

Bundle BCU Audit Committee 21 October 2025

- 1 09:30 - PRELIMINARY MATTERS
- 1.1 09:30 - AC25/131 Welcome and Apologies - Verbal (Chair)
- 1.2 09:31 - AC25/132 Declarations of Interest - Verbal (Chair)
- 1.3 09:32 - AC25/133 Unconfirmed Minutes of Meetings held on 19.08.25 - Attached (Chair)
AC25.133 Minutes from Audit Committee 19.08.25 V0.2 (Public)
- 1.4 09:35 - AC25/134 Matters Arising and Action Log - Attached (Chair)
AC25.134 Summary Action Log Audit Committee (Updated 14.10.25) Public
- 2 09:45 - GOVERNANCE
- 2.1 09:45 - AC25/135 Update on Outstanding Audit Recommendations - Presentation (Executive Director of Public Health)
Sharon Scott to join the meeting for this item
AC25.135 Civil Contingencies Audit Updates - September 25 v5
- 2.2 10:05 - AC25/136 Statutory Compliance Report - Paper (Director of Corporate Governance / Head of Statutory Compliance and Inquiries)
AC25.136 Compliance report 21.10.2025 v1.00
AC25.136.1 App 1 - IA Open Unsatisfactory v2.00
AC25.136.2 App 2 - IA Open Limited Assurance v1.00
AC25.136.3 App 3 - IA - closure summary v1.00
AC25.136.4 App 4 - IA for AC closure v2.00
AC25.136.5 App 5 - AW open v2.00
AC25.136.6 App 6 - AW recs closure summary v1.00
AC25.136.7 App 7 - all overdue policies v1.00
- 2.3 10:15 - AC25/137 Revised Policy Management Process - Paper (Director of Corporate Governance / Head of Statutory Compliance and Inquiries)
AC25.137 Revised Policy Management Process v0.04
AC25.137.1 Appendix 1 Draft Policy v0.03
AC25.137.2 Appendix 2 Policy Approval Route
- 2.4 10:25 - AC25/138 Risk Management Framework (Head of Risk Management)
AC25.138 Cover Sheet Risk Management Framework
AC25.138.1 Appendix 1 RM01 Risk Management Framework ENGLISH
- 2.5 10:35 - AC25/139 Corporate Risk Register Report - Paper (Head of Risk Management)
AC25.139 Audit Committee CRR Report October 2025 Public
- 2.6 10:45 - AC25/140 Corporate Governance Report - Paper (Director of Corporate Governance)
AC25.140 Corporate Governance Report (Cover paper)
AC25.140.1 Draft Governance Improvement Plan 2025-26
AC25.140.2 Workplan for Audit Committee (Live Version as at 14.10.25)
- 2.7 11:05 - BREAK
- 3 11:15 - INTERNAL AUDIT
- 3.1 11:15 - AC25/141 Internal Audit Progress Report - Paper (Head of Internal Audit)
Item to include an update from Helen Stevens-Jones on the Partnerships, Engagement and Communication Internal Audit Report
AC25.141 IA progress report Cover Sheet October 2025
AC25.141.1 BCUHB Audit Committee progress report October 2025
AC25.141.2 Progress Report for Audit September 2025 (HSJ update on IA)
- 4 11:45 - EXTERNAL AUDIT
- 4.1 11:45 - AC25/142 External Audit Progress Report - Paper (Audit Manager, Audit Wales)

a) *Urgent and Emergency Care Review*

b) *National Fraud Initiative 2024-25 Update*

AC25.142 Audit Committee Update 21102025

AC25.142.1 BCUHB Managing UEC Demand Report

AC25.142.2 Report Betsi Cadwaladr University Health Board

5 12:05 - COUNTER FRAUD

5.1 12:05 - AC25/143 Local Counter Fraud Service Report - Paper (Executive Director of Finance)

AC25.143 PUBLIC -Counter Fraud Audit Committee Q2 Report 2025-2026

AC25.143.1 PUBLIC Appendix A - CF Dashboard Q2 25-26

6 12:15 - CLOSING BUSINESS

6.1 12:15 - AC25/144 Agree Items for Referral to Board / Other Committees - Verbal (Chair)

6.2 12:17 - AC25/145 Review of Meeting Effectiveness - Verbal (Chair)

6.3 12:19 - AC25/146 Date of Next Meeting - 16.12.25

6.4 12:19 - 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 Public on 19 August 2025
in the Boardroom, Carlton Court, St Asaph and via Team

Committee Members Present	
Name	Title
Urtha Felda	Independent Member (Vice Chair of Audit Committee)
Dyfed Jones	Independent Member
Rhian Watcyn Jones	Independent Member (<i>via Teams</i>)
In Attendance	
Tehmeena Ajmal	Chief Operating Officer
Amanda Blaynee-Roberts	Policy and Compliance Manager (<i>Observer</i>)
Glesni Driver	Head of Statutory Compliance and Inquiries
Dyfed Edwards	Chair of the Health Board
Fflur Jones	Performance Audit Lead, Audit Wales
Joanna Garrigan	Finance Director, Commissioning and Strategy
Gareth Griffiths	Senior Estates Officer, Fire Legislation & Assurance (<i>part meeting</i>)
Dave Harries	Head of Internal Audit
Anthony Hughes	Risk Assurance Manager (<i>part meeting</i>)
Arwel Hughes	Head of Operational Estates (<i>part meeting</i>)
Nicola Jones	Deputy Head of Internal Audit
Phylis Makurunje	Aspiring Board Member
Maeve Puleston-Jones	Financial Audit Manager, Audit Wales
Michelle Phoenix	Financial Audit Manager, Audit Wales (<i>via Teams</i>)
Carol Shillabeer	Chief Executive
Paul Stocker	Audit Manager, Internal Audit
Danielle Timmins	Head of Counter Fraud
Pam Wenger	Director of Corporate Governance
Neil Williams	Senior Financial Account (<i>part meeting</i>)
Committee Support	
Philippa Peake Jones	Head of Corporate Governance
Laura Jones	Acting Corporate Governance Manager
Harriet Abbott	Corporate Governance Officer

PRELIMINARY MATTERS
<p>AC25/106 Welcome and Apologies</p> <p>Apologies were received for Russell Caldicott, Stuart Keen and Denise Roberts.</p>
<p>AC25/107 Declarations of Interest</p> <p>No declarations of interest were raised at the meeting.</p>

AC25/108 Unconfirmed Minutes of Meeting held on 8 May and 24 June 2025

It was resolved that the Committee:

- **AGREED** that the minutes of the Health Board meeting held on 8 May and 24 June 2025 were a true and accurate record.

AC25/109 Matters Arising and Action Log

Members received the action log and noted progress against the actions. It was highlighted that a number of actions have been open for a long period of time, the Director of Corporate Governance confirmed that a range of actions require further work and are not currently at the stage of closure. Some areas are being noted for discussion at separate Board briefing sessions to cover some of the issues raised.

Centre for Mental Health and Society (CfMHaS)

- In relation to action AC24/151.1 it was noted that there have been difficulties procuring an individual to complete the review and further work is required with the procurement team. The Terms of Reference have been completed and these have been attached as an appendix for information.

Internal Audit Progress Report: Limited Assurances relating to the Lessons Learnt Report

- In relation to action AC24.60.1.10 this was due to be discussed at the Chairs Advisory Group however due to shortages in the Corporate Governance and availability of Board Members the Group had not met. This will be discussed at the next meeting of the Group.

Speak Up Safely

- In relation to action AC24/121.2 the Head of Internal Audit confirmed that an Internal Audit on Speaking up Safely is due to commence during Quarter 2 and suggested that the action can be closed from an Internal Audit perspective.

Internal Audit Progress Report: Contracted Patient Services Review

- There was discussion around action AC25/69.1 as this was due to report to the August meeting and concerns were raised around how this is being taken forward. It was agreed that this action would remain open, the Director of Corporate Governance would discuss this further with the Chief Executive and circulate a briefing outside of the meeting as well as provide an update at the October meeting.

Internal Audit Progress Report: Scheme of Reservation and Delegation

- In relation to action AC25/69.2 it was noted by the Head of Internal Audit that for the Health Board to be compliant in 2025/26 there is a need to go through the process to confirm the formal delegation for sign off of healthcare agreements. It was agreed that this action would remain open and further discussion is required with the Executive Director of Finance.

Action:



- **AC25/109.1** Director of Corporate Governance to discuss the Contracted Patient Services Review with the Chief Executive, circulate a briefing outside of the meeting and further consideration of progress to be reported at the next Committee 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): AC25/73.1, AC25/67.1, AC25/63.1, AC25/65.1, AC25/62.1, AC25/61.1, AC25/61.2, AC25/59.1, AC25/59.2, AC25/59.3, AC25/59.4, AC25/39.1, AC25/33.2, AC25/32.2, AC25/06.2, AC24/151.2, AC24/154.5, AC24/121.1 and AC24.60.1.8

GOVERNANCE

AC25/110 Statutory Compliance Report

Members received the report and the Director of Corporate Governance / Head of Statutory Compliance and Inquires highlighted:

- The report has been revised to amalgamate a range of information including audit tracking and policy compliance.
- The report provides detail and highlights progress against Audit recommendations as well as providing assurance to the Committee around systems and processes. It was noted that Internal Audit continue to review recommendations that are rated as unsatisfactory and any high priority areas also follow this route.
- Work is taking place with Audit Wales around the Structured Assessment to identify any actions that can be closed as progress moves forward. Section 8 of the paper includes recommendations agreed for closure by Audit Wales which the Committee are being asked to approve.
- The report highlights high priority recommendations that are overdue, the Operating Model Audit Report relates to the Operational Governance Accountability Framework that was in place historically across the organisation.
- The report includes information relating to those recommendations that have been escalated to the Executive Committee in terms of providing sufficient evidence. There is a need for these recommendations to be closely monitored prior to closure to ensure the evidence being provided is satisfactory.
- There are a number of overdue policies however good progress is being made and the new policy will come back to the Committee.

In discussing the report, the Committee:

- Referred to the difficulties reviewing the appendices due to the size of the information, it was confirmed that this will be reviewed by the team to establish whether a lower level of detail can be provided to ensure the documentation is user friendly.
- Queried the narrative relating to high priority unsatisfactory recommendations and the Operational Governance Accountability Framework. It was confirmed that this is now aligned to the Foundations for the Future Programme therefore can only be progressed in line with the programme. It has been agreed with Internal Audit that the timeline is extended to ensure the action does not consistently report as overdue and once the new framework is complete, this will supersede the historic framework.

- Highlighted the levels of review and queried what the difference is between each level. It was confirmed that where recommendation do not include sufficient information and evidence they will be returned and resubmitted for additional review.
- Referenced the information relating to high-risk overdue policies that are still awaiting review. It was confirmed that appendix 8 provides the status of progress against all policies and these have been prioritised in terms of risk.
- Enquired whether interim guidance may be required for those areas awaiting All Wales guidance for example Consultant Job Planning. It was confirmed that an update on Consultant Job Planning was provided at the last People and Culture Committee, work is taking place to adopt a job planning policy, a follow up audit is currently taking place and this will be a priority area for Clara Day to action once in post as the Executive Medical Director. The People and Culture Committee will continue to closely monitor the progress and assurance will be provided back to the Audit Committee in due course.
- Noted that the Committee have an agreed process for Executive Leads to attend the Audit Committee to report on progress against audit recommendations. It was agreed that the next review should focus on the progress against the Contracted Patient Services Review recommendations at the meeting in October 2025 with the Consultant Job Planning being presented to the following meeting in December 2025.

Action:

- **AC25/110.1** Progress on Consultant Job Planning to be closely monitored by the People and Culture Committee and assurance provided back to the Audit Committee in due course.

It was resolved that the Committee:

- **NOTED** the content of the report.
- **AGREED** the recommendations included in section 8 of the report.

AC25/111 Review of the Standing Orders, Scheme of Reservation and Delegation and Standing Financial Instructions

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

- This a joint piece of work between governance and finance and is being shared with the Audit Committee ahead of further iterations before being submitted to the Health Board meeting in September 2025.
- The organisation has a high level of accountability and autonomy and there is a need to ensure the correct levels of delegation are included in the document to provide clear guidance across the Health Board.
- It has been suggested that a tier system is utilised which is consistent with other Health Boards to allow delegation to go down the relevant levels. This is also being aligned to the Foundations for the Future programme to ensure staff are aware which tier they align to as well as aligning to the Oracle system.
- Work is taking place to provide clarity around the approval of capital schemes and a training programme will be rolled out to ensure staff are clear in terms of their accountability and autonomy.

- Welsh Government have provided new Standing Financial Instructions (SFIs) for section 11 which follow new legislation in terms of procurement and this model has been applied to the Health Board SFIs to comply with the new legislation.

In discussing the report, the Committee:

- Queried whether the levels of delegation are standard across the NHS, it was confirmed that the Board and Chief Executive levels are standard however the Health Board has higher levels of accountability therefore there is a need to clarify the level of delegation for the additional tiers.
- Stated that confirmation of accountability is a significant area to clarify and it was confirmed that the comments shared will inform the next iteration of the report before it goes to the Board in September 2025 and a revised version will be shared with members outside of the Committee.

Action:

- **AC25/111.1** Further work is required in relation to the levels of delegation before this goes to the Board in September 2025.

It was resolved that the Committee:

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

AC25/112 Board Assurance Framework

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

- Each Committee has reviewed the relevant sections of the Board Assurance Framework and the Audit Committee has a role in the overall system to assurance.
- The report will be presented to the Health Board in September 2025.
- The document will be reviewed in terms of the volume of information and accessibility and a session on risk appetite is taking place next week.

It was resolved that the Committee:

- **RECEIVED** and **CONSIDERED** the contents and assurance rating of the Board Assurance Framework.

AC25/113 Fire Safety Annual Performance Report

Members received the report and the Head of Operational Estates and Senior Estates Officer, Fire Legislation & Assurance highlighted:

- The annual fire safety audit has taken place and there are two high scoring fire risks included on the Corporate Risk Register which relate to non compliance of fire safety systems and the age of the estate at Ysbyty Gwynedd.

- A fire safety risk assessment has been completed highlighting approximately 6% of assessment areas are outside of their review date confirming that these are related to non in-patient facilities, the team are now working to ensure 100% compliance.
- Fire safety training compliance for all staff is currently 88.75%, it is proposed to undertake a review of the current fire safety training delivery plan against the guidance provided within the new documentation on publication.
- Welsh Government funding for Estates was secured last year, there has been investment in a range of areas including Ysbyty Gwynedd where investment has been utilised to improve compliance on the site.
- Enforcement of fire safety within healthcare premises is the responsibility of the Fire and Rescue Authority who carried out three post fire audits during the reporting period. Recommendations were provided and action has been taken to address areas of concern.
- A total of nineteen fire incidents were reported to the fire safety team over the reporting period which highlights a 16% increase, work is taking place to address the issues.
- The Fire Safety Internal Audit review completed was issued as limited assurance, an action plan has now been developed and agreed and is reported via the Fire Safety Management Group.

In discussing the report, the Committee:

- Referred to the action plan developed to address the outcome of the Internal Audit and queried the timeframe of the actions. It was confirmed that some actions have now been addressed, sub action plans have been developed to address local issues on site and further work is required to address medium to long term issues such as training delivery.
- Highlighted the issues and non-compliance at Ysbyty Gwynedd and queried when the team expect to be compliant. It was confirmed that the team are taking a risk based approach, individual bids to Welsh Government continue to be made for additional funding and improvements to in patient wards are the priority area.
- Confirmed that report captures the responsive as well as the proactive work taking place and queried whether there is resource available to continue the proactive work in this space. It was confirmed that the team would benefit from additional resource which would allow certain areas to be targeted more effectively.
- Suggested clarity in terms of resource and investment would be useful to align with the Estates Strategy. It was confirmed that the Director of Environment and Estates is currently completing a gap analysis on Health and Safety as a whole which will include fire safety.

It was resolved that the Committee:

- **ACCEPTED** the **ASSURANCE** provided in the report.

FINANCE

AC25/114 Conformance Report

Members received the update and the Finance Director, Commissioning and Strategy highlighted:

- The conformance reports for Q4 2024/25 and Q1 2025/26 have been shared due to the timing of the reports.
- There has been consistency in the total number breaches within the system and the No PO No Pay remains in place.
- The number of waivers issued has significantly decreased compared to the same period last year, this is a big improvement and the team are working to maintain this level.
- Staff overpayments are lower than last year but the volume remains relatively high this is due to manager not completing the required paperwork when staff leave or change working hours and is an area of concern. NHS Wales Shared Services Partnership have approved and issued an All Wales overpayment procedure that should strengthen the current processes on recovering salary overpayments.
- There are a number of active claims in relation to losses and special payments, these require ongoing monitoring to ensure that any lessons are identified and actioned.
- There has been a reduction in the volume of Welsh Risk Pool penalties relating to Learning from Events Report (LFER) however there is a need to maintain momentum going forward and learn from those events.
- There were no Chairs Actions in relation to financial compliance during the reporting period.
- In relation to contract procurement, one policy relating to lease cars remains outstanding and is currently out for consultation.

In discussing the report, the Committee:

- Highlighted the slight decrease in the number of waivers stating that this does not represent a significant decrease. It was confirmed that although the decrease is small, the reduction has been maintained
- Queried how long losses and special payments and overpayment remain active. It was confirmed that these are reviewed on an on-going basis and there is provision in the system to write off losses when it is deemed that they will not be recovered.
- Referred to the Learning from Events Reports (LFERs) and queried whether the learning is being embedded. It was confirmed that a new process has been implemented and as part of the process, data is shared with divisions on a weekly basis to support local recovery of overdue submissions in real time. Significant progress is being made; the team are working closely with the Integrated Health Communities (IHCs) noting that processes do take time to embed into the current systems.

It was resolved that the Committee:

- **NOTED** and **DISCUSSED** the elements of performance.
- **APPROVED** the Losses and Special Payments for Q4 (January to March 2025) and Q1 (April to June 2025).

INTERNAL AUDIT

AC25/115 Internal Audit Progress Report

Members received the reports and there was discussion around the following Internal Audit Reports:

Orthopaedic Surgical Hub Llandudno Hospital

The report was discussed, an update was provided and it was highlighted:

- The project audit completed focus on two key areas: project delivery and performance, along with the associated management arrangements in place to progress the development.
- At the time of the review the projected completion date was 11 months later than originally set out in the contract.
- At the close of audit fieldwork there was a projected overspend of £1.673 million.
- Quality concerns have been raised, both in terms of the effectiveness of assurance and testing processes as well as aspects of project delivery itself.
- It was noted the several recommendations from previous Internal Audit reviews remained outstanding. There is a need for the Health Board to review its contract strategy, there have been delays linked to unresolved design elements and gaps in assurance have been identified in both the site progress reporting mechanisms and the commissioning programme.
- Several issues have also been noted in relation to financial controls, including the absence of a Project Bank Account and this resulted in an unsatisfactory assurance rating.

In discussing the update, the Committee:

- Raised concern in relation to the timeline and the projected deadline of January 2026. It was confirmed that this has been a complex project and initiatives are being put in place to support progress.
- Confirmed that the Executive Director of Finance is now the Senior Responsible Officer, the recommendations have been accepted and assurance provided that the actions will be progressed.
- Established that this is being discussed with the Cabinet Secretary on a monthly basis, the Director of Environment and Estates is actively progressing this work to ensure the work is completed to the timeline.
- Agreed that the Committee would welcome a briefing to be circulated outside of the meeting with confirmation of progress to date and clarity on the financial elements.

Waiting List Initiative Payments – IHC Centre

The report was discussed and it was highlighted:

- Concerns relating to Waiting List Initiative payments emerged as part of the Consultant Job Planning review as there is currently no policy in place to agree these payments.
- This links to the lack of job plans and contracts in place for consultants.

In discussing the update, the Committee:

- Agreed that job planning is a core issue and this will be addressed by the new Executive Medical director once in post. A Waiting List Initiative procedure is being developed and this area of work requires a planned approach and deployment plan.
- Confirmed that there are no consistent governance processes in place within the directorate however the Chief Operating Officer is meeting with her direct reports on a monthly basis to discuss how to deliver areas including finance, performance, quality and safety against the core targets.

- Stated that this work links in to the Scheme of Delegation and the operational governance framework to ensure services are configured correctly.

Effective Governance - Cancer Services

The report was discussed and it was highlighted:

- There has been a lack of progress in relation to clinical audit and this presents a risk to the service.
- Noted the high volume of incidents open on the datix system and it was confirmed that all levels of incidents are reported, the team swiftly respond to high level incidents that may cause harm however further work is taking place in this area.

Effective Governance - IHC East

The report was discussed and it was highlighted:

- The main issues include no financial balance and a high number of accountability letters not being signed. It was confirmed that the actions are being addressed and there is a need to start testing the governance arrangements and get more grip across all areas.

Performance Management Framework and Reporting

The report was discussed and it was highlighted:

- There is a lack of local performance measures, no clarity on focus of assurance and limited progress against the issues highlighted two years ago.

In discussing the update, the Committee:

- Raised concern around the delays in responding to Internal Audit to provide the required information and the importance of supporting the team with their fieldwork. It was confirmed that there are mechanisms in place to escalate concerns in this area to the Executive Committee
- Confirmed that issues are being discussed with the Chief Executive, work is taking place to review performance report along with the integrated performance framework in terms of rigour and robustness.
- Agreed that the Audit Committee Chair would write to the Chief Executive to highlight concerns regarding the lack of progress in relation to Performance and the Contracted Patient Services Review.
- The Director of Corporate Governance agreed to circulate a brief on progress against this review outside of the meeting and further consideration of progress will be reported at the next Committee meeting.

Internal Audit Progress Report

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

- A new template is now being used for this report and the Internal Audit report will be provided as supporting papers going forward.
- There has been an increase in the amount of follow-up actions submitted for closure.
- There have been some amendments made to the Internal Audit Plan 2025/26 which have been agreed in principle by the Chief Executive and the Director of Corporate Governance and the Committee were asked to approve the recommended additional reviews.

In discussing the report, the Committee:

- Queried how the productivity and efficiency work is going to be managed as the review has been deferred. It was confirmed that Internal Audit are aware of the Ministerial Advisory Group and the recommendations placed on the Health Board. The timing of this review would have duplicated these requirements however this may be reviewed later in the year to determine whether the organisation are fulfilling the recommendations from the Ministerial Review.
- Approved the recommended amendments welcoming an early review of the Adult and Older Persons Mental Health Unit at Ysbyty Glan Clwyd.
- Noted that an additional review focusing on procurement has been agreed to enable to organisation to benchmark against the All Wales work and identify the issues and areas where addition strengthens and controls are required.

Actions:

- **AC25/115.1** A briefing on Llandudno Hospital to be circulated outside of the meeting with confirmation of progress to date and clarity on the financial elements.
- **AC25/115.2** The Audit Committee Chair to write to the Chief Executive to highlight concerns regarding the lack of progress in relation to Performance and the Contracted Patient Services Review. Director of Corporate Governance to circulate a brief on progress against this review outside of the meeting and further consideration of progress will be reported at the next Committee meeting.

It was resolved that the Committee:

- **RECEIVED** the progress reports and **APPROVED** the amendments.

EXTERNAL AUDIT

AC25/116 External Audit Progress Report

Members received the update and Financial Audit Manager and Performance Audit Lead, External Audit highlighted:

- The audit of the 2024/25 has now been completed and a post project learning discussions are taking place to identify how the teams can work more efficiently going forward.
- The current audit work is progressing as planned with two reports reaching the clearance stage.

In discussing the report, the Committee:

- Queried the stages highlighted in relation to the All Wales thematic work on Urgent and Emergency Care. It was confirmed that part one and two are being addressed and the team are reviewing different options for part three and this will be confirmed once it has been approved.
- Highlighted that the filed work on the Structured Assessment has commenced, the Structured Assessment brief has been to the Executive Committee and agreed to share this with the Audit Committee.

Action:

- **AC25/116.1** Director of Corporate Governance to share the Structured Assessment brief with the Committee.

It was resolved that the Committee:

- **NOTED** the report.

AC25/117 Management Response to Audit Wales Planned Care Report

Members received the update and the Performance Audit Lead, External Audit highlighted:

- The report sets out the findings from planned care recovery work undertaken with the Health Board noting that this is a national thematic review that has been completed with all Health Boards in Wales.
- The work has considered the progress being made in tackling planned care challenges and reducing the waiting list backlog, with a specific focus on waiting list performance.
- The findings highlighted that the organisation is not achieving the necessary impact in reducing long patient waits and there is a need to run services more efficiently as well as plan and utilise funding for long-term and sustainable change, rather than short-term initiatives.
- There are insufficient arrangements in place for routine reporting of clinical risks associated with waiting list delays highlighting the lack of reports being shared with the relevant Committees regarding patient harm as a result of delayed treatment.

In discussing the report, the Committee:

- Queried how the organisation compare with other Health Boards, it was confirmed that there is negative comparison however the organisation does have the most challenging metrics compared to others.
- Referred to the report stating that oversight and challenges needs to be strengthened and queried how this area could be supported. It was confirmed that the organisation has a wide range of reporting mechanisms however there is no consistency of reporting. There is a need to monitor patient harm more effectively and the Health Board need to address the recommendations made at pace to deliver in specific areas.
- Highlighted that the Primary Care Board has now been refocused and is currently being chaired by the Chief Executive to move into the strategic space and utilise resources more effectively.
- Confirmed that the report has dual responsibility between the Executive Director of Finance and the Chief Operating Officer and agreed that the report is discussed in further detail by the Performance, Finance and Information Governance and Quality, Safety and Experience Committees and progress is reported back to the next meeting.

Action:

- **AC25/117.1** Progress in relation to the Audit Wales Planned Care Report to be discussed in further detail by the PFIG and QSE Committees and reported back to the Audit Committee.

It was resolved that the Committee:

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

COUNTER FRAUD

AC25/118 Local Counter Fraud Service Q1 Report

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

- The report template has been revised to use a similar dashboard to the Internal Audit report which will enable the team to measure the metrics against the workplan.
- There has been an increase in reactive cases and significant improvements have been made in managing the recommendations around declarations in interest.
- There has been more traction and focus on the proactive work with additional information being shared via BetsiNet.
- Training compliance is around 89%, however targeted training for high-risk areas is challenging.
- A review of risks around resource of the team has been completed and work is underway to identify funding streams to provide additional resource.
- New legislation in relation to the Economic Crime and Transparency Act will be in place from 1 September 2025 which may cause some risks therefore mitigating actions are being implemented.

In discussing the report, the Committee:

- Queried the outcome of the proactive exercise relating to the expenses system. It was confirmed that a scoping exercise has been completed with a small sample of data and no fraud was identified. This will now be repeated with a larger sample and will focus on high value expense claims and will be reported back to the Committee via this report.
- Referred to the investigation outcomes and the length of time to recover losses. It was confirmed that the aim is to identify and recover losses in the same quarter however fraud investigations are lengthy and complex and are not generally completed within a quarter however the annual reporting provides a clearer overview.

It was resolved that the Committee:

- **CONSIDERED** and **NOTED** the contents of the Q1 report.

FOR INFORMATION

AC25/119 Summary of Business to be Reported from Private

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

AC25/120 Corporate Governance Report

It was resolved that the Committee:

- **APPROVED** the Cycle of Business and Annual Report.

CLOSING BUSINESS

AC25/121 Agree Items for Referral to Board / Other Committees

It was agreed to alert the Board on the compliance report and the concerns raised around the number of policies being delayed. To assure the Board that the Planned Care Report would now be reviewed by the Performance, Finance and Information Governance and Quality, Safety and Experience Committees. It was agreed to highlight the concerns around the delay in Management Responses and actions to Internal Audit and that the Committee will refer these concerns to the Executive Committee.

AC25/122 Review of Meeting Effectiveness

It was agreed that there had been detailed discussion and constructive challenge and feedback. It was noted that it is important to have the relevant Directors present to discuss individual items.

AC25/123 Date of Next Meeting

Tuesday 21 October 2025, 9.30-1.30pm

Resolution to Exclude the Press and Public

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

Unconfirmed



Audit Committee Action Log (Public)

Updated 14.10.25

Open Actions						
Action No.	Minute Ref.	Date	Agreed Action	Lead	Timescale	Status
REMAIN OPEN						
1	AC25/109.1	19.08.25	Matters Arising and Action Log Director of Corporate Governance to discuss the Contracted Patient Services Review with the Chief Executive, circulate a briefing outside of the meeting and further consideration of progress to be reported at the next Committee meeting.	Pam Wenger	Dec 25	Remain Open 11.09.25 Director of Corporate Governance to discuss with the Chief Executive and report back to the Committee.
2	AC25/110.1	19.08.25	Statutory Compliance Report Progress on Consultant Job Planning to be closely monitored by the People and Culture Committee and assurance provided back to the Audit Committee in due course.	Clara Day	Dec 25	Remain Open 06.10.25 This is due to be considered at the People & Culture Committee in December 25 and an update will be provided at the next Audit Committee. 11.09.25 An update was provided to the People and Culture Committee in August 2025, this is due to go back to the People and Culture Committee in December 2025 once the new Executive Medical Director has commenced in post and will then come back to the Audit Committee.

3	AC25/69.2	08.05.25	<p>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.</p>	<p>Russell Caldicott Dave Harries</p>	<p>August 25 Revised timescale Dec 25</p>	<p>Remain Open 14.10.25 The Director of Performance and Commissioning has responsibility for this element, as this role is currently vacant the Director of Finance will include a report on contracts within the Health Board Finance Report and at this point the action is expected to be closed. 19.08.25 It was agreed during the meeting that this action should remain open as the delegation to Officers has not yet taken place. It was noted by the Head of Internal Audit that for the Health Board to be compliant in 2025/26 there is a need to go through the process to confirm the formal delegation for sign off of healthcare agreements. 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</p>
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						Compliance and delegation to Officers for 2025/26.
4	AC25/32.1	04.03.25	<p>Information Governance and Records Management Position 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.</p>	Pam Wenger Dylan Roberts	Oct 25	<p>Remain Open 11.09.25 The PFIG Committee received an update on Information Governance and Records Management at their meeting on 26.08.25 - please see link below to the paper and note item PF25.74 Information Governance: PFIG Agenda Bundle 26.08.25 This requires further discussion with the DDaT Team. 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 a future meeting. 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.</p>
5	AC24/151.1	05.11.24	<p>Centre for Mental Health and Society (CfMHaS) (Title changed from Response to Freedom of Information Request) A full evaluation report to be presented at the next Audit</p>	Pam Wenger Russell Caldicott	<p>March 25 May 25</p> <p>Revised timescale Dec 25</p>	<p>Remain Open 11.09.25 An update has been provided in the Corporate Governance Report. The procurement of an independent reviewer has been completed and the</p>



			Committee.			<p>evaluation report is anticipated to be available for the next meeting in December 2025.</p> <p>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.</p> <p>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.</p> <p>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.</p> <p>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)</p>
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						<p>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.</p>
6	AC24.60.1.10	07.05.24	<p>Internal Audit Progress Report Limited Assurances relating to the Lessons Learnt Report dated July 2023 and the follow up progress to date. Chair / Director of Corporate Governance to raise in the Chairs Advisory Group as an emerging topic.</p>	<p>Urtha Felda Pam Wenger Philippa Peake- Jones</p>	<p>June 25 Revised timescale Dec 25</p>	<p>Remain Open 06.10.25 This item has been included on the agenda for the next Chairs Advisory Group for discussion. 29.07.25 Verbal update by Vice Chair to be provided during the meeting. 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. 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. 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</p>



						<p>and the Chair will provide a verbal update at the Audit Committee in November.</p> <p>12.09.24 This will be discussed at the next Committee Chair's Meeting.</p> <p>02.09.24 Update to be provided during the meeting.</p> <p>18.07.24 To be raised at the next meeting in August 2024 as part of feedback from the Audit Committee Chair.</p>
ACTIONS PROPOSED FOR CLOSURE						
1	AC25/111.1	19.08.25	<p>Accountability Framework (Review of the Standing Orders, Scheme of Reservation and Delegation and Standing Financial Instructions) Further work is required in relation to the levels of delegation before this goes to the Board in September 2025.</p>	Pam Wenger	Oct 25	<p>Action proposed for closure 11.09.25 Discussions have taken place with the Director of Corporate Governance and Head of Internal Audit to agree the levels of delegation and this is being presented to the Board in September 2025.</p>
2	AC25/115.1	19.08.25	<p>Internal Audit Progress Report: Orthopaedic Surgical Hub Llandudno Hospital A briefing on Llandudno Hospital to be circulated outside of the meeting with confirmation of progress to date</p>	Russell Caldicott	Oct 25	<p>Action proposed for closure 14.10.25 An update report from the Executive Director of Finance has been shared with members and circulated in advance of the meeting.</p>
3	AC25/115.2	19.08.25	<p>Internal Audit Progress Report: Performance Management Framework and Reporting The Audit Committee Chair to write to the Chief Executive to highlight</p>	Urtha Felda Pam Wenger	Oct 25	<p>Action proposed for closure 09.10.25 Urtha Felda sent a letter to Carol Shillabeer raising the concerns discussed.</p>



			concerns regarding the lack of progress in relation to Performance and the Contracted Patient Services Review.			
4	AC25/116.1	19.08.25	External Audit Progress Report Director of Corporate Governance to share the Structured Assessment brief with the Committee.	Pam Wenger	Oct 25	Action proposed for closure 11.09.25 The Structured Assessment brief has been circulated to Board members and interviews with External Audit have been arranged.
5	AC25/117.1	19.08.25	Management Response to Audit Wales Planned Care Report Progress in relation to the Audit Wales Planned Care Report to be discussed in further detail by the PFIG and QSE Committees and reported back to the Audit Committee.	Russell Caldicott Tehmeena Ajmal	Dec 25	Action proposed for closure 11.09.25 The Planned Care Report has been presented to both the PFIG and QSE Committee and an update is included on the agenda for the October meeting. Monitoring of progress will now form part of regular reporting and will be included in the compliance report.
6	AC25/64.1	08.05.25	Corporate Risk Register and Board Assurance Framework 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 Nesta Collingridge	Oct 25	Action proposed for closure 09.09.25 A session with the Board has taken place and an item has been included on the agenda for the meeting in October 25 focussed on the review of the risk appetite and management framework. 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.
7	AC25/64.2	08.05.25	Corporate Risk Register and Board Assurance Framework A deep dive to take place in relation to risks CRR21-22 Orthodontic Services and CRR24-25 Dermatology and Plastic Surgery Services.	Pam Wenger Nesta Collingridge	Oct 25	Action proposed for closure 06.10.25 A report and presentation on Challenged Services went to the QSE Committee in September 2025 and this will continue to be monitored at each QSE Committee. 07.07.25 This has been scheduled for the QSE Committee in September 25 and will be reported back to the Audit Committee.
8	AC25/67.2	08.05.25	Welsh Health Circulars and Ministerial Directions Update on incomplete WHCs requiring immediate action at the next or a future meeting.	Pam Wenger Glesni Driver	Dec 25	Action proposed for closure 11.09.25 Reporting against WHCs will be presented on a bi-annual basis and this update will form part of the Statutory Compliance Report being presented to the Committee in December 25. 01.07.25 Work is taking place and this will be presented to a future meeting of the Committee. WHCs now form part of the Compliance Report which is included on the agenda for the August 25 meeting.
9	AC25/69.1	08.05.25	Internal Audit Progress Report Director of Performance and	Stephen Powell	August 25	Action proposed for closure 11.09.25 This action has been



			Commissioning to report on the progress of the follow up on the Contracted Patient Services – Quality and Safety arrangements at the August meeting.			superseded by action AC25/109.1 and propose this action is closed. 19.08.25 It was agreed during the meeting that this action should remain open as this was not reported to the meeting in August 25. 29.07.25 This is included on the agenda for the August 25 meeting.
10	AC25/70.1	08.05.25	Final Internal Audit Reports (Clinical Audit Report) 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 (Clara Day)	October 25	Action proposed for closure 11.09.25 The Clinical Audit Improvement Plan is included on the agenda for the October 25 meeting, propose this action is closed. 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.
11	AC25/04.1	16.01.25	Matters Arising and Action Log (Trusted Assessor) Board Development Session focussing on the role of the Trusted Assessor to be arranged.	Pam Wenger	March 25 Revised timescale October 25	Action proposed for closure 11.09.25 Discussion is taking place with the Health Board Chair around how best to deliver briefing sessions. Plans are in place to hold a session in November 25 on the role of the Trusted Assessor for those IMs that require this session. 29.07.25 This is being discussed with the Chief Operating Officer to arrange a session for Independent Members. 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.
12	AC24/124.3	12.09.24	<p>Update on Health Board Policies and Written Control Documents</p> <p>It was agreed that further work is required to put mechanisms in place and establish a process on the review of policies and procedures and an update will be provided in the future.</p>	Pam Wenger Glesni Driver	<p>Nov-24 Jan-25</p> <p>Revised timescale October 25</p>	<p>Action proposed for closure</p> <p>11.09.25 The update on the new process for policies has been included on the agenda go the meeting in October 2025.</p> <p>07.07.25 A revised policy is being developed and will be presented to the Committee in October 25.</p> <p>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.</p> <p>12.03.25 An update on progress around a revised policy process will be provided to the June 25 meeting.</p> <p>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.</p> <p>10.12.24 A paper has been included on the agenda for the January</p>



						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.
13	AC24/121.2	12.09.24	Speak Up Safely Future update to consider the compliance against the policy/protocol and particularly in the context of raising concerns and Whistleblowing arrangements.	Internal Audit Jason Brannan Tracey Eccles Rebecca Testa Gareth Evans	Nov 24 Jan 25 March 25 May 25 Revised timescale October 25	Action proposed for closure 09.09.25 Dave Harries confirmed that an Internal Audit review on Speaking up Safely is currently being agreed and will commence shortly therefore suggested this action can now be closed form an Internal Audit perspective. This was agreed with the Workforce Team. 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. 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



						<p>reporting data to allow comparison against other Health Boards / Trusts.</p> <p>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.</p> <p>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</p>
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						<p>Audit Plan for 2025-26, which is being presented for approval at the March 25 meeting.</p> <p>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 adaptations to current practice that may be needed in relation to Public Disclosure (Whistleblowing)</p> <p>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.</p>
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Closed Actions (as agreed at meeting on 19.08.25)

Action No.	Minute Ref.	Date	Agreed Action	Lead	Timescale	Status
1	AC25/73.1	08.05.25	<p>Local Counter Fraud Service Q4 Report 2024/25</p> <p>Draft report following the engagement visit from the NHS Counter Fraud Authority to come back to the next meeting.</p>	Danielle Timmins	August 25	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	AC25/67.1	08.05.25	Welsh Health Circulars and	Pam Wenger	August 25	01.07.25 This information has been



			<p>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.</p>	<p>Glesni Driver Urtha Felda</p>		<p>shared by Urtha Felda.</p>
3	AC25/63.1	08.05.25	<p>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.</p>	<p>Pam Wenger Georgina Roberts Jason Brannan</p>	August 25	<p>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 Managers Induction and Handbook to be undertaken in Q3 with Implementation and socialisation in Q4 25/26.</p>
4	AC25/65.1	08.05.25	<p>Breaches to the Standing Orders Review the anomalies in relation to the list of breaches reported and confirm the reporting arrangements in terms of publishing papers.</p>	<p>Pam Wenger Philippa Peake-Jones</p>	August 25	<p>07.07.25 The Board approved the Annual Report at the meeting in June 25.</p>
5	AC25/62.1	08.05.25	<p>Risk Impact of Overdue Policies Update on progress of the overdue policy process to come back to the next meeting with deadline / completion targets to be included.</p>	<p>Pam Wenger Glesni Driver</p>	August 25	<p>01.07.25 This will be included in the Statutory Compliance report being presented to the next meeting in August 25.</p>
6	AC25/61.1	08.05.25	<p>Update on External and Internal Recommendations External Audit recommendations to remain open and come back to the next meeting, potentially in private session, for further discussion.</p>	<p>Pam Wenger Glesni Driver</p>	August 25	<p>01.07.25 This will be included in the Statutory Compliance report being presented to the next meeting in August 25.</p>



7	AC25/61.2	08.05.25	<p>Update on External and Internal Recommendations Update the limited assurance recommendations table to include the overall number of recommendations for future reports.</p>	Pam Wenger Glesni Driver	August 25	01.07.25 This will be included in the Statutory Compliance report being presented to the next meeting in August 25.
8	AC25/59.1	08.05.25	<p>Matters Arising and Action Log Executive Director of Finance to monitor progress against the reconciliation of whole-time equivalents posts and ESR data and report back to the Committee.</p>	Russell Caldicott	August 25	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.
9	AC25/59.2	08.05.25	<p>Matters Arising and Action Log Director of Corporate Governance to assess the progress of the Job</p>	Pam Wenger	August 25	07.07.25 The Audit Committee received an update from the Chief Executive at the meeting held in June



