committee in June 25. | Danielle Timmins | Russ Caldicott | 24.06.25 | **CLOSED** Went to Comm in June 25 |
| 16.01.25 | Audit Committee item AC25/04 | Audit Committee | The Role of Internal Audit | The video developed has been shared at the AC Development Session in Feb 25 and an update to be provided to the April meeting in relation to the Comms plan and revised video. | Glesni Driver Dave Harries | Pam Wenger | 30.04.25 | **CLOSED** Went to Comm in May 25 |
| 16.01.25 | Action AC25/10.1 from Audit Committee | Audit Committee / Pam Wenger | Health Board Policies<br><br>Report on overdue policies (not WCDs) | An update on HB Policies and WCDs went to the January meeting. A report focussing on overdue policies to go to the Committee in April. | Glesni Driver | Pam Wenger | 30.04.25 | **CLOSED** Went to Comm in May 25 |
| 25.02.25 | Discussion with PW and PPJ re: March 25 agenda | PW & PPJ | Annual Report Compliance with the Corporate Governance Code | PPJ agreed with PW to put this forward from March 25 | Philippa Peake-Jones | Pam Wenger | 30.04.25 | **CLOSED** Went to Comm in May 25 |
| 24.08.24 | Email from Andrea Hughes on 24.08.24 | Andrea Hughes | Counter Fraud Policy – was due to Sept meeting but not ready, also not ready for Nov meeting, needs to go to consultation (see email from AH 24.10.24)<br>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.<br>• Draft Policy in development and being progressed by Head of Counter Fraud.<br>Action AC24/166.1 to be addressed in the policy. | Danielle Timmins | Russell Caldicott | 04.03.25 | **CLOSED** Went to Comm in March 25 |
| 05.11.24 | Action AC24/167.1 | Audit Committee | Section 117 Mental Health Placements (Private agenda) | Present an update paper to the Committee. | Russell Caldicott | Russell Caldicott | 04.03.25 | **CLOSED** No further action needed |
| 12.09.24 | Action from Audit Committee 12.09.24 | Audit Committee | Audit Wales Community Pharmacy Data Matching Pilot | Lois Lloyd to provide an update to the Committee | Lois Lloyd | Pam Wenger | 16.01.25 | **CLOSED** Went to Comm in Jan 25 |
| 16.09.24 | Action AC24.94.9 from Audit Committee | Audit Committee | Effective Governance – (IHC) Central - Final Internal Audit Report | Update on the impact of the actions being taken to reduce the number of outstanding complaint responses (see email sent to Di Platt 01.10.24) PW suggested adding to agenda under an item – Update on Internal Audit Actions (see email from PW 08.10.24) | Gareth Evans / Di Platt | Gareth Evans | 16.01.25 | **CLOSED** Went to Comm in Jan 25 |
| 24.10.24 | Action AC24/124.2 from Audit Committee | Audit Committee / Pam Wenger | Health Board Policies | A summary as to which policies carry the biggest risks (financial, legal compliance, safety etc) and progress being made against them. | Glesni Driver | Pam Wenger | 16.01.25 | **CLOSED** Went to Comm in Jan 25 |
| 29.10.24 | Email from Pam re: Action AC24.43.6 from Audit Committee | Pam Wenger | Welsh Risk Pool | Level of exposure costs in terms of WRP payments | Matt Joyes | Pam Wenger | 16.01.25 | **CLOSED** Went to Comm in Jan 25 |
| 05.11.24 | Action AC24.154.4 from Audit Committee | Audit Committee | Internal Audit Progress Report | Due to the lack of regular oversight of the Llandudno Hospital | Pam Wenger | Pam Wenger | 16.01.25 | **CLOSED** Went to Comm in Jan 25 |

| | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| | | | | Orthopaedic Surgical Hub invite Chris Stockport to join the January 25 meeting (this is also being noted via PFIG) | | | | |
| 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 |