			Evaluation Process and report back to the Committee.			25 confirming that the issue had been discussed and resolved with the Trade Unions.
10	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	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.
11	AC25/59.4	08.05.25	Matters Arising and Action Log Director of Corporate Governance to review whether the historic recommendations from 2022 have been closed and provide an update outside of the meeting.	Pam Wenger	August 25	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.
12	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	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.
13	AC25/33.2	04.03.25	Risk Report and Corporate Risk Register Share an update on Civil Contingencies with the Audit Committee.	Nesta Collingridge	Aug 25	<p>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.</p> <p>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.</p> <p>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</p>



						the development of risks and they have explained to PPHP that updates will be provided in the next meeting as to the position.
14	AC25/32.2	04.03.25	Information Governance and Records Management Position Access Control Policy and Record Management Code of Practice to be uploaded to the Audit Committee IMs area on the Teams Channel.	Carol Johnson Laura Jones	June 25	01.08.25 A copy of the Access Control Standard has been circulated to the Audit Committee for information. 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.
15	AC25/06.2	16.01.25	Update on Open Audit Recommendations – Final Audit Report on Llandudno Hospital Orthopaedic Surgical Hub Review introducing virtual sign off for capital programmes under the SFIs as part of the review of the SORD.	Russell Caldicott Pam Wenger	June 25	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. 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. 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.
16	AC24/151.2	05.11.24	<p>Centre for Mental Health and Society (CfMHaS) (Title changed from Response to Freedom of Information Request) Gain the opinion of the Information Commissioner on the FOI.</p>	Pam Wenger Phil Meakin	<p>Jan-25 March-25 May-25</p> <p>Revised timescale June 25</p>	<p>27.07.25 There is no further update on this action therefore it is recommended for closure.</p> <p>16.04.25 A communication has been received from the ICO (letter dated 31.01.25). The letter confirmed that there has been a complaint made to the ICO and provided the Health Board with guidance and advice on how to resolve and revisit the complaint and clarify a response in accordance with the relevant rules/laws for FOI Requests. The letter from the ICO also requested a copy of the final letter to the complainant which was duly sent on 09.04.25.</p> <p>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.</p> <p>08.01.25 Associate Director of</p>



						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).
17	AC24/154.5	05.11.24	Internal Audit Progress Report Review the option to include Fire Safety Training within Mandatory Training rather than it being at staff discretion and also review the policy.	Stuart Keen Russell Caldicott	Jan 25 May 25 Revised timescale June 25	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). 30.04.25 Contact made with Workforce to confirm whether Fire Safety Training is already part of the Mandatory Training programme. 25.02.25 The Director of Environment & Estates is taking this forward to build this into the training modules. 09.01.25 Update from RC to follow.
18	AC24/121.1	12.09.24	Speak Up Safely Share benchmarking information from other Health Boards in relation to the number of concerns being raised.	Jason Brannan Tracey Eccles Rebecca Testa Gareth Evans	Nov 24 Jan 25 March 25 May 25	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



					<p>Revised timescale June 25</p>	<p>SUS. Review of Internal process to capture data ongoing in BCUHB - to be completed by September 25. Ongoing collaboration of data sharing across Wales.</p> <p>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.</p> <p>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.</p> <p>28.10.24 The Freedom to Speak Up Lead Guardian has begun liaising with colleagues from across the other Health Boards and will explore</p>
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						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.
19	AC24.60.1.8	07.05.24	<p>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.</p>	Philippa Peake Jones to inform the Quality, Safety and Experience Committee (QSE)	<p>May 24 Nov 24 Jan 25</p> <p>Revised timescale June 25</p>	<p>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.</p> <p>10.04.25 A follow up review is being undertaken and the findings will be shared as soon as possible.</p> <p>04.03.25 A follow up Audit has been commissioned.</p> <p>12.02.25 As the Director of Performance & Commissioning is now post, this will be considered at the QSE Committee in May 25.</p> <p>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.</p> <p>24.10.24 Action to remain open and</p>



						<p>to be taken forward with the new Director of Planning & Commissioning.</p> <p>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.</p> <p>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</p>
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21st October 2025

Civil Contingencies Audit Recommendations

Emergency Preparedness Resilience & Response

Sharon Scott: Head of EPRR



GIG
CYMRU
NHS
WALES

Bwrdd Iechyd Prifysgol
Betsi Cadwaladr
University Health Board

presented

Audit body	Report Title	Year	Assurance Level	Number of report recommendations	Number of recommendations implemented/ complete	Total number of report recommendations open
Internal Audit	<p>Civil Contingencies Internal Audit</p> <p>Recommendation 1: Escalation process As a Category 1 responder, the Health Board is required to have robust business continuity plans in place.</p> <p>Recommendation 2: Incomplete Plan Coverage Several departments have not submitted current BCPs and while 47 BCPs are live, a significant number (43) are still awaiting Director sign off.</p> <p>Recommendation 3: Limited Plan Testing While some exercises have been conducted, most BCPs and incident plans have not been tested.</p> <p>Recommendation 4: Training A training matrix is in place for Management on Call staff, but not all staff have completed the required training (current completion rate is 71%).</p> <p>Recommendation 5: Outdated Policies and Procedures. Core EPRR policies, templates, and guidance documents are still under review, such as the Business Continuity Operational Response Framework.</p>	2025	Limited	5	0	5



1 – Escalation Process

PROGRESS TO DATE	BARRIERS TO IMPLEMENTATION/ DELIVERY –	MITIGATION IN PLACE TO ENSURE DELIVERY	PLAN AND TIMELINE FOR DELIVERY
<p>Recommendation 1: A Business Continuity dashboard has been established, a RAG system has been introduced and a % compliance indicator.</p> <p>The denominators are still being worked up, however, we do have the final denominator for MH/LD Division.</p> <p>The first CCAG since implementing the new process was 30th September, this has been presented to the group.</p>	<p>The EPRR team are relying on the IHCs and services to respond in a timely manner to the request.</p>	<p>The EPRR team have set up Business Continuity workshops to support IHCs and services.</p> <p>Templates have been created and circulated for services to populate.</p>	<p>To continue supporting the IHCs/ Womens and MH/LD to obtain denominators for accurate reporting, monitoring and compliance rates.</p> <p>31st March 2026.</p>



2 – Incomplete Plan

PROGRESS TO DATE	BARRIERS TO IMPLEMENTATION/ DELIVERY –	MITIGATION IN PLACE TO ENSURE DELIVERY	PLAN AND TIMELINE FOR DELIVERY
<p>Recommendation 2: A Business Continuity mapping template has been created and signed off by the Head of EPRR. All BCPs received to date are now inputted and reporting through via the dashboard. The template has been shared with IHCs to assist in identifying a denominator and updating/creating plans.</p> <p>MH/LD are now reporting accurately with a correct denominator established.</p> <p>A Business Continuity dashboard has been established, a RAG system has been introduced and a % compliance indicator as illustrated on previous slide.</p>	<p>The EPRR team are relying on the IHCs and services to respond in a timely manner to the request.</p>	<p>The EPRR team have set up Business Continuity workshops to support IHCs and services.</p> <p>Templates have been created and circulated for services to populate.</p> <p>Targeting Red RAG ratings first.</p>	<p>To continue supporting the IHCs/ Womens and MH/LD to obtain denominators for accurate reporting and compliance rates.</p> <p>31st March 2026.</p>



3 – Limited Plan Testing

PROGRESS TO DATE	BARRIERS TO IMPLEMENTATION/ DELIVERY –	MITIGATION IN PLACE TO ENSURE DELIVERY	PLAN AND TIMELINE FOR DELIVERY
<p>Recommendation 3: An Options appraisal to meet recommendations within internal audit report has been drafted by the Head of EPRR.</p> <p>Proposals to support timely and consistent Exercising and Testing of Plans to progress effectively across BCUHB services.</p> <p>A Preliminary Options Appraisal was presented to the CCAG 30th September for comments on the approach.</p>	<p>Timeline of the governance process to comment and sign off the paper.</p>	<p>The Head of EPRR is prioritising the paper update to take through the correct governance process.</p> <p>Preliminary Paper has already been presented to CCAG 30th September by way of an introduction and comments.</p>	<p>To continue drafting the final paper and send through governance routes.</p> <p>15th December 2025.</p>



4 – Training

PROGRESS TO DATE	BARRIERS TO IMPLEMENTATION/ DELIVERY –	MITIGATION IN PLACE TO ENSURE DELIVERY	PLAN AND TIMELINE FOR DELIVERY
<p>Recommendation 4: An EPRR Training dashboard has been established, denominators identified for each command level and a % compliance aspect. The new approach was presented to CCAG 30th September.</p> <p>The dashboard includes Internal EPRR Major Incident & Loggist training. Further work is being undertaken to include External training colleagues have attended and the feedback received from colleagues.</p> <p>A ‘training prospectus’ will be developed and made available to all staff via the Resilience pages on Betsi Net. This will direct staff to role specific training as well as generic training e.g. EPRR e-learning; on-call training; multi-agency exercises etc.</p>	<p>The EPRR team are relying on the management on call colleagues to freely attend the training sessions scheduled, as the training is not mandatory.</p>	<p>The EPRR team have set up a Teams resource channel for all management on call colleagues, a Betsinet repository of plans and additional documentation to support.</p> <p>Training sessions will continue to be scheduled monthly to ‘mop up’ colleagues who are yet to attend.</p> <p>External LRF courses available.</p>	<p>To continue supporting the IHCs/ Womens and MH/LD on call colleagues with training resources and dates for training days, both internal and external.</p> <p>31st March 2026.</p>



5 – Outdated Policies & Procedures

PROGRESS TO DATE	BARRIERS TO IMPLEMENTATION/ DELIVERY –	MITIGATION IN PLACE TO ENSURE DELIVERY	PLAN AND TIMELINE FOR DELIVERY
<p>Recommendation 5: The Business Continuity Plan template and Business Impact Analysis templates have been updated to include Cyber.</p> <p>The Business Continuity SOP that is currently on Betsi Net has been updated and presented to CCAG on 30th September 2025 for discussion and sign off.</p> <p>A paper has been drafted and went to CCAG on 30th September 2025 for approval that covers the above amendments / updates.</p>	<p>Timeliness of any meetings and the work required to progress and complete.</p>	<p>The EPRR team have set up meetings to ensure the work is of the correct standard and differentiate between Policies / Procedures to ensure correct governance routes are taken.</p>	<p>To continue amendments with the support of the Head of Statutory Compliance & Inquiries.</p> <p>30th November 2025.</p>



Teitl adroddiad: <i>Report title:</i>	Statutory Compliance Report			
Adrodd i: <i>Report to:</i>	Audit Committee			
Dyddiad y Cyfarfod: <i>Date of Meeting:</i>	Tuesday, 21 October 2025			
Crynodeb Gweithredol: <i>Executive Summary:</i>	<p>The purpose of this report is to provide the Committee with:</p> <ul style="list-style-type: none"> an update on compliance activities, including: <ul style="list-style-type: none"> ➤ internal and external audits ➤ regulatory body reviews ➤ policy management ➤ UK Covid-19 Inquiry and Thirlwall Inquiry. 			
Argymhellion: <i>Recommendations:</i>	<p>The Committee is asked to:</p> <ul style="list-style-type: none"> NOTE the content of the report APPROVE the Audit Wales recommendations put forward for closure – see section 2.6 and Appendix 4. 			
Arweinydd Gweithredol: <i>Executive Lead:</i>	Pam Wenger, Director of Corporate Governance			
Awdur yr Adroddiad: <i>Report Author:</i>	Glesni Driver, Head of Statutory Compliance and Inquiries			
Pwrpas yr adroddiad: <i>Purpose of report:</i>	I'w Nodi <i>For Noting</i> <input checked="" type="checkbox"/>	I Benderfynu arno <i>For Decision</i> <input checked="" type="checkbox"/>	Am sicrwydd <i>For Assurance</i> <input checked="" type="checkbox"/>	
Lefel sicrwydd: <i>Assurance level:</i>	Arwyddocaol <i>Significant</i> <input type="checkbox"/> Lefel uchel o hyder/tystiolaeth o ran darparu'r mecanweithiau / amcanion presennol <i>High level of confidence/evidence in delivery of existing mechanisms/objectives</i>	Derbyniol <i>Acceptable</i> <input type="checkbox"/> Lefel gyffredinol o hyder/tystiolaeth o ran darparu'r mecanweithiau / amcanion presennol <i>General confidence / evidence in delivery of existing mechanisms / objectives</i>	Rhannol <i>Partial</i> <input checked="" type="checkbox"/> Rhywfaint o hyder/tystiolaeth o ran darparu'r mecanweithiau / amcanion presennol <i>Some confidence / evidence in delivery of existing mechanisms / objectives</i>	Dim Sicrwydd <i>No Assurance</i> <input type="checkbox"/> Dim hyder/tystiolaeth o ran y ddarpariaeth <i>No confidence / evidence in delivery</i>
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: <i>Justification for the above assurance rating. Where 'Partial' or 'No' assurance has been indicated above, please indicate steps to achieve 'Acceptable' assurance or above, and the timeframe for achieving this:</i>				
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:	Building an Effective Organisation
Link to Strategic Objective(s):	
Goblygiadau rheoleiddio a lleol:	Compliance with statutory compliance requirements
Regulatory and legal implications:	
Yn unol â WP7, a oedd EqIA yn angenrheidiol ac a gafodd ei gynnal?	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
In accordance with WP7 has an EqIA been identified as necessary and undertaken?	
Yn unol â WP68, a oedd SEIA yn angenrheidiol ac a gafodd ei gynnal?	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.
In accordance with WP68, has a SEIA identified as necessary been 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)	Not applicable, other than those relating to individual regulatory body reviews and audit reports
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	Not applicable, other than those relating to individual regulatory body reviews and audit reports
Financial implications as a result of implementing the recommendations	
Goblygiadau gweithlu o ganlyniad i roi'r argymhellion ar waith	Not applicable, other than those relating to individual regulatory body reviews and audit reports
Workforce implications as a result of implementing the recommendations	
Adborth, ymateb a chrynodeb dilynol ar ôl ymgynghori	The report has been prepared as an amalgamated report of all compliance-related requirements
Feedback, response, and follow up summary following consultation	
Cysylltiadau â risgiau BAF: (neu gysylltiadau â'r Gofrestr Risg Gorfforaethol)	Not applicable, other than those relating to individual regulatory body reviews and audit reports
Links to BAF risks: (or links to the Corporate Risk Register)	
Rheswm dros gyflwyno adroddiad i fwrdd cyfrinachol (lle bo'n berthnasol)	Not applicable
Reason for submission of report to confidential board (where relevant)	

**Camau Nesaf:
Gweithredu argymhellion**

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

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 – closure summary
- Appendix 4 – Internal Audit – recommendations for Audit Committee closure approval
- Appendix 5 – Audit Wales – open recommendations
- Appendix 6 – Audit Wales – closure summary
- Appendix 7 – Policy Management – all overdue policies

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BETSI CADWALADR UNIVERSITY HEALTH BOARD STATUTORY COMPLIANCE REPORT

1. INTRODUCTION

This report provides an update on statutory compliance activities, including internal and external audits, compliance with regulatory body reviews, updates on policy management, and national inquiries.

2. INTERNAL AUDIT

2.1 Internal Audit – new audit reports

Table 1 below shows all the Internal Audit reports received up to 29th August 2025.

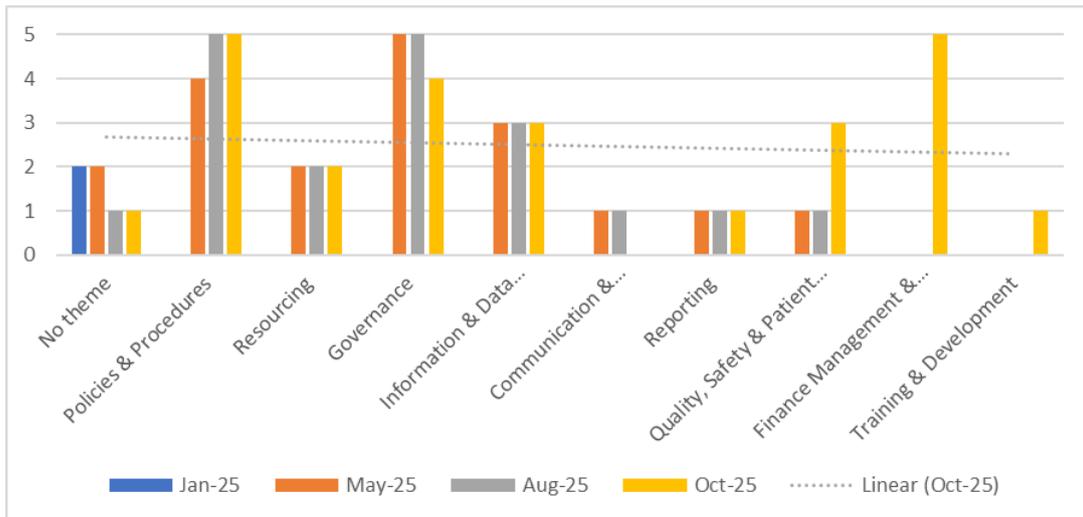
Limited	Corporate Legislative Compliance: Civil Contingencies Act 2004
Unsatisfactory	Orthopaedic Surgical Hub Llandudno Hospital - 2025

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 overdue their original implementation date, and number put forward for closure to the Executive Committee on 17th September 2025. The table also includes the total number of high priority recommendations overdue their original implementation date by 6 months or more (as at 29th August 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	2	2	1
Consultant Job Planning	Interim Executive Medical Director; Deputy Director of People	14	12	2	0
Waiting List Initiative payments – IHC Centre	Chief Operating Officer	1	1	0	0
Orthopaedic Surgical Hub Llandudno	Executive Director of Finance	7	0	0	1
Effective Governance – Integrated Health Community - East	Chief Operating Officer	1	0	0	0
Effective Governance - Cancer Services	Chief Operating Officer	1	0	0	0
	Total	25	15	4	2

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



A copy of all open 'unsatisfactory' assurance recommendations is included in Appendix 1.

2.3 Internal Audit – open 'Limited' assurance recommendations

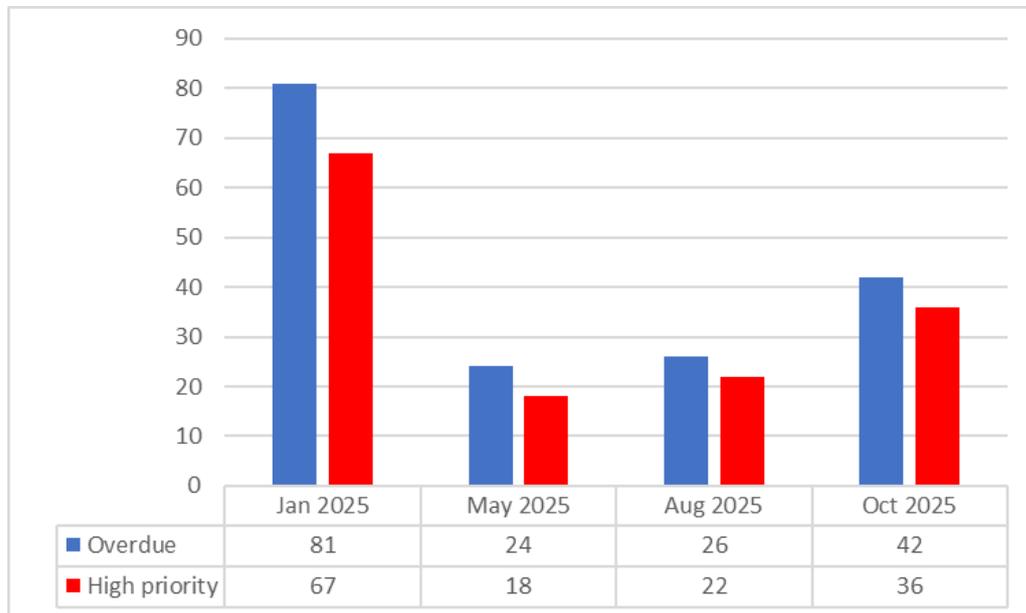
Table 3 below shows a summary, by Executive, of all open 'limited' assurance recommendations, the number of these overdue their original implementation date, and number put forward for closure to the Executive Committee on 17th September 2025. The table also includes the total number of high priority recommendations overdue their original implementation date by 6 months or more (as at 29th August 2025):

Executive Lead	Total 'Limited' Assurance recs - Open	Open 'Limited' assurance recs overdue original implementation date	High priority recommendation overdue original implementation date by 6 months or more	'Limited' Assurance recs put forward for closure
Executive Director of Nursing	13	5	1	0
Chief Operating Officer	8	4	4	0
Deputy Director of People	2	0	0	0
Director of Corporate Governance	11	0	0	0
Executive Director of Finance	4	1	1	5
Interim Executive Medical Director	4	4	3	0
Interim Executive Medical Director; Deputy Director of People	7	6	6	0
Director of Performance and Commissioning	8	5	5	0
Director of Partnerships, Engagement and Communications	11	3	0	0
Director of Environment and Estates	10	10	7	0
	78	38	27	5

A copy of 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 Audit Committee meetings during 2025, and of those overdue, the total that are 'high priority'.



2.4 Internal Audit – approved recommendations for Committee review

Table 4 below provides a summary of all recommendations approved for closure by the lead Executive Team Member and Executive Committee on 17th September 2025.

Executive Lead	Approved for closure by Executive	Awaiting approval by Executive
Chief Digital and Information Officer	5	
Chief Executive	2	
Chief Operating Officer		5
Executive Director of Nursing	1	
Interim Executive Director of Transformation and Strategic Planning	2	
Deputy Director of People	7	
Interim Executive Medical Director		1
Executive Director of Finance	13	
Total	30	6

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

Audit recommendations have been submitted to Internal Audit for review, and a response is awaited.

Work has continued to source additional evidence for the 20 audit recommendations returned for evidence, as reported to the last Audit Committee. Once received, this will be submitted to Internal Audit for further review.

2.6 Internal Audit – recommendations for Committee closure approval

There are a number of Internal Audit recommendations that now need Audit Committee approval. These fall into three different categories:

- a) recommendations that have been approved for closure in line with the approved closure process by both the Lead Executive Team Member and Executive Team, and reviewed and approved for closure by Internal Audit but not yet presented to the Audit Committee for final closure approval
- b) recommendations that have been approved for closure in line with the approved closure process by both the Lead Executive Team Member and Executive Team, but are outside the scope of the Internal Audit Charter for review but need final closure approval by the Audit Committee
- c) historical recommendations reviewed by Internal Audit, with request for Executive to review recommendation prior to closure – now reviewed by Executive, and put forward for final closure approval by Audit Committee.

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

Recommendation 1: It is proposed that these recommendations are approved for closure by the Audit Committee.

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

3. AUDIT WALES

3.1 Audit Wales – new audit reports

No new Audit Wales reports have been published as at 29th August 2025.

3.2 Audit Wales – open recommendations

The details of all the open Audit Wales recommendations are included in Appendix 5.

Table 5 below shows the number of Audit Wales recommendations overdue their original implementation date by 6 months or more (as at 29th August 2025):

Report Title	Original implementation date	Number overdue original implementation date - 6 months	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	2	Chief Operating Officer

3.3 Audit Wales – approved recommendations for Audit Wales review

Table 6 below provides a summary of all external audit recommendations approved for closure by the lead Executive Team Member and Executive Committee on 17th September 2025– these will now be shared with Audit Wales for review.

Executive Lead	Approved for closure
Chief Operating Officer	2
Director of Corporate Governance	1
Total	3

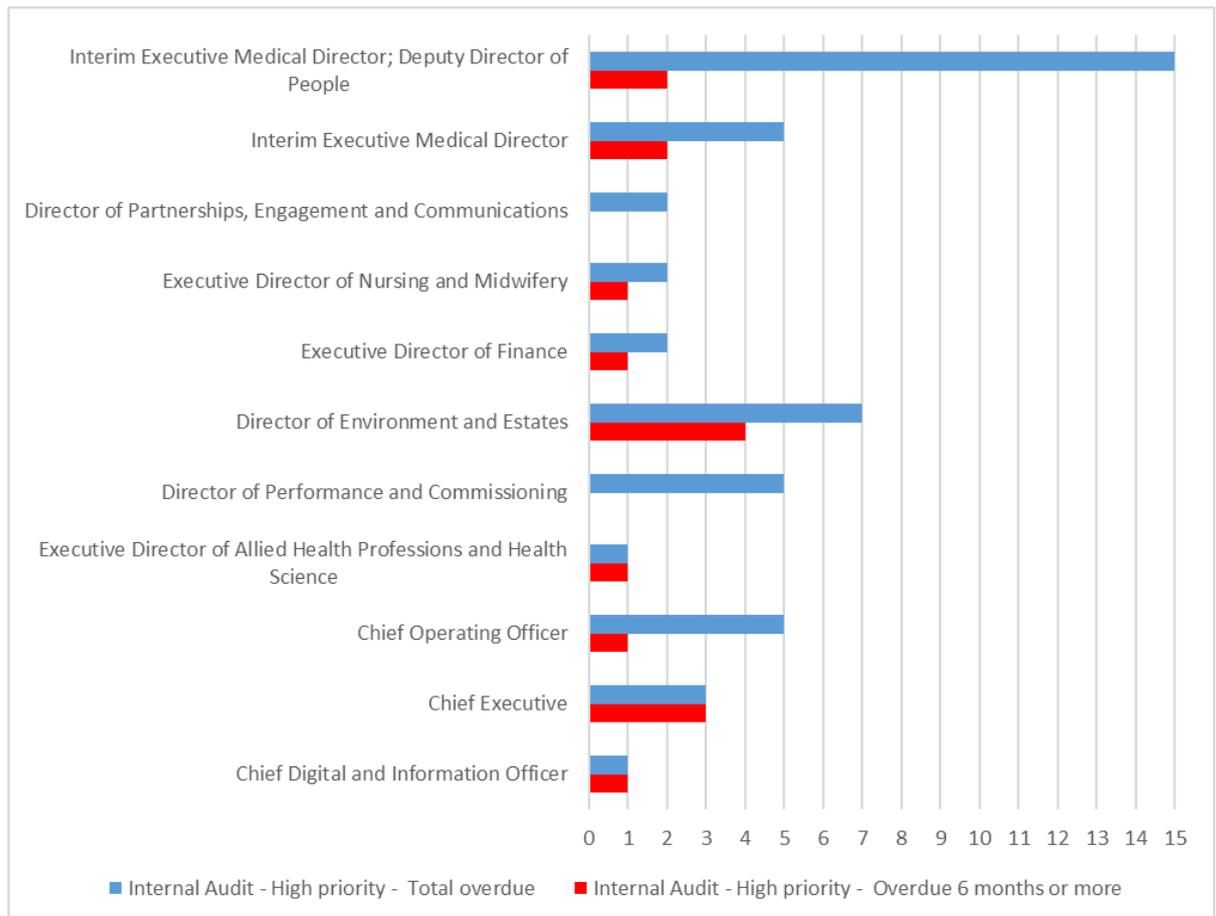
A summary of the closure narrative for each of the recommendations is included in Appendix 6.

4. AUDIT - OVERVIEW

4.1 Summary of all audit recommendations

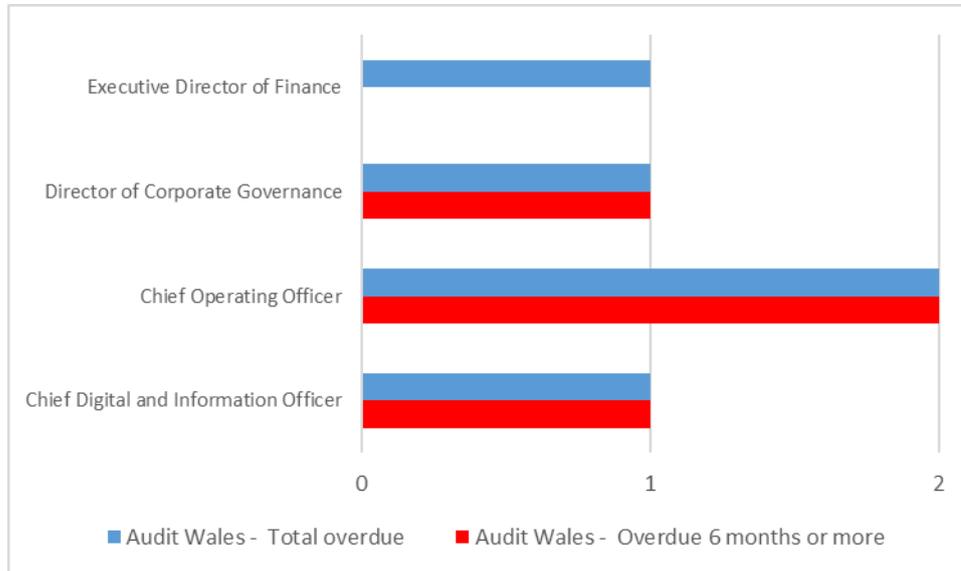
4.1.1 Internal Audit - Open and overdue 'high priority' recommendations

Graph 3 below provides details of all open 'high priority' Internal Audit recommendations overdue the original implementation, and the number that are overdue by 6 months or more (as at 29th August 2025), listed by Lead Executive Team Member.



4.1.2 Audit Wales - open and overdue 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 29th August 2025), listed by Lead Executive Team Member.



4.2 Overview of audit reports

Table 7 below provides an overview of the position relating to Audit Wales and Internal Audit reports and recommendations as at 29th August 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	33	2	110	23	48	16

4.3 Overview of all recommendations

Table 8 below provides a summary of all recommendations, and their position in the closure approval process.

	As at 14/03/2025	As at 24/04/2025	As at 29/07/2025	As at 29/07/2025
New Internal Audit recommendations	46	60	98	20
New Audit Wales recommendations	8	24	0	0
Pending - Executive Committee	0	0	0	29
With Internal Audit for review	0	0	0	8
With Audit Wales for review	0	0	0	8
For Audit Committee closure approval	0	0	59	64

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 **Audit Handbook**

The Statutory Compliance Team has developed an Audit Handbook to provide Health Board colleagues with the knowledge they need should they be involved in an audit, whether this be an internal audit or external audit. The Handbook sets out roles and responsibilities, including those for senior management and the Health Board Committees.

Full consultation has taken place with the audit bodies during the development of the Handbook.

The Audit Handbook is now published on the [Audit intranet site](#) on BetsiNet, and complements the information already included on that site around both internal and external audit.

5. REGULATORY BODY REVIEWS (NON-AUDIT BODIES)

5.1 Healthcare Inspectorate Wales

5.1.1 [Ysbyty Gwynedd Maternity Services](#)

Health Inspectorate Wales (HIW) published an inspection report pertaining to the Unannounced Inspection of Ysbyty Gwynedd Maternity Services on 5th June 2025. The inspection took place from 18-20th February 2025.

HIW issued the service with the following immediate assurances:-

The Health Board must ensure that:

- Medical handover between antenatal and intrapartum patient care are effective, clearly and routinely documented and communicated during handover. This is to ensure that all women across the unit are prioritised effectively and in a timely manner, to maintain the safety of mothers and unborn babies
- Obstetricians are supported to undertake and complete mandatory training in a timely manner within Ysbyty Gwynedd and across the Health Board's Maternity Services
- A risk assessment is completed, and mitigations implemented to minimise the risk of harm and maintain the safety of mothers and babies until training compliance has improved to an appropriate and safe level.

5.1.2 [Ysbyty Gwynedd, Emergency Department](#)

HIW published an inspection report pertaining to the Unannounced Inspection of Ysbyty Gwynedd Emergency Department on the 24th July 2025. The inspection took place from the 14-16th April 2025.

HIW issued the service with the following immediate assurances: -

- HIW requires details on how the Health Board will ensure that measures are in place to maintain the medication room temperature within accepted parameters of between 8 and 25 degrees Centigrade
- HIW requires details on how the Health Board will ensure that the resuscitation trolley is checked regularly and that all items past their expiry date, and items in opened packaging, are removed and replaced
- HIW requires details on how the Health Board will ensure that the paediatric area is adequately staffed at all times when children are accommodated.

As outlined within the inspection reports, 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 Delivery Group (EDG), and up to the Quality Safety and Experience (QSE) Committee.

5.1.3 **Announced/Unannounced Inspections (1)**

Between 29-30th July 2025, HIW undertook an inspection at Cemlyn Ward, Ysbyty Cefni. The Health Board received verbal feedback from HIW following the inspection, and immediate assurance plan. This will be reported in the next paper, as the Health Board have not yet received any documentation from HIW.

5.1.4 **Concerns/Requests for Assurance (9)**

The Health Board received nine concerns/requests for assurance from HIW. All responses from the Health Board receive approval from Responsible Directors and the appropriate Lead Executive Team Member prior to submission to HIW. These are subject to oversight and monitoring via the Health Board's Regulatory Assurance Group (RAG) which reports to the Executive Delivery Group (EDG).

5.2 **Care Inspectorate Wales**

A visit to Enhanced Community Residential Services (ECRS), a domiciliary provision within the Mental Health and Learning Disabilities Service, was undertaken by the Health Board's Responsible Individual on 4th July 2025. No immediate patient safety issues were identified. Areas of good practice was recognised, with three recommendations made in relation to areas for improvement.

5.3 **Public Services Ombudsman for Wales**

5.3.1 **Public Interest Reports (PIRs)**

The Health Board has 1 ongoing Public Interest Report issued by the Ombudsman.

[PIR received March 2025 \(Case ref ID2087 / 202301141\)](#)

The Ombudsman upheld the complaints and made a number of 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, Executive Delivery Group and Quality Safety and Experience (QSE) Committee.

Eight of the actions have been completed with one remaining action due for completion on 25th September 2025. The Health Board wrote to the Liverpool University Hospitals NHS Foundation Trust, and has received their findings and evidence which has been shared with the Ombudsman. The final recommendation deadline in relation to implementing a Commissioning Assurance Framework (CAF) is in progress and on track for completion.

Improvement Focus:

- Strengthening the monitoring and performance review of commissioned care
- Enhancing proactive referrals and MDT discussions to improve patient outcomes
- Ensuring comprehensive and timely patient information and consent processes
- Implementing robust action plans with clear accountability and deadlines
- Implement a Commissioning Assurance Framework (CAF).

5.3.2 Learning from the Ombudsman

The Quality Team continue to collaborate with other Health Boards in Wales via the NHS Wales Ombudsman Safety and Learning network to review published reports and discuss themes for wider learning. The network also helps identify ways which the Health Board can improve how it captures, tracks and monitors Ombudsman recommendations and compliance.

When a Health Board complaint is upheld by the Ombudsman, the final report findings and recommendations are presented to the Patient Safety Group and Clinical Effectiveness Group for discussion.

6. POLICY MANAGEMENT

6.1 Executive Policy Oversight Group policy approvals

Table 9 below lists the policies reviewed and approved by the Executive Policy Oversight Group (EPOG) since the last update. 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
WP1b - NHS Wales Secondment Policy	Interim Deputy Director of People	2018
QD01 - BCUHB Quality Regulatory Policy	Executive Director of Nursing and Midwifery	New Policy

The revised Terms of Reference for the EPOG were approved by the Executive Committee on 27th August 2025, where a new vice-chair was appointed (Interim Executive Director of Transformation and Strategic Planning), and strengthened membership.

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. All policies overdue their review date pose a risk to the Health Board, however, those relating to 'patient safety' were identified as those posing the highest risk as there is a potential direct impact on the safety of patients.

On 27th June 2025, the Statutory Compliance Team submitted a request to the Executives for updates on progress around policies overdue a review, with a response deadline a month later, on 25th July 2025. A number of responses were received, but some still remain outstanding as at 29th August 2025, despite a number of reminders.

Table 10 below provides details of the overdue policies relating to patient safety. This shows an improved position, with a reduction of 11 from the 15 reported at the August Audit Committee.

Name	Effective Date	Review Date	Responsible Director
A Clinical Policy for DNACPR For Adults in Wales - V4.pdf	01/12/2020	01/12/2022	Chief Operating Officer
BH-004 - Transfusion of Blood Components Outside the Acute Hospital Setting - V2.0.pdf	01/09/2021	01/08/2024	Chief Operating Officer
CW01 - BCUHB Paediatric Escalation Policy - V3.pdf	01/09/2018	01/09/2019	Chief Operating Officer
MD17 - Interventions Not Normally Undertaken (INNU) Policy - V1.1.pdf	24/07/2018	01/09/2021	Executive Medical Director

Appendix 7 provides a full list of all overdue policies as at 27th June 2025, and progress updates provided up to 29th August 2025.

6.3 Overdue procedures and written control documents

The Statutory Compliance Team continues to work with Executives to progress overdue procedures and other written control documents (WCDs).

6.4 Overdue policy-documents – by Executive

Table 11 below provides the total number of all policies, other WCDs, and all-Wales documents.

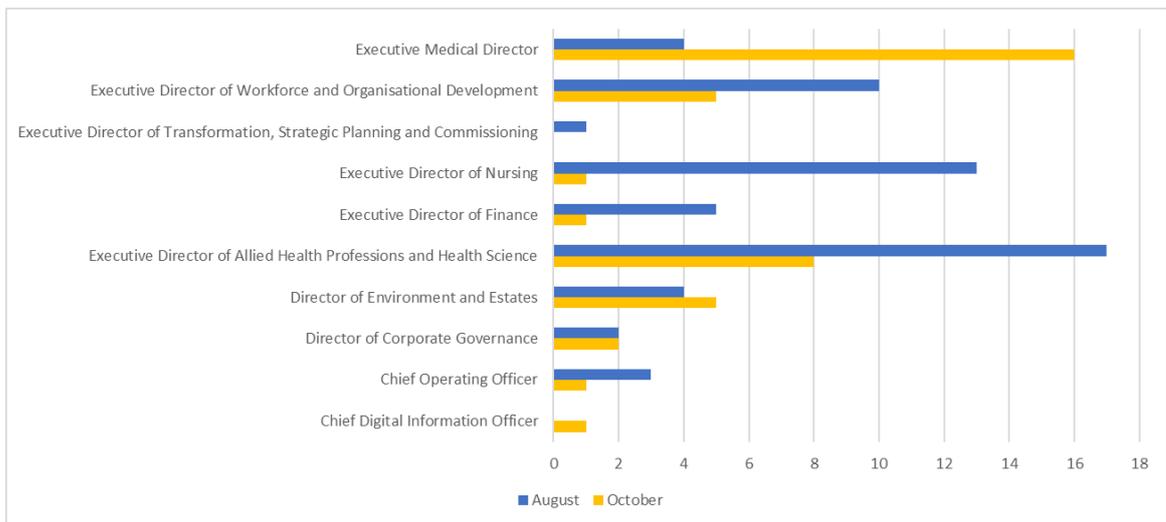
	October Audit Committee								
	Information as at 29/08/2025								
	Policies			Other WCDs			All Wales		
	Total	Overdue	% overdue	Total	Overdue	% overdue	Total	Overdue	% overdue
Chief Digital Information Officer	4	1	25%	26	2	8%	4	4	100%
Chief Executive	0	0	0%	2	1	50%	0	0	0%
Chief Operating Officer	6	1	17%	144	40	28%	8	5	63%
Director of Corporate Governance	4	2	50%	11	3	27%	0	0	0%
Director of Environment and Estates	6	5	83%	3	3	100%	0	0	0%
Executive Director of Allied Health Professions and Health Science	27	8	30%	80	26	33%	3	0	0%
Executive Director of Finance	2	1	50%	15	3	20%	1	1	100%
Executive Director of Nursing	6	1	17%	108	9	8%	7	5	71%
Executive Director of Public Health	0	0	0%	12	1	8%	0	0	0%
Executive Director of Transformation, Strategic Planning and Commissioning	0	0	0%	0	0	0%	1	1	100%
Executive Director of Workforce and Organisational Development	23	5	22%	63	11	17%	18	4	22%
Executive Medical Director	26	16	62%	169	55	33%	11	4	36%
	104	40	38%	633	154	50%	53	24	45%

The total number of policies exclude any all-Wales documents, and also only includes a total of one document where there is both a Welsh and English version available. This total also excludes any appendices aligned to a policy, which are currently separately on the Policy Management System (PMS).

The WCD information includes all procedures, guidelines, procedures, protocols, strategies and 'other' documents currently listed on the PMS. It only includes a total of one document where there is both a Welsh and English version available. This total excludes any appendices aligned to any WCD, which are currently listed separately on the PMS.

The all-Wales document information includes every all-Wales policy and WCD, but excludes all appendices listed separately on the PMS, and also only include a total of one document where there is both a Welsh and English version available. Again, this total excludes any appendices aligned to any all-Wales documents, which are currently listed separately on the PMS.

Graph 5 below provides a comparison of the number of overdue policy documents, by Executive. If an Executive is not listed, there are no overdue policy assigned to that Executive.

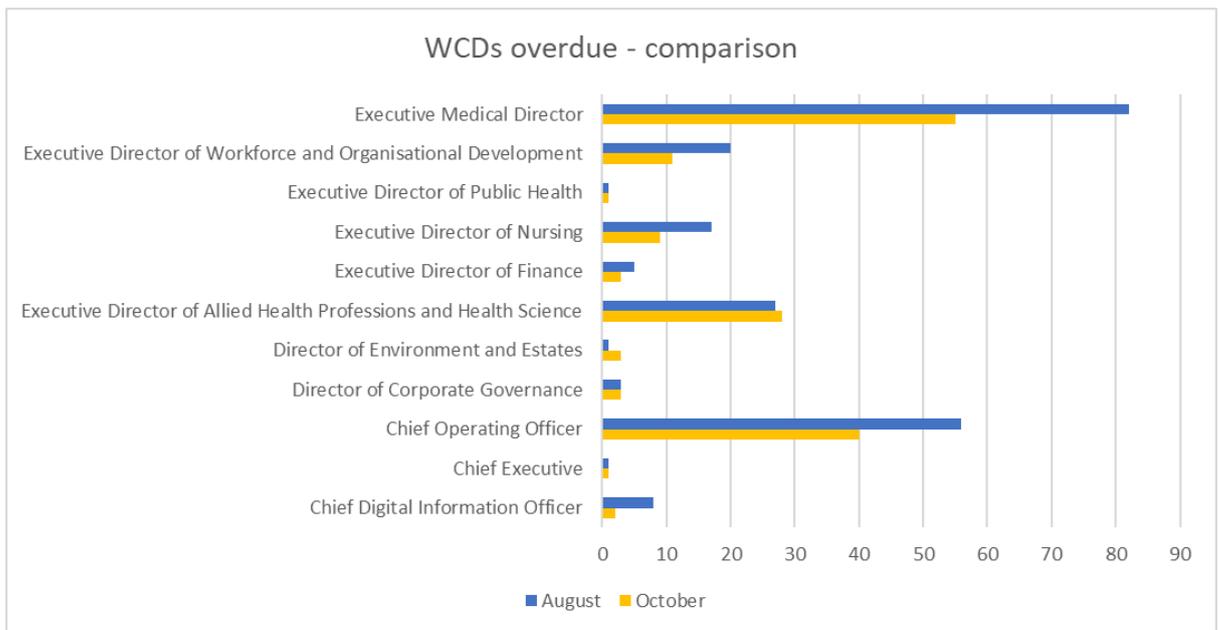


There is a marked improvement in the total number of overdue policies from that reported at the August Audit Committee. There is, however work to be done in some areas.

6.5 Overdue WCD-documents – by Executive

There is a marked improvement in the total number of overdue policies in all but one portfolio from that reported at the August Audit Committee

Graph 6 below provides a comparison of the number of overdue WCDs, by lead Executive Team Member. If a lead Executive Team Member is not listed, there are no overdue written control documents assigned to that Executive.



6.6 Overdue all-Wales policy-documents – by Executive

Graph 7 below provides a comparison of the number of overdue all-Wales policies and WCDs, by Executive. If an Executive is not listed, there are no overdue written control documents assigned to that Executive.



Again, there is a marked improvement in the total number of overdue all-Wales in most portfolios.

As reported at the last Audit Committee, the Health Board should produce its own policy documents if there is a delay in the implementation of all-Wales documents.

A proposal on dealing with all-Wales policies, procedures and other written control documents that are due a review, where an updated all-Wales is not yet available is being considered as part of the work around the revised policy management process.

7. STATUTORY INQUIRIES

7.1 UK COVID-19 INQUIRY

The UK Covid-19 Inquiry is split into 10 different investigations – or ‘Modules’ – which examine different parts of the UK’s preparedness for and response to the pandemic and its impact. By the end of 2025, the Inquiry will have completed hearings in nine of the ten investigations. The Inquiry will conclude its public hearings on 5th March 2026 at the end of the Module 10 hearing.

7.1.1 Module updates

Module 1 – Resilience and preparedness

The report on the first Module, Resilience and Preparedness, was published on 18th July 2024.

The Inquiry has received further updates from the UK, Welsh and Scottish governments and the Northern Ireland Executive regarding actioning the recommendations made by the Chair of the Inquiry, Baroness Hallett, in her [Module 1 report regarding pandemic preparedness and resilience](#), which was published in July 2024. Below are the links to each response received.

- [Link to the Welsh government’s six-month update](#)
- [Link to the UK government’s Resilience Action Plan](#)
- [Link to the Scottish government’s progress update](#)
- [Link to the Northern Ireland Executive’s second response to the Module 1 report](#)

Links to these responses are set out on the [recommendations monitoring page](#), including subsequent correspondence sent by the Inquiry Chair to each administration.

Module 2- Core UK decision-making and political governance

Public hearings for the Module 2 investigation – including Modules 2A (Scotland), 2B (Wales) and 2C (Northern Ireland) – were held in London, Edinburgh, Cardiff and Belfast between October 2023 and May 2024. The Chair heard evidence from witnesses including serving and former Prime and First Ministers as well as other senior politicians, scientists, experts, government advisers and civil servants.

The UK Covid-19 Inquiry will publish its report and recommendations into Module 2 on 30th November 2025, which concludes its investigation into Module 2.

Module 3 - Impact of Covid-19 pandemic on healthcare systems in the 4 nations of the UK

The Inquiry’s report into Module 3 will be published in Spring 2026. This is likely to be the report where the most recommendations from the Inquiry will need to be actioned by the Health Board.

Module 4 - Vaccines and therapeutics

The Inquiry's report into Module 4 will follow shortly after the publication of the Module 3 report.

Module 5 - Procurement

Module 5 opened on 24th October 2023 to consider and made recommendations regarding the procurement and distribution to end-users across the four nations of the United Kingdom of key healthcare related equipment and supplies, including PPE, ventilators and oxygen.

The Module assessed the robustness and effectiveness of procurement processes, the adequacy of the items obtained (including their specification, quality and volume) and the effectiveness of their distribution to the end-user. It also considered the UK-wide procurement of lateral flow tests and PCR tests.

Module 5 public hearings took place between 3rd and 27th March 2025.

Module 6 - Care sector

Hearings for the Inquiry's Module 6 have now concluded, and ran from 30th June to 31st July 2025. Throughout the hearings, evidence was heard from bereaved family members who lost loved ones in care settings, representatives of people who were working in care homes during the pandemic, care sector regulators and key decision makers.

Module 7 – Test, Trace and Isolate

The public hearing for Module 7 took place from 12th to 30th May 2025, examining the different test, trace and isolate programmes across the four nations of the UK.

Module 8 - Children and Young People

Module 8 opened on 21st May 2024 to consider the impact of the pandemic on children across society in England, Wales, Scotland and Northern Ireland, including those with special educational needs and/or disabilities and from a diverse range of ethnic and socio-economic backgrounds.

The Inquiry plans to hear evidence for this investigation across four weeks from 29th September to 23rd October 2025.

Module 9 – Economic response

On 10th September 2025, the Inquiry held its final preliminary hearing for its investigation into Module 9.

This Module looks at the economic interventions taken by the UK Government and Devolved Administrations in response to the Covid-19 pandemic. This Module will examine, and make recommendations on, the economic support for business, jobs, the self-employed, vulnerable people and those on benefits, and the impact of key economic interventions.

Public hearings for this Module are scheduled to take place from 24th November to 14th December 2025.

Module 10 - Impact on society

Module 10 opened on 17th September 2024, and is the final Module of the Covid-19 UK Inquiry. This Module will examine the impact of Covid on the UK population, with a particular focus on key workers, the most vulnerable, the bereaved, mental health and wellbeing. The Module will also seek to identify where societal strengths, resilience and or innovation reduced any adverse impact.

Due to the wide range of issues being investigated, the Chair was minded to designate only Core Participant applicants who can speak to a range of industries and/or parts of society impacted and are representative of the whole of the UK.

The Inquiry used roundtables as one method of gathering information for Module 10, to bring together a diverse range of organisations to share their perspectives on the societal impact of the pandemic. A total of nine roundtables took place between February and June 2025, with each exploring a different aspect of this Module.

7.2 THIRLWALL INQUIRY

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

The Inquiry has written to Core Participants with an update on the progress of the final report.

The Chair, Lady Justice Thirlwall, is expected to send out warning letters from September 2025 and the final report will be completed by the end of November. The report will then undergo copyediting and typesetting, ahead of publication in early 2026.

Members may also be aware of the documentaries that have been aired around Lucy Letby.

7.3 Response to Inquiry reports, and learning from Inquiries

It is likely that there will be actions for the Health Board in respect of both these Inquiries, which will be reviewed, monitored and actioned by the 'Discovery and Learning Steering Group', chaired by the Executive Director of Nursing and Midwifery.

8. **RECOMMENDATIONS FOR COMMITTEE DECISION**

8.1 The Committee is asked to:

- **NOTE** the contents of the report
- **APPROVE RECOMMENDATION 1** - the Audit Wales recommendations put forward for closure, endorsing that the work has been completed and implemented, as per the recommendation– see section 2.6 and Appendix 4.

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 – CLOSURE SUMMARY

APPENDIX 4 – INTERNAL AUDIT – RECOMMENDATIONS FOR AUDIT COMMITTEE CLOSURE APPROVAL

APPENDIX 5 – AUDIT WALES – OPEN RECOMMENDATIONS

APPENDIX 6 – AUDIT WALES – CLOSURE SUMMARY

APPENDIX 7 – POLICY MANAGEMENT – ALL OVERDUE POLICIES

OPEN 'UNSATISFACTORY' RECOMMENDATIONS

ID	Report Title	Year	Priority	Recommendation Title	Recommendation	Management Response	Final Approver	Original implementation date	Revised implementation date	Number of Revisions	Latest update
0455	Operating Model	2024	High	Matter Arising 1: Operating Model (Design and Operation)	<p>1.1(b) The Health Board, through the Chief Executive should undertake a full review of the operating model including:</p> <ul style="list-style-type: none"> A review of the Operating Model, as implemented, to ensure it is fit for purpose in delivering the Corporate/Strategic Objectives, long-term strategy/medium term plan of the Health Board. A review of all twenty-six services identified as 'Outstanding Design – Clinical' with urgency, noting some represent current risk to the Health Board. Review of the role, remit and accountability of corporate posts where the services they oversee are delivered through Operational Services, for which they have no delegated responsibility or accountability. A review of funding, to ensure any Operating Model/Structure is affordable and transparency in funding is ensured. 	<p>1.1 (b) Arana (external consultancy) was commissioned in November to undertake an initial review of the operating model. The Chief Executive, supported by the Senior Associate Director of People in May 2024, will commence an engagement process with the Board and other colleagues to consider changes to the organisational structure. This will take account of the gaps in assurance that have been identified as part of this internal audit.</p>	Carol Shillabeer, Chief Executive	30/06/2024	31/03/2026	1	Work continues engaging with staff groups as part of developing the new model. Work stream meetings set up for the 5 work streams that present highlight reports to the programme board. The implementation should be 31.03.2026
0457	Operating Model	2024	High	Matter Arising 2: Operational Governance and Accountability Framework (Design and Operation)	<p>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.</p>	<p>As part of the organisational structure review, all accountability frameworks will be reviewed</p>	Carol Shillabeer, Chief Executive	30/06/2024	31/03/2026	2	Agreed to change the implementation date to 31/03/26 following discussion with Dave Harries to align to the Foundations for the Future.
1427	Consultant Job Planning	2024	High	Objective 1: There is relevant and up to date procedures in place that are available to staff and align to the All-Wales guidance.	<p>1.1 Health Board Policy</p> <p>Health Board Policy The Health Board has no Policy or Procedure detailing the expectations of both management and Consultant in discussing and agreeing the Job Plan in line with the nationally agreed Consultant Contract. Based on our review, it has not had a comprehensive Policy in place for thirteen years, per the original review undertaken by the former Wales Audit Office in 2011.</p> <p>Limited training is provided to all individuals involved in the job plan process.</p>	<p>1.1 Review and update Job Planning policy to be aligned with All Wales guidance and nationally agreed Consultant Contract, which is readily accessible to staff.</p>	Sreeman Andole, Interim Executive Medical Director; Jason Brannan, Deputy Director of People	31/05/2025			All Wales guidance stalled. Meeting with WoD, LNC, OMD and BMA arranged for 26.08.25 to finalised local draft document
1428	Consultant Job Planning	2024	High	Objective 1: There is relevant and up to date procedures in place that are available to staff and align to the All-Wales guidance.	<p>1.2 Health Board Policy</p> <p>The Health Board has no Policy or Procedure detailing the expectations of both management and Consultant in discussing and agreeing the Job Plan in line with the nationally agreed Consultant Contract. Based on our review, it has not had a comprehensive Policy in place for thirteen years, per the original review undertaken by the former Wales Audit Office in 2011.</p> <p>Limited training is provided to all individuals involved in the job plan process.</p>	<p>1.2 Continue with regular updates of compliance to IHC/Division, to reflect organisational job planning status.</p>	Sreeman Andole, Interim Executive Medical Director; Jason Brannan, Deputy Director of People	31/05/2025			All Wales guidance stalled. Meeting with WoD, LNC, OMD and BMA arranged for 26.08.25 to finalised local draft document
1429	Consultant Job Planning	2024	High	Objective 1: There is relevant and up to date procedures in place that are available to staff and align to the All-Wales guidance.	<p>1.3 Health Board Policy</p> <p>The Health Board has no Policy or Procedure detailing the expectations of both management and Consultant in discussing and agreeing the Job Plan in line with the nationally agreed Consultant Contract. Based on our review, it has not had a comprehensive Policy in place for thirteen years, per the original review undertaken by the former Wales Audit Office in 2011.</p> <p>Limited training is provided to all individuals involved in the job plan process.</p>	<p>1.3 Complete a training needs analysis across BCUHB to establish training for medical and management teams by March 2025.</p>	Sreeman Andole, Interim Executive Medical Director; Jason Brannan, Deputy Director of People	31/05/2025			Training on Allocate for operational teams continuing. Roadshows on hold until All Wales guidance shared Regular IHC discussions occurring. Specialties are being contacted individually to ask what support is needed from the job planning team to achieve compliance requirement figures
1430	Consultant Job Planning	2024	High	Objective 1: There is relevant and up to date procedures in place that are available to staff and align to the All-Wales guidance.	<p>1.4 Health Board Policy</p> <p>The Health Board has no Policy or Procedure detailing the expectations of both management and Consultant in discussing and agreeing the Job Plan in line with the nationally agreed Consultant Contract. Based on our review, it has not had a comprehensive Policy in place for thirteen years, per the original review undertaken by the former Wales Audit Office in 2011.</p> <p>Limited training is provided to all individuals involved in the job plan process.</p>	<p>1.4 Develop and deliver targeted training sessions for managers and consultants by April 2025.</p>	Sreeman Andole, Interim Executive Medical Director; Jason Brannan, Deputy Director of People	31/05/2025			Roadshows on hold until all Wales guidance shared

1431	Consultant Job Planning	2024	Medium	Objective 1: There is relevant and up to date procedures in place that are available to staff and align to the All-Wales guidance.	<p>2.1 Medical Resourcing</p> <p>Through discussion with all clinical directorates/divisions, each advised on the limited support available to them in relation to Medical and Dental Contract matters, following the removal of a dedicated medical staffing resource. We have confirmed this was absorbed in 2019.</p> <p>The Office of the Medical Director is responsible for some people related functions, with limited contingency arrangements in the event of annual leave/prolonged absence.</p> <p>There is possibility of duplication within the Health Board through the operation of standalone people systems and development of silo expertise.</p>	2.1 Provide comprehensive training for consultants and managers on job planning processes, focusing on linking individual objectives with organisational goals.	Sreeman Andole, Interim Executive Medical Director; Jason Brannan, Deputy Director of People	30/09/2025		Roadshows on hold until All Wales guidance shared
1432	Consultant Job Planning	2024	Medium	Objective 1: There is relevant and up to date procedures in place that are available to staff and align to the All-Wales guidance.	<p>2.2 Medical Resourcing</p> <p>Through discussion with all clinical directorates/divisions, each advised on the limited support available to them in relation to Medical and Dental Contract matters, following the removal of a dedicated medical staffing resource. We have confirmed this was absorbed in 2019.</p> <p>The Office of the Medical Director is responsible for some people related functions, with limited contingency arrangements in the event of annual leave/prolonged absence.</p> <p>There is possibility of duplication within the Health Board through the operation of standalone people systems and development of silo expertise.</p>	2.2 Establish clear communication channels for escalating job planning concerns or discrepancies.	Sreeman Andole, Interim Executive Medical Director; Jason Brannan, Deputy Director of People	30/09/2025		IHC meetings identifying discrepancy but without All Wales guidance individual decisions only rather than pan HB guidance
1433	Consultant Job Planning	2024	High	Objective 1: There is relevant and up to date procedures in place that are available to staff and align to the All-Wales guidance.	<p>3.1 EJob Plan First and second sign-off</p> <p>Through a review of first and second sign off details in the Ejob plan system, and verification with the seven clinical directorates / divisions, there were several issues noted with the accuracy of the information on the system . This includes gaps in second approvers, officers no longer in post, and inconsistency with operational management included as either first or second sign off. There was also test data included in the live system.</p>	3.1 Develop a standardised and systematic approach to monitor job plan completion rates, reporting results to the appropriate forums.	Sreeman Andole, Interim Executive Medical Director; 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	High	Objective 1: There is relevant and up to date procedures in place that are available to staff and align to the All-Wales guidance.	<p>3.2 EJob Plan First and second sign-off</p> <p>Through a review of first and second sign off details in the Ejob plan system, and verification with the seven clinical directorates / divisions, there were several issues noted with the accuracy of the information on the system . This includes gaps in second approvers, officers no longer in post, and inconsistency with operational management included as either first or second sign off. There was also test data included in the live system.</p>	3.2 Create escalation protocols for addressing non-compliance promptly and on regular basis and appropriate form.	Sreeman Andole, Interim Executive Medical Director; 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	Medium	Objective 1: There is relevant and up to date procedures in place that are available to staff and align to the All-Wales guidance.	<p>4.1 Business Continuity</p> <p>The EJob Plan system is a hosted platform on the cloud and is wholly reliant on an internet connection. We have not reviewed the contractual arrangement regarding disaster recovery arrangements with the supplier.</p> <p>We have confirmed there is no documented business continuity plan in place centrally but are unsighted whether there are arrangements in place locally.</p>	4.1 The system is web based so accessible anywhere and backup by Allocate.	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	Medium	Objective 1: There is relevant and up to date procedures in place that are available to staff and align to the All-Wales guidance.	<p>4.2 Business Continuity</p> <p>The EJob Plan system is a hosted platform on the cloud and is wholly reliant on an internet connection. We have not reviewed the contractual arrangement regarding disaster recovery arrangements with the supplier.</p> <p>We have confirmed there is no documented business continuity plan in place centrally but are unsighted whether there are arrangements in place locally.</p>	4.2 Testing and approval of Medical Dental and Elements report from ESR (sessional payments) which will all periodically audits to verify that job plans reconcile with system records and ensure session payments are accurate.	Sreeman Andole, Interim Executive Medical Director; Jason Brannan, Deputy Director of People	30/09/2024		Access to the dashboard and communications on monthly budget template process to be issued to all CFO's. Delays with meeting with services to sign off the report, agreed to reschedule with colleagues in Surgical West for final sign off of proof of concept before 21 August 2025. Meeting to review and sign off with view to gain approval to move forward to implement across the Health Board organised for 21 August 2025.

1437	Consultant Job Planning	2024	Medium	Objective 1: There is relevant and up to date procedures in place that are available to staff and align to the All-Wales guidance.	<p>4.3 Business Continuity</p> <p>The EJob Plan system is a hosted platform on the cloud and is wholly reliant on an internet connection. We have not reviewed the contractual arrangement regarding disaster recovery arrangements with the supplier.</p> <p>We have confirmed there is no documented business continuity plan in place centrally but are unsighted whether there are arrangements in place locally.</p>	4.3 Automate data entry processes wherever possible to reduce human error in transferring information to ESR.	Sreeman Andole, Interim Executive Medical Director; Jason Brannan, Deputy Director of People	30/09/2024		Delays with meeting with services to sign off the report, agreed to reschedule with colleagues in Surgical West for final sign off of proof of concept before 21 August 2025. Work is ongoing to ensure the business continuity elements are covered and workforce teams support where possible, a manual feed is taken for e-job plan and shared with workforce intelligence team on a weekly basis
1446	Consultant Job Planning	2024	High	Objective 5: The completion rates of job plans are monitored and reported to an appropriate forum, with further escalation if there is low compliance	<p>10. Medical and Dental Job Plan reporting</p> <p>There is inadequate reporting of medical and dental job plan performance, across the Health Board from operational management to the Executive and associated scrutiny meetings up to Committee for assurance.</p>	10. Compliance report sent out each week to IHCs/Division which breaks down job plan compliance and can be filtered to obtain more detail as required.	Sreeman Andole, Interim Executive Medical Director; Jason Brannan, Deputy Director of People	30/04/2025		Meeting to review and sign off with view to gain approval to move forward to implement across the Health Board organised for 21 August 2025.
1447	Consultant Job Planning	2024	High	Objective 5: The completion rates of job plans are monitored and reported to an appropriate forum, with further escalation if there is low compliance	<p>11.1 Medical Workforce Group & People & Culture Executive Delivery Group (EDG)</p> <p>The Medical Workforce Group (MWG) has responsibility in its Terms of Reference that it "...will receive regular reports (on job plans) as per its Cycle of Business" but we have been unable to verify they have actually received any reports for assurance recently.</p> <p>Of the ten MWG meetings scheduled to take place this calendar year, only three have taken place (April, June and September 2024).</p> <p>The MWG provides assurance to the People & Culture EDG although we have been advised this meeting has similarly not been taking place, exposing an operational gap in control and assurance across the Health Board.</p>	11.1 To establish the People and Culture EDG which the Medical Workforce Group will report into. The TORs for Medical Workforce are to be reviewed.	Sreeman Andole, Interim Executive Medical Director; Jason Brannan, Deputy Director of People	30/04/2025		MWG is now meeting on a regular basis where job planning is open the agenda. The P&C EDG has not yet recommenced but Job Planning is regularly reported to PCC and plans are in place to include in People Operations Report going forward.
1448	Consultant Job Planning	2024	High	Objective 5: The completion rates of job plans are monitored and reported to an appropriate forum, with further escalation if there is low compliance	<p>11.2 Medical Workforce Group & People & Culture Executive Delivery Group (EDG)</p> <p>The Medical Workforce Group (MWG) has responsibility in its Terms of Reference that it "...will receive regular reports (on job plans) as per its Cycle of Business" but we have been unable to verify they have actually received any reports for assurance recently.</p> <p>Of the ten MWG meetings scheduled to take place this calendar year, only three have taken place (April, June and September 2024).</p> <p>The MWG provides assurance to the People & Culture EDG although we have been advised this meeting has similarly not been taking place, exposing an operational gap in control and assurance across the Health Board.</p>	11.2 Dashboards will be provided to Medical Workforce Group	Sreeman Andole, Interim Executive Medical Director; Jason Brannan, Deputy Director of People	30/04/2025		Compliance is now reported at MWG and update going to PCC in absence of reestablishment of P&C EDG
1551	Waiting List Initiative payments – IHC Centre	2025	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.	<p>1. Health Board Procedure</p> <p>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).</p>	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.	Tehmeena Ajmal, Chief Operating Officer	31/07/2025		The WLI procedure is currently in development. However, the procedure needs to follow the Health Board approval / governance process – this involves completing and obtaining an approved Impact Assessment Screening Tool (IAST) / Equality Impact Assessment (EqIA) before drafting a procedure. Once the above IAST and EqIA and the procedure have been approved through the various committees, the document will then need to go through a consultation period. Therefore, the timeline (Target date) previously noted of the 31 July 2025, needs to be reviewed and extended
1570	Effective Governance - Cancer Services	2025	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.	<p>3. Clinical Audit</p> <p>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.</p>	3. 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. Cancer SLT have also fed back that the Health Board needs to invest in a Chief Clinical Information Officer. Oncology is currently reliant on locum and agency medics who have no SPAs in their job plans only DCCs resulting in limited capacity. 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.	Tehmeena Ajmal, Chief Operating Officer	31/03/2026		New Clinical Strategy being developed with Clinical audit a key element. Away day arranged for September with Consultant Oncologists. On target for implementation date

1613	Effective Governance – Integrated Health Community - East	2025	High	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.	<p>4. Clinical Audit</p> <p>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.</p>	4. Develop implementation plan with owners for monitoring and review.	Tehmeena Ajmal, Chief Operating Officer	30/09/2025			No update received
1643	Orthopaedic Surgical Hub Llandudno Hospital - 2025	2025	High	Objective 2: Project Performance	<p>1. Procurement/Contract Strategy</p> <p>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. 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. 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. The findings of this (and a wider evaluation of the project delivery would help mitigate these issues on future projects.</p>	<p>1. 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.</p> <p>The approach undertaken with regards to Llandudno will not be progressed for future developments, with contracts awarded based on financial ceilings.</p> <p><i>LOH: Contract executed so limited opportunity to change other than specific terms and such is unlikely to be accepted by the contractor.</i></p>	Russell Caldicott, Executive Director of Finance	31/10/2025			All direct awards are being reviewed by the Director of Corporate Governance and Executive Director of finance. Working closely with NWSSP colleagues to ensure processes are completed within Governance guidelines.
1644	Orthopaedic Surgical Hub Llandudno Hospital - 2025	2025	High	Objective 2: Project Performance	<p>2. Design delays</p> <p>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.</p> <p>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.</p> <p>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</p>	<p>2. The design strategy included in Action 1 above will be used to assess the core packages to be employer or contractor designed and include:</p> <ol style="list-style-type: none"> 1. Who undertake what design packages. 2. The design stages. 3. Design transfer/novation arrangements. 4. Design warranty or professional indemnity arrangements. 5. Roles and responsibilities under the contract and for the retained team. 6. Coordination and technical submission arrangements and design variance obligations/restrictions. <p>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.</p> <p>The design development, programme and risks shall be reviewed monthly and reported with escalation and mitigation.</p> <p><i>LOH: Continue to report and review monthly with escalations and</i></p>	Russell Caldicott, Executive Director of Finance	31/08/2025			No update received
1649	Orthopaedic Surgical Hub Llandudno Hospital - 2025	2025	Medium	Objective 4: Financial Management	<p>7. Capital Projects Manual</p> <p>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.</p>	7. The current Capital Projects Manual shall be reviewed by the Director of Environment and Estates in conjunction with the Health Boards Capital Accountant	Russell Caldicott, Executive Director of Finance	31/03/2026			Director of Estates and environment will be undertaking this work in Q3
1650	Orthopaedic Surgical Hub Llandudno Hospital - 2025	2025	High	Objective 4: Financial Management	<p>8. Changes approvals</p> <p>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.</p> <p>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.</p> <p>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.</p>	8. 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.	Russell Caldicott, Executive Director of Finance	31/10/2025			Paper to update on project being supplied to private PFIG meeting in August.

1652	Orthopaedic Surgical Hub Llandudno Hospital - 2025	2025	High	Objective 6: Site Progress	<p>10. Inspecting Regime RIBA Stage 5</p> <p>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”.</p> <p>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.</p> <p>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 <i>inspections should be carried out by individuals with experience in similar construction technologies</i>. The absence of dedicated oversight in this area raises concerns regarding the adequacy of assurance over the broader construction works.</p>	<p>10. 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.</p> <p><i>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.</i></p>	Russell Caldicott, Executive Director of Finance	30/09/2025			No update received
1653	Orthopaedic Surgical Hub Llandudno Hospital - 2025	2025	Medium	Objective 6: Site Progress	<p>11. Inspection restrictions</p> <p>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.</p>	<p>11. 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.</p> <p><i>LOH: Staff to be requested to obtain CSCS accreditation if their role requires it.</i></p>	Russell Caldicott, Executive Director of Finance	31/12/2025			No update received
1654	Orthopaedic Surgical Hub Llandudno Hospital - 2025	2025	High	Objective 6: Site Progress	<p>12. Commissioning Programme</p> <p>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 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 <i>Main and Enabling Works programmes</i>. The report provides further background as to the issues and engagement to date.</p> <p>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.</p> <p>Whilst noting the above concerns as raised about commissioning it is</p>	<p>12. At the outset of the project adequate time shall be allowed for commissioning, witnessing and validation according to the specific requirements of the project including the appointment of a Commissioning Manager.</p> <p><i>LOH: A commissioning manager has been appointed and integrated programme for agreement and adoption by stakeholders is being developed.</i></p>	Russell Caldicott, Executive Director of Finance	31/10/2025			No update received

OPEN 'LIMITED' RECOMMENDATIONS

ID	Report Title	Year	Priority	Recommendation Title	Recommendation	Management Response	Final Approver	Original implementation date	Revised implementation date	Number of Revisions	Latest update
0298	Falls Management	2023	High	Matter Arising 3: Training (Operation and Design)	3.1a: To review training compliance for all areas relating to Patient Handling training and ensure staff who require training undertake this as soon as possible.	3.1a: Manual Handling (MH) is a Tier One risk on the BCUHB risk register scoring 16 requiring regular review of actions being completed. MH training compliance data cascaded monthly to respective IHC's/Division Director of Operations to include compliance, did not attend rates and available capacity for upcoming 2 months. Capacity within the MH training team to be optimised with focused recruitment drive for Band 6 posts (x3) supported by workforce.	Angela Wood, Executive Director of Nursing and Midwifery	01/01/2024	31/07/2025	6	The recent focus has been on the Universities Tender for the MH training provision of its students. BCUHB have applied for this contract to enable continuity of training and assurance that students are trained to the right level prior to commencing their placements with BCUHB. Outcome awaited. A report has been submitted to Central HMT for their consideration of the Health, Safety and Security Service using the Disability Resource Centre at YGC for the service and as a training venue. Investment would be required. Manual Handling Manager is continuing to meet with Service Leads to determine the level of Level 2 training needed. Once complete, ESR will be updated to endeavour to target the right employees for the right course
0491	Health and Safety - 2024	2024	Medium pre 01/10/2024	Matter Arising 3: Health & Safety Training (Operation)	3.1a : The Health Board Executive Lead for Health and Safety ensures Policy reference 5.1.3 Training for Health Board Executive Directors and Independent Members is adhered to: "the Health Board will provide suitable and sufficient training and instruction to Members of the Board in respect of H&S Management. This will also include responsibilities under section 37 of the Health and Safety at Work etc. Act 1974 and the Corporate Manslaughter and Corporate Homicide Act 2007".	3.1a: Further training for Executive Team to be arranged, Executive responsibility to ensure attendance	Stuart Keen, Director of Environment and Estates	01/09/2024			It is proposed that the HSE are engaged to deliver to the Executive Team the NEBOSH HSE Certificate in Health and Safety Leadership Excellence. This work will be captured as part of the H&S Training Needs Analysis scheduled for FY 2025-26.
0493	Health and Safety - 2024	2024	High	Matter Arising 5: Gap analysis (Operation)	5.1: The gap analysis is reviewed and management identify what further work needs undertaking to ensure areas of risk / focus remain relevant. This should be considered alongside the strategy to inform Health and Safety activity across the Health Board	5.1: The Review of the Gap Analysis has commenced, completion is due in April 2024	Stuart Keen, Director of Environment and Estates	30/04/2024			15/08/2025: A full review of the Health and Safety Review process was undertaken early in 2025. The decision to transition from the 'old' process to the NHS Employers Health and Safety Standards was made to provide the organisation and its services/team a more robust framework. The transition began in
1340	Corporate Legislative Compliance - Fire Safety	2024	High	Matter Arising 1: Governance (Design)	1.1b Fire safety reporting groups and committees should meet at regular intervals as per their agreed terms of reference. 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	29/10/2024	10/04/2025	1	No update provided
1341	Corporate Legislative Compliance - Fire Safety	2024	Medium	Matter Arising 2: Policy for the Management of Fire Safety (Design)	2.1a The Health Board review and update its policy for the Management of Fire Safety to ensure compliance with the Welsh Health Technical Memorandum (WHTM) 05-01 'Firecode – Managing healthcare fire safety', and Welsh Assembly Government NHS Wales Fire Safety Policy.	2.1a Fire Safety Policy to be reviewed and updated to reflect the current management structure and contents in accordance with current legislation and WHTM 05-01 Firecode - Managing healthcare fire safety.	Stuart Keen, Director of Environment and Estates	20/03/2025			Fire Safety Policy currently going through the BCUHB approval process
1342	Corporate Legislative Compliance - Fire Safety	2024	Medium	Matter Arising 3: Fire Risk Assessments (Operation)	3.1a All officers accountable for Fire Risk Assessments ensure documents are reviewed and updated at regular intervals to ensure potential and new risks have been identified and evaluated. This should be monitored and escalated via the Fire Safety Management Group.	3.1a Fire Safety Advisors to ensure Fire Risk Assessments are undertaken within the recognised timeframes contained within HTM05-03: Operational provisions Part K - Guidance on fire risk assessments in complex healthcare premises. Reports will be generated and presented to the Fire Safety Management Group. Results will be escalated as appropriate.	Stuart Keen, Director of Environment and Estates	26/03/2025			At the most recent Fire Safety Management Meeting held on 19th June 2025 it was reported that compliance was at 92%.
1343	Corporate Legislative Compliance - Fire Safety	2024	High	Matter Arising 4: Fire Training (Operation)	4.1a The Health Board ensure compliance with its Fire Safety Policy and ensure full participation of its employees through a tailored training programme applicable to their individual needs. This should be constantly monitored through the Fire Safety Management Group to ensure staff compliance.	4.1a Fire Safety training to be carried out in accordance with the Fire Safety Training Delivery Plan contained within Fire Safety Policy ES04. Staff compliance levels will be reported through the Fire Safety Management Group. Data will be collected from ESR and reported accordingly. Training needs analysis will be reviewed against the new HTM 05-03 Part A.	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	High	Matter Arising 6: Site Specific Issues / Documentation (Operation)	6.1a (i) Management ensure issues identified in Appendix C of this report should be progressed through local arrangements and assurance provided to the Fire Safety Management Group on progress / completion.	6.1a (i) Action plan has been generated to address the issues raised in Appendix C of this report and progress on resolving the findings will be reported to the Fire Safety Management Group.	Stuart Keen, Director of Environment and Estates	20/03/2025			Action Plan is presented at the Fire Safety Management Group. A review of actions will be presented at the meeting on 21st August 2025 and agreement to close this action
1346	Corporate Legislative Compliance - Fire Safety	2024	High	Matter Arising 6: Site Specific Issues / Documentation (Operation)	6.1a (ii) Management ensure issues identified in Appendix C of this report should be progressed through local arrangements and assurance provided to the Fire Safety Management Group on progress / completion.	6.1a (ii) Review the current arrangements for the undertaking of pre-planned maintenance and present the findings and recommendations to the Fire Safety Management Group.	Stuart Keen, Director of Environment and Estates	20/03/2025			Maintenance contracts to be reviewed at the Fire Safety Management Group meeting on 21st August 2025 and agreement to close this action.
1347	Corporate Legislative Compliance - Fire Safety	2024	High	Matter Arising 6: Site Specific Issues / Documentation (Operation)	6.1a (iii) Management ensure issues identified in Appendix C of this report should be progressed through local arrangements and assurance provided to the Fire Safety Management Group on progress / completion.	6.1a (iii) Report the number and results of Fire Drills to the Fire Safety Management Group.	Stuart Keen, Director of Environment and Estates	27/11/2024			Fire Drill audit review programme to be updated by each Fire Safety Advisor and presented at the Fire Safety Management Group meeting on 21st August 2025
1348	Corporate Legislative Compliance - Fire Safety	2024	High	Matter Arising 6: Site Specific Issues / Documentation (Operation)	6.1a (iv) Management ensure issues identified in Appendix C of this report should be progressed through local arrangements and assurance provided to the Fire Safety Management Group on progress / completion.	6.1a (iv) Review the current arrangements for the undertaking of Fire drills across BCUHB and present the findings and recommendations to the Fire Safety Management Group.	Stuart Keen, Director of Environment and Estates	27/11/2024			Fire Drill audit review programme to be updated by each Fire Safety Advisor and presented at the Fire Safety Management Group meeting on 21st August 2025

1438	Consultant Job Planning	2024	High	Objective 2: Job plans accurately reflect both the individual and organisation activity requirements and are completed in a timely manner.	<p>5.1 Job Plan annual review</p> <p>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.</p> <p>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</p>	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	30/04/2025		Meeting to review and sign off with view to gain approval to move forward to implement across the Health Board organised for 21 August 2025. Access to the dashboard and communications on monthly budget template process to be issued to all CFO's. Delays with meeting with services to sign off the report, agreed to reschedule with colleagues in Surgical West for final sign off of proof of concept before 21 August 2025. Meeting to review and sign off with view to gain approval to move forward to implement across the Health Board organised for 21 August 2025.
1439	Consultant Job Planning	2024	High	Objective 2: Job plans accurately reflect both the individual and organisation activity requirements and are completed in a timely manner.	<p>5.2 Job Plan annual review</p> <p>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.</p> <p>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</p>	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	30/04/2025		This is monitored by MWG on a regular basis
1440	Consultant Job Planning	2024	High	Objective 2: Job plans accurately reflect both the individual and organisation activity requirements and are completed in a timely manner.	<p>5.3 Job Plan annual review</p> <p>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.</p> <p>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</p>	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	30/04/2025		No update as still waiting all Wales guide.
1441	Consultant Job Planning	2024	High	Objective 2: Job plans accurately reflect both the individual and organisation activity requirements and are completed in a timely manner.	<p>6.1 Directorate/Specialty objectives are explicit</p> <p>There is a generic statement within the Service Outcomes section of job plans "To ensure service and jobplan aligned to deliver CPG and wider BCU Strategic direction", (sic). The Service Outcomes section overall was either incomplete or noted "During job plan discussions need to review this".</p> <p>From our review, we are unclear how management are approving job plans without expected service objectives.</p> <p>We note different approaches taken in agreeing team objectives where colleagues collectively agree on the service requirements and then meet individually as part of the job plan approach to agree individual objectives. These should be SMART and recorded in the system.</p>	6.1 Establish with the team a cross-departmental assessment to address identified areas not complete, for example service outcomes not recorded.	Sreeman Andole, Interim Executive Medical Director; 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	High	Objective 2: Job plans accurately reflect both the individual and organisation activity requirements and are completed in a timely manner.	<p>6.2 Directorate/Specialty objectives are explicit</p> <p>There is a generic statement within the Service Outcomes section of job plans "To ensure service and jobplan aligned to deliver CPG and wider BCU Strategic direction", (sic). The Service Outcomes section overall was either incomplete or noted "During job plan discussions need to review this".</p> <p>From our review, we are unclear how management are approving job plans without expected service objectives.</p> <p>We note different approaches taken in agreeing team objectives where colleagues collectively agree on the service requirements and then meet individually as part of the job plan approach to agree individual objectives. These should be SMART and recorded in the system.</p>	6.2 Schedule regular reviews of job planning practices to ensure continuous improvement and compliance with audit standards.	Sreeman Andole, Interim Executive Medical Director; 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	High	Objective 4: Completed job plans reconcile to system records and session payments are correct.	<p>8. Regular review of payments to agreed job plan commitments</p> <p>We identified six (27%) of the twenty-two job plans with a variance between the sessions paid and that recorded on the job plan.</p> <p>We also found a variance in Intensity Band payments and are unclear whether these payments are subject to annual review or simply roll-over.</p> <p>The payment of only whole sessions could adversely impact the Health Board to deliver against its waiting lists as this does not always reflect the agreed job plan.</p>	8. Medical Dental and Elements report from ESR (under development) will be able to flag up issues with sessional pay, intensity bandings.	Sreeman Andole, Interim Executive Medical Director; Jason Brannan, Deputy Director of People	30/04/2025		Access to the dashboard and communications on monthly budget template process to be issued to all CFO's. Delays with meeting with services to sign off the report, agreed to reschedule with colleagues in Surgical West for final sign off of proof of concept before 21 August 2025. Meeting to review and sign off with view to gain approval to move forward to implement across the Health Board organised for 21 August 2025.

1445	Consultant Job Planning	2024	Medium	Objective 4: Completed job plans reconcile to system records and session payments are correct.	9. Additional sessions undertaken outside of the substantive post We found instances where some Consultants are undertaking additional sessional work for the Health Board, but these are not fully reflected/declared within their substantive job plan – This could lead to a Working Time Directive breach.	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; Jason Brannan, Deputy Director of People	30/09/2025				Delays with meeting with services to sign off the report, agreed to reschedule with colleagues in Surgical West for final sign off of proof of concept before 21 August 2025.
1501	Establishment Control	2025	High	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. 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 General Ledger.	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.	Russell Caldicott, Executive Director of Finance	31/03/2025	30/06/2025	1		this work continues to progress.
1524	Clinical Audit - 2025	2025	Medium	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: (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 (b) Schedule regular departmental audits of project folders to confirm that evidence is there – on quarterly basis to be captured with reports produced (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	Sreeman Andole, Interim Executive Medical Director	01/04/2025	30/06/2025	1		Evidence submitted and quarterly reports also will develop over time with more evidence to support. The Tier 2 will take time to get the information – so probably end Q2 or Q3 for some more detail of lessons learnt, and examples. Meeting taking place in September SCEG, and COB has Tier 2 on the agenda to review those approved and on plan, and any additional ones that may be requested to be added. The attached is comparable to Tier 1 procedure and is in place, but as noted will take time to capture details. For Tier 3 since we started the process in April, we have sent a total of 671 email reminders to the open & overdue projects This has helped move 23% (102/447) of the projects to completed and the overall status for 2024/25 now sits at just 22.1% (99/447) open, down from 72.9% (326/447) and only 12.1% (54/447) being overdue, down from 56.6% (253/447). Unfortunately a large number, 25% (111/447), have triggered the “Auto-Withdrawn” status due to non-response to all three of our reminder emails sent during April, May & June.
1525	Clinical Audit - 2025	2025	High	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	Sreeman Andole, Interim Executive Medical Director	01/04/2025	30/06/2025	1		Evidence submitted and quarterly reports also will develop over time with more evidence to support. The Tier 2 will take time to get the information – so probably end Q2 or Q3 for some more detail of lessons learnt, and examples. Meeting taking place in September SCEG, and COB has Tier 2 on the agenda to review those approved and on plan, and any additional ones that may be requested to be added. The attached is comparable to Tier 1 procedure and is in place, but as noted will take time to capture details. For Tier 3 since we started the process in April, we have sent a total of 671 email reminders to the open & overdue projects This has helped move 23% (102/447) of the projects to completed and the overall status for 2024/25 now sits at just 22.1% (99/447) open, down from 72.9% (326/447) and only 12.1% (54/447) being overdue, down from 56.6% (253/447). Unfortunately a large number, 25% (111/447), have triggered the “Auto-Withdrawn” status due to non-response to all three of our reminder emails sent during April, May & June.
1526	Clinical Audit - 2025	2025	High	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.	Sreeman Andole, Interim Executive Medical Director	01/04/2025	30/06/2025	1		Evidence submitted and quarterly reports also will develop over time with more evidence to support. The Tier 2 will take time to get the information – so probably end Q2 or Q3 for some more detail of lessons learnt, and examples. Meeting taking place in September SCEG, and COB has Tier 2 on the agenda to review those approved and on plan, and any additional ones that may be requested to be added. The attached is comparable to Tier 1 procedure and is in place, but as noted will take time to capture details. For Tier 3 since we started the process in April, we have sent a total of 671 email reminders to the open & overdue projects This has helped move 23% (102/447) of the projects to completed and the overall status for 2024/25 now sits at just 22.1% (99/447) open, down from 72.9% (326/447) and only 12.1% (54/447) being overdue, down from 56.6% (253/447). Unfortunately a large number, 25% (111/447), have triggered the “Auto-Withdrawn” status due to non-response to all three of our reminder emails sent during April, May & June.

1527	Clinical Audit - 2025	2025	High	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 A large number of Tier 3 audits (183) are overdue with no revised dates of completion. 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: 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). 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	Sreeman Andole, Interim Executive Medical Director	01/04/2025	30/06/2025	1	Evidence submitted and quarterly reports also will develop over time with more evidence to support. The Tier 2 will take time to get the information – so probably end Q2 or Q3 for some more detail of lessons learnt, and examples. Meeting taking place in September SCEG, and COB has Tier 2 on the agenda to review those approved and on plan, and any additional ones that may be requested to be added. The attached is comparable to Tier 1 procedure and is in place, but as noted will take time to capture details. For Tier 3 since we started the process in April, we have sent a total of 671 email reminders to the open & overdue projects This has helped move 23% (102/447) of the projects to completed and the overall status for 2024/25 now sits at just 22.1% (99/447) open, down from 72.9% (326/447) and only 12.1% (54/447) being overdue, down from 56.6% (253/447). Unfortunately a large number, 25% (111/447), have triggered the “Auto-Withdrawn” status due to non-response to all three of our reminder emails sent during April, May & June.
1532	Board Assurance Framework and Risk Management	2025	High	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. 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. 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	01/03/2026			<i>No update provided</i>
1534	Contracted Patient Services: Quality and Safety Arrangements - Follow-up	2025	High	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	30/06/2025			<i>No update provided</i>
1535	Contracted Patient Services: Quality and Safety Arrangements - Follow-up	2025	High	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	30/06/2025			<i>No update provided</i>
1536	Contracted Patient Services: Quality and Safety Arrangements - Follow-up	2025	High	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	30/06/2025			<i>No update provided</i>
1537	Contracted Patient Services: Quality and Safety Arrangements - Follow-up	2025	High	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	Stephen Powell, Director of Performance and Commissioning	30/06/2025			<i>No update provided</i>
1538	Contracted Patient Services: Quality and Safety Arrangements - Follow-up	2025	High	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	30/06/2025			<i>No update provided</i>
1552	Waiting List Initiative payments – IHC Centre	2025	High	Objective 2: WLI activity is only commissioned and agreed to be undertaken in uncontracted time.	2.1 WLI Payments 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.	Tehmeena Ajmal, Chief Operating Officer	31/05/2025	30/09/2025	1	Additional mandatory questions have been added to the “Test” version of the electronic form for which associated data workflows are being tested. Solution upgrade release to be deployed by 31st August 2025 after testing period. Evidence is provided via a screenshot of the additional fields added for the relevant questions that have been included to address this recommendation.
1553	Waiting List Initiative payments – IHC Centre	2025	High	Objective 2: WLI activity is only commissioned and agreed to be undertaken in uncontracted time.	2.2 WLI Payments 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.	Tehmeena Ajmal, Chief Operating Officer	31/03/2026	30/09/2025	1	Additional mandatory questions have been added to the “Test” version of the electronic form for which associated data workflows are being tested. Solution upgrade release to be deployed by 31st August 2025 after testing period. Evidence for ref 1552 and 1555 is provided via a screenshot of the additional fields added for the relevant questions that have been included to address this recommendation. This is an ongoing longer term programme of work

1554	Waiting List Initiative payments – IHC Centre	2025	High	Objective 2: WLI activity is only commissioned and agreed to be undertaken in uncontracted time.	2.3 WLI Payments 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 specialties / IHC interpret uncontracted sessions to include SPA while others do not, as revealed in this audit.	Tehmeena Ajmal, Chief Operating Officer	31/06/2025		This is an ongoing longer term programme of work
1555	Waiting List Initiative payments – IHC Centre	2025	High	Objective 2: WLI activity is only commissioned and agreed to be undertaken in uncontracted time.	2.4 WLI Payments 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.	Tehmeena Ajmal, Chief Operating Officer	31/05/2025		Additional mandatory questions have been added to the “Test” version of the electronic form for which associated data workflows are being tested. Solution upgrade release to be deployed by 31st August 2025 after testing period. Evidence for ref 1552 and 1555 is provided via a screenshot of the additional fields added for the relevant questions that have been included to address this recommendation.
1557	Partnerships, Engagement and Communication	2025	Medium	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 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 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. This will include: • Introduction of two new columns to the PEC Delivery Plan: o Benefits/Improvements – outlining the intended or actual change resulting from the action. o Evidence – detailing the supporting documentation or data required to verify delivery and impact. • Named leads for each action in the Delivery Plan will be responsible for collating appropriate evidence and submitting updates against this framework. • Quarterly internal assurance checks will be introduced to assess the quality and completeness of submitted evidence and to support ongoing audit readiness. Target Implementation Date: The revised approach will be implemented in Q1 2025–26 (by end June 2025) and	Helen Stevens-Jones, Director of Partnerships, Engagement and Communications	30/06/2025		Complete - see consolidated plan Q1 delivery evidence attached in folder PECQ1
1558	Partnerships, Engagement and Communication	2025	High	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 We reviewed the evidence provided and found the following issues and limitations: • There is no SOP/policy in place outlining the engagement process and requirements. • Engagement toolkits – 2/7 published toolkits require staff to use their personal email addresses/contact details to access and use the resources. • 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. • 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. Key Deliverables: 1. Develop and implement a standard operating procedure (SOP) that outlines: • The Health Board’s expectations for engagement. • Required steps and responsibilities at each stage of the process. • Links to national guidance (e.g. WG guidance on service change). • Monitoring, assurance, and reporting requirements.	Helen Stevens-Jones, Director of Partnerships, Engagement and Communications	30/09/2025		A Co-Production, Consultation and Engagement Toolkit has been developed and will be presented and discussed at the Strategic Planning and Service Change meeting in September 2025. (Draft is attached as evidence)
1559	Partnerships, Engagement and Communication	2025	High	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 We reviewed the evidence provided and found the following issues and limitations: • There is no SOP/policy in place outlining the engagement process and requirements. • Engagement toolkits – 2/7 published toolkits require staff to use their personal email addresses/contact details to access and use the resources. • 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. • 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. Key Deliverables: 2. Review and update all published toolkits and guides on the Public Engagement Guides and Resources BetsiNet page: • Update all materials dated 2021/2022 by July 2025. • Ensure all resources reflect current policy, best practice, and staff feedback. • Include version control, update dates, and named contact for each document.	Helen Stevens-Jones, Director of Partnerships, Engagement and Communications	30/09/2025		Two staff engagement workshops have taken place. These have supported the co-design the draft engagement framework and principles and staff shared their ideas on toolkits and training. The engagement intranet section has since been updated to reflect the discussions and work is now underway to develop a Teams channel to support the Staff Engagement Community of Practice.

1560	Partnerships, Engagement and Communication	2025	High	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.	<p>3.3 Staff resources</p> <p>We reviewed the evidence provided and found the following issues and limitations:</p> <ul style="list-style-type: none"> • There is no SOP/policy in place outlining the engagement process and requirements. • Engagement toolkits – 2/7 published toolkits require staff to use their personal email addresses/contact details to access and use the resources. • 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. • The Welsh Government Guidance on Service Change and Key Lines of Enquiry Framework document referred to is not accessible via BetsiNet. 	<p>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.</p> <p>Key Deliverables:</p> <p>3. Ensure all toolkits and resources do not advise the use of personal emails</p>	Helen Stevens-Jones, Director of Partnerships, Engagement and Communications	30/09/2025		A reminder to staff regarding the use of personal email details has been added to the engagement intranet section and details of who to contact regarding the resources has been added
1561	Partnerships, Engagement and Communication	2025	High	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.	<p>3.4 Staff resources</p> <p>We reviewed the evidence provided and found the following issues and limitations:</p> <ul style="list-style-type: none"> • There is no SOP/policy in place outlining the engagement process and requirements. • Engagement toolkits – 2/7 published toolkits require staff to use their personal email addresses/contact details to access and use the resources. • 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. • The Welsh Government Guidance on Service Change and Key Lines of Enquiry Framework document referred to is not accessible via BetsiNet. 	<p>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.</p> <p>Key Deliverables:</p> <p>4. Restore access to all key documents referenced:</p> <ul style="list-style-type: none"> • Upload the Welsh Government Guidance on Service Change and the Key Lines of Enquiry Framework to BetsiNet. • Ensure all links are checked quarterly for functionality. 	Helen Stevens-Jones, Director of Partnerships, Engagement and Communications	30/09/2025	All resources checked and updated. The Key Lines of Enquiry framework is superceded by the Co-Production, Consultation and Engagement toolkit.	
1562	Partnerships, Engagement and Communication	2025	High	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.	<p>3.5 Staff resources</p> <p>We reviewed the evidence provided and found the following issues and limitations:</p> <ul style="list-style-type: none"> • There is no SOP/policy in place outlining the engagement process and requirements. • Engagement toolkits – 2/7 published toolkits require staff to use their personal email addresses/contact details to access and use the resources. • 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. • The Welsh Government Guidance on Service Change and Key Lines of Enquiry Framework document referred to is not accessible via BetsiNet. 	<p>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.</p> <p>Key Deliverables:</p> <p>5. Introduce a maintenance and review schedule:</p> <ul style="list-style-type: none"> • Annual check and update of all engagement resources, with oversight by the Public Engagement and Communications Team. • Assign responsible owner(s) for each section or toolkit 	Helen Stevens-Jones, Director of Partnerships, Engagement and Communications	30/09/2025	Annual check took place in May 2025 and is scheduled for further annual review on May 2026. Named Engagement Officer has been assigned to the review.	
1563	Partnerships, Engagement and Communication	2025	High	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.	<p>4. Operational oversight</p> <p>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.</p>	<p>4. Enhancing the Recording and Escalation of Progress and Issues</p> <p>Introduce a standardised and reliable approach to documenting progress updates and escalation of key issues across all relevant internal meeting types.</p> <p>This will include:</p> <ol style="list-style-type: none"> 1. Ensure log of progress and escalation is used during: <ul style="list-style-type: none"> 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: <ul style="list-style-type: none"> 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	30/09/2025	<i>No update provided</i>	
1564	Partnerships, Engagement and Communication	2025	High	Objective 3: The effectiveness of actions taken above have/are being measured to demonstrate whether anticipated benefits are being achieved.	<p>5.1 Benefits Realisation</p> <p>There is no consistent formal benefits realisation process in place to manage and monitor benefits / improvements post implementation. We noted the following limitations:</p> <ul style="list-style-type: none"> • Benefits / improvements were not clearly defined at the outset. • Benefits / improvements are not consistently reviewed, measured or reported for all implemented actions. • Difficult to reconcile reported benefits / impact to specific implemented improvement actions. • Limited evidence of benefits provided for review. 	<p>5.1 Integrate expected benefits and evidence of impact into routine delivery and monitoring.</p> <p>Key Deliverables:</p> <ol style="list-style-type: none"> Integrate benefits tracking into the PEC Delivery Plan, including: <ul style="list-style-type: none"> o Two new columns: "Expected Benefit/Improvement" and "Evidence of Impact" o Routine completion and updates by action owners as part of monitoring cycles <p>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)</p>	Helen Stevens-Jones, Director of Partnerships, Engagement and Communications	30/06/2025	<i>No update provided</i>	

1565	Partnerships, Engagement and Communication	2025	High	Objective 3: The effectiveness of actions taken above have/are being measured to demonstrate whether anticipated benefits are being achieved.	5.2 Benefits Realisation There is no consistent formal benefits realisation process in place to manage and monitor benefits / improvements post implementation. We noted the following limitations: • Benefits / improvements were not clearly defined at the outset. • Benefits / improvements are not consistently reviewed, measured or reported for all implemented actions. • Difficult to reconcile reported benefits / impact to specific implemented improvement actions. • Limited evidence of benefits provided for review.	5.2 Integrate expected benefits and evidence of impact into routine delivery and monitoring. Key Deliverables: 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. 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	31/07/2025			No update provided
1566	Partnerships, Engagement and Communication	2025	High	Objective 3: The effectiveness of actions taken above have/are being measured to demonstrate whether anticipated benefits are being achieved.	5.3 Benefits Realisation There is no consistent formal benefits realisation process in place to manage and monitor benefits / improvements post implementation. We noted the following limitations: • Benefits / improvements were not clearly defined at the outset. • Benefits / improvements are not consistently reviewed, measured or reported for all implemented actions. • Difficult to reconcile reported benefits / impact to specific implemented improvement actions. • Limited evidence of benefits provided for review.	5.3 Integrate expected benefits and evidence of impact into routine delivery and monitoring. Key Deliverables: 3. Report benefits realisation status bi-annually to the PPHP Committee 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	30/09/2025			On track for PPHP Committee October 2025.
1567	Partnerships, Engagement and Communication	2025	High	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 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. Key Steps: 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 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. 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	30/11/2025			Bi-annual update on track for PPHP Committee October 2025. Further updates for 2025/26 scheduled with Board Secretariat. PEC SLT review delivery and assurance quarterly.
1569	Effective Governance - Cancer Services	2025	High	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 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 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. Actions • 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. • Ensure working focus groups such as SACT improvement etc are documented	Tehmeena Ajmal, Chief Operating Officer	31/03/2026			Business case approved for £7.3m recurrent funding in May 2025 updates from working groups to be given at SLT and PFIG On scheduled for target date of 31/3/2026
1571	Effective Governance - Cancer Services	2025	High	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 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.	Tehmeena Ajmal, Chief Operating Officer	31/10/2026			Incidents continue to decrease and is on target
1573	Standards of Business Conduct – Declarations of Interest, Gifts and Hospitality - follow-up	2025	Medium	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: • 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	Pam Wenger, Director of Corporate Governance	30/09/2025			The Corporate Governance Hub is in the process of being created. This will be held on the Corporate Governance Sharepoint Site. On track for 30/09/2025

1574	Standards of Business Conduct – Declarations of Interest, Gifts and Hospitality - follow-up	2025	High	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: • Ensure all scheduled notifications are functioning as intended. • Ensure published data is accurate and can be reconciled to source data. • Ensure published guidance documentation is consistent with NHS Wales requirements and relevant to Health Board staff.	Pam Wenger, Director of Corporate Governance	30/09/2025			These are live and on the website
1575	Standards of Business Conduct – Declarations of Interest, Gifts and Hospitality - follow-up	2025	High	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: • Ensure all scheduled notifications are functioning as intended. • Ensure published data is accurate and can be reconciled to source data. • Ensure published guidance documentation is consistent with NHS Wales requirements and relevant to Health Board staff.	Pam Wenger, Director of Corporate Governance	31/10/2025			Work is ongoing to align with the PADR process
1576	Standards of Business Conduct – Declarations of Interest, Gifts and Hospitality - follow-up	2025	High	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: • Review reporting arrangements and ensure staff declarations are subject to Audit Committee oversight and scrutiny in line with policy requirements.	Pam Wenger, Director of Corporate Governance	31/08/2025			The Audit Committee Cycle of Business has been reviewed in Draft at Committee and will be published once finalised
1577	Standards of Business Conduct – Declarations of Interest, Gifts and Hospitality - follow-up	2025	High	Matter Arising 4: Board Members declarations of interest (Operation)	SAME AS 2.1 (a) 4.1 (a) The Director of Corporate Governance: • Ensures Board Member declarations are accurate and comprehensive throughout the year – not limit due diligence work to year end. • Reminds Board Members of the requirement to declare all outside employment as part of their mandatory annual declaration of interest, and to notify the Office of the Board Secretary (Corporate Governance Directorate April 2024 onwards) of any changes as and when they arise. • Ensures the public register of Board Member interests is maintained and kept up to date.	SAME AS 2.1 (a) 4.1 (a): Management: • Ensure all scheduled notifications are functioning as intended. • Ensure published data is accurate and can be reconciled to source data. • Ensure published guidance documentation is consistent with NHS Wales requirements and relevant to Health Board staff.	Pam Wenger, Director of Corporate Governance	30/09/2025			These are live and on the website
1578	Standards of Business Conduct – Declarations of Interest, Gifts and Hospitality - follow-up	2025	High	Matter Arising 4: Board Members declarations of interest (Operation)	SAME AS 2.1 (b) 4.1 (b) The Director of Corporate Governance: • Ensures Board Member declarations are accurate and comprehensive throughout the year – not limit due diligence work to year end. • Reminds Board Members of the requirement to declare all outside employment as part of their mandatory annual declaration of interest, and to notify the Office of the Board Secretary (Corporate Governance Directorate April 2024 onwards) of any changes as and when they arise. • Ensures the public register of Board Member interests is maintained and kept up to date.	SAME AS 2.1 (b) 4.1 (b): Management: • Ensure all scheduled notifications are functioning as intended. • Ensure published data is accurate and can be reconciled to source data. • Ensure published guidance documentation is consistent with NHS Wales requirements and relevant to Health Board staff.	Pam Wenger, Director of Corporate Governance	31/10/2025			Work is ongoing to align with the PADR process
1579	Standards of Business Conduct – Declarations of Interest, Gifts and Hospitality - follow-up	2025	High	Matter Arising 5: BCU staff declarations of interest (Operation)	SAME AS 2.1 (a) 5.1 (a) Management: • Ensure line managers are aware of their responsibilities regarding approving declarations of interest (and gifts and hospitality). • Ensure staff understand when, and how often, a declaration should be made. • Establish controls and /or oversight arrangements to manage and escalate non responses (from Decision Makers) and failure to approve (by line managers). • Ensure data extracted from Declare is reviewed and adjusted appropriately prior to reporting (e.g. to Audit	SAME AS 2.1 (a) 5.1 (a): Management: • Ensure all scheduled notifications are functioning as intended. • Ensure published data is accurate and can be reconciled to source data. • Ensure published guidance documentation is consistent with NHS Wales requirements and relevant to Health Board staff.	Pam Wenger, Director of Corporate Governance	30/09/2025			These are live and on the website
1580	Standards of Business Conduct – Declarations of Interest, Gifts and Hospitality - follow-up	2025	High	Matter Arising 5: BCU staff declarations of interest (Operation)	SAME AS 2.1 (b) 5.1 (b) Management: • Ensure line managers are aware of their responsibilities regarding approving declarations of interest (and gifts and hospitality). • Ensure staff understand when, and how often, a declaration should be made. • Establish controls and /or oversight arrangements to manage and escalate non responses (from Decision Makers) and failure to approve (by line managers). • Ensure data extracted from Declare is reviewed and adjusted appropriately prior to reporting (e.g. to Audit	SAME AS 2.1 (b) 5.1 (b): Management: • Ensure all scheduled notifications are functioning as intended. • Ensure published data is accurate and can be reconciled to source data. • Ensure published guidance documentation is consistent with NHS Wales requirements and relevant to Health Board staff.	Pam Wenger, Director of Corporate Governance	31/10/2025			Work is ongoing to align with the PADR process
1581	Standards of Business Conduct – Declarations of Interest, Gifts and Hospitality - follow-up	2025	High	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: • Ensure all offers of hospitality and sponsored events are declared, reviewed, and approved prior to attending per policy requirements. All retrospective declarations to be escalated. • All hospitality and sponsored events to be approved by a Director / Assistant Director. • Ensure all declarations pending approval are reviewed and approved / declined. • Ensure provider details are recorded to enable effective monitoring per policy requirements.	Pam Wenger, Director of Corporate Governance	31/03/2026			Not yet due - will be worked on in the next quarter

1582	Standards of Business Conduct – Declarations of Interest, Gifts and Hospitality - follow-up	2025	High	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: <ul style="list-style-type: none"> • Ensure all offers of hospitality and sponsored events are declared, reviewed, and approved prior to attending per policy requirements. All retrospective declarations to be escalated. • All hospitality and sponsored events to be approved by a Director / Assistant Director. • Ensure all declarations pending approval are reviewed and approved / declined. • Ensure provider details are recorded to enable effective monitoring per policy requirements. 	Pam Wenger, Director of Corporate Governance	31/03/2026		Not yet due - will be worked on in the next quarter
1587	Grievance Management	2025	High	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 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	31/08/2025		Task & Finish Group established to review reporting categories for cases in ESR to ensure accuracy and consistency. Discussions have taken place at Employment Team Meetings and guidance circulated to the team. A revised Exceptions Report has been developed to ensure that progress on cases is closely monitored and underlying reasons are captured so that themes and patterns can be identified.
1588	Grievance Management	2025	Medium	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 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	31/08/2025		Teams have been reminded that lessons learnt should be completed at the conclusion of each case. Lessons learnt are part of discussions at team meetings.
1611	Effective Governance – Integrated Health Community - East	2025	High	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 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.	Tehmeena Ajmal, Chief Operating Officer	31/07/2025		No update provided
1612	Effective Governance – Integrated Health Community - East	2025	High	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 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.	Tehmeena Ajmal, Chief Operating Officer	30/09/2025		No update provided
1617	Falls Management - Follow up	2025	High	Matter Arising 2: All Wales Falls and Bone Health Multifactorial Assessment (FBHMA) (Operation)	2.1(a) - Action 1 - RECOMMENDATION: Staff should be reminded, through training, of the requirement to ensure the Falls and Bone Health Multifactorial Assessment (FBHMA) and documentation pertaining to patient falls, provides sufficient information to fully understand the patients' needs and requirements to minimise the risk of a potential fall. Compliance with this should be reviewed through existing audit mechanisms. Current status - Partially implemented FINDING Training data provided by the Ward Accreditation Team shows an upward trend in falls training 1A and 1B over the past year. The Health Board's mandatory Falls Prevention E-learning module 1B, related to the FBHMA, has been updated. Additionally, a "how to" guide has been produced, featuring examples of effective risk assessments for FBHMA and patient handling forms. This guide offers extra clarity and expectations for Agency workers when operating within the Health Board.	2.1(a) - Action 1 - All Wales Falls and Bone Health Multifactorial Assessment (FBHMA) WNCR deliver monthly training to Registered Nurses and HCSW/Therapists/Specialist Teams to demonstrate how to access, use and input on WNCR – Chief Nursing Information Officer (July 2025). The East Therapy team already adhere to FBHMA assessment processes and communicate outcomes with ward staff. The Central Therapy Team has committed to the following action, with implementation complete by end Q2: Most ward managers in Glan Clwyd Hospital have read-only access to Therapy Manager and can view the therapists' documentation. We will extend access to all ward managers and/or falls champions in Glan Clwyd hospital and all community hospitals. Therapists are also present daily on the wards and attend board rounds. Pertinent information relating to mobility, transfer and function will be shared and communicated at Board Rounds to enable nursing staff to update the FBHMA assessment. We will also review staff compliance with the	Angela Wood, Executive Director of Nursing and Midwifery	30/09/2025		Therapy staff are inputting updates into the WNCR in relation to the FBHMA. We are further reviewing therapy manager access for Ward Managers and Ward Champions. The BCUHB Falls training compliance for Therapies is as follows: Part 1A = 92.3% Part 1B = 92.67%

1618	Falls Management - Follow up	2025	High	Matter Arising 2: All Wales Falls and Bone Health Multifactorial Assessment (FBHMA) (Operation)	<p>2.1(a) - Action 2 - RECOMMENDATION: Staff should be reminded, through training, of the requirement to ensure the Falls and Bone Health Multifactorial Assessment (FBHMA) and documentation pertaining to patient falls, provides sufficient information to fully understand the patients' needs and requirements to minimise the risk of a potential fall. Compliance with this should be reviewed through existing audit mechanisms.</p> <p>Current status - Partially implemented FINDING Training data provided by the Ward Accreditation Team shows an upward trend in falls training 1A and 1B over the past year. The Health Board's mandatory Falls Prevention E-learning module 1B, related to the FBHMA, has been updated. Additionally, a "how to" guide has been produced, featuring examples of effective risk assessments for FBHMA and patient handling forms. This guide offers extra clarity and expectations for Agency workers when operating within the Health Board.</p>	<p>2.1(a) - Action 2 - The West Therapy Team has committed to the following action, with implementation complete by end Q2: The detail regarding the approach to improvement is in the process of being agreed by the Therapy leads. Changes to a patients' function can be documented in the WNCR which the ward would have access to. The leads will make staff aware of the FBHMA domains on the assessment form so they ensure assessment outcomes can be correctly communicated to the ward in the WNCR and board rounds in FBHMA terms.</p>	Angela Wood, Executive Director of Nursing and Midwifery	30/09/2025		<p>Physiotherapy – this was discussed at the ops meeting with USC / planned care deputies on 29/7/2025. Action: to take to the in-patient improvement group meeting & link with in-patient team to ensure that all staff are noting changes in patients' function / mobility updates in the WNCR & at board rounds, enabling the nursing staff to be able to update the FBHMA domains on the assessment form. FBHMA to be added to the physiotherapy induction pack so staff aware of the domains.</p> <p>Occupational Therapy - discussed with acute and commity leads 7/07/25 for current process and actions arising.</p> <p>Action: Acute in-patient pathway updated identifying when to update WNCR with changes to function updates and this will be included with a copy of the FBHMA domains in departmental resources / update will follow for community. Both the pathway(s) and FBHMA will be shared with existing staff and included in inductions for new staff for in-pt areas.</p> <p>AHP Directors to look at setting up a pan BCUHB working group . To be included as an agenda item for pan BCU Therapy SLT. Also</p>
1619	Falls Management - Follow up	2025	High	Matter Arising 2: All Wales Falls and Bone Health Multifactorial Assessment (FBHMA) (Operation)	<p>2.1(b) RECOMMENDATION - To reduce the inconsistent information amongst documentation, standardising of patient fall documentation should be considered.</p> <p>FINDING FOLLOWING FOLLOW-UP REVIEW: The Welsh Nursing Care Record (WNCR) digital system does not automatically populate patient details, such as mobility status, from the admission assessment section into the FBHMA. This issue affects all of Wales and the project to address it is expected to begin in approximately 18 months. In the meantime, the Health Board is mitigating the risk through control measures outlined in section 2.1a. A review of the questions within the FBHMA and the patient handling form is needed. Some questions, like "Is the patient at risk of falls?" seem repetitive. It may be beneficial to merge the forms or reduce the repetition.</p>	<p>2.1(b) All Wales Falls and Bone Health Multifactorial Assessment (FBHMA). WNCR Team to complete deep dive / audit of 30 patients to review completion and the quality of patient fall documentation –this will be done in July 2025 by the Chief Nursing Information Officer and reported back to the Strategic Falls group in September 2025 for action. Note: There are no formal plans on an All-Wales basis to update the national WNCR system. However, BCUHB will continue to request relevant information is auto populated on a future update.</p>	Angela Wood, Executive Director of Nursing and Midwifery	30/09/2025		<p>Deep Dive / Audit has commenced and will be completed by the end of August Data will be reviewed and presented back to Strategic Falls group at the end of September</p>
1620	Falls Management - Follow up	2025	High	Matter Arising 2: All Wales Falls and Bone Health Multifactorial Assessment (FBHMA) (Operation)	<p>2.1(c) RECOMMENDATION: Reminder to staff that all FBHMAs are to be completed upon patient transfer between wards. Compliance with this should be reviewed through existing audit mechanisms.</p> <p>FINDING FOLLOWING FOLLOW-UP REVIEW: The Health Board has created a dashboard to assist the wards in enhancing their quality by tracking the completion of the FBHMA. In addition to the control measures cited with section 2.1a In our sample testing of 36 patients, eight (22%) FBMHAs were found to be outdated due to patient transfers. Reassessment is necessary if the patient's condition or environment changes, or at a minimum, weekly, as specified in section 7.1 of the Falls Policy. Discussions with Ward Managers revealed that the FBHMA currently only triggers as overdue for review after a week has passed, rather than upon patient transfer. Other systems (STREAM, WNCR and Patient Administration System PAS) all capture patient transfer, however the FBHMA</p>	<p>2.1(c) All Wales Falls and Bone Health Multifactorial Assessment (FBHMA) Chief Nursing Information Officer to chase DHCW for a date as to when the request for change to ensure alert to trigger reassessment on transfer will be implemented in WNCR, the request will be made in July 2025 and monitored through the Strategic Falls Group.</p>	Angela Wood, Executive Director of Nursing and Midwifery	30/09/2025		<p>Continued ongoing discussions with DHCW around the technical functionality for restarting the clock on alerts when the patient is transferred SHCW unable to commit to a date at this point. Chief Nursing Information Officer will continue these discussions with DHCW and escalate if not making any progress</p>

1621	Falls Management - Follow up	2025	High	Matter Arising 3: Training (Operation and Design)	<p>3.1(a) To review training compliance for all areas relating to Patient Handling training and ensure staff who require training undertake this as soon as possible.</p> <p>Current status – Partially implemented</p> <p>Both the capacity of the patient handling team and training facilities continues to be an issue with regards to staff receiving patient handling training. Finding Evidence shows an increasing trend in both Patient Handling and Falls training over the last twelve months. Manual/Patient Handling remains a tier one risk on the risk register with a score of 16 (ID3893); this risk is regularly reviewed. Additionally, there is a risk for patient falls (ID5095), which includes eight actions; five of which have been completed. One of the actions includes addressing capacity within the manual handling team (ID25560), due by 30 June 2025. The Health and Safety Department have appointed two manual handling advisors in May 2025, with a start date of 1 st July 2025. 2-year formal period of development required to facilitate full and effective</p>	<p>3.1(a) Action 1 - Training Manual Handling Mandatory Training compliance to be monitored by the Strategic Falls Group – this will be done at each meeting and any non-compliance escalated to the relevant services for action. (ongoing).</p>	Angela Wood, Executive Director of Nursing and Midwifery	Ongoing		Manual Handling Mandatory Training compliance to be monitored by the Strategic Falls Group - this action is complete. A report is produced by the Manual Handling Manager for the standing item on the agenda.
1622	Falls Management - Follow up	2025	High	Matter Arising 3: Training (Operation and Design)	<p>3.1(a) To review training compliance for all areas relating to Patient Handling training and ensure staff who require training undertake this as soon as possible.</p> <p>Current status – Partially implemented</p> <p>Both the capacity of the patient handling team and training facilities continues to be an issue with regards to staff receiving patient handling training. Finding Evidence shows an increasing trend in both Patient Handling and Falls training over the last twelve months. Manual/Patient Handling remains a tier one risk on the risk register with a score of 16 (ID3893); this risk is regularly reviewed. Additionally, there is a risk for patient falls (ID5095), which includes eight actions; five of which have been completed. One of the actions includes addressing capacity within the manual handling team (ID25560), due by 30 June 2025. The Health and Safety Department have appointed two manual handling advisors in May 2025, with a start date of 1 st July 2025. 2-year formal period of development required to facilitate full and effective</p>	<p>3.1(a) Action 2 - Training There is also a review underway by Manual Handling Manager with Service Leads to ensure those identified on ESR as requiring this training is accurate – Head of Health & Safety (29th August 2025).</p>	Angela Wood, Executive Director of Nursing and Midwifery	29/08/2025		The recent focus has been on the Universities Tender for the MH training provision of its students. BCUHB have applied for this contract to enable continuity of training and assurance that students are trained to the right level prior to commencing their placements with BCUHB. Outcome awaited. This has impacted on the Manual Handling Manager's ability to meet with Service Leads to determine the level of Level 2 training needed. Once complete, ESR will be updated to endeavour to target the right employees for the right course.
1623	Falls Management - Follow up	2025	High	Matter Arising 3: Training (Operation and Design)	<p>3.1(a) To review training compliance for all areas relating to Patient Handling training and ensure staff who require training undertake this as soon as possible.</p> <p>Current status – Partially implemented</p> <p>Both the capacity of the patient handling team and training facilities continues to be an issue with regards to staff receiving patient handling training. Finding Evidence shows an increasing trend in both Patient Handling and Falls training over the last twelve months. Manual/Patient Handling remains a tier one risk on the risk register with a score of 16 (ID3893); this risk is regularly reviewed. Additionally, there is a risk for patient falls (ID5095), which includes eight actions; five of which have been completed. One of the actions includes addressing capacity within the manual handling team (ID25560), due by 30 June 2025. The Health and Safety Department have appointed two manual handling advisors in May 2025, with a start date of 1 st July 2025. 2-year formal period of development required to facilitate full and effective</p>	<p>3.1(a) Action 3 - Training Discussions ongoing regarding the upskilling of Manual Handling Champions to support the Corporate Team with local delivery of refresher training, thereby reducing the number of colleagues attending a classroom-based refresher – Head of Health, Safety & Security -October 2025.</p>	Angela Wood, Executive Director of Nursing and Midwifery	30/10/2025		A meeting was held with Wrexham University regarding a bespoke Train the Trainer module for Manual Handling Champions. Last correspondence 30/07/2025. Response from University outstanding. Quotes have been received from a manual handling training provider to upskill Manual Handling Champions theory and practical knowledge to enable them to support the delivery of patient handling refresher training.
1625	Falls Management - Follow up	2025	High	Matter Arising 3: Training (Operation and Design)	<p>3.1(c) Consider a more formal training method for the bedside learning programme, and consider resources required to provide this to staff. Ensure records of training are kept.</p> <p>Current status – Partially implemented Finding</p> <p>Bedside learning has continued with the support of the Health Board's Health and Safety team, who review FBHMA documents on the ward. However, accurate records of the number of trained staff are still not maintained. Moving forward, the Falls Champions will take over this learning and will keep a record of the staff they train through bedside learning, as this is a core part of their role and included in their protected time of four hours.</p>	<p>3.1(c) Training Falls Champions to deliver bed side learning. Champions will record / log training. Training logs (monitored / reported via local Quality & Safety Groups and Accountability Meetings). Reported to Strategic Falls Group via IHC Divisional reporting slides – IHC Divisional Falls Leads (October 2025).</p>	Angela Wood, Executive Director of Nursing and Midwifery	30/10/2025		Falls Champions identified across inpatient areas (4 hours protected time per month); Ward Accreditation team developing the network, support framework for Falls Champions and will include 1:1 support if required in ward environment; Falls Champion network sessions planned for Sept/Oct to include training session on Beside learning; Falls Leads per IHC to update progress as standing item on HB Inpatient Falls group agenda and feedback slide.

1626	Falls Management - Follow up	2025	High	Matter Arising 3: Training (Operation and Design)	<p>3.1(d) Determine what training agency staff receive relating to patient falls and whether it is in line with training that the Health Board staff undertake and sufficient to ensure effective completion of falls documentation.</p> <p>Current status – Partially implemented Finding Agency workers are encouraged to complete the E-learning module 1A (with access via the All-Wales learning platform. This is referenced in Section 10 of the Falls Policy. The Agency Onboarding Process commenced in September 2023, with the new checklist in place from October 2023. This involves verifying whether the agency staff have completed falls training (either the Health Board's E learning module 1A training or an alternative falls training course). Although the Health Board encourages agency staff to complete the E-learning module 1A, and identifies if they have undergone alternative training, it remains challenging to ascertain whether agency staff have received training comparable to that provided to</p>	<p>3.1(d) Training Temporary Staffing Team to complete monthly quality audits on 10% of agency workforce to ensure compliance with Falls 1a & 1b – Associate Director People Services, West (starting July 2025 then ongoing). Note: As of December 2024, it is Mandatory to complete the Falls Mandatory Training prior to onboarding / working in BCUHB. Prior to onboarding and throughout working at BCUHB, we have the assurance that all are accessing the same standard of training, and each worker receives proof of compliance in the form of a certificate with validity period dates on completing both Falls modules.</p>	Angela Wood, Executive Director of Nursing and Midwifery	Ongoing		There has been a short delay in the audit starting in July 2025 due to a review of the mandatory training dashboard. Also there was a short delay in communicating the expectations for the information needed to the agency. The first audit will be completed by 31st August 2025 and results will be shared the Temporary Staffing Governance meeting and for evidence as part of the recommendations.
1627	Falls Management - Follow up	2025	High	Matter Arising 4: Governance (Operation)	<p>4.1(a) Action 1: The development of a standardised strategy that routinely identifies themes, trends, and lessons learned could enhance health boards' response to patient falls.</p> <p>Current status - Partially implemented Finding In conjunction with evidence provided within recommendation 4.1b, the Health Board continues to implement a strategy that routinely identifies themes, trends, and lessons learned. The following was provided to evidence this: <ul style="list-style-type: none"> • A Chair's report from the Health Board Strategic Inpatient Falls group is presented to the Patient Safety Group on a monthly update. • The Strategic Inpatient Falls Prevention Group meet monthly, which is an opportunity to share findings, themes and lessons learned. • Falls are subject to focused review contained within Datix system. • Executive Led Integrated Concerns Oversight Panels are in place; previously Rapid Learning Panels, to gain assurance that reviews of serious incidents are taking place to identify </p>	<p>4.1(a) Action 1: Governance Chairs of local (IHC) Divisional Falls Learning Forums to ensure SWARM document completed locally as part of post falls review (monitored / reported via local Quality & Safety Groups and Accountability Meetings). Reported to Strategic Falls Group via IHC Divisional reporting slides – IHC Divisional Falls Leads (ongoing). Completion monitored via Matrons monthly metrics – Matrons (August 2025 and then after ongoing).</p>	Angela Wood, Executive Director of Nursing and Midwifery	Ongoing		Best practice guidance (approved by Health Board Inpatient Falls group and Patient Safety Group) for weekly IHC falls learning and improvement panels, highlights the SWARM (hot debrief) document to be uploaded onto the Datix Incident reporting system as part of the panels decision making process regarding omissions of care; The IHC Falls Leads where the SWARM document was not routinely used as part of the post fall process have been contacted directly to raise awareness.
1628	Falls Management - Follow up	2025	High	Matter Arising 4: Governance (Operation)	<p>4.1(a) Action 2: The development of a standardised strategy that routinely identifies themes, trends, and lessons learned could enhance health boards' response to patient falls.</p> <p>Current status - Partially implemented Finding In conjunction with evidence provided within recommendation 4.1b, the Health Board continues to implement a strategy that routinely identifies themes, trends, and lessons learned. The following was provided to evidence this: <ul style="list-style-type: none"> • A Chair's report from the Health Board Strategic Inpatient Falls group is presented to the Patient Safety Group on a monthly update. • The Strategic Inpatient Falls Prevention Group meet monthly, which is an opportunity to share findings, themes and lessons learned. • Falls are subject to focused review contained within Datix system. • Executive Led Integrated Concerns Oversight Panels are in place; previously Rapid Learning Panels, to gain assurance that reviews of serious incidents are taking place to identify </p>	<p>4.1(a) Action 2: Governance Best practice guide (Falls Learning & Improvement) to be re-shared pan BCUHB to reinforce the requirement for completion of the SWARM document – Strategic Falls Group (July 2025).</p>	Angela Wood, Executive Director of Nursing and Midwifery	31/07/2025		The requirement and rationale for the SWARM document will be raised as part of the August and September HB Inpatient Falls agenda as July meeting was postponed to enable the membership to attend a virtual national Falls conference.

1629	Falls Management - Follow up	2025	High	Matter Arising 4: Governance (Operation)	<p>4.1(a) Action 3: The development of a standardised strategy that routinely identifies themes, trends, and lessons learned could enhance health boards' response to patient falls.</p> <p>Current status - Partially implemented Finding In conjunction with evidence provided within recommendation 4.1b, the Health Board continues to implement a strategy that routinely identifies themes, trends, and lessons learned. The following was provided to evidence this:</p> <ul style="list-style-type: none"> • A Chair's report from the Health Board Strategic Inpatient Falls group is presented to the Patient Safety Group on a monthly update. • The Strategic Inpatient Falls Prevention Group meet monthly, which is an opportunity to share findings, themes and lessons learned. • Falls are subject to focused review contained within Datix system. • Executive Led Integrated Concerns Oversight Panels are in place; previously Rapid Learning Panels, to gain assurance that reviews of serious incidents are taking place to identify 	4.1(a) Action 3: Governance When Falls Champions established pan BCUHB, completion of SWARM will also be monitored / audited by Falls Champions (commenced April 2025, implementation December 2025).	Angela Wood, Executive Director of Nursing and Midwifery	31/12/2025			The rationale and requirement of the SWARM document will be an element of the Bedside Learning training planned for Sept/October; Feedback will be via IHC Falls Leads.
1632	Performance Management Framework and Reporting	2025	High	Objective 1: There is a governance structure with mechanisms for regular monitoring and escalation in place.	<p>1. Governance 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.</p>	1. 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.	Stephen Powell, Director of Performance and Commissioning	30/09/2025			No update provided
1633	Performance Management Framework and Reporting	2025	High	Objective 2: There is evidence to support reported performance data and narrative.	<p>2. Performance 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.</p>	<p>2. Local performance indicators and escalations are created where a services performance is showing early signs of distress or consistently failing a target.</p> <p>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.</p> <p>The Performance Team working with the relevant Service Lead, will include the source and rationale underpinning any local metrics.</p>	Stephen Powell, Director of Performance and Commissioning	30/09/2025			No update provided
1634	Performance Management Framework and Reporting	2025	High	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.	<p>3. Performance Accountability Whilst we note executive accountability meetings take place and accountability/service performance reports produced; these are not operating consistently as expected.</p> <p>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.</p>	<p>3. Finding accepted. 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.</p>	Stephen Powell, Director of Performance and Commissioning	30/09/2025			No update provided
1648	Orthopaedic Surgical Hub Llandudno Hospital - 2025	2025	High	Objective 4: Financial Management	<p>6. Project VAT calculations 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.</p> <p>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 transparency and reporting for the significant changes in the VAT assumptions made to date.</p>	<p>6. 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.</p> <p><i>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.</i></p>	Russell Caldicott, Executive Director of Finance	31/10/2025			A draft updated Scheme of Reservation and Delegation will be reviewed at the August Audit Committee.
1651	Orthopaedic Surgical Hub Llandudno Hospital - 2025	2025	High	Objective 5: Validation of costs and contractual payments	<p>9. Retention figure 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.</p>	<p>9. The process for movement on retention values will be documented in the revised Scheme of Reservation and Delegation.</p>	Russell Caldicott, Executive Director of Finance	31/10/2025			A draft updated Scheme of Reservation and Delegation will be reviewed at the August Audit Committee.

1655	Orthopaedic Surgical Hub Llandudno Hospital - 2025	2025	High	Objective 7: Equipping	<p>13. Equipment budget</p> <p>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.</p> <p>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.</p> <p>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.</p>	<p>13. 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.</p> <p><i>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.</i></p>	Russell Caldicott, Executive Director of Finance	30/09/2025			<i>No update provided</i>
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SUMMARY OF INTERNAL AUDIT RECOMMENDATIONS APPROVED FOR CLOSURE BY EXECUTIVE COMMITTEE

Summary of recommendation with rationale for closure

EXECUTIVE DIRECTOR OF NURSING

1	1600	Duty of Quality	QMS Guide is now operational in the QMS digital assessment app for users to access.
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INTERIM EXECUTIVE DIRECTOR OF TRANSFORMATION AND STRATEGIC PLANNING

1	1512	Transformation & Improvement	Remaining Major Change Programme Director posts now appointed to, and all 4 reporting to the Executive Director of Transformation and Planning. Allocation of team to the priority programmes now agreed with the CEO.
2	1513		Major Change programmes report directly to the Executive Committee via AAA reporting. The Strategic Planning and Service Change Group, a sub group of the Executive Committee chaired by the CEO, oversees the overall programme of work, and the PPHP committee of the Board now receives a Director of Planning report as a standing agenda item, a new development that has been well received by Board members.

EXECUTIVE DIRECTOR OF FINANCE

1	0276	Accounts Receivable	Local Counter Fraud Policy and Charity Policies now complete and signed off.	
2	1245	Budgetary Control User access & Delegated limits	Following successful pilot and testing of the new improved Oracle leavers process, the new system is live.	
3	1331	Orthopaedic Surgical Hub Llandudno Hospital	The Account has now been set up.	
4	1333		The Cost Advisers, Design Consultants, and CDM (Construction Design and Management) Advisors were appointed via the Health Board's local consultancy framework. At the time of initial procurement, the individual works packages were valued below £7 million and were therefore procured in accordance with the framework's thresholds and procedures. Change in Scope and Contract Value: During the design development phase, the procurement strategy evolved, resulting in an increase in the overall contract values to above £7 million. This change was driven by the complexity and scale of the project becoming more defined as design progressed. Justification for Retaining Existing Consultants: The appointed consultant teams demonstrated the necessary capacity, capability, and relevant experience to support the increased contract values. Their continued involvement was deemed essential to maintain continuity, avoid disruption, and mitigate risks to programme, cost, and quality. A change in consultant support at that stage would have introduced significant inefficiencies and potential delays due to the loss of project knowledge and established working relationships. Framework Compliance: The HB's local framework permits appointments based on both fee percentage and time charge mechanisms. These procurement routes were utilised in accordance with the framework's terms and conditions and formalised under contract. The approach remains compliant with procurement regulations and ensures value for money through transparent and auditable fee structures. It is noted and agreed that an additional fee has been approved in relation to the contract variations and elongations encountered during the course of the project. This adjustment reflects the scope changes and extended timelines, and has been reviewed and accepted by all relevant parties. The decision to retain the existing consultant teams under the local framework is justified on the grounds of continuity, efficiency, and risk mitigation. The procurement approach remains within the scope of the framework and is contractually sound.	
5	1334		The consultants are appointed under the frameworks contract.	
6	1337		There is now a monthly meeting in place.	
7	1465		Review of Cost Savings Arrangements	The Director of V&S has set up a governance structure. An Executive lead has been assigned to each workstream. All sources of information relating to emerging opportunities are reviewed and shared on a regular basis to ensure every opportunity is considered. Executives are asked to provide updates at IPEDG and Divisional Directors are clear on accountability.
8	1466			The guidance reflects the need to show clearly any slippage on delivery of schemes, and the PFIG/HB reports include that information on a scheme by scheme basis. In addition to this, the IPEDG and Programme board undertake deep dives on individual themes and leads are asked to provide details of blockages and challenges to enable Executives to support the removal of barriers. Highlight report presented at V&S Programme board includes delivery against submitted plans. Regular meetings are also held with V&S leads to discuss progress and challenges on a local level.
9	1540	Discretionary Capital Funding Allocation	Capital prioritisation was submitted through CIG, Execs and HB.	
10	1547	Standing	Reports now as per cycle of business are being reported to the Audit Committee.	
11	1548	Financial	Quarterly reports are presented by NWSSP to the PFIG meetings.	
12	1645	Orthopaedic Surgical Hub Llandudno Hospital - 2025	All Project Board meetings have agendas, minutes and action logs.	
13	1647			

CHIEF DIGITAL AND INFORMATION OFFICER

1	1383	Intelligence Led Organisation	Initial exploration complete. Potential use of Knowledge transfer partnership agreement with Swansea university ongoing. Agreement in place to work with Bangor University on advanced analytics in the 25/26 academic year. Student MSc analytics project on Urgent and Emergency Care being scoped - student identified, project brief to be set
2	1390		Data quality included in series of podcasts (audit action 1398). Bespoke training and guidance is provided to WPAS users in response to identified errors or changes to ways of working to accommodate initiatives such as insourcing, outsourcing and waiting list validation.
3	1396		The training needs analysis did not identify the need for specific training provision other than support in accessing data. This requirement was met as part of the launch of the redeveloped IRIS information portal in June 2025. Analytical methodologies used to inform and monitor planned care programmes are introduced and explained through programme meetings and local follow up discussions. The DI&I team will continue to work closely with the Planned Care major change programme and operational teams to identify and act on training needs.

4	1398		Series of three videos produced describing flows and uses of data. Agreement in place for these to be included in the mandatory data element of the Betsi Foundations learning programme.
5	1486	Network and Disaster Recovery	Work completed April 2025.

DEPUTY DIRECTOR OF PEOPLE

1	1504	Job Evaluation	The new JE policy and process was launched on 1st August 2025.
2	1505		The new JE policy and process was launched on 1st August 2025. This now incorporates DMT approval for all banding reviews prior to being submitted to job evaluation.
3	1506		Routine audit testing has commenced which looks at live vacancies and whether the JD has a valid CAJE ref. The findings of the audits are reported to Local Partnership Forum (LPF and the JEPS steering group.
4	1507		Email from Jason Brannan approving the statement provided in May and also the confirmation that LPF will be the oversight group for any reported exceptions.
5	1508		The new JE policy and process was launched on 1st August 2025. This now incorporates DMT approval for all banding reviews prior to being submitted to job evaluation. The manager is now asked to submit the SMA form directly to payroll once the JE outcome is given, thus avoiding any delays to pay uplifts.
6	1510		Agreed with Internal Audit the management response to this would be the same as number 4. Attached email from Jason Brannan approving the statement provided in May and also the confirmation that LPF will be the oversight group for any reported exceptions. Also attached the LPF report from February 2025 that confirms the reporting process.
7	1584	Grievance Management	Updated ER Cases report now contains data regarding Respect & Resolution Cases and will be included in report to People & Culture Committee.

CHIEF EXECUTIVE (APPROVED FOR CLOSURE BY THE DIRECTOR OF CORPORATE GOVERNANCE)

1	0455	Operating Model	Board approved the Foundations for the Future paper on 29th May 2025 to proceed with the detailed design work.
2	1316	Recruitment of substantive and interim executive and senior posts Final Internal Audit Report	The Chief Executive has confirmed delegated authority for the Strategic Recruitment Team to complete new starter payroll forms for senior appointments where there is clearly documented approval of the starting salary by the appointing Director and, where necessary, the Remuneration Committee, which will be included in the CEO 'Local' SORD.

**INTERNAL AUDIT RECOMMENDATIONS FOR AUDIT COMMITTEE CLOSURE APPROVAL
FOR AUDIT COMMITTEE FINAL CLOSURE APPROVAL - SEE SPECIFIC CATEGORIES**

ID	Report Title	Year	Assurance Level	Priority	Recommendation Title	Recommendation	Management Response	Final Approver	Original implementation date	Revised implementation date	Number of Revisions	Closure narrative	Internal Audit narrative supporting closure
For AC closure - IA reviewed and approved closed													
0150	Nursing Roster Management: Introduction of e-timesheets for Agency staff	2022	Limited	Medium pre 01/10/2024	Matter Arising 1: Policies and Procedures (Operation)	1.1: Policy WP28a requires a review, needs to include a reference to the E-timesheets also include the SOP within the documents to be read alongside the policy section on the first page. 1.2 Draft SOP needs to be approved and activated.	1.1: Policy WP28a has been reviewed and is with Workforce Policy Group for consideration. Policy to be approved and deployed with a clear compliance audit schedule in place and commenced. 1.2 Draft SOP to be reviewed to amend reference to unpaid break to acknowledge the risks associated on safe staffing in conjunction with Corporate Nursing Team. 1.3 Interim SOP (with exception of paid break element) to be approved for a 3 months period to ensure clarity of process and accountability in intervening period.	Jason Brannan, Deputy Director of People	31/07/2022	31/05/2025	5	The SOP that supports the e Roster policy has been reviewed by the policy group and signed off by the People Services Directors group	Closed. Copy of SOP and approval received.
0154	Establishment control – Leaver management	2021	Limited	High	Matter Arising 1 - Operational management compliance (Operation)	Workforce and OD should progress the plans to improve leaver management as a priority, to ensure all employment controls are adhered to by operational areas e.g. submission of staff termination form to Payroll Services; return of all Health Board property/ID badge; and Network access is revoked.	The Workforce Performance and Planning team which incorporates ESR and Establishment Control have already reviewed how terminations are actioned and concur with the above recommendation. The management action will be to make changes to the current processes which involve managers completing the current ESR Exception Form. This will be replaced by moving to this being actioned via ESR Self Service. The rationale for the change to ESR Self Service is that it will support through providing a prompt to the manager to request property and stop network access as part of the termination process. This will not guarantee the return, the onus would remain with the manager, however, ESR will serve as the	Jason Brannan, Deputy Director of People	31/01/2022	31/07/2024	5	The Staff Movement Advice (SMA) form was implemented on the 15th April 2024. As part of the initial implementation, the IT workflow was not initiated to allow for some time for staff to become familiar and use the form. On the 23rd May 2024 the SMA Dashboard was shared with the Workforce Systems Team to review the data and workflows. Initial analysis has identified some data quality issues, therefore, the team have requested some further analysis from NWSSP regarding the fields and process for obtaining the data relating to remaining or leaving the NHS to inform the IT workflow. The team have requested an update from NWSSP by 20 June 2024 with an aim to implementing before 31 July 2024	Closed. Intranet pages available with appropriate documentation, Dash board in place
0260	Data analysis – Triangulation of data	2023	Limited	High	Matter Arising 3: Quality, Safety and Experience Committee reporting (Operation)	3.1a: The Quality, Safety and Experience Committee Members stipulate all the data it requires for assurance purposes.	3.1a: Following changes within the Board arising from Special Measures, the new members of the Committee are working with the Executive Director of Nursing and Midwifery (as executive lead for the QSE Committee) to revise the committee terms of reference and cycle of business. As a result, the reporting expectations and requirements will be revised. The special measures reviews of patient safety and quality governance systems by the Independent Special Advisors will also inform this work.	Angela Wood, Executive Director of Nursing and Midwifery	30/09/2023	31/12/2023	1	The QSE terms of reference and cycle of business, including standard reports as revised and approved by Board in January 2024.	CLOSED: Closed on the basis that development session has been held for members views and ToR and cycles of business have been updated
0277	Clinical Audit – Tier 1 National Audits	2023	Limited	Medium pre 01/10/2024	Matter Arising 1: Clinical Audit Plan 2023/24 (Operation)	1.1: The Clinical Audit Plan for 2023/24 should be formally approved at the appropriate committee.	1.1: The Clinical Audit Plan for 2023/2024 was prepared and submitted initially to the Strategic Clinical Effectiveness Meeting on 14th February for discussion and agreement. Following this the Clinical Audit Plan was prepared and submitted to Quality, Safety and Experience Committee (QSE) on 7th March, the meeting was then stood down. The paper was then submitted to Quality Delivery Group (QDG) on 17th April, due to QSE not having any further dates to present at that time and due to changes in Board membership all of the Committees were not meeting at that time. It was therefore appropriate Nick Lyons signed it off as Executive Medical Director and Acting Chief Executive Officer at that time.	Nick Lyons, Executive Medical Director	31/07/2023		0	The Clinical Audit Plan for Tier 1 went to QSE Committee in August and is incorporated into future cycle of business from Strategic Clinical Effectiveness Group to be submitted when relevant. The quarterly reports show the current situation at that time of relevant published Tier 1 reports and where they are in the cycle process and any concerns are escalated to QDG and QSE where relevant. Processes are in place to flag up concerns on monthly basis within local Clinical Effectiveness Group with approach of sorting those concerns and avoiding escalation where possible. Due to local Clinical Effectiveness Groups running differently on each site, from November the Clinical Effectiveness Team sharing a monthly update to each IHC and Divisions sharing current position with regard to Tier1, Tier 2 and	Closed on the basis that the process has changed and approval of plan is now via the Exec Quality Delivery Group

0282	Clinical Audit – Tier 1 National Audits	2023	Limited	Medium pre 01/10/2024	Matter Arising 5: Learning from audits (Operation)	5.1: Ensure that the local service meeting minutes, which contain the lessons learned from the audits as specified within the service assessment of compliance form, are sent to the clinical effectiveness department as part of the assurance process.	5.1: Following recent meeting with Internal Auditor the Service assessment form was amended July 2023 to request evidence of discussions and how these are shared as part of the assurance process. Clinical Audit Facilitators will ensure that all details are completed before accepting the form as completed and the update will be included in the relevant quarterly report.	Nick Lyons, Executive Medical Director	23/07/2023		0	The Clinical Audit Facilitators have developed a Service Assessment of Compliance against Key standards (KPIs) form which is sent to the Clinical Audit Lead after each publication. This allows the Clinical Lead to note where discussions are held, which meetings information is fed back, how learning is shared. This information is then captured in the Quarterly reports and Annual report and also shared within local Clinical Effectiveness Groups (CEG). We review our processes regularly to ensure we are capturing as much as we can to share at relevant groups. On monthly basis we share an update with IHCs and Divisions on their current position with Tier 1 audits which shows the current position/progress also noting any concerns that need addressing. If this is not done through the relevant local Clinical	Evidence of learning, with supporting papers were received.
0296	Falls Management	2023	Limited	High	Matter Arising 2: All Wales Falls and Bone Health Multifactorial Assessment (FBHMA) (Operation)	2.1b: To reduce the inconsistent information amongst documentation, standardising of patient fall documentation should be considered.	2.1b: The Welsh Nursing Care Record currently does not auto populate with patient detail such as mobility status form the admission assessment section into the FBHMA. This will be future enhancement to the Welsh Nursing Care Record on an all-Wales basis. To mitigate this risk: - the Health Board Training resources stress the requirement for using this detail to promote accurate and consistent patient profile.	Angela Wood, Executive Director of Nursing and Midwifery	01/02/2024	30/04/2024	1	This is part of the WNCR roll out plan but no date as yet, potentially into 2025/26, in the meantime we have local mitigation in place, therefore put forward for closure. While waiting for the all Wales Welsh Nursing Care Record enhancements to functionality of the system, to auto populate patient detail such as patients individualised communication needs the Health Board has implemented the following: •Promoting Therapy colleagues to access and update the Welsh Nursing Care Record following assessment and delivery of therapy 'How to' guide developed by Health Board Welsh Nursing Care Record team and will be shared with the Health Board Falls leads-How to guide attached as evidence to support closure. Also attached as evidence to support closure are the metrics re the Falls and Patient Handling risk	Has been subject to a follow up review
0299	Falls Management	2023	Limited	High	Matter Arising 3: Training (Operation and Design)	3.1b: Review Safeguarding training to include post falls management.	3.1b: Internal training facilities to be identified by each IHC by December 2023. MH corporate team to progress contract arrangements for external training facilities to support capacity by December 2023.	Angela Wood, Executive Director of Nursing and Midwifery	30/12/2023	30/09/2024	2	No external delivery sites are available. Each IHC was requested to identify further suitable rooms but were unable to do so. Due to this, this action cannot be progressed and therefore is proposed for closure.	Has been subject to a follow up review
0300	Falls Management	2023	Limited	High	Matter Arising 3: Training (Operation and Design)	3.1c Consider a more formal training method for the bedside learning programme, and consider resources required to provide this to staff. Ensure records of training are kept.	3.1c: Text messaging reminders for booked training session to be implemented to reallocate capacity from Did Not Attend (DNA) individuals. Health Board Falls Lead to make a formal request to the Safeguarding all Wales programme regarding consideration of safeguarding following recurrent falls.	Angela Wood, Executive Director of Nursing and Midwifery	01/04/2024	30/06/2024	1	BCUHB Head of Adult Safeguarding attended the National Safeguarding Network chaired by Public Health Wales. Falls agenda discussed with the Director of the Safeguarding for PHW and it was confirmed that falls specifically is not a subject area to be taken forward on the work plan for 2024-25. When falls and safeguarding are discussed we do have statutory process i.e. the Adult at Risk process, to address any concerns raised.	Has been subject to a follow up review
0304	Falls Management	2023	Limited	High	Matter Arising 4: Governance (Operation)	4.1b: Lessons learned information included in Datix should be reviewed regularly to ensure learning is communicated/reported as appropriate, and to deter staff entering a full stop or a dash in the section.	4.1b: Action 1 - Each Integrated Health Community (IHC) Health Board has established weekly harms review meeting that includes Inpatient Falls, to improve the sharing of lessons learned the Health Board will develop a SOP to ensure standardised practice across the IHCs.	Angela Wood, Executive Director of Nursing and Midwifery	30/12/2023	30/09/2024	4	SOP approved at BCUHB Inpatient Falls Group 11/09/2024 and Patient Safety Group 24/09/2024. Copy of minutes provided as evidence 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	Management response in place and a recent follow up has taken place

0319	Decarbonisation	2023	Limited	High	Matter Arising 2: Project Delivery (Design / Operation)	2.1a: To complete the actions within the specified timeframe, greater focus and scrutiny is required on the action plan.	2.1a: The Health Board is currently part of the discussions as all actions, timeframes and targets are being reviewed Welsh Government. The Decarbonisation Programme Board do monitor those actions at risk however in the current financial climate all actions will be reviewed and prioritised accordingly to understand what can be implemented and actioned with a realistic timeframe.	Stuart Keen, Director of Environment and Estates	31/05/2024		0	The Action Plan is in place, and is attached as evidence for closure	DCR reviewed and actions and progress against each are RAG rated. This is in line with other Health Board's I've audited. Action can be closed.
0327	Lessons Learnt	2023	Limited	High	Matter Arising 2: Make it Safe (Plus) (Design)	2.1: Management to formally document and communicate the principles and requirements of Make it Safe (Plus) to ensure consistency across the Health Board. Governance, reporting, and escalation requirements to be clearly defined.	2.1: A full review of the incident process and procedure has been commenced, which will be co-designed with staff to ensure that the new procedure is fit for purpose and workable for staff undertaking rapid reviews/investigations and learning.	Angela Wood, Executive Director of Nursing and Midwifery	31/03/2024	30/09/2024	3	Integrated concerns framework now live and implemented - all evidence on ICF page on BetsiNet.	Evidence confirms MIS has been replaced by Rapid Review - supporting evidence provided.
0338	Water Safety	2024	Limited	High	Matter Arising 3: Training and competence (Operation)	3.1: Management to ensure all staff members that have been allocated tasks and responsibilities impacting water safety (including outlet flushing, wash-hand basin / tap cleaning, maintenance, strategy development etc) have received adequate training in respect of water hygiene and microbiological control appropriate to the task they are responsible for conducting.	3.1a: Operational Estates staff have received the appropriate training to be able to carry out their duties / responsibilities safely.	Stuart Keen, Director of Environment and Estates	03/01/2024		0	Training with Operational Estates reviewed and completed. Copy of training plan provided as evidence for closure	Register of staff having completed training provided - doc covers the three areas. Note - we cannot verify from the info provided that the document captures ALL relevant Estates staff.
0339	Water Safety	2024	Limited	High	Matter Arising 3: Training and competence (Operation)	3.1: Management to ensure all staff members that have been allocated tasks and responsibilities impacting water safety (including outlet flushing, wash-hand basin / tap cleaning, maintenance, strategy development etc) have received adequate training in respect of water hygiene and microbiological control appropriate to the task they are responsible for conducting.	3.1b: Design a training package (Power Point Presentation and Questionnaire to evidence learning) for Non-Estates staff and get it approved at Strategic Infection Prevention Group.	Stuart Keen, Director of Environment and Estates	22/02/2024		0	The Draft training package was presented at the Water Safety Group and Strategic Infection Prevention Group, following a number of comments. The final draft presented and approved at the Water Safety Group on 10/04/2024, and a copy of the training package is included as evidence for closure.	Copy presentation provided for review - closed on this basis but note issues re training on 0340.
0345	Follow-up: Delivery of Health Board savings	2024	Limited	High	Matter Arising 1: Board reporting of savings and changes in year from the Financial Plan	The Executive Director of Finance: - Ensures the Financial Plan outlines and recommends all proposed actions relating to unachieved savings for the Board to consider and approve. - Ensures any decision to fund undelivered cash releasing savings is formally approved by the Health Board. - Provides a full audit trail to Committee/Board of the savings requirement for 2023/24 to include the following: • Where/what changes have happened between the Financial Plan (£30m) and current reported savings (£30.9m). • What the 'Stretch Target' is and how it has reduced from £7m to £5.7m and the likelihood of it being achieved. • Evidence of how the £13.5m Dis-investments	As stated, the Health Board from July of the 2023/24 financial year has consistently reported the need to deliver £25.2m of savings (in Board papers of the 30th March and 22nd June reported as £18.2m plus £7m). The additional savings stretch, to increase the target was reported to Board on the 30th March, with the final stretch target £30.9m, which has been reported at Board and Committees during 2023/24. The £7m reported as stretch in the June 2023 report was incorrectly labelled as stretch, this was part of the original plan that made up the total ask of £25.2m for 2022/23. The stretch element totals £5.7m and was contained within the plan, the total targeted savings of £30.9m therefore the resultant value for savings	Russell Caldicott, Interim Executive Director of Finance	31/03/2024		0	The CRES Holding Ccode has been cleared down to zero at the close of 2023/24 there will be no c/f of non delivery of savings into 2024/25. Going forward, the Savings Targets are to be applied to the Opening Budgets at Month 1; the use of negative CRES Holding codes has been ceased. This action can be closed.	From the minutes of the September Audit Committee the, 'Interim Deputy Executive Director Finance presented an overview of the current financial position and the report providing an update on the first five months of 2023/24 (April 23 to August 23) on conformance with the Health Board's Standing Orders (SOs), incorporating Standing Financial Instructions (SFIs) and Scheme of Reservation and Delegation of Powers (SoRD), in relation to Single Tender Waivers and Losses payments.' Action to be closed.

0346	Follow-up: Delivery of Health Board savings	2024	Limited	High	Matter Arising 2: Voluntary Early Release – Recurring Savings	The Executive Director of Finance ensures all approved VERS applications are acted on in accordance with the requirements of the Remuneration and Terms of Service Committee, with budget and establishment adjusted accordingly.	The financial impact associated with any decisions presented through to the Remuneration Committee will be shared on a monthly basis with the Executive Director of Finance. Decisions taken enacted in accordance with the governance of the Health Board with any queries over implementation raised with the Health Board Secretary for confirmation at a subsequent meeting of the Remuneration Committee.	Pam Wenger, Director of Corporate Governance	31/01/2024		0	This reporting has now commenced, with the first time being after the March Remuneration Committee. The Committee Secretary has e-mailed decisions of a financial nature to the Executive Director of Finance, and a copy of an e-mail is included as evidence to support closure.	Close on the basis that there have been no further VERS.
0348	Follow-up: Delivery of Health Board savings	2024	Limited	High	Matter Arising 4: Transformational Savings and Transformational Team review	The Health Board: • Completes an updated review of transformational opportunities, underpinned by impact assessments but recognising these will likely take a long period of time to embed and deliver cash releasing savings. • Reviews the role of the Transformational Team in driving service change and savings.	Recommendation 1: Opportunities The following is an up to date summary of the narrative that has been consistently supplied in relation to this recommendation: The purpose and role of the Transformation and Improvement team has always been to support and enable the organisation to transform and improve itself. It's the only way it works, as change that is centrally generated and driven never sticks as it is not created and owned locally by the front line teams. As part of Special Measures, there is a deliverable (#5.4 – now complete) that is around ensuring that the Transformation and Improvement resource is allocated to support the priority areas. It has been agreed that the Portfolio Office continues	Chris Stockport, Executive Director of Transformation and Strategic Planning	31/03/2024		0	In terms of transformational opportunities for cash releasing savings, this is being discharged through the Value and Sustainability programme that is in the process of being mobilised. Five areas of opportunity have been identified (Clinical Variation, Non Pay, Medicines Management, Continuing Healthcare and Workforce) and streams of work are being commissioned to progress with them. Due to this, it is proposed that this recommendation be closed to avoid duplication of reporting.	Closed as HB is now focused on value and sustainability driven by WG which is looking at opportunities for transformation. Also separate review of transformation team undertaken which evidenced allocation of resource to priorities / special measures.
0349	Follow-up: Delivery of Health Board savings	2024	Limited	High	Matter Arising 4: Transformational Savings and Transformational Team review	The Health Board: • Completes an updated review of transformational opportunities, underpinned by impact assessments but recognising these will likely take a long period of time to embed and deliver cash releasing savings. • Reviews the role of the Transformational Team in driving service change and savings.	Recommendation 2: Role of Transformational Team As per the narrative associated with recommendation 1 above, this has been the subject of a deliverable as part of Special Measures. This is marked as complete with strong documentation and evidence to support the process applied and approach taken. Propose that this recommendation is therefore marked as complete and closed.	Chris Stockport, Executive Director of Transformation and Strategic Planning	31/03/2024		0	Narrative from audit report is to propose that this recommendation is marked as complete and closed.	Closed as HB is now focused on value and sustainability driven by WG which is looking at opportunities for transformation. Also separate review of transformation team undertaken which evidenced allocation of resource to priorities / special measures.
0350	Deprivation of Liberty Safeguards (DoLS) - 2024	2024	Limited	Medium pre 01/10/2024	Matter Arising 1: MCA training levels 1 and 2 (Operation)	1.1a (i): Review training data to identify those staff that have not undertaken training. Once identified, confirm with staff the requirement to complete the training. Where this is not undertaken, escalate as appropriate.	1.1a (i): Undertake a review of MCA mandatory training data for Bank, Locum and Honorary staff and identify low compliance areas in each staffing group.	Angela Wood, Executive Director of Nursing and Midwifery	30/09/2024			Review of training figures has been completed with compliance shared at respective Safeguarding Forums across the Health Board. However, non-compliance will be escalated at the Safeguarding Performance and Governance Group in November and then into the Quality Delivery Group. This will be a recurring action. There is work planned with temporary staffing units to cleanse the data of those currently active on a bank basis. This will improve compliance figures and will be monitored by services.	Current training compliance is evidenced through its inclusion on the MHLDS safeguarding forum agenda. Further evidence provided in 0366 demonstrates reporting into other relevant forums (IHCs).
0351	Deprivation of Liberty Safeguards (DoLS) - 2024	2024	Limited	Medium pre 01/10/2024	Matter Arising 1: MCA training levels 1 and 2 (Operation)	1.1a (ii): Review training data to identify those staff that have not undertaken training. Once identified, confirm with staff the requirement to complete the training. Where this is not undertaken, escalate as appropriate.	1.1a (ii): Identify staffing groups who have low compliance and provide data monthly to service leads to action.	Angela Wood, Executive Director of Nursing and Midwifery	30/09/2024			All MCA compliance data is now shared at respective Safeguarding Forums. This action is complete but is a recurring action that will remain open as part of the Safeguarding Forum agenda as compliance / non-compliance will be escalated as per action 350.	As above further evidence to support the recommendation in 0366.
0353	Deprivation of Liberty Safeguards (DoLS) - 2024	2024	Limited	Medium pre 01/10/2024	Matter Arising 1: MCA training levels 1 and 2 (Operation)	1.1a (iv): Review training data to identify those staff that have not undertaken training. Once identified, confirm with staff the requirement to complete the training. Where this is not undertaken, escalate as appropriate.	1.1a (iv): Report monthly compliance of MCA training for bank, locum and honorary staff to IHC Safeguarding Forums for oversight and assurance.	Angela Wood, Executive Director of Nursing and Midwifery	30/06/2024	30/09/2024	1	All MCA compliance data is now shared at respective Safeguarding Forums. This action is complete but is a recurring action that will remain open as part of the Safeguarding Forum agenda as compliance / non-compliance will be escalated as per action 350.	As above further evidence to support the recommendation within 0366

0356	Deprivation of Liberty Safeguards (DoLS) - 2024	2024	Limited	High	Matter Arising 2: DoLS authorisations (Design)	2.1a (i): Supervisory to continue addressing quality issues with relevant areas and continue to review capacity of BIAs and Mental Health Assessor (a s12(2) Approved Doctor).	2.1a (i): Demand and capacity modelling for Best Interest Assessments to be developed by the Safeguarding Business Team to support data driven decisions.	Angela Wood, Executive Director of Nursing and Midwifery	31/07/2024	31/12/2024	1	Support / Q&A Sessions have been held across West, Central and East areas focusing on the quality of the paperwork. The Supervisory Body (DoLS/MCA Team) continues to link directly with wards to request necessary amendments ensuring documentation is satisfactory. The DoLS data and best interest assessments are included in the data dashboard. The DoLS monthly report for December shows improvement to the quality of the paperwork during December 2024. Regular monthly reporting is now in place and this action can be closed. Issues, concerns, good practice is reported into the Mental Health Legislative Committee for oversight and assurance.	Closed as dashboard in place	
0357	Deprivation of Liberty Safeguards (DoLS) - 2024	2024	Limited	High	Matter Arising 2: DoLS authorisations (Design)	2.1a (ii): Supervisory to continue addressing quality issues with relevant areas and continue to review capacity of BIAs and Mental Health Assessor (a s12(2) Approved Doctor).	2.1a (ii): Increase the Supervisory Body's capacity to complete best interest assessments within agreed timescales and legislative compliance by training 5 additional BIA's from Q2 onwards.	Angela Wood, Executive Director of Nursing and Midwifery	31/03/2025				The five Health Board staff members have commenced the BIA qualification course in Q3 and are due to qualify in Q4. Supervision is in place for all staff. The capacity to complete additional assessments and train BIA's is in place. This action can now be closed and will be monitored as part of quarterly SGPG reporting and Mental Health Legislative Committee reporting.	As at 15/01/25 5 BCUHB staff members have completed the BIA Course
0358	Deprivation of Liberty Safeguards (DoLS) - 2024	2024	Limited	High	Matter Arising 2: DoLS authorisations (Design)	2.1a (iii): Supervisory to continue addressing quality issues with relevant areas and continue to review capacity of BIAs and Mental Health Assessor (a s12(2) Approved Doctor).	2.1a (iii): Work Based Quality Improvement programme to be developed and implemented within the 3 high referring areas with high QA rejection rates for applications.	Angela Wood, Executive Director of Nursing and Midwifery	30/09/2024	31/03/2025	1	The data analyst has created a Power BI dashboard to capture key performance data regarding compliance of applications within timescales and other relevant data. Monthly reports are produced to highlight areas where improvement is required. The Supervisory Body, BIA's and the MCA training lead link directly with the areas of low compliance to provide targeted intervention, advice and support if required. Issues, concerns, and good practice is reported into SGPG, Safeguarding Forums and the Mental Health Legislative Committee for assurance and oversight.	Dashboard in place	
0359	Deprivation of Liberty Safeguards (DoLS) - 2024	2024	Limited	High	Matter Arising 2: DoLS authorisations (Design)	2.1a (iv): Supervisory to continue addressing quality issues with relevant areas and continue to review capacity of BIAs and Mental Health Assessor (a s12(2) Approved Doctor).	2.1a (iv): Standard Operating Procedure for MCA and BIA service to be reviewed to strengthen visibility of the team within high risk areas. To include structured weekly visits/daily calls by the MCA Team to high referral areas i.e. DGH and Community Hospitals to increase profile of the MCA Team, provide support for staff, feedback regarding application QA rejection themes (date, signatures) etc.	Angela Wood, Executive Director of Nursing and Midwifery	30/09/2024	31/03/2025	2	Action for closure, monitoring of progress and review of all actions is undertaken and delivered at the Mental Health Legislative Committee. 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. 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. BIA's have a greater presence at DGH sites.	Evidence indicates a decline in application related issues. The dashboard enables the team to effectively track and oversee high risk areas. There is also a positive trend in training compliance	
0361	Deprivation of Liberty Safeguards (DoLS) - 2024	2024	Limited	High	Matter Arising 2: DoLS authorisations (Design)	2.1a (vi): Supervisory to continue addressing quality issues with relevant areas and continue to review capacity of BIAs and Mental Health Assessor (a s12(2) Approved Doctor).	2.1 (vi): Digitalise MCA and DoLS documentation to ensure that mandatory fields are completed prior to submission and audit standards.	Angela Wood, Executive Director of Nursing and Midwifery	31/03/2025				Digitalisation of MCA and DoLS documentation is being led by Welsh Government. The DoLS Form 1 (Application Form) has been produced and agreed by the National group. A pilot of the DoLS Form 1 will commence in Q4. This action is now led nationally and is completed from an internal perspective. BCUHB are leading on the digitalisation of the documentation.	Public Health Wales and the Welsh Government are now leading the initiative. BCUHB is actively participating in meetings and has committed to piloting the updated digital documentation, expected in 2025-26. No additional internal actions can be taken.

0362	Deprivation of Liberty Safeguards (DoLS) - 2024	2024	Limited	High	Matter Arising 3: DoLS Documentation (Operational)	3.1a (i): Managing Authorities to ensure that the applications are completed appropriately and returned in a timely manner. Where issues are identified with quality or timeliness, the Supervisory Body should communicate issues with relevant staff, provide support and ensure staff	3.1a (i): MCA/DoLS Team to review Standing Operating Procedure for DoLS Applications detailing timescales within the process.	Angela Wood, Executive Director of Nursing and Midwifery	30/09/2024			No further action can be undertaken at this time. The timescales are clearly recorded in process and legislation. A National review of the DoLS process is to be explored by UK Government. Welsh Government are fully aware of the challenges and continue to provide limited additional funding.	Within SOP
0363	Deprivation of Liberty Safeguards (DoLS) - 2024	2024	Limited	High	Matter Arising 3: DoLS Documentation (Operational)	3.1a (ii): Managing Authorities to ensure that the applications are completed appropriately and returned in a timely manner. Where issues are identified with quality or timeliness, the Supervisory Body should communicate issues with relevant staff, provide support and ensure staff have undertaken appropriate training. Where issues remain this should be escalated as appropriate.	3.1a (ii): MCA/DoLS Team to provide key performance data regarding compliance of applications within timescales to the managing authorities.	Angela Wood, Executive Director of Nursing and Midwifery	30/09/2024			The action is complete. Data is shared at monthly Safeguarding Forums and directly with Managing Authorities. However, the DoLS/MCA Data Dashboard will provide additional assurance and governance.	DOLS dashboard provides data on performance regarding applications. DOLS monthly summary reports include data from dashboard broken down into East, central and west
0364	Deprivation of Liberty Safeguards (DoLS) - 2024	2024	Limited	High	Matter Arising 3: DoLS Documentation (Operational)	3.1a (iii): Managing Authorities to ensure that the applications are completed appropriately and returned in a timely manner. Where issues are identified with quality or timeliness, the Supervisory Body should communicate issues with relevant staff, provide support and ensure staff have undertaken appropriate training. Where issues remain this should be escalated as appropriate.	3.1a (iii): Provide the Managing Authority with opportunities to reflect on the quality of documentation through quarterly learning sessions to commence in Q2. As per action 2.1a: Develop a Work Based Quality Improvement Plan based on themes and trends of the data analysis initially focussing on high referral areas to support reduced rejection rates at QA. Within the improvement plan identify measure for	Angela Wood, Executive Director of Nursing and Midwifery	31/03/2025			Support / Q&A sessions have been held across West, Central and East areas focusing on the quality of paperwork. The Supervisory Body (DoLS Team) continues to link directly with wards to request necessary amendments ensuring documentation is satisfactory. The DoLS data and best interest assessments are included in the data dashboard. The DoLS monthly report shows improvement to the quality of the paperwork during	Closed as dashboard in place
0366	Deprivation of Liberty Safeguards (DoLS) - 2024	2024	Limited	High	Matter Arising 3: DoLS Documentation (Operational)	3.1a (v): Managing Authorities to ensure that the applications are completed appropriately and returned in a timely manner. Where issues are identified with quality or timeliness, the Supervisory Body should communicate issues with relevant staff, provide support and ensure staff have undertaken appropriate training. Where issues remain this should be escalated as appropriate.	3.1a (v): MCA and DoLS activity to become a standard item agenda at all Safeguarding Forum's to allow continuous oversight and awareness.	Angela Wood, Executive Director of Nursing and Midwifery	30/06/2024			Agreed by Chairs of Safeguarding Forums for MCA/DoLS to become a standing agenda item. Now embedded into monthly agendas - copy provided as evidence to support closure	Evidence provided
0489	Health and Safety - 2024	2024	Limited	High	Matter Arising 2: Monitoring and reporting of Health and Safety (Operation)	2.1a: Management ensure regular monitoring, reporting, communication, escalation and de-escalation of Health & Safety issues through the appropriate governance structure, in line with the HS01 policy and terms of reference for relevant meetings (Strategic Occupational Health and Safety Group, Quality Safety and Experience Committee and Risk Management Group).	2.1a: Reporting to QSE recommenced in December 2023, however SOHSG will now report to People and Culture Committee, we are assuming this committee will escalate issues to RMG	Carol Shillabeer, Chief Executive	29/02/2024			This is included in the terms of reference for the People and Culture Committee	Confirmed following provision included in the PCC ToR - "provide oversight, delivery and monitoring of Health and Safety strategies, planning, policies, performance and regulatory compliance;" Strategic Occupational H&S report presented June 25. 25/26 CoB - H&S Annual Report - annually - Aug25 H&S Improvement Plan - annually - Dec25 SOHSG Chairs report submitted Apr25 PCC
1272	Risk Management - June 2024	2024	Limited	High	Matter Arising 3: Risk Management Group (Operation)	3.1: Consideration should be given to the role of the Risk Management Group and whether alternative arrangements may provide effective and regular scrutiny of operational risk registers, and corporate risks for escalation/de-escalation	3.1: The role and remit of the Risk Management Group will be reviewed, and a paper has been drafted for discussion of 'the role and future of RMG' with proposed options at the June meeting. The proposals also notes the need to increase this meeting to monthly. Options will be further considered by the Executive Team for alternative arrangements to provide more effective, regular scrutiny of operational risks and corporate risks. The new arrangement will be approved by Executive Team and Audit Committee. A new arrangement will be established following approval in Q2. Any agreed changes will be reflected in a revised Risk Management Framework and supporting procedures. A terms of reference will be	Pam Wenger, Director of Corporate Governance	30/09/2024			The TORs were re-submitted to ET on 04/12/2024 and approved. Decision log attached noting where the terms of reference were approved.	Minutes from 9th July 2024 Audit Committee p.g 19 confirm review of whether the risk management group was sufficient and the agreement to create a risk scrutiny group to better review risks. ToR approved by ET as shown in decision log. Risk management procedure attached as evidence showing the updated process.

1284	Effective Governance – Integrated Health Community (IHC) Central	2024	Limited	High	Matter Arising 2: Financial control assurance (Operation)	2.1: The IHC Director ensures the Financial Control Group complies with its Terms of Reference and actively supports the IHC in delivering its expenditure reduction to meet its allocated resource.	2.1: Financial Recovery Plan meetings have been re-established and the ToR will be developed to reflect the reporting arrangements to Performance, Finance and Information Governance (PFIG). The purpose of these groups will be to oversee the planning and delivery of financial targets whilst understanding the impacts of the necessary change to deliver a reduction in financial spend. The implementation of the Financial Recovery framework for the IHC including regular meetings supported by the ToR, will be in place by end of July 2024.	Imran Devji, Interim Chief Operating Officer	31/07/2024	31/12/2024	1	From December 2024 a Directors Finance Recovery Group meeting was established to review the Financial constraints, the documentation submitted (evidence) is noted below Financial Recovery (Directors) Group 1.ToR 2.Action Log 3.Minutes 18.12.24 (Final V1.0) 4.Minutes 03.01.25 (Final V1.0) 5.Minutes 15.01.25 (Final V1.0) 6.Minutes 29.01.25 (Final V1.0)	ToR is in place for the financial recovery group detailing its responsibility to review the financial recovery plan. Within these meetings financial recovery is a standard agenda item giving updates on the current Health Board position. The group is a sub group of the Directors meeting and can raise issues at the CIHC SLT, or PFIG meetings for information, discussion or approval.
1287	Effective Governance – Integrated Health Community (IHC) Central	2024	Limited	High	Matter Arising 4: Concerns, Complaints, Incidents (Operation)	4.1: The IHC Director: • Ensures the IHC responds to all complaints according to expected reporting timelines and all learning is shared across the IHC. • Ensures operational management review all open incidents.	4.1: The IHC have since developed trajectories to address the backlog of Open and overdue complaints, which will support completion of complaints against the reporting timelines. The QODG will receive assurance through the	Tehmeena Ajmal, Chief Operating Officer	31/07/2024			As noted in the 03.02.25 update section progress was provided to Audit Committee and evidence was provided to request for this recommendation to be closed. Attached is the evidence email with documentation. The IHC have been working	Evidence provided shows consistent reduction in number of complaints dropping from a high of 231 open complaints in April to 58 in December. Compliance with targets has improved from 31.25% in May to 60.34% in December. Although this is
1303	Budgetary Control	2024	Limited	High	Matter Arising 2: Accountability Letters (Operation)	2.1a The Health Board ensures compliance with Standing Financial Instruction 5.2.1 & 5.2.6.	2.1a Management accepts the recommendation for issuing out Accountability letters as this was not undertaken in the 2023/24 financial year. However, in year (as occurred with many other Health Boards) expenditure control measures were set through Executive and leadership forums, with mitigations centring upon the issuing of expenditure control limits by Directorate and Area. This practice was similar to that deployed in 'other' Health Boards and for BCUHB supported attainment of enhanced performance in year compared to original plans. It is managements view these Health Board endorsed controls and expenditure limits set in 2023/24 offered mitigation in the absence of the issuing of the	Russell Caldicott, Interim Executive Director of Finance	30/09/2024			Accountability letters have been issued to all areas and were done so 13th June with return date of 28th June.	Accountability letters reviewed as part of the 24/25 Budgetary Control internal audit. In depth testing on letters being sent out and signed was completed. New medium action raised. This action can be closed as it has been superseded.
1306	Budgetary Control	2024	Limited	Medium pre 01/10/2024	Matter Arising 5: Virement Procedure (Operation)	5.1a The Virement procedure is reviewed and updated as necessary ensuring the requirements stipulated in the Standing Financial Instructions are embedded throughout. The procedure should then be published on the Finance Policy/Procedure intranet site for all Budget Holders/Managers to comply with.	5.1a The Finance teams currently operate a budget virement, management agreeing to an action to review the existing local finance procedure and will look to incorporate the existing procedure (with any amendments following review) within the Budget Manager Handbook.	Russell Caldicott, Executive Director of Finance	30/09/2024			The procedure has been approved by the EDoF and is available on the Finance Betsinet page https://nhs.wales365.sharepoint.com/:u:/r/sites/BCU_Intranet_FIN/SitePages/Fina.aspx?csf=1&web=1&e=EuzEZA The handbook (section 3A Budgetary control) has been updated to make reference to the updated procedure on budgetary movements (virements) https://nhs.wales365-my.sharepoint.com/:b:/r/personal/neil_williams5_wales_nhs_uk/Documents/Neil/A/contract%20and%20procurement/Budget%20Manager%20Handbook%20(Febuary%202025).pdf?csf=1&web=1&e=OthHq5	This was covered during the recent Budgetary Control internal audit review. Virements are being managed appropriately. Action can be closed.
1307	Budgetary Control	2024	Limited	Medium pre 01/10/2024	Matter Arising 6: Budget Holder/Manager Training Plan (Operation)	6.1a A training plan is developed that outlines the risk-focused training required for relevant Health Board Officers with attendance recorded and reported through the Finance Conformance report to the Audit Committee.	6.1a Management have already developed a Training Plan. With an example of implementation of risk-based training being the Procurement and Contracting training supported and delivered by NWSSP as part of the response to the Special Measures Action Plan (incorporating the Independent Contract Procurement Review Actions). The training delivery has been reported to Audit Committee members and Performance, Finance and Information Governance Committee (PFIGC), Health Board and Welsh Government. A rolling programme was agreed going forward, with face to face dates booked for communities in Centre (11 June), East (18th June), Alder House NHS Shared Services Staff (20th June) and	Russell Caldicott, Interim Executive Director of Finance	18/07/2024			2 further training sessions have taken place in September taking the total number of budget holders trained to 220. Further sessions are scheduled for October and December. Recommend for closure – A rolling programme of training has been developed delivered jointly by NWSSP Procurement and Finance – 220 staff have been reached so far this year. Previous updates have confirmed that the Executives have received training and a new appointments will receive this as part of their Induction Programme. The training delivery has been reported to Audit Committee members and Performance, Finance and Information Governance Committee (PFIGC), Health Board and Welsh Government. An update is now being incorporated in the Conformance Report. The distribution of the Accountability Letters to	Training attendance records for procurement and IPROC provided. Training covered within the 24/25 Budgetary Control internal audit review. This action can be closed as it has been superseded by a new action raised within this audit.

1344	Corporate Legislative Compliance - Fire Safety	2024	Limited	High	Matter Arising 5: Annual Management Fire Audit (Operation)	5.1a Management ensure compliance with the requirement of Welsh Health Technical Memorandum (WHTM) 05-01 'Firecode – Managing healthcare fire safety, and annual management fire audit be submitted within the mandatory timeframes.	5.1a Fire Safety Audit to be conducted as detailed in WHTM05/01 Managing Healthcare Fire Safety utilising the Fire Safety Audit System. The outcomes communicated to the Board via the escalation process through the SOHSG	Stuart Keen, Director of Environment and Estates	06/08/2024			Fire Safety Audit submitted and reported at Strategic Occupational Health and Safety Meeting in September 2024 by means of a AAA report. Request action is closed	Fire report has been submitted in 2024 - copy of papers / report received.
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For AC closure - outside IA scope

0146	Maternity Cross-Border Arrangements	2021	Reasonable pre 01/10/2024	Medium pre 01/10/2024	Matter Arising 3 – Escalation of issues (Operation)	Women's Division management to complete and submit the SBAR to the Health Board Chief Executive Officer. The outcome of the Executive level discussion with the Countess should be formally recorded at the appropriate Health Board forum. Concerns regarding quality of care must be escalated and the Health Board should undertake quality and safety audits to review issues raised.	• SBAR Briefing Report: Re Continued Quality Assurances Concerns Relating to Maternity Services at the Countess of Chester Hospital prepared and present to the Health Board's, Chief Executive Officer on 22/10/2021. • Letter highlighted local concerns about Maternity Services at the Countess of Chester drafted for the Health Board's Chief Executive Officer, for the attention of Cheshire CCG's Chief Executive Officer inviting a conversation to understand whether they share similar concerns and experiences to BCUHB, with regards to ongoing lack of quality assurances and in relation to specific clinical outcome measures in the Maternity Services they commission by the Countess of Chester Hospital NHS Foundation	Imran Devji, Interim Chief Operating Officer	31/12/2021	31/05/2024	9	The commissioning of services is being discussed within the Health Board, and the COCH-commissioned service should not differ to any other. The Health Board is currently discussing commissioning services at Executive Level, including that commissioned from COCH.
0507	Fragmented Care Records	2024	Reasonable pre 01/10/2024	Medium pre 01/10/2024	Matter Arising 3:ED Change Function (Operation)	3.1 The Change function should be established as defined	3.1: ED Forum has been agreed for end of June 2024 that will have all representations from EDs's present. There is a forum for Symphony updates/reviews that take place on a regular basis and is historically chaired by one of the DGMS for Emergency care. The meeting has clinical representation to support decision making and currently reports via the 6 goals programme board.	Dylan Roberts, Chief Digital and Information Officer	31/08/2024			Symphony has a pan BCU group established with representation from clinicians and operational managers. All change requests are channelled through this forum to be discussed and agreed before implementation. Meetings of the forum are minuted. Evidence provided - change log, symphony user group ToR
0508	Fragmented Care Records	2024	Reasonable pre 01/10/2024	Medium pre 01/10/2024	Matter Arising 4: ED Project Reporting (Operation)	4.1 The Reporting structure from the ED project should be established as defined.	4.1: This is under review in transition from Symphony programme board to Symphony user group, which will have a governance reporting process through ED board, into 6 Goals for Urgent and Emergency care	Dylan Roberts, Chief Digital and Information Officer	31/08/2024			Symphony user group established. Agenda and minutes attached. Recommend closure of this action.
0536	Digital Operating Model	2023	Reasonable pre 01/10/2024	Medium pre 01/10/2024	Matter Arising 8: Cloud Strategy (Operation)	8.1: The Cloud Strategy should be finalised.	8.1: The BCU Cloud Strategy is in development, having been delayed whilst the All Wales Infrastructure Programme (AWIP) Cloud Strategy was developed in order to take in to account any relevant criteria. The BCU Cloud Strategy will be a pragmatic Hybrid Cloud approach taking account of private and public Cloud provisioning rather than simply Cloud First.	Dylan Roberts, Chief Digital and Information Officer	31/03/2024	31/03/225	2	Sessions have continued drafting the initial document. This should be available to review by 31st March 2025. Implementation date from 1st June 2025
1311	Corporate Legislative Compliance: NHS (Appointment of Consultants) (Wales) (Amendment) Regulations 2005	2024	Reasonable pre 01/10/2024	Medium pre 01/10/2024	Matter Arising 3: Interview process of consultants (Operation)	3.1a: Management to seek views of AAC panel members to review current administration arrangements for panels and improvements required to ensure panels are effective.	3.1a: A new bank of questions and model answers, allocated to each of the AAC membership roles, will be created and consulted with Medical Leadership team and Independent Members.	Sreeman Andole, Interim Executive Medical Director	31/07/2024	30/11/2024	1	The model questions and answers have now been finalised, and will be provided with AAC interview pack - effective immediately
1312	Corporate Legislative Compliance: NHS (Appointment of Consultants) (Wales) (Amendment) Regulations 2005	2024	Reasonable pre 01/10/2024	Medium pre 01/10/2024	Matter Arising 3: Interview process of consultants (Operation)	3.1b: Management to seek views of AAC panel members to review current administration arrangements for panels and improvements required to ensure panels are effective.	3.1b: The standard AAC pack will be updated with the new bank of questions. When issued to panel members, they will be given one week prior to the interview to propose any alternative questions, otherwise it will be assumed they will use one of the standard questions issued in the pack. New guidance will be issued to AAC panel members on how to use the new question bank, how to model questions and assess the answers given by candidates.	Sreeman Andole, Interim Executive Medical Director	31/08/2024	30/11/2024	1	The model questions and answers have now been finalised, and will be provided with AAC interview pack - effective immediately

1315	Recruitment of substantive and interim executive and senior posts Final Internal Audit Report	2024	Reasonable pre 01/10/2024	Medium pre 01/10/2024	Matter Arising 2: Payment of allowances to officers in addition to the JESP salary band (Design)	2.1 Health Board Management: • Expedite the creation of an operational procedure that captures ways in which additional allowances can be considered, whilst recognising the shift to agile/remote working. In doing so it may wish to consider a 'Regional allowance' akin to the 'High-Cost Area Allowance' (London Weighting) that sets a minimum/maximum allowance it will consider in addition to the JESP banded salary, whilst ensuring it complies fully and within its Delegated Authority. This should be made clear at advert inclusive of the JESP Band. • Always ensures value for money when considering recurring additional allowances; When referring to the Relocation Policy as the	The Remuneration Committee will put in place a protocol in relation to 'hybrid working' which follows the principles set out in the relocation policy	Carol Shillabeer, Chief Executive	30/09/2024			The Remuneration Committee approved the Protocol in September. Recommended for closure - Remuneration Committee agreed a local allowance for hybrid working, in exceptional circumstances.
1319	Recruitment of substantive and interim executive and senior posts Final Internal Audit Report	2024	Reasonable pre 01/10/2024	Medium pre 01/10/2024	Matter Arising 6: Remuneration Committee reporting (Operation)	6.1 The Lead Executive Director to the Remuneration Committee seeks feedback from Committee Members on the content of the reports produced concerning Executive and Senior Manager Appointments and Senior Agency Interim Appointments and Extensions to ensure the Committee can fulfil its Terms of Reference 9.6 and 9.7 respectively.	6.1 The Deputy Director of People and the Director of Corporate Governance will work together to improve the reporting going forward and seek feedback from members as part of this process.	Carol Shillabeer, Chief Executive	30/09/2024			The Report format for the VSM has been updated with clarity in terms of the recommendations and decisions required by the committee. Recommended for closure - the new VSM report has been approved by the Director of Corporate Governance
1373	Intelligence Led Organisation	2024	Reasonable	Medium	Matter Arising 1: Skills (Operation)	1.1 A DI&I workforce plan should be developed, based on assessment of current and future needs for information and include an identification of skills required together with staff levels. The plan should consider various methods for obtaining skills and resource including: • creating time for staff to develop their skills and experiment with tools; • partnering with universities in order to obtain advanced skills and share learning; • partnering with third part organisations in order to access resource; and • recruitment of staff to key posts	1.1 Programme of analyst face to face, skills development sessions to be established. This will provide the opportunity to share learning and skill and co-develop solutions to analytical challenges	Dylan Roberts, Chief Digital and Information Officer	15/12/2024			Complete - Analysis team meetings with dedicated development sessions in place. December session focussed on statistical process control, future sessions include transformation and innovation methodologies, clinical coding, Finance and costings data, Public Health Intelligence and Quality.
1374	Intelligence Led Organisation	2024	Reasonable	Medium	Matter Arising 1: Skills (Operation)	1.2.1 A DI&I workforce plan should be developed, based on assessment of current and future needs for information and include an identification of skills required together with staff levels. The plan should consider various methods for obtaining skills and resource including: • creating time for staff to develop their skills and experiment with tools; • partnering with universities in order to obtain advanced skills and share learning; • partnering with third part organisations in order to access resource; and • recruitment of staff to key posts	1.2.1 Recruitment of staff to key posts Analysis Manager (internally) appointed on 31st October 2024, start date to be confirmed and handover to be completed.	Dylan Roberts, Chief Digital and Information Officer	01/12/2024			Complete - Gwennan Charlton appointed as Information Analysis Manager with effect from November 2024.

1375	Intelligence Led Organisation	2024	Reasonable	Medium	Matter Arising 1: Skills (Operation)	1.2.2 A DI&I workforce plan should be developed, based on assessment of current and future needs for information and include an identification of skills required together with staff levels. The plan should consider various methods for obtaining skills and resource including: <ul style="list-style-type: none"> • creating time for staff to develop their skills and experiment with tools; • partnering with universities in order to obtain advanced skills and share learning; • partnering with third part organisations in order to access resource; and • recruitment of staff to key posts 	1.2.2 Recruitment of staff to key posts Progress recruitment to fill current vacancies in Data Warehouse and Analysis Teams	Dylan Roberts, Chief Digital and Information Officer	30/12/2024			Complete - posts referenced all progressing having had ECR approval. Analysis team - Account manager posts IHC West Acute and community ECR67759 & 69345 and UEC Lead (Gwennan Charlton backfill) ECR 69841 out to advert. Development team Band 6 commenced January 2024 (ECR63100), Band 7 ECR 63257 offer made 9/1/25 subject to employment checks
1376	Intelligence Led Organisation	2024	Reasonable	Medium	Matter Arising 1: Skills (Operation)	1.3.1 A DI&I workforce plan should be developed, based on assessment of current and future needs for information and include an identification of skills required together with staff levels. The plan should consider various methods for obtaining skills and resource including: <ul style="list-style-type: none"> • creating time for staff to develop their skills and experiment with tools; • partnering with universities in order to obtain advanced skills and share learning; • partnering with third part organisations in order to access resource; and • recruitment of staff to key posts 	1.3.1 Understanding Requirements SBAR to be developed to outline future resource requirements to support WPAS and data quality improvements beyond the final stage (phase 5) of the WPAS single instance project) as part of the annual planning cycle.	Dylan Roberts, Chief Digital and Information Officer	30/11/2024	28/02/2025		Requirements included in DDaT growth paper shared with Executives. WG resource secured for a further 12 months to complete WPAS project phase 5 activities. Confirmation email from WG attached as evidence. Action Complete.
1377	Intelligence Led Organisation	2024	Reasonable	Medium	Matter Arising 1: Skills (Operation)	1.3.2 A DI&I workforce plan should be developed, based on assessment of current and future needs for information and include an identification of skills required together with staff levels. The plan should consider various methods for obtaining skills and resource including: <ul style="list-style-type: none"> • creating time for staff to develop their skills and experiment with tools; • partnering with universities in order to obtain advanced skills and share learning; • partnering with third part organisations in order to access resource; and • recruitment of staff to key posts 	1.3.2 Understanding Requirements Workshop to understand the future requirements of the Data Warehousing and Information Development based on NDR / LDR and cloud-based opportunities. This will identify skill requirements and gaps within the team.	Dylan Roberts, Chief Digital and Information Officer	15/12/2024			Complete - workshop held with members of DI&I management and Data Warehouse Teams and the Health Board's newly appointed Data Architect. Will inform work associated with action 1378.
1379	Intelligence Led Organisation	2024	Reasonable	Medium	Matter Arising 1: Skills (Operation)	1.3.4 A DI&I workforce plan should be developed, based on assessment of current and future needs for information and include an identification of skills required together with staff levels. The plan should consider various methods for obtaining skills and resource including: <ul style="list-style-type: none"> • creating time for staff to develop their skills and experiment with tools; • partnering with universities in order to obtain advanced skills and share learning; • partnering with third part organisations in order to access resource; and • recruitment of staff to key posts 	1.3.4 Understanding Requirements DI&I Teams training needs assessment to be undertaken (Q3 milestone of 24/25 annual plan)	Dylan Roberts, Chief Digital and Information Officer	31/12/2024			Complete - 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.

1381	Intelligence Led Organisation	2024	Reasonable	Medium	Matter Arising 1: Skills (Operation)	1.4.1 A DI&I workforce plan should be developed, based on assessment of current and future needs for information and include an identification of skills required together with staff levels. The plan should consider various methods for obtaining skills and resource including: <ul style="list-style-type: none"> • creating time for staff to develop their skills and experiment with tools; • partnering with universities in order to obtain advanced skills and share learning; • partnering with third part organisations in order to access resource; and • recruitment of staff to key posts 	1.4.1 External Partners Nominees of DI&I teams to be identified and develop leaflet / information packs for careers events and agree attendance at future programme of events (DDaT workforce strategy action)	Dylan Roberts, Chief Digital and Information Officer	31/01/2025				Slide pack developed. Interested colleagues identified, pool to be confirmed to ensure representation at all possible events across North Wales. Slides produces included as evidence. Action Completed.
1382	Intelligence Led Organisation	2024	Reasonable	Medium	Matter Arising 1: Skills (Operation)	1.4.1 A DI&I workforce plan should be developed, based on assessment of current and future needs for information and include an identification of skills required together with staff levels. The plan should consider various methods for obtaining skills and resource including: <ul style="list-style-type: none"> • creating time for staff to develop their skills and experiment with tools; • partnering with universities in order to obtain advanced skills and share learning; • partnering with third part organisations in order to access resource; and • recruitment of staff to key posts 	1.4.2 External Partners Follow up on initial conversations to explore opportunities for joint working with Bangor University's Business School in relation to their advanced analytics courses and develop a joint action plan to include input to course material and potential analytic projects.	Dylan Roberts, Chief Digital and Information Officer	31/12/2024				Follow up meeting took place with Bangor Uni. Lead analyst identified as key contact to ensure ongoing engagement - Action Complete
1384	Intelligence Led Organisation	2024	Reasonable	Medium	Matter Arising 2: Tools (Operation)	2.1.1 The detail over the actions to improve the use of technology for intelligence should be improved: <ul style="list-style-type: none"> • the use of automation; • the use of the NDR and how it will feed intelligence within BCU; and • the use of AI and modelling tools. 	2.1.1 RPA (Robotic Process Automation) paper to be presented to SLT with proposed use case for development, focussed around WPAS data quality. Further roll out of this will be core to the department's 2025/26 annual plan	Dylan Roberts, Chief Digital and Information Officer	30/11/2024				Complete - Paper presented to DDaT Senior leadership team and subsequently to the Clinical Design Authority (CDA) on 5/12/2024 with approval to proceed with an oncology proof of concept around 'booked no outcome' appointments.
1385	Intelligence Led Organisation	2024	Reasonable	Medium	Matter Arising 2: Tools (Operation)	2.1.2 The detail over the actions to improve the use of technology for intelligence should be improved: <ul style="list-style-type: none"> • the use of automation; • the use of the NDR and how it will feed intelligence within BCU; and • the use of AI and modelling tools. 	2.1.2 Review of available tools and assessment of current use and capability to inform future development plans	Dylan Roberts, Chief Digital and Information Officer	31/01/2025				2 x analysts on Advanced Analytics Programme. Internal cohort of Python training ongoing. Development team working through Google Cloud Skills Boost Programme. Action Completed.
1386	Intelligence Led Organisation	2024	Reasonable	Medium	Matter Arising 2: Tools (Operation)	2.1.3 The detail over the actions to improve the use of technology for intelligence should be improved: <ul style="list-style-type: none"> • the use of automation; • the use of the NDR and how it will feed intelligence within BCU; and • the use of AI and modelling tools. 	2.1.3 Review completion of Google Cloud Skills Boost learning package and set action plan for next cohort of staff to complete early in 2025	Dylan Roberts, Chief Digital and Information Officer	15/12/2024				Complete - Review of progress against Google Cloud skills boost undertaken across Development and Analysis Teams and further participants and learning identified.
1387	Intelligence Led Organisation	2024	Reasonable	Medium	Matter Arising 2: Tools (Operation)	2.1.4 The detail over the actions to improve the use of technology for intelligence should be improved: <ul style="list-style-type: none"> • the use of automation; • the use of the NDR and how it will feed intelligence within BCU; and • the use of AI and modelling tools. 	2.1.4 Agree attendees and feedback to team arrangements for future NHS Wales Modelling collaborative hackathon events to support development of forecasting capabilities.	Dylan Roberts, Chief Digital and Information Officer	15/12/2024				Complete. Analysts identified and feedback arrangements in place through team meetings and development sessions
1400	Charitable Funds - 2024	2024	Reasonable	Medium	Matter Arising 1: Governance and escalation (Operation)	1.1b) The Charity Declaration of Trust is periodically reviewed to ensure continued relevance.	1.1b) The Declaration of Trust will be included on the CFC Cycle of Business for the Charitable Funds Committee, to be reviewed annually	Russell Caldicott, Executive Director of Finance	30/04/2025	30/06/2025	1		Cycle of business approved at CFC meeting on 3 June
1402	Charitable Funds - 2024	2024	Reasonable	Medium	Matter Arising 1: Governance and escalation (Operation)	1.2b) The Charity Risk Register is reviewed by the Charitable Funds Committee in accordance with the Medium approved Cycle of Business.	1.2b) The Charity Risk Register is to be included on the Charitable Funds Committee agenda in accordance with the approved Cycle of Business	Russell Caldicott, Executive Director of Finance	30/04/2025	30/06/2025	1		Cycle of business approved at CFC meeting on 3 June

1412	Charitable Funds - 2024	2024	Reasonable	Medium	Matter Arising 4: Income (Operation)	4.1a) The register of fundraising events is monitored and maintained. Where expected income is not received within the prescribed timescales, this is escalated appropriately.	4.1a) All BCUHB staff to be regularly reminded, on a quarterly basis, of their role in ensuring all fundraising events are recorded on the Fundraising Registration Form (Fundraising Registration Form). Currently staff are not regularly reporting fundraising activity to the Charitable Support Team, so the team is often made aware of the activity after it has been carried out.	Russell Caldicott, Executive Director of Finance	30/04/2025			Fund Advisor updates: https://nhs.wales365.sharepoint.com/sites/BCU_Intranet_AWLAS
1511	Transformation & Improvement	2025	Reasonable	Medium	Objective 1: The structure and roles of the functions within the Team are in line with the funding, establishment and principles agreed by the Board.	<p>1. Transformation financial budget and ESR establishment</p> <p>As noted above, there are two items impacting the T&I cost centre, which remain to be resolved:</p> <p>1 – costs relating to a previous Health Board contract, where it has not yet been determined by Finance where these costs will be allocated</p> <p>2 – Reduction in funding for RIGA funds; it is not clear how these will impact the financial position for the T&I cost centre.</p> <p>We recognise that these issues are not directly attributable to T&I financial management, as they fall outside the T&I team's control and involve Finance in the allocation of certain costs and reserves. However, the findings need to be</p>	<p>a) Address the unresolved historic contract issue and reach agreement with Finance Directorate on where the payment (if applicable) will be charged to.</p> <p>b) Establish the recurrent funding position for Transformation and Improvement for 2025/26 onwards.</p>	Paolo Tardivel, Interim Executive Director of Transformation and Strategic Planning	30/06/2025			<p>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.</p> <p>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.</p>
1521	Clinical Audit - 2025	2025	Reasonable	Medium	Objective 1: There is appropriate guidance and documentation in place for the undertaking of Clinical Audit within the Health Board.	<p>1. Guidance and documentation</p> <p>Section 7.3 of the MD22 - Clinical Audit Policy & Procedure document does not accurately represent the current process for approval of the annual clinical audit plan. It states the Audit Committee are responsible for approval, however we are advised the Executive Quality Delivery Group approves the plan. The requirements for the Audit Committee to receive assurance on clinical audit are not reflected in the policy and procedure.</p>	<p>1. The Clinical Audit Policy will need to be reviewed to confirm that the Quality, Safety and Experience Committee will be responsible for approving the Clinical Audit Plan and assurance will be provided to Audit Committee in terms of the adequacy and assurances around the plan.</p>	Sreeman Andole, Interim Executive Medical Director	14/03/2025			The policy has been updated and uploaded and so action is closed

For AC closure - review by IA of pre-2022 recommendations - IA requested Executive to review. Executive reviewed and approved												
0646	Roster management	2019/20	N/A	High	Submission of timesheets by agencies	Agencies are formally reminded of the requirement to submit timesheets within 48 hours to ensure roster managers have sufficient time to check these. Compliance with the submission of timesheets to be monitored and where there are continued delays this should be escalated via contract arrangements.	Formal letter to be issued to all agencies from Executive Director of Workforce & Organisational Development Communication to be sent to all Heads of Nursing, Matrons and Ward Managers to emphasise requirement to lock down and record variations to working hours Training sessions to be held again with Heads of Nursing, Matrons and Ward Managers to ensure understanding of requirements	Jason Brannan, Deputy Director of People	30/06/2022	30/09/2022	1	<i>Pending - AC closure - Review by IA of pre-2022 recommendations - IA wants Executive to review. Executive reviewed and approved. Now for Audit Committee closure approval.</i>

0647	Roster management	2019/20	N/A	High	Implementation of 1 hour breaks	<p>3.1: The Temporary Staffing Team to regularly review 12 hour shifts on the system (prior to submission to payroll) and amend the break times as per the procedures.</p> <p>3.2 Agencies are formally reminded of the requirement to input breaks according to the timesheets submitted, and reminded of the declaration included on the system where they are confirming the details entered are correct.</p> <p>3.3 Roster managers to be formally reminded of the requirement to check shifts match timesheets / exception sheets before they are locked for payment.</p> <p>3.4 The 12 hour shifts where the break has not been adjusted should be identified and steps taken to recover the overpayments.</p> <p>3.5 The Temporary</p>	(as per 1.2) Draft SOP to be reviewed to amend reference to unpaid break to acknowledge the risks associated on safe staffing in conjunction with Corporate Nursing Team. Revised SOP to be clear on responsibility within Nursing for amending working hours in line with Safe Care Revised SOP approved by People & Culture Executive Delivery Group and implemented	Jason Brannan, Deputy Director of People	31/08/2022	30/09/2022	1	<p>Pending - AC closure - Review by IA of pre-2022 recommendations - IA wants Executive to review. Executive reviewed and approved.</p>
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'OPEN' AUDIT WALES RECOMMENDATIONS

ID	Report Title	Recommendation Title	Recommendation	Management Response	Final Approver	Original implementation date	Revised implementation date	Number of Revisions	Latest update
0394	Structured Assessment 2022	Recommendation 12: Improve performance and financial oversight for digital and estates	<p>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:</p> <ul style="list-style-type: none"> review any funding gaps in the digital and estates strategies to determine if they are financially feasible. Update the relevant committee on the findings of the financial feasibility review and how any associated risks will be managed. introduce periodic committee reports that not only focus on actions completed but the impact its digital and estates strategies are having on the organisation. 	<p>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.</p>	Dylan Roberts, Chief Digital and Information Officer	31/12/2023	31/03/2025	1	<p>(Update on behalf of DDaT only) Cost Pressure bids for DHCW SLA increases and Microsoft Licence increases have been secured.</p> <p>£197,461 inflationary increase cost pressures are currently being presented for funds to be drawn down into the DDaT Budget (this is out of an original cost pressure of £291,000.</p> <p>No allocation for growth bids has been successful to date and these include, but are not limited to EHR External Support, Digital Inclusion, Digital Innovation (including AI and Digital Academy). Implementation date revised to 31/03/2026.</p>
0399	Structured Assessment 2023	Recommendation tracking	<p>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.</p>	<p>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.</p>	Pam Wenger, Director of Corporate Governance	31/07/2024	31/03/2026	2	<p>The first new Compliance Report will be presented to the Audit Committee on 19th August, and this includes a section around regulatory compliance, which is the update provided to QSE. As previously reported, there is a considerable amount of work to be done to put this in place, as it involves others outside the Corporate Governance Directorate.</p>

0400	Structured Assessment 2023	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.	Pam Wenger, Director of Corporate Governance	31/07/2024	31/03/2026	2	The first new Compliance Report will be presented to the Audit Committee on 19th August, and this includes a section around regulatory compliance, which is the update provided to QSE. As previously reported, there is a considerable amount of work to be done to put this in place, as it involves others outside the Corporate Governance Directorate.
1364	Urgent and Emergency Care: Flow out of Hospital – North Wales Region	Addressing key gaps in capacity	R10. The Health Board and local authorities need to work together to develop joint solutions to address key gaps in service capacity, in particular, domiciliary care and reablement services which would enable timelier discharge of patients to their own home.	Sub-regional: Utilise Further Faster Funding and action planning In Central, D2RA team at the front door working as Trusted Assessors to address the gaps in assessment capacity working together with local authorities to support reablement provision ongoing work to support more timely discharge required for POC with agreed Trusted assessment pathways Central Area Integrated Services Board considers the development of joint solutions to address key gaps in service capacity e.g the Denbigh Health and Social Care Programme. The Health Board have developed the Tuag Adref service in the West to provide for a reablement service and domiciliary care is now jointly commissioned by Local Authorities and the Health Board.	Tehmeena Ajmal, Chief Operating Officer	Ongoing			<i>No update provided</i>
1424	Board Effectiveness Follow-up – Betsi Cadwaladr University Health Board	Executive Team	A key priority for the new Chief Executive will be to build a stable, cohesive, and appropriately skilled Executive Team that can provide the organisation with the operational leadership it needs. This will include settling on the right mix of Executive Director portfolios, reducing reliance on interim arrangements for senior leadership roles, and building leadership capacity and capability for the Health Board's corporate governance arrangements	No management response within report	Carol Shillabeer, Chief Executive				Executive Team in a more stable position, with recruitment plans in place for the Executive Director of Workforce and OD. Substantive Executive Medical Director appointed.

1453	Structured Assessment 2024	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. Key actions include: • Review of the operational governance arrangements including the role of the Senior Leadership Team	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	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. Key actions include: • Agree how the Board can engage with services, which will include plans in terms of service reviews; • Establish a reporting mechanism to the Board in terms of service visits	Pam Wenger, Director of Corporate Governance	30/06/2025			In progress: Board Visits presentation given to the Board in July with an agreement on next steps to the September 2025 Board
1463	Review of Cost Savings Arrangements	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: 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	31/10/2025			This continues to be an ongoing ambition.

1467	Review of Cost Savings Arrangements	Recommendation 2.3	The Health Board should strengthen its approach to the identification and delivery of savings by: 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	31/03/2025			The 24/25 full year effect of the recurrent savings schemes was £44m, so £4m short of the £48m target. For 25/26 as at Month 4, recurring schemes with a full year effect of £24.3m have been identified to date against the £40m target. All the financial reports document the recurring full year effect of savings identified and the message will continue to be shared both at IPEDG, programme board and locally via the CFOs about the need to find savings on a recurring basis.
1470	Review of Cost Savings Arrangements	Recommendation 3.1	When updating its savings guidance, the Health Board should ensure: R3.1: That the guidance provides greater clarity around how and when the views of service users and stakeholders should be canvassed in the process of generating savings ideas.	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	Ongoing 2025			This is ongoing, and a proposal about how to refresh the 'Small Change big difference' will be taken to a future programme board.
1514	Urgent and Emergency Care: Flow out of Hospital – North Wales Region	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) 2. Conwy, Denbighshire & Flintshire local authorities and the Health Board have a WASPI in place since the implementation of the SPOAs. (OWNER: CHC Commissioning Manager)	Tehmeena Ajmal, Chief Operating Officer	31/10/2024	01/06/2025	1	Information has been provided from DDAT team on discussions with HB and RPB on the need for a WASPI. Whilst a solution of an integrated information sharing system is awaited with options being considered. The IHCs and LAs meet weekly to discuss patients requiring support for discharge to progress as timely as possible and in line with D2RA guidance. UEC workstreams 3 and 4 are also focused on supporting the timely progression of clinically optimised patients to facilitate effective hospital flow which include LA representation,

1520	Urgent and Emergency Care: Flow out of Hospital – North Wales Region	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.	<p>Sub-regional: THIS RECOMMENDATION CONSISTED OF 8 DIFFERENT ACTIONS, AND HAS BEEN SPLIT DOWN TO SEPARATE RECOMMENDATIONS - SEE 1363-1372 AND 15-14-1520)</p> <p>8. Actively seek ways to increase local authority access for systems held within BCUHB. (OWNER: Acting Assistant Director of Care Homes Support)</p>	Tehmeena Ajmal, Chief Operating Officer	31/10/2024	31/04/2025	1	<p>Ongoing work between HB and LAs has involved pilot study (Anglesey) to test the viability of WCCIS system but the outcome concluded this system was not suitable. Consideration of Connecting Care as the development is believed would help greater working across boundaries / organisations, but this is some way off development. Therapy Manager replacement is on hold awaiting approval of whether can continue which is also an option being considered for opportunity to enable greater access.</p> <p>Weekly meetings are established with IHCs and LAs to discuss patients requiring support for discharge to progress as timely as possible and in line with D2RA guidance</p> <p>UEC workstreams 3 and 4 are also focused on supporting the timely progression of clinically optimised patients to facilitate effective hospital flow which include LA representation,</p>
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**SUMMARY OF AUDIT WALES RECOMMENDATIONS PROPOSED FOR CLOSURE
FOR COMMITTEE APPROVAL**

Summary of recommendation with rationale for closure

DIRECTOR OF CORPORATE GOVERNANCE

1	1450	Structured Assessment 2024	Reports to the Board on the Executive Committee including strengthening reporting arrangements from Groups
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CHIEF EXECUTIVE

1	1419	Board	Annual Report presented to Board, and also the appointment of Interim Director of People.
2	1423	Effectiveness Follow-up –	Board Development Plan as reported last year but also the board plan that went to the Board in May 2025.

POLICIES OVERDUE THEIR REVIEW AS AT 27/06/2025
 UPDATES RECEIVED AS AT 29/08/2025

Name	Effective Date	Review Date	Responsible Director	Risk category	Original Qtr for review	Updated Qtr for Review	Q4 2024/25 progress update	Q1 2025/26 updates
A Clinical Policy for DNACPR For Adults in Wales - V4.pdf	01/12/2020	01/12/2022	Chief Operating Officer	Patient safety				No update provided
All Wales Email Use Policy - V2.pdf	26/06/2018	26/06/2018	Chief Digital Information Officer	IT	Q4 2024/25			UPDATE 18/08/25 - Final draft reviewed and awaiting approval Policy Team feedback on update: Can you please provide the details of where this is to be approved i.e. Meeting and Date.
All Wales Information Governance Policy - V2.pdf	14/01/2021	13/01/2023	Chief Digital Information Officer	IT	Q4 2024/25			Update 18/08/25: IG & Info Security policies merged - final draft reviewed and awaiting approval Policy Team feedback on update: Can you please provide the details of where this is to be approved i.e. Meeting and Date.
All Wales Information Security Policy - V2.pdf	14/01/2021	13/01/2023	Chief Digital Information Officer	IT;#Reputational	Q4 2024/25			Update 18/08/25: IG & Info Security policies merged - final draft reviewed and awaiting approval Policy Team feedback on update: Can you please provide the details of where this is to be approved i.e. Meeting and Date.
All Wales Internet Use Policy - V3.pdf	14/01/2021	13/01/2023	Chief Digital Information Officer	IT;#Reputational	Q4 2024/25			Update 18/08/25: Final draft reviewed and awaiting approval Policy Team feedback on update: Can you please provide the details of where this is to be approved i.e. Meeting and Date.
All Wales Policy on Insurance, NHS Indemnity & related Risk Management for Potential Losses & Special Payments.pdf	11/09/2018	11/09/2020	Executive Director of Finance	Financial;#Legal	Q3 2024/25			No update provided
BCUHB - Claims Governance Policy, Clinical Negligence and Personal Injury - V8.pdf	12/12/2019	01/07/2021	Director of Corporate Governance	Legal;#Financial	Q4 2024/25	Q2 2025/26	The Executive Team approved the Case for Change covering Legal Services in January 2025 which now provides a fundamentally different approach. The new policy continues to be drafted however acute staffing pressures in one team has taken up management time meaning the Q4/March 2025 target is at risk, and may slip to the May 2025 Board for approval	29/07/25: Aligned to the ADP, a new Legal Services Policy will be complete by end of Q2
BH-004 - Transfusion of Blood Components Outside the Acute Hospital Setting - V2.0.pdf	01/09/2021	01/08/2024	Chief Operating Officer	Patient safety				No update provided
CW01 - BCUHB Paediatric Escalation Policy - V3.pdf	01/09/2018	01/09/2019	Chief Operating Officer	Patient safety	Q4 2024/26		30/01/2025 - Corporate Governance Directorate review of this overdue policy - likely not a policy document but rather a procedure - "Procedures are detailed instructions that describe how to implement a policy or perform a task. They outline the steps, roles, responsibilities, and resources involved in a process and provide guidance for achieving a desired outcome." Author to consider this when reviewing	No update provided
ES01 - BCUHB Asbestos Policy & Management Plan.pdf	31/05/2022	31/05/2025	Director of Environment and Estates	Health and Safety				No update provided
ES02 - Policy for the Management of Safe Water Systems.pdf	10/05/2022	10/05/2025	Director of Environment and Estates	Health and Safety				No update provided
ES03 - Waste Management Policy - V5.pdf	01/09/2020	01/09/2023	Director of Environment and Estates	Health and Safety	Q3 2024/25		30/01/2025 - Corporate Governance Directorate review of this overdue policy - likely not a policy document but rather a procedure - "Procedures are detailed instructions that describe how to implement a policy or perform a task. They outline the steps, roles, responsibilities, and resources involved in a process and provide guidance for achieving a desired outcome." Author to consider this when reviewing	No update provided
ES04 - Policy for the Management of Fire Safety - V0.4.pdf	01/11/2020	01/04/2022	Director of Environment and Estates	Health and Safety	Q3 2024/25		30/01/2025 - Corporate Governance Directorate review of this overdue policy - likely not a policy document but rather a procedure - "Procedures are detailed instructions that describe how to implement a policy or perform a task. They outline the steps, roles, responsibilities, and resources involved in a process and provide guidance for achieving a desired outcome." Author to consider this when reviewing	No update provided
ES05 - Policy for the Management of Ventilation Systems - V1.0.pdf	08/03/2022	08/03/2025	Director of Environment and Estates	Health and Safety			This policy has now transferred to the Director of Environment and Estates, who will need to undertake a review of this policy	No update provided
F02 - Lease Car & Pool Vehicle Policy and Procedure - V.03.pdf	12/08/2021	15/08/2024	Executive Director of Finance	Financial	Q4 2024/25		30/01/2025 - Corporate Governance Directorate review of this overdue policy - likely not a policy document but rather a procedure - "Procedures are detailed instructions that describe how to implement a policy or perform a task. They outline the steps, roles, responsibilities, and resources involved in a process and provide guidance for achieving a desired outcome." Author to consider this when reviewing. UPDATE 20/02/2025 - The policy and procedure are currently being updated to reflect guidance on National Minimum Wage and mileage rates. Update and consultation scheduled to be completed by 31 March 2025.	No update provided
HS23 - CCTV and Body Worn Video (BWBV) Policy - V1.0.pdf	15/03/2022	15/03/2025	Executive Director of Workforce and Organisational Development	Health and Safety;#HR/Staff				No update provided
INF03 - Informatics Change Management Policy - V1.pdf	21/01/2020	13/01/2023	Chief Digital Information Officer	IT	Q4 2024/25		Policy INF03 IT SYSTEMS CHANGE MANAGEMENT POLICY and the associated ICT procedure are both currently going through the approval process as per guidance, we understand it has been shared with the organisation for feedback on comments and is due to go to the ITIG Meeting for review and approval.	Update 16/07/2025. Currently awaiting confirmation that the updated version has been accepted. Policy Team feedback on update: Currently with Martin Parry to work with Jen from Equalities to make sure the EQIA is on the correct template. Once this has been addressed and all documents sent back to the Policies Inbox it will be added to the Executive Policy Oversight Group Agenda in September for that final approval.
ISU03 - Volunteering Policy - V0.1.pdf	09/12/2014	12/01/2017	Executive Director of Workforce and Organisational Development	HR/Staff	Q3 2024/25			This is a Finance policy. Policy Team feedback on update: Discussions to take place between Executives to seeks approval of change of Executive lead
MD10 - Medical & Dental Staff Study Leave Policy - V0.1.pdf	20/10/2014	20/10/2017	Executive Medical Director	HR/Staff	Q4 2024/25	Q1 2025/26	30/01/2025 - Corporate Governance Directorate review of this overdue policy - likely not a policy document but rather a procedure - "Procedures are detailed instructions that describe how to implement a policy or perform a task. They outline the steps, roles, responsibilities, and resources involved in a process and provide guidance for achieving a desired outcome." Author to consider this when reviewing. 05/02/2025 - update from OMD Still on target for completion end of Q1	This is a Finance policy. Policy Team feedback on update: Discussions to take place between Executives to seeks approval of change of Executive lead
MD11 - Medical & Dental Staff Professional Leave Policy - V0.1.pdf	20/10/2014	20/10/2017	Executive Medical Director	HR/Staff	Q4 2024/25	Q2 2025/26	Still on target for completion end of Q1	Due to go to LNC may be more Q2 as finalised
MD13 - Annual Leave & Special Leave Policy for Medical & Dental Staff - V0.1.pdf	20/10/2014	20/10/2017	Executive Medical Director	HR/Staff	Q1 2025/26	Q2 2025/26	Still on target for completion end of Q1	Due to go to LNC may be more Q2 as finalised
MD17 - Interventions Not Normally Undertaken (INNU) Policy - V1.1.pdf	24/07/2018	01/09/2021	Executive Medical Director	Patient safety			Still under discussion - talk of a National Policy, all HBs are now considering beginning to initiate their own reviews - no movement yet though	03/07/2025: Still under discussion - talk of a National Policy, all HBs are now considering beginning to initiate their own reviews - no movement yet though. 14/08/25 - No change. Still as above.



Teitl adroddiad: <i>Report title:</i>	Revised Policy Management Process
Adrodd i: <i>Report to:</i>	Audit Committee
Dyddiad y Cyfarfod: <i>Date of Meeting:</i>	Tuesday, 21 October 2025
Argymhellion: <i>Recommendations:</i>	The Committee is asked to: <ul style="list-style-type: none">• NOTE and COMMENT on the proposed policy management process to enable to work on the consultation of the overarching policy; and• NOTE that following comments the final Policy will be considered at the Audit Committee in December 2025.
Arweinydd Gweithredol: <i>Executive Lead:</i>	Pam Wenger, Director of Corporate Governance
Awdur yr Adroddiad: <i>Report Author:</i>	Glesni Driver, Head of Statutory Compliance and Inquiries
Cyswllt ag Amcan/Amcanion Strategol: <i>Link to Strategic Objective(s):</i>	Not applicable, other than those relating to individual policies, procedures and other written control documents
Goblygiadau rheoleiddio a lleol: <i>Regulatory and legal implications:</i>	It is essential that the Health Board has up to date and accurate policies, procedures and other written control documents in order to comply with relevant legislation and minimise any associated risk
Yn unol â WP7, a oedd EqIA yn angenrheidiol ac a gafodd ei gynnal? <i>In accordance with WP7 has an EqIA been identified as necessary and undertaken?</i>	The Equality duty is not applicable. This report is purely administrative in nature and submitted for information only. The associated public sector duties are not engaged (there are no associated impacts on any of the protected groups).
Yn unol â WP68, a oedd SEIA yn angenrheidiol ac a gafodd ei gynnal? <i>In accordance with WP68, has an SEIA identified as necessary been undertaken?</i>	The Socio-Economic duty is not applicable. This report is purely administrative in nature and submitted for information only. The associated public sector duties are not engaged (the report does not relate to a decision, strategic or otherwise).
Manylion am risgiau sy'n gysylltiedig â phwnc a chwmpas y papur hwn, gan gynnwys risgiau newydd (croesgyfeirio at y BAF a'r CRR) <i>Details of risks associated with the subject and scope of this paper, including new risks (cross reference to the BAF and CRR)</i>	There are risks relating to policies, procedures and other written control documents that have passed their 1-year or 3-year mandatory review period following initial approval. It is essential that the Health Board has up-to-date and accurate policies and written control documents in order to comply with relevant legislation and minimise any associated risk
Goblygiadau ariannol o ganlyniad i roi'r argymhellion ar waith <i>Financial implications as a result of implementing the recommendations</i>	Not applicable, other than those relating to individual policies, procedures and other written control documents

<p>Goblygiadau gweithlu o ganlyniad i roi'r argymhellion ar waith</p> <p><i>Workforce implications as a result of implementing the recommendations</i></p>	<p>Not applicable, other than those relating to individual policies, procedures and other written control documents</p>
<p>Adborth, ymateb a chrynodeb dilynol ar ôl ymgynghori</p> <p><i>Feedback, response, and follow up summary following consultation</i></p>	<p>Updates from the initial consultation around the revised policy management process have been incorporated. Once reviewed by the Executive Team and Audit Committee, the Policy Management Policy and Policy Management Procedure will be submitted onto BetsiNet for Health Board-wide consultation, with updates made as necessary, with the current approval routes followed for both the Policy and Procedure prior to publication.</p>
<p>Cysylltiadau â risgiau BAF: (neu gysylltiadau â'r Gofrestr Risg Gorfforaethol)</p> <p><i>Links to BAF risks:</i> (or links to the Corporate Risk Register)</p>	<p>Not applicable, other than those relating to individual policies, procedures and other written control documents.</p>
<p>Rheswm dros gyflwyno adroddiad i fwrdd cyfrinachol (lle bo'n berthnasol)</p> <p><i>Reason for submission of report to confidential board (where relevant)</i></p>	<p>Not applicable</p>
<p>Camau Nesaf: Gweithredu argymhellion</p> <p><i>Next Steps:</i> <i>Implementation of recommendations</i></p> <p>Once reviewed by the Executive Committee and Audit Committee, the Policy Management Policy and Policy Management Procedure will be submitted onto BetsiNet for Health Board-wide consultation, with updates made as necessary at the end of that consultation period, and the current approval routes followed for both documents prior to publication.</p>	
<p>Rhestr o Atodiadau:</p> <p><i>List of Appendices:</i></p> <p>Appendix 1: Draft Policy Appendix 2: Policy approval route</p>	

REVISED POLICY MANAGEMENT PROCESS

1 PURPOSE

The purpose of this report is to provide the Audit Committee with an overview of the revised policy management process within the Health Board. It outlines the rationale for change, highlights the key improvements made to streamline and clarify the management of corporate policy-related documents.

The report also summarises interim changes already implemented, the categorisation of corporate versus local documents, and the next steps for consultation and implementation to ensure compliance, consistency, and improved engagement across the organisation.

2 INTRODUCTION

At present, some policies, procedures and other written control documents (WCDs)¹ held on the Health Board's Policy Management System on BetsiNet are potentially no longer appropriate or relevant, with many not having been reviewed for a number of years, and therefore breach the current Health Board policy around the management of policies (*Policy for the Management of Health Board wide Policies, Procedures & other Written Control Documents*, herein referred to as '*Corporate Policy Management Policy*').

The current process around the management of policies, procedures and other WCDs in the Health Board is not fit for purpose, and is a contributing factor to the current state of policy-related documents² being overdue a review. The current process is seen as laborious and cumbersome, and lacks clarity. In order to make improvements to ensure compliance, the Statutory Compliance Team has undertaken an initial consultation throughout the Health Board to revise and introduce a new, more streamlined and user-friendly process.

As part of this review, revisions were required to the '*Policy for the Management of Health Board wide Policies, Procedures & other Written Control Documents*', required, as well as the introduction of a Procedure, which details the series of actions to be conducted when preparing policy-related documents. In addition, the categories of previously held policy-related documents were reviewed to ensure that the correct types of corporate document are centrally held.

¹ The term 'written control document' is used to describe protocols and guidelines.

² The term 'policy-related document' will be used as the collective name for policies, procedures and other WCDs.

2.1 Interim process changes

In the short term, and whilst the full consultation and approval process takes place, the Statutory Compliance Team have made some interim changes to simplify the process and reduce the workload for those preparing or reviewing policy-related documents, and to introduce a more robust process to ensure compliance. The feedback around these interim changes has been extremely positive, and due to this, there is much more positive engagement around the policy management, which will assist in the implementation of the new process.

3 CORPORATE POLICY-RELATED DOCUMENTS

At present, there is a mixture of both 'corporate' and 'local' policy-related documents held on the Policy Management System. As part of the new process, only Corporate or Health Board-wide policies, procedures and other WCDs will be included within the '*Corporate Policy Management Policy*' and therefore retained on the Policy Management System, whereas 'local' policy-related documents will need to be stored and managed locally.

A Corporate or Health Board-wide policy, procedure and other WCDs are those that relate to:

- more than one directorate or division or department across the Health Board
- one directorate/department that spans more than one physical location
- relate to the direct or indirect treatment and/or impact on our patients
- where there could be wider impact on the whole organisation.

If a document relates to any kind of treatment of or contact with a patient, it should be classed as a 'corporate' document, whether it relates to one speciality, department, division or not.

3.1 'Local' Procedures

'Local Procedures' or 'Standard Operating Procedures' (directorate, division and departmental-specific documents), which relate to a single directorate or division, where there is no wider impact on the organisation, or where other areas do not need to be made aware of its existence are not to be included in our corporate policy processes going forward. Examples of such documents include Standard Operating Procedures (SOPs) explaining an internal process such as dealing with mail, or an internal process around dealing with queries.

It will be the responsibility of the lead Executive Director of local procedures or SOPs not subject to the new Health Board process to determine the appropriate approval and scrutiny process for those documents.

4 POLICY-RELATED DOCUMENT DEFINITIONS

4.1 Current policy-related documents

The current 'Policy on Policies' requires that the following documents are held centrally on the Policy Management System, and published on BetsiNet:

- Strategy
- Policy
- Protocol
- Procedure
- Guideline
- Standards
- Cognitive Aids

4.2 Proposed policy-related documents

It is proposed to reduce this to the following corporate policy-related documents – these can be clinical or non-clinical in nature:

<u>Corporate Policy</u>	<p>A written statement of intent, describing the broad approach or course of action that the organisation is taking with a particular issue eg compliance to legislation.</p> <p>Corporate policies affect all of the organisation, are stored centrally, listed on the Policy Management System, and published on BetsiNet.</p>
<u>Corporate Procedure</u>	<p>A standardised method of performing clinical or non-clinical tasks that is relevant organisation-wide.</p> <p>Corporate procedures affect all of the organisation, are stored centrally, listed on the Policy Management System, and published on BetsiNet.</p>
<u>Corporate Protocol</u>	<p>A written code of practice, including recommendations, roles and standards to be met, which can also include details of competencies and delegation of authority.</p> <p>Corporate protocols affect all of the organisation, are stored centrally, listed on the Policy Management System, and published on BetsiNet.</p>
<u>Corporate Guidelines</u>	<p>Give general advice and recommendations for dealing with specific circumstances. They differ from procedures and protocols by giving options of how something might be carried out. They are used in conjunction with knowledge and expertise of the individual using them.</p> <p>Corporate guidelines affect all of the organisation, are stored centrally, listed on the Policy Management System, and published on BetsiNet.</p>

5 **POLICY-DOCUMENT TEMPLATES**

As policies differ in the type of information and detail they contain to that of procedures and other WCD documents, there will now be two new templates – one for policies, and another for procedures and other WCDs.

6 **CONSULTATION AROUND POLICY-RELATED DOCUMENTS**

In the current 'Policy on Policies', there is an option to submit a draft policy-related document for Health Board-wide consultation. At present, issues do arise when Health Board consultation has not taken place – this is a risk to the Health Board when certain elements have not been considered, which causes issues and delays, often much too late in the process, requiring changes to the documentation once final approval has been given. Also, there are occasions where the responsible Executive Team Member is not aware of the existence of a new or revised policy-related document assigned to their portfolio.

Therefore, with the revised process, it will be mandated that all policy-related documents are published in draft on BetsiNet for full Health Board consultation, for a minimum period of two weeks, prior to the document being submitted for final approval as per the approval routes detailed in the next section.

This will allow all interested parties an opportunity to review the draft documentation to ensure that it is fit for purpose and compliant before approval and publication.

7 **APPROVAL ROUTES**

The current approval route, where policy-related documents are to be endorsed and approved is not clear, is causing confusion for policy owners, delays the process, varies across the Health Board, and contributes to the lack of engagement with the policy management process.

Even though the current policy approval process is a maximum of three steps, with only two approval steps for the majority of document, the process is being overly delayed due to 'local' and often historical requirements for the review and approval of these documents – many take several months to follow this process before it reaches the '*Corporate Policy Management Policy*' approval requirements. Due to this, the local requirements around approvals is distorting the perception of the Health Board's policy approval process, which is impacting the engagement of policy owners across the Health Board.

Please note that the new policy management process will not include requirements around any 'local' approval routes that a directorate or department wishes or is required to undertake prior to final approval – this will be at the discretion of the lead Executive Team Member, and is outside the scope of the this process, the revised Policy on Policies, and associated Procedure.

7.1 Proposed policy approval route

As mentioned above, policies are high-level documents, documenting the Health Board's written statement of intent, describing the broad approach or course of action that the organisation is taking with a particular issue, for example, to comply with legislation. These are therefore strategic documents that do not contain detailed processes and/or instructions, but set the overall policy statement and commitment for the issue, in line with the Health Board's strategic objectives.

Going forward, it is now proposed that all policies are approved by an Executive Led Group. The draft list of approval routes by category is provided in Appendix 1.

7.2 Proposed procedure and other WCD approval route

Unlike policies, these are detailed documents, which should be approved by specialist groups, where all the necessary clinical and/or other expertise are present so that the detail can be examined and tested prior to approval.

It is now proposed that all procedures and other WCDs are approved by specialist groups, as determined by the lead Executive.

Again, the details have been provided to the Statutory Compliance Team by a combination of both the Executive Team Members and policy SPOCs.

As with policies, there are certain areas within the Health Board where there is currently no clear route or reporting structure into a specialist group, therefore an interim proposal has been put in place.

8 ALL-WALES OR EXTERNAL POLICIES, PROCEDURE AND OTHER WRITTEN CONTROL DOCUMENTS

All-Wales or external policy-related documents are those that are developed and collectively approved for adoption outside the Health Board.

8.1 Agreements to adopt all-Wales/external documents

The process around the adoption of these policy-related documents in the Health Board depends on whether there is an all-Wales or external agreement around how Health Boards should adopt such documents.

For example, the Welsh Partnership Forum (WPF) develops and reviews workforce policies on behalf of the partners by NHS Wales Employers. All Wales Policies developed and reviewed by the WPF form part of the agreed National Pay Terms and Conditions and therefore, organisations are required to implement them as they stand, with no variation. When this is the case, the policy-related document will not require any Health Board approval prior to implementation, with the relevant document being made available with all other policy-related documents on BetsiNet.

8.2 Adoption of other all-Wales/external documents

Where no such agreement is in place for other external/all-Wales policy-related documents, they will need to follow the Health Board approval route.

8.3 Impact Assessments

If an all-Wales or external EQIA or similar document has been completed on an all-Wales or external basis, the Health Board would still require a Health Board-specific impact assessment to be conducted to ensure that there are no adverse impacts from implementing the policy-related document. It will therefore be necessary to complete and seek approval of an EQIA and Impact Assessment Screening Tool for every external/all-Wales document to review the potential impacts on the Health Board. A copy of the completed and approved EQIA and Impact Assessment Screening Tool document will need to accompany the all-Wales/external document when submitting to the Statutory Compliance Team.

8.4 All-Wales policy-related documents for review

At present, there are a number of all-Wales policy-related documents that are overdue a review, as per the timelines within the current 'Policy on Policies'. However, it is appreciated that the review of these documents is outside the Health Board's control.

It is therefore proposed that when an all-Wales or external policy-related document is due a review, where an updated all-Wales is not yet available:

- the current all-Wales document is reviewed, and if approved by the lead Executive Team Member, an extension of the review date granted, or;
- a new policy-related document is created by the Health Board until a revised all-Wales/external document becomes available, as per the process detailed earlier in this paper.

This will be at the discretion of the lead Executive Team Member.

If an extension to an existing all-Wales/external document is granted, the details of approval to be submitted to the Statutory Compliance Team so that the Policy Management System can be updated accordingly.

9 'POLICY ON POLICIES' CONSULTATION

Once the above recommendations contained within this paper are approved by the Committee, the draft 'Policy on Policies' and associated Procedure will be updated if necessary, and published as a draft on BetsiNet for Health Board-wide consultation. Once this consultation has taken place, the documentation will be updated as necessary, and the 'Policy on Policies' and associated Procedure submitted through the current approval route. Once approved, the documentation will be published on BetsiNet, and the new process will be implemented.

10 POLICY MANAGEMENT SYSTEM

If the reduction in the policy-related document categories is approved, in line with Section 4.2, a number of current policy-related documents listed as for example 'strategy' will need to be removed from the Policy Management System and stored locally as necessary. The Statutory Compliance Team will liaise with the Executives to progress this work.

11 COMMUNICATION AND ENGAGEMENT

The Statutory Compliance Team have already been engaging with policy owners around the interim changes to the process, and this will continue with workshops, training videos and a refreshed Policy Management intranet page to assist those involved in creating new or reviewing existing policy-related documents.

12 **DELEGATION OF AUTHORITY**

If the Committee approves the revised approval routes (as per Appendix 1), work on updating the terms of reference for the relevant committees/meetings/groups will take place to ensure that there is clarity around the delegated responsibilities to approve such documents. This will be progressed by the Director of Corporate Governance.

13 **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 policy-related work lies with the relevant directorate, division, or department as part of business-as-usual functions.

14 **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, as part of the work to revise the current 'Policy on Policies', and the creation of the new related Procedure, the Equality Impact Assessment and the Impact Assessment Screening Tool will be completed to identify any potential impacts.



CORPORATE POLICY MANAGEMENT POLICY

Reference Number:		
Version Number:		
Policy Approved / Ratified by:	Group Name	Date of meeting
	Group	
	Delivery Group	
Date EQIA Completed:		
Date IAST Completed:		
Date of Next Review:		
Date of Publication:		
Link to Primary and Secondary Legislation, Ministerial Directions or Welsh Health Circulars etc:		
Group with authority to approve supporting procedures:		
Accountable Executive Director:	Name	Role title
	Pam Wenger	Director of Corporate Governance
Author(s):	Name	Role title
	Glesni Driver	Head of Statutory Compliance and Inquiries

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DRAFT

~~CORPORATE POLICY MANAGEMENT POLICY~~ ~~POLICY ON THE MANAGEMENT OF CORPORATE POLICIES, PROCEDURES AND OTHER WRITTEN CONTROL DOCUMENTS~~

1 POLICY STATEMENT

Having certain policies in place is a statutory requirement for NHS Wales bodies, but not every policy falls under statute. Some are legally required, some are mandated by Welsh Government/NHS Wales, and others are local 'best practice' or organisational governance tools.

1.1 Statutory Requirements

Under legislation such as the NHS (Wales) Act 2006, Health and Safety at Work Act 1974, Equality Act 2010, and other UK-wide/Welsh regulations, NHS organisations must have documented policies in certain areas, for example:

- Health and Safety Policy – required by the Health and Safety at Work Act
- Equality and Diversity/Equal Opportunities Policy – required by the Equality Act
- Data Protection/Information Governance Policy – required by UK GDPR and the Data Protection Act 2018
- Safeguarding Policies – required under the Social Services and Well-being (Wales) Act 2014
- Whistleblowing (Raising Concerns) Policy – statutory protection under the Public Interest Disclosure Act 1998
- Employment-related policies – some are rights (eg disciplinary, grievance, parental leave, flexible working).

These are statutory policies: NHS Wales organisations are legally obliged to have them.

1.2 Nationally Mandated NHS Wales Policies

NHS Wales also operates under an All-Wales Employment Policy Framework, agreed with Trade Unions, which standardises HR/employment-related policies across all Health Boards and Trusts. Examples are:

- Disciplinary Policy
- Grievance Policy
- Managing Attendance at Work Policy

While not all of these are statutory laws, they are mandatory under NHS Wales governance arrangements, so Health Boards must adopt them.

1.3 Organisational (Local) Policies

Beyond statutory and mandated policies, individual NHS Wales organisations develop local policies to support governance, safety, and consistency, eg:

- Medical device management policies
- Infection prevention and control protocols
- Risk management policies
- Policy for policy management

These are not statutory in themselves, but they demonstrate good governance and compliance with overarching statutory duties (eg duty of quality, duty of candour, duty of safety under the Health and Social Care (Quality and Engagement) (Wales) Act 2020).

1.4 This Policy will ensure that Betsi Cadwaladr University Health Board (BCUHB) delivers its aims, objectives, responsibilities and legal requirements transparently and consistently in relation to its management of Policies, Procedures and other written control documents.

1.5 The Health Board has a statutory duty to ensure that appropriate policies (supported by procedures and other control documents) are in place in order to comply with legislation and regulation. Having effective, up to date and accessible corporate Policies, Procedures and other written control documents also helps to promote governance best practice, guide staff and minimise risks.

1.6 This Policy describes the Health Board's guiding principles that underpins decisions, behaviours and actions for everything we do.

1.7 Procedures and other written control documents translate these principles into more detailed instructions or guidance including individual responsibilities.

1.8 A Corporate Policy, Procedure and other written control documents are those that relate to more than one directorate or division, and where there is a wider impact on the whole organisation.

2 POLICY COMMITMENT

2.1 Our Policies, Procedures and other written control documents will be in keeping with the organisational Values and Behaviours Framework.

2.2 Our documents will be written in plain language so that all staff, stakeholders and where appropriate people using our services, are clear about what is expected.

2.3 It will be possible to find them easily on our internet and/or intranet sites. Each document will have a lead Executive Director who has responsibility for making sure that it is regularly reviewed and kept up to date.

- 2.4 All impact assessments will be completed for all Policies, Procedures and other written control documents. This includes an assessment of the impact upon the Welsh language. Policies, Procedures and other written control documents will not be approved without a completed Impact Assessment Screening Tool (IAST).
- 2.5 Where a procedure or other written control document has been developed in support of a policy, it may not be necessary to undertake a further IAST if the impact is assessed to be the same. In this instance, the IAST for the policy must be referenced in the procedure/ other written control document. This will have to be confirmed in discussion with the impact assessment leads within Equality, Welsh Language etc.
- 2.6 All Policies, Procedures and other written control documents held on the Corporate Policy, Procedure and other written control documents Register will be published on BetsiNet, and will be provided in both English and Welsh language.
- 2.7 Our staff and stakeholders will be actively consulted during the development of all policies (and where appropriate procedures and other written control documents).
- 2.8 With regard to People Policies, Procedures and other written control documents, engagement with the Trade Unions is welcomed. All People Policies should be considered by Trade Unions via the Local Partnership Forum prior to formal approval.
- 2.9 There will be clear and appropriate approval mechanisms that reflect the scope and content of the document.
- 2.10 The Corporate Governance Directorate will provide central management of the Corporate Policy, Procedure and other written control documents Register and monitor compliance with this policy.

3 SUPPORTING PROCEDURES AND WRITTEN CONTROL DOCUMENTS

- 3.1 This Policy will be supported by the Corporate Policies, Procedures and Other Written Control Documents Management Procedure.
- 3.2 Other supporting documents are:
- Records Management Policy (IG01)
 - Corporate Records Management Procedure ((IG02)
 - Impact Assessment Screening Tool (IAST) (OBS06)
 - Integrated Equality Assessment (WP7).
- 3.3 The IAST and Integrated Equality Assessment have been completed, and include details relating to both this overarching Policy and its related Procedure.

4 SCOPE

- 4.1 All employees must follow this Policy and related procedures and/or other written control documents.
- 4.2 This Policy is applicable to all employees with responsibilities for the development of BCUHB corporate policies, procedures and other written control documents.
- 4.3 This includes permanent, contracted or temporary staff of every grade, within every specialty and role.
- 4.4 Details of the process around the approval to implement all-Wales Policies and Procedures are contained within the *'Procedure on the Management of Corporate Policies, Procedures and other Written Control Documents'*.

5 IMPACT ASSESSMENTS

- 5.1 The Equality Impact Assessment (EqIA) form has been completed, and no impact found in relation to any of the areas contained within that document.
- 5.2 In addition, the Impact Assessment Screening Tool (IAST) has also been completed, and again no impact found in relation to any of the areas contained within that document.
- 5.3 The rationale for this is that this Policy is a document which describes the Health Board's commitment to ensuring that it delivers its aims, objectives, responsibilities and legal requirements transparently and consistently in relation to its management of Policies, Procedures and other written control documents only.
- 5.4 However, each Policy that is created as a result of this Policy may need to consider the different potential impacts.

6 TRAINING

- 6.1 There are no training implications as a result of the introduction of this review Policy.
- 6.2 However, the Compliance Team within the Corporate Governance Directorate will ensure that there is familiarisation of the revised processes as part of their business-as-usual duties.

7 RESOURCE IMPLICATIONS

- 7.1 There are no resource implications relating to the implementation of this Policy.

8 MONITORING AND ONGOING REVIEW OF POLICY

8.1 The Corporate Governance Directorate will undertake periodical and ongoing reviews of the Policy to ensure its continued suitability, and compliance to all legislative and regulatory requirements.

9 REVIEW PERIOD

9.1 This document will be reviewed in no more than 3 years from date of publication.

10 SUMMARY OF REVIEWS / AMENDMENTS

Version number:	Date of Review:	Date of Approval:	Date published:	Summary of Amendments / Changes:
0.01	02/04/2025			Total re-write of the DOCG01 - 'Policy for the Management of Health Board Wide Policies, Procedures & Other Written Control Documents' due to complete process change
0.02				Updates following review by Compliance Team: Removal of duplication re: 'documents to be read in conjunction' Change of wording in relation to staff/employees
0.03	02/09/2025			Updated information in relation to statutory requirements around policies in the 'Policy Statement' section

11 DISCLAIMER

If the review date of this document has passed, please ensure that the version you are using is the most up to date either by searching:

- Policies section of BetsiNet
- Contacting the Document Author
- Or the [Corporate Governance Directorate](#)

This is a controlled document, the master copy is retained by the Corporate Governance Directorate

We do not encourage printing as the electronic version posted on BetsiNet is the master copy. Any printed copies of this document are not controlled.

This document should **not** be saved onto local or network drives but should always be accessed from [BetsiNet](#).

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POLICY APPROVAL ROUTE

Whilst this is subject to change the general rule of thumb for approval of Written Control Documents is outlined below:

Board, Committees or Executive Group – The Board, Committees or named Executive Group are required to approve Policies and Strategies, as detailed within BCUHB’s Scheme of Delegation and Reservation. The Board will be responsible for the formal approval of BCUHB Strategy and Policies that Committees, Legislation or the Scheme of Delegation deem require Board approval.

Executive Directors – Local Procedures, Protocols and Guidelines can be approved by an Executive Team Member of the responsible function.

Type of Policy	Executive Group	Board or Committee
Quality Patient Safety Clinical Effectiveness	Quality Delivery Group	<ul style="list-style-type: none"> • Board (Complaints, Incidents, Putting Things Right)
Workforce (Staffing, equality and diversity)	People and Culture People Executive Group	<ul style="list-style-type: none"> • Welsh Partnership Forum All Wales Workforce Policies
Health and Safety (including Estates)	People and Culture People Executive Group	<ul style="list-style-type: none"> • Board (Health and Safety) via People and Culture Committee
Financial and Performance	Integrated Performance and Quality Group	<ul style="list-style-type: none"> • Audit (for certain policies under Scheme of Delegation) • Board (Joint Commissioning Committee Policies) • Board (Performance Management Framework)
Governance	Executive Committee (Emergency Planning, Information Governance, Welsh Language, Risk, Legal, Informatics)	<ul style="list-style-type: none"> • Board (Risk Management Framework, Overarching Policy Framework, Standards of Business Conduct) • Audit (for certain policies under Scheme of Delegation) • Charitable Funds Committee (for certain policies under Scheme of Delegation)
Planning	Strategic Planning and Service Change Group	<ul style="list-style-type: none"> • Board (Patient, public, staff, partnership and stakeholder engagement and co-production strategies, Integrated Planning Framework)

<p>Teitl adroddiad:</p> <p><i>Report title:</i></p>	<p>RISK MANAGEMENT FRAMEWORK</p>
<p>Adrodd i:</p> <p><i>Report to:</i></p>	<p>Audit Committee</p>
<p>Dyddiad y Cyfarfod:</p> <p><i>Date of Meeting:</i></p>	<p>Tuesday 21 October 2025</p>
<p>Crynodeb Gweithredol:</p> <p><i>Executive Summary:</i></p>	<p>This report presents the revised Risk Management Framework (RM01) for the period 2025–2027, developed to strengthen the Health Board’s approach to risk governance and ensure alignment with strategic objectives, national and international best practice, and statutory requirements.</p> <p>Minor revisions have been made to the Framework (previously approved 2024 and revisions approved at the Risk Scrutiny Group September 2025 and for the Executive Committee October), updates are highlighted in yellow for ease.</p> <p>The updates reflect the current process of urgent risks and escalation route to the Executive Committee. The risk appetite was agreed by the Board 27th August 2025 and is reflected in the document and subject to annual review, with the output of the session detailed appetite across 5 risk types., Quality Risk, Financial Risk, Regulatory/Compliance Risk, Reputational Risk and Innovation.</p> <p>The Risk Management Framework was reviewed by Internal Audit in April 2025 noting substantial assurance as part of the wider Internal Audit on Risk Management.</p> <p>The Framework will be recommended for approval by the Board on the 27th November.</p>
<p>Argymhellion:</p> <p><i>Recommendations:</i></p>	<ul style="list-style-type: none"> • RECOMMEND endorsement of the Risk Management Framework for onward assurance for the Board’s approval in November 2025.
<p>Arweinydd Gweithredol:</p> <p><i>Executive Lead:</i></p>	<p>Pam Wenger, Director of Corporate Governance</p>
<p>Awdur yr Adroddiad:</p> <p><i>Report Author:</i></p>	<p>Nesta Collingridge Head of Risk Management</p>



Pwrpas yr adroddiad: Purpose of report:	I'w Nodi <i>For Noting</i> <input type="checkbox"/>	I Benderfynu arno <i>For Decision</i> <input checked="" type="checkbox"/>	Am sicrwydd <i>For Assurance</i> <input type="checkbox"/>	
Lefel sicrwydd: Assurance level:	Arwyddocaol <i>Significant</i> <input checked="" type="checkbox"/> Lefel uchel o hyder/tystiolaeth o ran darparu'r mecanweithiau / amcanion presennol <i>High level of confidence/evidence in delivery of existing mechanisms/objectives</i>	Derbyniol <i>Acceptable</i> <input type="checkbox"/> Lefel gyffredinol o hyder/tystiolaeth o ran darparu'r mecanweithiau / amcanion presennol <i>General confidence / evidence in delivery of existing mechanisms / objectives</i>	Rhannol <i>Partial</i> <input type="checkbox"/> Rhywfaint o hyder/tystiolaeth o ran darparu'r mecanweithiau / amcanion presennol <i>Some confidence / evidence in delivery of existing mechanisms / objectives</i>	Dim Sicrwydd <i>No Assurance</i> <input type="checkbox"/> Dim hyder/tystiolaeth o ran y ddarpariaeth <i>No confidence / evidence in delivery</i>
Cyfiawnhad dros y gyfradd sicrwydd uchod. Lle bo sicrwydd 'Rhannol' neu 'Dim Sicrwydd' wedi'i nodi uchod, nodwch gamau i gyflawni sicrwydd 'Derbyniol' uchod, a'r terfyn amser ar gyfer cyflawni hyn: Justification for the above assurance rating. Where 'Partial' or 'No' assurance has been indicated above, please indicate steps to achieve 'Acceptable' assurance or above, and the timeframe for achieving this: N/A				
Cyswllt ag Amcan/Amcanion Strategol: Link to Strategic Objective(s):	Building an Effective Organisation			
Goblygiadau rheoleiddio a lleol: Regulatory and legal implications:				
Yn unol â WP7, a oedd EqIA yn angenrheidiol ac a gafodd ei gynnal? In accordance with WP7 has an EqIA been identified as necessary and undertaken?	Yes 2024 approved, no updates required			
Yn unol â WP68, a oedd SEIA yn angenrheidiol ac a gafodd ei gynnal? In accordance with WP68, has an SEIA identified as necessary ben undertaken?	Not applicable			
Goblygiadau ariannol o ganlyniad i roi'r argymhellion ar waith Financial implications as a result of implementing the recommendations	Not applicable			
Goblygiadau gweithlu o ganlyniad i roi'r argymhellion ar waith Workforce implications as a result of implementing the recommendations	Not applicable			
Adborth, ymateb a chrynodeb dilynol ar ôl ymgynghori Feedback, response, and follow up summary following consultation	Risk Scrutiny Group 09/09/2025 comments updated in document and Executive Committee 17/09/2025. Risk Appetite 25/26 updated by the Board			
Rheswm dros gyflwyno adroddiad i fwrdd cyfrinachol (lle bo'n berthnasol)	Not applicable			



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

Camau Nesaf:

Next Steps:

Board Approval.

Communication of changes with Risk leads, on Betsinet and update Framework on External pages

Decision Making Framework to reference risk appetite.

Rhestr o Atodiadau:

List of Appendices:

- 1- Risk Management Framework

RISK MANAGEMENT FRAMEWORK

1. PURPOSE

To present the revised Risk Management Framework (RM01) for formal approval by the Board, following endorsement by the Executive Committee and Audit Committee. The Framework outlines the Health Board's strategic approach to risk management for the period 2025–2027.

2. BACKGROUND

The Risk Management Framework has undergone a comprehensive review to ensure alignment with:

- The Health Board's strategic objectives and integrated performance and planning frameworks.
- National and international best practice (e.g., ISO 31000:2018, COSO ERM Framework).
- Legislative and regulatory requirements (e.g., NHS Wales Act, Health and Safety at Work Act).

It is scheduled for Board approval on **27 November 2025** and will go live on **1 December 2025**.

3. RISK APPETITE

The Board set their risk appetite in a developmental session on the 27 August 2025 and is subject to annual review. The appetite session referenced the Good Governance Institute Appetite Risk Matrix for Sensitive Decision Making, for risk types in order to score appetite.

The output of the session detailed appetite across five risk types:

Quality Risk: There was willingness to be 'open' and consider all potential delivery options and choose while also providing an acceptable level of reward (and VfM). We are prepared to accept the possibility of short-term, managed risks to quality or safety where there is strong evidence that the change will deliver long-term improvement in patient outcomes. We will embed investigation and learning into all decisions, ensuring the duty of candour remains central to our approach. <15

Financial Risk: There was an agreed consensus on an 'open' appetite and consider all potential delivery options and choose while also providing an acceptable level of reward (and VfM). There was an agreed consensus to invest for return and minimise the possibility of financial loss by managing the risks to a tolerable level. Value and benefits considered (not just cheapest price). Resources allocated in order to capitalise on opportunities. <15

Regulatory/Compliance Risk: There was an agreed consensus supporting an 'open' risk appetite to consider all potential delivery options and choose while also providing an acceptable level of reward (and VfM). Challenge would be problematic but we are likely to win it and the gain will outweigh the adverse consequences. <15

Reputational Risk: There was an agreed consensus to ‘seek’ some reputational risks and an eagerness to be innovative and to choose options offering potentially higher business rewards (despite greater inherent risk). We are willing to take bold decisions that may attract significant scrutiny if they are in the best interests of patient safety and service improvement. Reputation is actively managed through transparent, values-based communication, and we view public interest as an opportunity to demonstrate leadership. <20

Innovation: There was a clear consensus to ‘seek’ innovation, with eagerness to be forward-thinking and to pursue options offering potentially higher business rewards. We actively pursue innovations that challenge current practice while implementing controls to minimise risks to patient safety, where there is strong potential for substantial improvement in outcomes. Controlled trials, pilot programmes, and transparent stakeholder engagement remain integral to this approach. <20

Score tolerances are communicated for each risk domain and risks should be managed throughout the Health Board in line with domain scores.

4. BUDGETARY/FINANCIAL IMPLICATIONS

There are no budgetary implications associated with this Framework.

Resources for progressing the work around the management of risk lies with the relevant directorate, division, or department as part of business-as-usual functions.

5. EQUALITY AND DIVERSITY IMPLICATIONS

The Health Board has undertaken an Equality Impact Assessment on the implementation of the Risk Management Framework and procedures to ensure that it is inclusive and does not discriminate against any protected characteristics.

The assessment has highlighted an equality impact concern regarding the availability of the documentation in a format to address any visual impairment disabilities. Any Red Amber Green (RAG) ratings in Datix and other documents will have descriptors for those with colour blindness and RM01-03 will be available in Welsh as well as all risk training. Further support to understand the document is also available through bespoke support and training through the corporate risk team.

Any other challenges to implement or apply these Risk Management documents can be communicated to the corporate risk team in order to ensure the Health Board to positively meet its responsibilities under the equalities and human rights legislation.

6. CONCLUSION

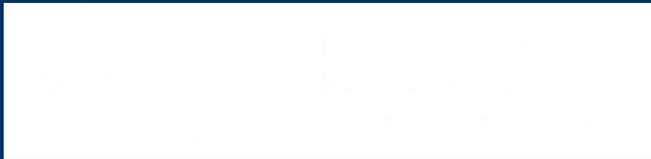
The revised Risk Management Framework (RM01) 2025–2027 provides a comprehensive and integrated approach to identifying, assessing, and managing risk across the Health Board. It reflects our commitment to embedding a proactive and transparent risk culture that supports the delivery of safe, high-quality, and innovative services. The Framework aligns with national and international best practice, clearly defines roles and responsibilities, and sets out a structured governance model to ensure effective oversight and assurance.

By adopting this Framework, the Board will reinforce its leadership role in risk governance, support continuous improvement, and ensure that risk management remains a core component of strategic and operational decision-making.

7. RECOMMENDATIONS

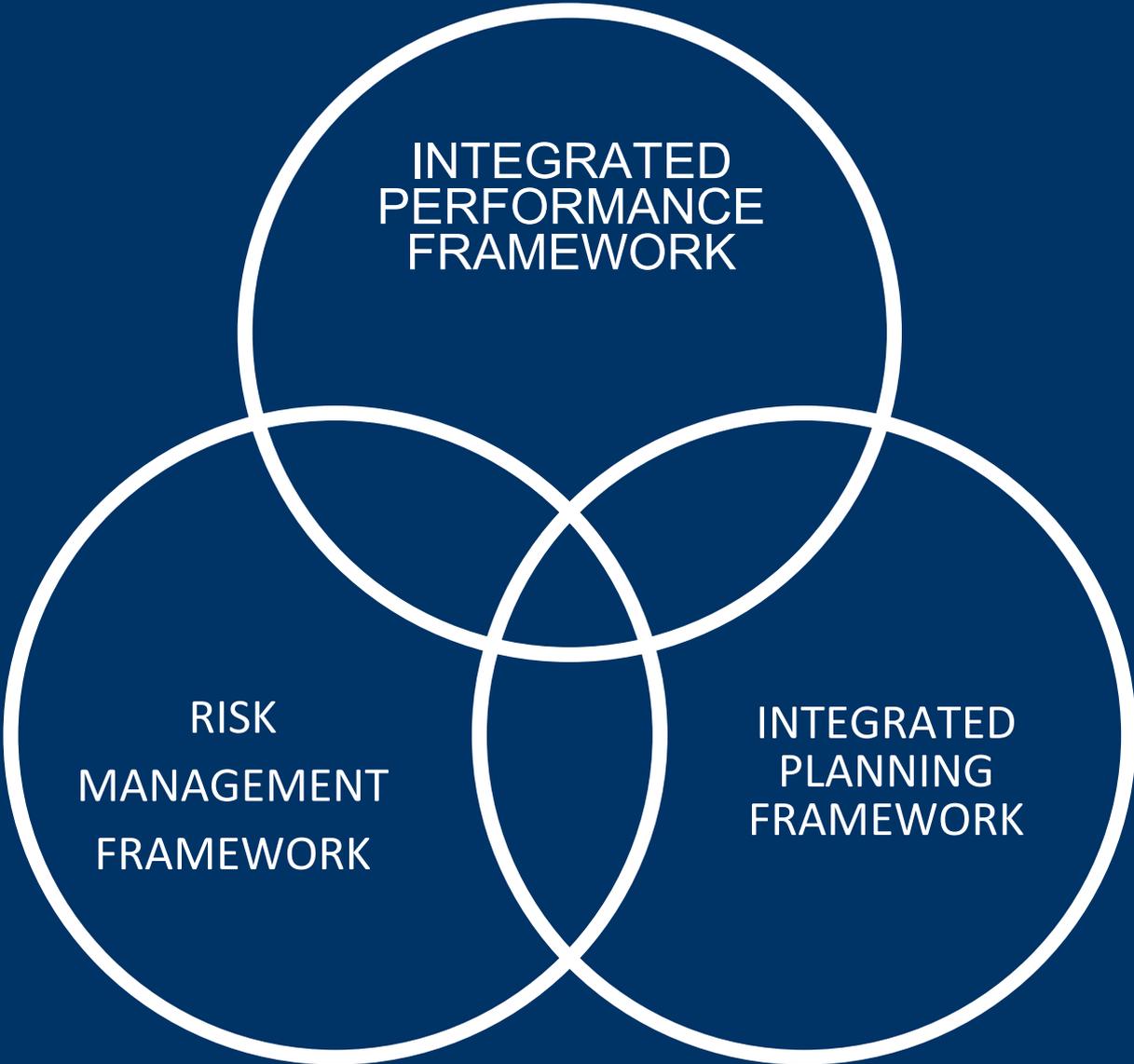
The Audit Committee is asked to:

- **RECOMMEND** endorsement of the Risk Management Framework for onward assurance to the Board for approval in November 2025.



RISK MANAGEMENT FRAMEWORK

2025-27





Author & Title	Pam Wenger Director of Corporate Governance Dr Nesta Collingridge Head of Risk Management		
Responsible Department / Director:	Corporate Governance > Risk Management Carol Shillabeer Chief Executive		
Approved by:	Health Board – 27 November 2025 Audit Committee (AC) – 21 October Executive Committee 17 September 2025		
Date approved:	27 November 2025 25 July 2024		
Date activated (live):	1 December 2025 September 2024		
Documents to be read alongside this document:	Risk Management Procedures (RM02) Risk Management Training Procedures (RM03) Terms of Reference Risk Scrutiny Group BCUHB Integrated Performance Framework BCUHB Integrated Planning Framework Health and Safety Policy (HS01) Risk Assessment Guidance (HS03) Concerns Policy and Procedure (PTR01 and PTR01A) Information Governance Policy Health and Safety Policy		
Date of next review:	28 Sept 2027		
Date EqIA completed:	Sept 2023 (Original 2016)		
First Operational:	28 Sept 2023		
Previously reviewed:	Sept 2023	Health Board - 25 July 2024 Audit Committee (AC) - 18 July 2024 Executive Team 26 June 2024	Sept 2025
Changes made yes/no:	Yes - 28 Sept 2023 Approved at Board Major revisions made	Yes - Intermediate updates; as approved at: 18/07/2024 Audit Committee and 25/07/2024 Health Board Meeting– Formalisation of the Risk Scrutiny Group, and key updates to the Risk Framework and Procedures.	Yes - Intermediate updates- Escalation route

PROPRIETARY INFORMATION

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GLOSSARY OF TERMS

Risk: A risk is the uncertainty that something could or may happen that will have an impact on the achievement of the Health Board's objectives and priority areas. Risk is expressed in terms of likelihood (probability of the risk occurring) and consequence (impact if the risks were to occur).

Distinguishing between a risk and an issue: A risk is an event that might occur and that could have an effect (can be positive but usually negative) upon the organisation and/or its stakeholders. A risk is characterised by uncertainty. An issue is something that has already happened or will definitely happen. An issue is a certainty. For example, 'we are short staffed' or 'lack funding to deliver a service', are issues (as these are already happening) and the risk will be the implications of staff shortage or the lack of funding to the successful delivery of our operational and strategic objectives. What these uncertainties (doubt) may cause, is what will constitute (give rise) to risks in both cases.

Assurance: This is a process to provide evidence that the controls in place are effective and working and that the Health Board is doing its best to appropriately reduce and manage risks to the achievement of its operational and strategic objectives.

Actions: Actions are the subsequent steps required following the application of controls to address or further mitigate residual (current) risk to as low as reasonably possible (target) level.

Board Assurance Framework: comprises of strategic risks developed by Executive Committee members from the Strategic Plans and Objectives that could prevent the Health Board's from fulfilling its strategic objectives/priorities.

Business Continuity: Business continuity is the capability of the Health Board to continue the delivery of products and services within acceptable timeframes at predefined capacity during a disruption. Business continuity is a temporary and alternative measure initiated during a disruption that ensures continuity of service provision whilst a permanent solution is found, or usual services/operations are resumed. The holistic process of business continuity management is an essential tool in ensuring an organisation's resilience.

Controls: These are measures or interventions implemented by the Health Board that reduce the likelihood of a risk and/or the impact/severity of a risk. The types of controls used in reducing risks include preventive, corrective, detective and directive controls. Gaps in control describe the weaknesses identified having put mitigation controls in place.

Corporate Risk Register: A corporate risk register is a repository used to record significant risks that could impact the strategic objectives and operations of the Health Board. Developed by services, corporate functions and members of the Executive Committee, the register provides a comprehensive overview of the key risks facing the organisation. It is a pivotal tool to help proactively strengthen risk oversight and management.

Risk Assessment: This is the overall process of risk identification, analysis and risk evaluation. This is achieved by identifying risks, examining the characteristics of each risk and comparing individual risks against the Health Board's risk appetite. Risk assessment techniques include questionnaires and checklists, workshops and brain storming sessions, and inspections and audits.

Risk Appetite: The amount and type of risk that an organisation is willing to seek or retain in its pursuit of its objectives.

Risk Framework: Set of activities that support the risk management process, i.e., the risk architecture, strategy and protocols.

Risk Management: Coordinated activities to direct or control risks within an organisation. These are management activities that deliver the most favourable outcome and reduce the volatility and variability of that outcome.

Risk Mitigation: This refers to the process of reducing risk exposure through minimising its likelihood and/or lessening the severity of its impact were it to materialise. Types of risk mitigations include the 5Ts (treat, tolerate, terminate, transfer or take opportunity).

Senior Information Responsible Risk Officer (SIRO): This may include the Director responsible for the Directorate or Executive Director or Deputy Executive Director or nominated Executive Sponsor.

Take Opportunity: The type of risk with potential to enhance the achievement of the organisation's objectives. Opportunity risk management is the approach that seeks to maximise on benefits of taking risks i.e., innovation, new systems, processes and procedures, services etc.

Terminate: Risk response that is appropriate when certain activities that give rise to risks are not necessary or worth doing and should be stopped. Also known as avoidance or elimination.

Tolerating: The decision to accept the risk and the impact should the following risk occur without taking any further steps to mitigate it. This is often to avoid significant investment or resources as the response would be disproportionate to the potential harm or gain. Also referred to acceptance or retention. Decision to tolerate any risks that are outside the risk appetite threshold for a particular domain of risk should be made at senior level proportionate to the level of risk.

Transfer: Risk response for risks outside the Health Board's appetite that the organisation wishes to transfer or share with other providers by way of contracts (outsourcing), insurance, joint venture etc. This option is particularly suited to mitigating financial risks or risks to assets.

Treat: Risk response by way of introducing cost effective controls to alter or reduce risk.

Target Risk: Ultimate level of risk that is desired by the Health Board when planned additional controls (see actions) have been implemented to address residual risk to as low as reasonably possible and/or within the Health Board's risk appetite.

RISK MANAGEMENT FRAMEWORK

- The Health Board endeavours to establish a positive risk and safety culture in the organisation, where unsafe practice (clinical, managerial, etc.) is not tolerated and where every member of staff is committed and empowered to identify/correct/escalate system weaknesses.
- The Health Board is committed to ensuring a robust infrastructure to manage risks ensuring an integrated approach, and where risks crystallise, to evidence improvement.
- The Health Board's intention is to **minimise** the risk to the delivery of quality services in the Health Board's accountability and compliance frameworks, **maximise** performance and is **open** to opportunity with considered risk taking.
- To deliver **safe, quality** services, the Health Board will encourage staff to work in collaborative partnership with each other and service users and carers to **minimise** risk to the greatest extent possible and promote patient well-being as a duty of care to the population.

The Board intends to demonstrate an ongoing commitment to improving the management of risk throughout the organisation by:

- Ensuring a dynamic approach to strategic risk management to support achievement of the Health Board's vision, aims, and strategic objectives;
- Promoting considered risk taking, within authorised and defined limits in-line with the Board's appetite for risk (see Appendix 1-Risk Appetite Statement);
- Adopting an integrated approach to risk management in order to facilitate a cross-functional collaboration of system-wide risks that includes risks related to: clinical care, health and safety, staff wellbeing, financial and business planning, workforce planning, corporate and information governance, performance management, project / programme management, research and development;
- Embedding effective risk management systems and processes within the organisation and promoting the ethos that risk management is everyone's business, with clearly defined roles and responsibilities;
- Creating an environment that is as safe as is reasonably practicable, by ensuring that risks are continuously identified, assessed and well managed, i.e. where possible eliminate, transfer or treat risks to an acceptable level;
- Fostering an organisational culture of openness and willingness to report risks, incidents and near misses to ensure organisation wide learning;
- Establishing clear and effective communication mechanisms that enable a comprehensive understanding of risks at all levels of the organisation by the use of directorate, specialist and organisational-wide risk registers; and

- Providing appropriate training to staff to ensure effective implementation of risk management arrangement

1. PURPOSE OF THIS FRAMEWORK

The Framework seeks to ensure:

- that the Health Board's risks in relation to the delivery of services (provided and commissioned) and care to patients are minimised;
- that the wellbeing of patients, staff and visitors is optimised;
- that opportunities are maximised;
- that the assets, business systems and finances of the Health Board are protected; and
- the implementation and ongoing management of a comprehensive, integrated (clinical and non-clinical) approach to the management of risk across the organisation.

2. SCOPE OF THE RISK MANAGEMENT FRAMEWORK

This framework applies to Board members; all staff of the Health Board; agency staff; contractors brought in to undertake work on behalf of the Health Board, for example capital and estates works; students; locums; volunteers; individuals employed on honorary contracts; and, other third parties engaged in Health Board business. It applies to all activities of the Health Board, including those related to the commissioning of services. Managers at all levels within the Health Board must take an active lead to ensure that risks are managed effectively and to support the development of a risk aware culture within the Health Board.

This framework will:

- Outline the risk management philosophy through our risk statement, identifying arrangements for embedding risk management;
- Explain the role, expectations and appetite of the Board in relation to risk and risk management;
- Detail the high-level roles and responsibilities for implementing and complying with this framework;
- Explain the arrangements for complying with all relevant legislation;
- Detail risk priorities for the present year;
- Detail the high-level Committee structure accountability in relation to risk, internal reporting requirements, assurance arrangements and external reporting controls;
- Signpost the specific policies, procedures and terms of reference and which the Health Board will publish to ensure that all staff understand what is required of them.

3. THE BOARD'S APPETITE FOR RISK

The Board recognises that risk is inherent in the provision and commissioning of healthcare services, and therefore a defined approach is necessary to articulate risk context, ensuring that the organisation understands and is aware of the risks it is prepared to accept in the pursuit of its aims and objectives.

Risks throughout the organisation will be managed within the Board's risk appetite, or where this is exceeded, action will be taken to reduce the risk. The Board is prepared to accept some financial risk and regulatory challenges if appropriate controls and defence strategies are in place. The Board support innovation despite potential short-term quality impacts and reputational risks, as long as there is potential for long-term rewards like improved outcomes for stakeholders and opportunities for staff recruitment, retention and development. The Board takes a holistic view of value for money, with price not being the sole determining factor.

The Health Board seeks to be innovative and will challenge current working practices and financial risk in terms of its willingness to take opportunities where positive gains can be anticipated. The Board's annual Risk Appetite, detailing acceptable levels of risk across five risk types (financial, regulatory/compliance, innovation, quality and reputational), is outlined in Appendix 1.

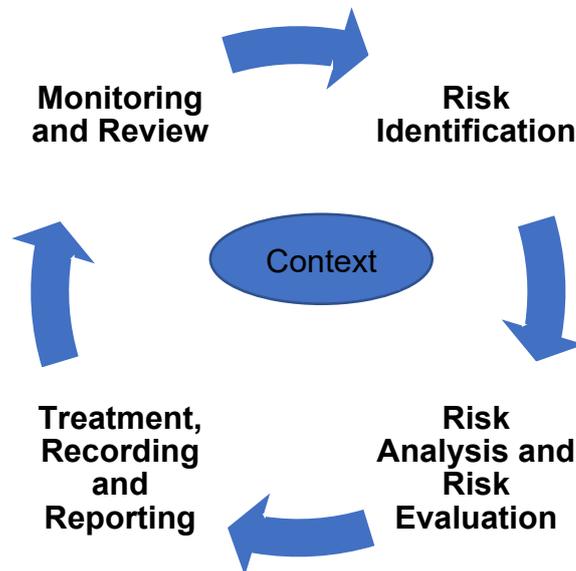
4. RISK MANAGEMENT PROCESS

Risk Management is the systematic application of management policies, practices and procedures to identifying, analysing, assessing, treating and monitoring risk in a way that will enable organisations to minimise losses and maximise opportunities.

The aim of risk management is not to remove risk altogether, but to manage risk to an acceptable level, considering the cost of minimising the risk and reducing risk exposure (the level of risk that the organisation is exposed to, either in regard to an individual risk or the cumulative exposure to the risks faced by the organisation).

The Board has adopted a structured approach to risk management, whereby risks are identified, assessed and controlled, and if appropriate, escalated or de-escalated through the governance mechanisms of the organisation. The process is defined in four key steps:

Figure 1 - Risk Management Process



1. RISK IDENTIFICATION

The Health Board cannot manage risk effectively unless it knows what the risks are. Risk identification is therefore vital to the success of the organisation's risk management process, and ultimately the safe delivery of care. This should be done within context.

2. RISK ANALYSIS AND RISK EVALUATION

Assessment and scoring of risk are used to determine the level of risk, using the Health Board's risk matrix to ensure a consistent approach is adopted across the organisation.

3. TREATMENT, RECORDING AND REPORTING

Treatment is how the risk will be managed, and what the required actions are to achieve an acceptable level of risk. All risks are recorded on a Datix risk register, which is a formal record of all risks raised, which makes up the Operational Risk Register.

4. MONITORING AND REVIEW

Part of managing risk is to continually review and update, and to capture the changes and progress of mitigation.

5. RISK ARCHITECTURE

The current enterprise risk architecture within the Health Board is shown below in a risk management model.

LEVELS OF RISK

The Risk Management Framework defines three levels of risk:

1. Strategic Risks – Risks that represent a threat to achieving the Health Board's strategic objectives or its continued existence. Strategic risks also include risks that are widespread beyond the local area, and risks for which the cost of control is significantly beyond the scope of the local budget holder.
2. Operational Risks – Risks that arise as a result of the day-to-day running of the Health Board and include a broad spectrum of risks comprising clinical risk (e.g., arising from incidents and complaints), financial risk (including fraud); legal risks (e.g., arising from employment law or health and safety regulation); regulatory risk; risk of loss or damage to assets or system failures; etc.
3. Project Risks – Risks that may impact on the delivery of a programme of work or project. All significant projects must be risk assessed before they are progressed, with each project required to have a separate risk register.

RISK REGISTERS

Board Assurance Frameworks, Corporate Risk Registers and Operational Risk Registers can work together in an integrated risk management model:

Board Assurance Framework (BAF)

- Focuses on the top <10 strategic risks that could impact achievement of the Health Boards objectives and priorities.
- Owned by the Board and tied directly to the strategic plan.
- Risks reflect external and internal issues affecting strategy.
- Regularly reviewed by Board and Executive Committee.
- Held by the risk team.

Corporate Risk Register (CRR)

- Consolidates key risks escalated up from the operational level based on the possible impact on Boards objectives and priorities. May include 10-40 major corporate-wide risks.
- Provides Executive Committee with enterprise view of significant operational and strategic risks.
- Enables corporate risk reporting, monitoring and oversight.
- Risk flows to BAF as appropriate.
- Overseen by the corporate risk team, maintained on Datix.

Operational Risk Registers

- Day to day operational risks which impact on service delivery. Includes clinical, financial, compliance, IT risks etc.
- Mandatory for all services to have a register on Datix.
- Service Risk Leads or Risk Champions responsible for maintaining and managing service risk register and escalates higher risks through Senior Responsible Officers and Corporate Risk Team for awareness and where appropriate consideration on the CRR.

Project Risks

- Project lead responsible for ensuring risks are captured and maintained.
- Acceptable for the project risk register to be held locally (not on Datix) but significant risks which could impact on day to day operations or have a wider impact on the Health Board should be escalated to a Datix risk register to allow for overview and consistency of reporting.
- Project team escalate higher risks through Senior Responsible Officers and Risk Scrutiny Group for awareness.

This model provides top-down and bottom-up connectivity to enable robust risk management at all levels and alignment to strategy.

All staff should be aware of the potential for risks to emerge which may affect the business of the Health Board and all staff should be prepared to identify and report risks as appropriate. When a possible risk is identified, staff should aim to discuss it first with their line manager. This is to avoid duplication of effort, as sometimes risks are identified which are already being managed but have perhaps been articulated differently. Once it is confirmed that a new risk has been identified, the details should be entered onto the Datix system. This will normally be achieved through a service risk lead/champion.

Once correctly identified and assessed, the risk should be logged on a risk register, depending on the seriousness of the risk. Where possible risks should be managed at the lowest level possible, proportionate to the level of exposure to which the risk.

Risks scored ≥ 15 should be sent to the Senior Information Responsible Risk Officer (SIRO) (*N.B. this may include the Director responsible for the Directorate or Executive Director or Deputy Executive Director or nominated Executive Sponsor*), for awareness and consideration on the CRR, if critical/strategic in nature. Operational risks scored ≥ 20 should be sent to the most senior responsible person for management support and advice.

Risks scored $9 > 12$, Risk owners are expected to ensure that there are appropriate processes, systems and governance arrangements in place to regularly review, scrutinise and effectively manage all risks within their areas. They will be required to

periodically present their Divisional risk register reports and assurance of robust risk arrangements to the Risk Scrutiny Group.

Risks scored 1-8 should be regularly reviewed, scrutinised, approved, reduced and managed at the service or departmental levels while those which score above 8 should be escalated in accordance with guidance and the approval of either the relevant quality and safety meeting and/or the triumvirate.

ESCALATION/DE-ESCALATION

Risks should be regularly reviewed and escalated or de-escalated to the appropriate risk register within the Committee or divisional meeting which reviews the risk. Before a risk is presented to a **SIRO** for approval, it should be quality assured by the Corporate Risk Team and take the assurance that robust action plans are in place.

For escalation of a risk on to the CRR the service risk lead should contact their Executive Director through the appropriate channels and the corporate risk team via their regional risk manager.

Figure 2 - Risk Management Meeting & Escalation/De-escalation

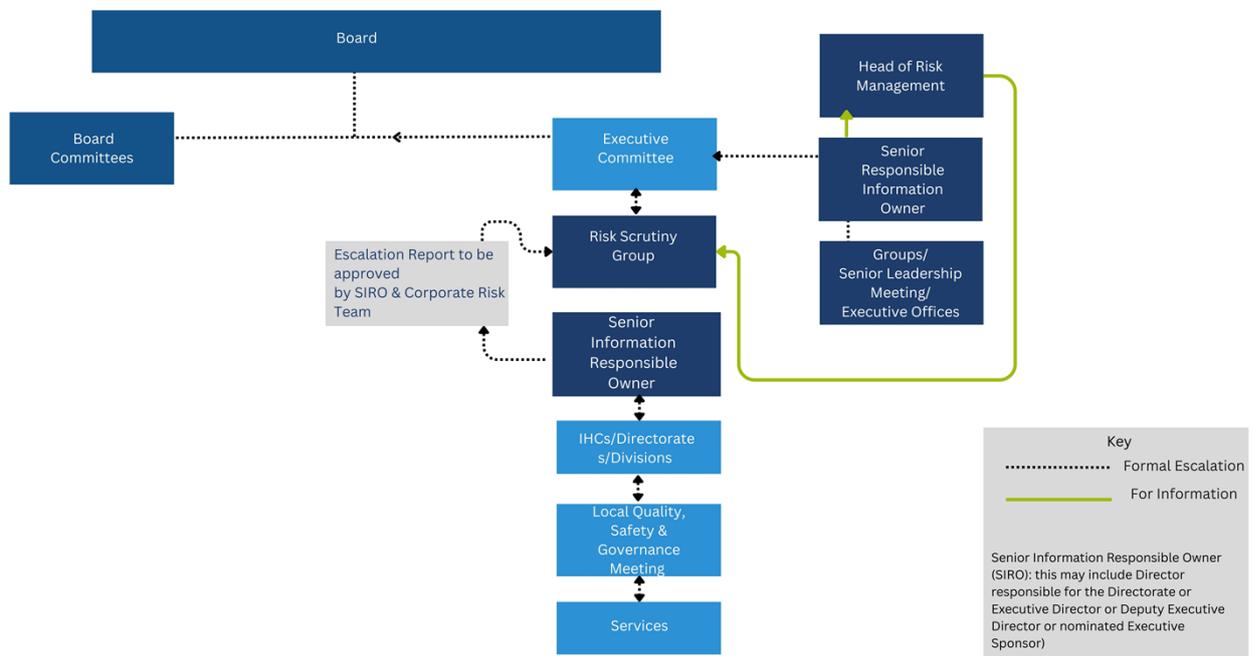
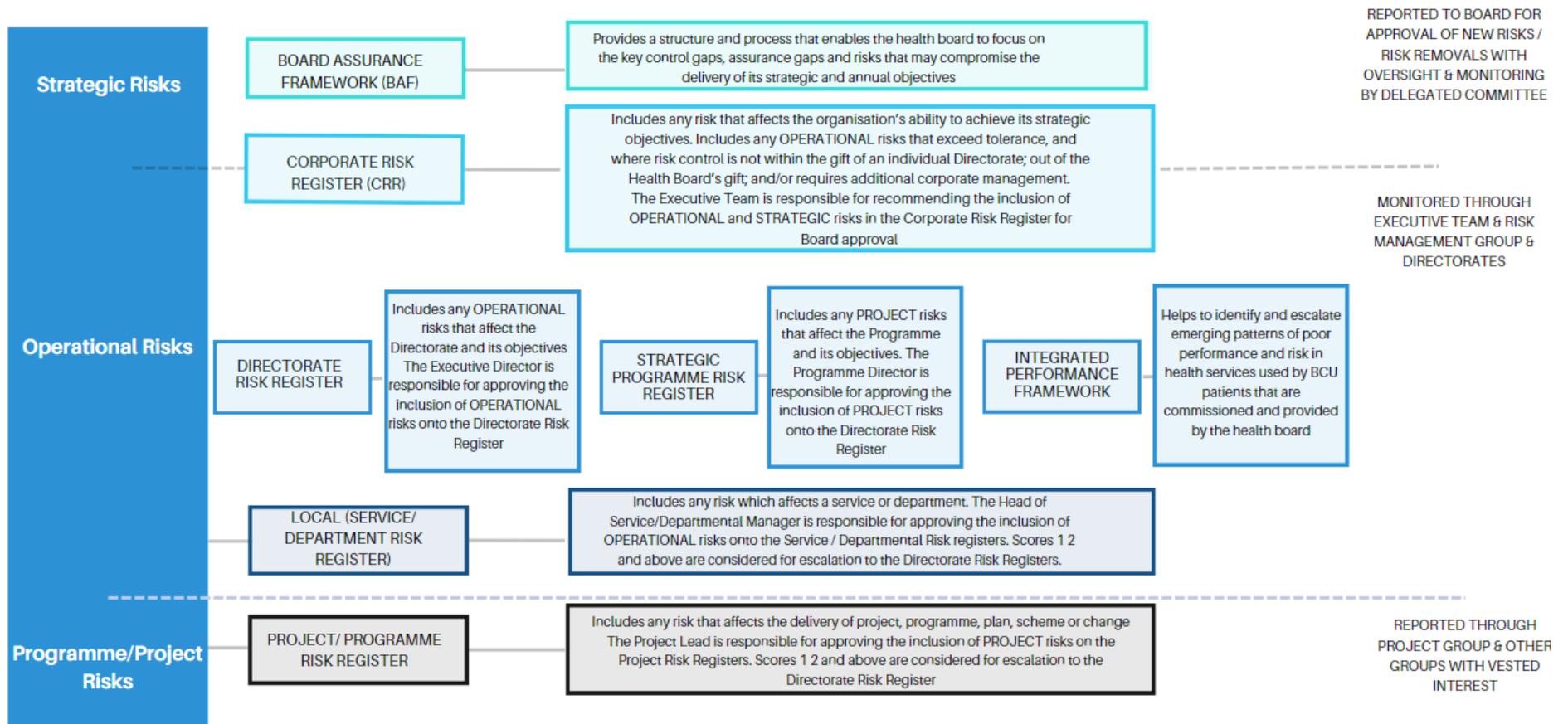


Figure 3 - Risk Management Register



6. RISK STRATEGY

To effectively manage risks, our organisation will take a comprehensive approach across several areas. This will include robust reporting mechanisms to keep leadership and the Board apprised of risks, using systems like risk registers to log and track risks, ensuring staff have adequate training and clear responsibilities, implementing standardised risk management processes, fostering a culture of openness around risks, and continuously monitoring and improving through quality assurance. Together these initiatives across reporting, systems, people, processes, culture and improvement will enable us to better anticipate, manage and mitigate the risks we face in alignment with our values and strategic objectives.

Reporting

- Services to provide their directorates on assurances over the management of the local service risk register.
- Risk Scrutiny Group to oversee risk processes in line with procedures to supports continuous improvement and monitoring of trends in relation to KPIs (outlined in RM02).
- Corporate risk report to Executive Committee and Board Committees on risk actions plans and updates. Terms of reference and cycle of businesses for all support risk as a standing agenda item.
- Board Assurance Framework (BAF) risk report to Board.

Figure 4 – Strategic Register Reporting Cycle

Register /Tier	Review	Formal Review	Approval Escalation/ De-escalation	Committee Oversight	Board
Board Assurance Framework	Reviewed Bi-Monthly	Risk Scrutiny Group	Executive Committee Meeting	Quarterly	Bi-Annually (or any escalations via Audit Committee Chair's report)
Corporate Risk Register				Quarterly	Quarterly

Systems

- Datix to be used to log risks.
- Risk priorities will influence integrated planning.

Processes

- Process in relation to risk management procedures are detailed in RM02 'Risk Management Procedures' and throughout this framework as well as RM03 outlines 'Risk Management Training Procedures' and plans. Risk identification, assessment and treatment processes as detailed in section 4.
- Risk monitoring and review processes, risk reporting and escalation processes.

Culture

- The cultural tone is detailed in the statement and approach to risk as well as supported by the way in which processes are carried out, dynamic and diligence. Risk clearly noted as everyone's business and supported by detailing responsibilities.

People

- Risk management responsibilities are clear for all staff and have been further detailed in section 7.
- The Health Board is committed to continuous learning which applies across risks management. Training as a part of ensuring continuous improvement is crucial. Knowledge of good identification processes and how to manage risk is essential to the successful embedding and maintenance of effective risk management. To support this, a programme of training will be delivered as follows:

Staff Group	Training Need	Frequency
Board Members & Directors & Deputies	Strategic Risk Management Training	Every 2 years
Service managers/Risk owners/Service Risk Leads	Mandatory Operational Risk Management Training	Every 2 years
All staff	Basic awareness on corporate induction as well as a bespoke offer of face to face or virtual risk training	On starting and ad hoc offer as required (Patient safety mandatory module contains risk management

awareness for
clinical staff)

Strategic (BAF) Risks:

The 'three lines of assurance' have been outlined in relation to independent and objective audits and reviews of risk management practices 'The three lines of assurance' includes internal/external audit, regulators, professional body reviews and scrutiny. Provides assurance to senior management and Board on effectiveness of risk management.

The three lines of assurance also clarify roles for review and oversight:

First line of assurance: Reviews by operational management

Second line of assurance: Oversight by risk management/compliance functions

Third line of assurance: Independent assurance from audit/regulators

This model structures risk management oversight at the Risk Scrutiny Group Executive **Committee**, Board Committees and Board levels for the Health Board.

7. ROLES AND RESPONSIBILITIES

Effective risk management requires clear definition of the roles, responsibilities, and accountabilities across the organisation. This section outlines the duties and obligations relating to risk for the Board, relevant Committees, key groups and individuals within the Health Board.

THE BOARD:

The Board (Executives, Directors and Independent Members) being the governing body responsible for strategy, performance, governance, risk management, and ensuring statutory duties are met. The Board is accountable for effective oversight per NHS (Wales) Act and other healthcare regulations.

The cycle of business for the Board is set to receive the CRR and BAF on a quarterly/bi-annual basis. It is the duty of the Board to discuss and advise on the content and progress of action plans in the BAF. It is also the duty of the Board to appropriately monitor BCUHB's significant risks noted in the CRR, associated controls and assurances outline as well taking a view on the overall decision of tolerating a risk or challenging the possible lack of progression.

The Board is responsible for ensuring that the Health Board consistently follows the principles of good governance; ensuring that the systems, policies and people are in place to manage risks and its effectiveness. The Board will be focused on key risks and driving the delivery of the Health Board's strategic objectives. Gaining assurance demonstrates good oversight of effective risk identification and management; risk

architecture as well as due diligence including robust governance. It is a key principle of accountability.

The workplans for the Board and each of its Committees will be aligned to the BAF and CRR, ensuring appropriate focus on areas of risk. In the context of this Framework the Board will:

1. demonstrate its continuing commitment to risk management through the application and interest in the overall compliance with this Framework;
2. ensure, through the Chief Executive, that the responsibilities for risk management outlined in this document are communicated, understood and maintained;
3. take a proactive role in 'horizon scanning' for emerging threats/risks to the delivery of the Health Board's strategic objectives, and ensuring that controls put in place in response, manage risks to an acceptable level;
4. commit financial, managerial, technological and educational resources necessary to adequately control identified risks;
5. ensure that lessons are learned and disseminated into practice from complaints, claims and incidents, and other patient experience data;
6. oversee and participate in the risk assurance process;
7. allocate strategic risks to Committees for oversight;
8. ensure communication with partner organisations on problems of mutual concern including risks;
9. ensure that appropriate structures are in place to implement effective risk management; and
10. receive reports from the Committees of the Board in line with terms of reference and workplans of those committees.

AUDIT COMMITTEE (AC):

Provides assurance on governance, risk management, internal controls, financial reporting and internal/external audits. The Committee is responsible for points 1-5 as noted above.

The cycle of business for the Committee is set to receive the CRR and BAF in its entirety on a bi-monthly basis. The Audit Committee, on behalf of the Board, will be responsible for providing oversight of the adequacy and management of the CRR and BAF arrangements.

PERFORMANCE, FINANCE AND INFORMATION GOVERNANCE COMMITTEE (PFIG):

Oversees financial and operational performance, information governance, and delivery of plans/targets. The Committee is also responsible for points 1-5 as noted above. The cycle of business for the Committee is set to receive the section of the CRR and BAF to which it is accountable for on a bi-monthly basis.

QUALITY SAFETY AND EXPERIENCE COMMITTEE (QSE):

Reviews quality of care, patient safety issues, clinical effectiveness and outcomes, patient experience. The Committee is also responsible for points 1-5 as noted above. The cycle of business for the Committee is set to receive the section of the CRR and BAF to which it is accountable for on a bi-monthly basis.

Risk Management Forum:

The Risk Management Forum reports to the Risk Scrutiny Group and advises on any risk documentation ensuring the Framework and any other relevant policies and procedures are in place. The Forum will review the processes and report on any weaknesses identified to ensure that the Board has in place effective systems for the reporting of risk, and the management of risk registers (local, directorate and corporate) and the Board's Assurance Framework.

Specifically, the Forum is responsible for:

RISK SCRUTINY GROUP:

The Risk Scrutiny Group reports to the Executive Committee and advises on any risk management issues, including all significant risks arising from activities within the organisation. The Group is responsible for scrutinising the CRR and BAF ensuring appropriate escalation of operational risks. The Group will report on any weaknesses identified to ensure that the Board has in place effective systems for the reporting of risk, and the management of risk registers (local, directorate and corporate) and the Board's Assurance Framework.

Specifically, the Group is responsible for:

- Operationalising the objectives of the Risk Management Framework through the organisation's directorates, by embedding risk management and establishing local risk reporting procedures to ensure the effective integrated management of risk and assurance;
- Coordinating the escalation of all clinical and non-clinical risks, making recommendations to, and advising the Executive Committee and Board accordingly;
- Reviewing and monitoring the CRR and BAF;
- Advises on any risk documentation ensuring the Framework and any other relevant policies and procedures are in place
- Coordinating the achievement of the objectives of the Risk Management Framework through the organisation's directorates, by embedding risk management and establishing local risk reporting procedures to ensure the effective integrated management of risk and assurance;
- Reviewing high risk recommendations made by the Internal Audit Service, ensuring that where appropriate they are acted upon and recorded through risk registers and the BAF appropriately.

EXECUTIVE COMMITTEE

The Executive Committee holds accountability for individual risks listed on the BAF and CRR and plays a key role in the ongoing review of the risk register. They are responsible for identifying risks that require escalation or de-escalation, and for providing regular updates on the progress of action plans aimed at mitigating and managing the risks under their remit.

7.1 INDIVIDUAL RESPONSIBILITIES

All members of staff, and those working on behalf of the Health Board, have an individual responsibility for managing risk. They must understand and adhere to this Risk Management Framework. The following individuals have specific responsibility, accountability and authority for risk management, as part of their existing roles:

CHIEF EXECUTIVE (CEO)

The Chief Executive Officer (CEO) serves as the Accountable Officer for the Health Board, holding overarching responsibility for ensuring compliance with statutory and legal obligations, as well as adherence to governance guidance issued by the Welsh Government. This accountability extends across key areas including risk management, health and safety, financial and organisational controls, and overall governance. The CEO is ultimately responsible for

- ensuring the Health Board maintains an up-to-date Risk Management Framework endorsed by the Board;
- promoting a risk management culture throughout the Health Board;
- ensuring that there is a framework in place, which provides assurance to the Board in relation to the management of risk and internal control;
- ensuring that risk issues are considered at each level of business planning, from the corporate process to the setting of staff objectives;
- setting out their commitment to the risk management principles, which is a legal requirement under the Health and Safety at Work Act 1974. The Welsh Government requires the Chief Executive to sign a Governance Statement annually on behalf of the Board. This outlines how risks are identified, evaluated and controlled, together with confirmation that the effectiveness of the system of internal control has been reviewed.

EXECUTIVES & DIRECTORS

Executives and/or Directors have overall responsibility for the operational management of risks within their Directorates and are the named senior responsible officer for individual risks on the CRR and BAF.

They are also responsible for the effective allocation of resources to timely reduce risks within their remit, while ensuring prompt escalation and de-escalation of risks where appropriate. They shall also be responsible for ensuring that senior managers under their portfolio have effective risk management systems and processes in place in their directorates, divisions, sites, and services to demonstrate robust identification, assessment, mitigation and management of all risks.

They are responsible for ensuring that best practice in risk management and a positive risk-aware culture are fully embedded in their portfolio. Executives **and Directors** will work with the risk management team to ensure the appropriate use of the BAF and CRR.

Executives and Directors play a pivotal role in setting the expected cultural tone, one which is positive and encourages identification, risk is not to be considered as negative or to be avoided. The Executives and Directors will do so by ensuring communication is open, and transparent where all staff have the confidence to raise a risk. Executives and Directors will seek assurances that risk training is well attended for their regions and departments. Good risk awareness, awareness of roles and responsibilities, timely management of action plans, and a sense of accountability. Executives and Directors will seek assurances respective risk registers are maintained regularly, action plans are well managed, well communicated and actions which have blocks are escalated in a timely manner. Registers are expected to be agile and reflective of the service. Executives and Directors will foster a culture of continuous improvement supporting teams to engage with Better by Betsi, a community of continuous improvement, enhancing innovation with risk identification, mitigations strategies for their service. Executives will take a proactive identification approach to counter fraud risks.

In addition, Clinical Executive Directors (Executive Medical Director, Executive Director of Nursing & Midwifery, Executive Director of Therapies & Health Sciences, and the Executive Director of Public Health) have collective responsibility for clinical quality governance, which will include patient safety, incident management and patient experience, and will therefore have a responsibility to ensure that clinical risks are appropriately managed in-line with this Framework.

DIRECTOR OF CORPORATE GOVERNANCE

The Director of Corporate Governance is the delegated lead for risk management in the Health Board, and is accountable for leading on the design, development and implementation of the integrated BAF and Risk Management Framework.

The Director of Corporate Governance will:

- lead the embedding of an effective risk management culture throughout the Health Board;

- work closely with the Chair; Chief Executive; Chair of the Audit Committee; and, Executive Directors, to implement and maintain an appropriate Risk Management Framework and related processes, ensuring that effective governance systems are in place;
- develop and communicate the Board's risk awareness, appetite and tolerance;
- lead and participate in risk management oversight at the highest level, covering all risks across the organisation on a Health Board basis;
- lead the ongoing development of the Risk Scrutiny Group (established by the Executive Committee).

HEAD OF RISK MANAGEMENT

The Head of Risk Management is accountable to the Director of Corporate Governance, and in relation to risk management will specifically:

- provide specialist advice in relation to controls and assurances for a range of functions at all levels in the organisation to support the effective management of clinical and non-clinical risk and governance;
- ensure a central system is in place to collate risk registers across the Health Board, which link to the BAF;
- support the management and development of the BAF and Risk Management Framework;
- work with directorates and Heads of Service to ensure risks are escalated in accordance with the Risk Management Framework;
- compile the CRR and BAF, for Board;
- support the development and functioning of the Risk Forum and Risk Scrutiny Group; and
- provide training, information and advice to operational staff and corporate functions on risk management and risk registers, ensuring linkage to the BAF.

CORPORATE RISK TEAM

The corporate risk management team will facilitate and ensure effective risk management practices are in place throughout the organisation. The team will support the escalation of risks the CRR and BAF. The risk management team will support services by validating risk registers, including the adequacy of the risk descriptions, controls, and assurances and justification of the risk scoring and take a lead on assurances of compliance pan BCU.

They will advise all colleagues including Executives and Directors in managing their risks. The risk team will lead the development of procedures as required under this framework. They will ensure the delivery of training to staff who have responsibilities

under this policy. They will be responsible for the overall management of the risk module in Datix.

SENIOR MANAGERS

Senior managers will take the lead on risk management within their divisions, sites and areas and set the example through visible and exemplary leadership.

They are also responsible for supporting the effective allocation of resources in managing, escalating and de-escalating operational and strategic risks within their remit. The risk service lead and risk team will work with senior managers to ensure risks are articulated appropriately and described in line with procedures and will further support organisational wide learning.

The risk management team will provide healthy challenge and support to those risks that do not have adequate actions or action plans and have not progressed in a timely manner with a route to escalation to SIROs. Senior manager will provide SIROs with regular assurances around effective management of risk registers.

SERVICE RISK LEADS

Services are required to nominate a risk lead/champion on behalf of the service to ensure the risk register is well maintained and risk is championed throughout the service facilitating good identification processes. Service risk leads will support the operational management of their respective service risk register and will liaise with the risk management team around escalation or de-escalations of risks and will work on any feedback around the quality assurance of the risk register. Service managers and service risk leads will be responsible for ensuring activities and action plans within risks are regularly maintained. All leads and champions will have regular risk management training.

ALL STAFF

All staff including, Trade Union colleagues and contractors are required to comply with this Risk Management Framework, raise any issues of concern to the attention of their line manager and to appropriately minimise and manage risks to the best of their knowledge and ability. Controls and actions implemented in mitigating risks must be timely disseminated to all staff involved with the management of the risk. All staff are expected to share intelligence around any potential risks with contractors providing services within and on behalf of the Health Board. Risk is the responsibility of all staff of the Health Board; agency staff; contractors brought in to undertake work on behalf of the Health Board, for example capital and estates works; students; locums; volunteers; individuals employed on honorary contracts; and, other third parties engaged in Health Board business.

INDEPENDENT MEMBERS (IMs)

Independent Members have an important role in risk management in seeking assurance on the robustness of processes and the effectiveness of controls through

constructive, robust, positive and effective challenge to the Executives, Directors and senior management. IMs are expected to satisfy themselves that the Health Board's risk management arrangements are effective, efficient and fit-for-purpose. IMs will provide healthy challenge on those risks that are not treated in a timely manner; the overall decision to tolerate the risk and/or the risks alliance to Health Board objectives.

IMs will challenge overall Board decision-making ensuring this is within the Boards risk appetite. In addition, IMs chair Board Committees and in line with the relevant Committee's terms of reference, should gain and provide assurance to the Board that risks within its remit are being managed effectively by the risk owners and report any areas of concern to the Board. IMs should seek assurance in ensuring a measured risk culture.

INTERNAL AUDIT

The relationship between risk management and Internal Audit is critical. Risk management is concerned with the assessment of risk and the identification of existing and additional controls, whereas Internal Audit's role is to evaluate these controls and test their efficiency and effectiveness. This is undertaken through the Internal Audit programme of work. Accordingly, the Head of Internal Audit will:

- a. Provide an overall opinion each year to the Accountable Officer of the organisation's risk management, control and governance; to support the preparation of the Annual Governance Statement;
- b. Focus the internal audit work on the significant risks as identified by management, and audit the risk management processes across the organisation;
- c. Audit the organisation's risk management, control and governance through operational audit plans, in a way that affords suitable priority to the organisation's objectives and risks;
- d. Provide assurance on the management of risk and improvement of the organisation's risk management, control and governance; by providing line management with recommendations arising from audit work.

LOCAL COUNTER FRAUD SERVICES

The Health Board's nominated Local Counter Fraud Specialist (LCFS) provides assurance to the Board regarding risks relating to fraud and/or corruption. The Health Board's Annual Counter Fraud Work Plan, as agreed by the Audit Committee identifies the arrangements for managing and mitigating risks as a result of fraud and/or corruption. Where such issues are identified they are investigated by the LCFS, and then reported to the Audit Committee as appropriate. The LCFS works with the Chief Executive, Executive Committee and Director of Corporate Governance to review any fraud or corruption risks. Such risks are referred to the relevant risk register for the Directorate concerned, and are then escalated through the Health Board's escalation process. The Executive Committee recognises that fraud, bribery, and corruption pose significant risks that require proactive

management. To protect the interests of our stakeholders, act ethically, and comply with counter fraud laws and regulations, we commit to proactively identify fraud risks and vulnerabilities across the Health Boards operations through audits, reviews of complaints and allegations, and risk assessments. Routinely assess changes that may impact exposure to fraud, bribery and corruption. This also includes effective controls tailored to the highest risk areas identified. This includes clear financial controls, investigation and response diligence, training, and ensuring robust channels for reporting concerns.

SENIOR INFORMATION RISK OFFICER

The Board will nominate an Executive or Director as the Senior Information Risk Officer (SIRO) with delegated responsibility by the Chief Executive for ensuring that information risks are treated as a priority for business outcomes.

8. MONITORING THE EFFECTIVENESS OF THE RISK MANAGEMENT FRAMEWORK

Compliance with this Framework is monitored by the Executive Committee and the Audit Committee. The Annual Governance Statement is signed by the CEO and sets out the organisational approach to internal control. This is produced at the end of the financial year and is scrutinised as part of the annual accounts process and presented to the Board with the accounts, as part of the Annual Accountability Report. The Corporate Risk Team and Risk Scrutiny Group will take a lead on seeking assurances and providing Committees and Board with an overview of the Health Board's effectiveness and compliance. The Head of Internal Audit will also provide an opinion together with the summarised results of the internal audit work performed during the year.

The Health Board's risk management arrangements are also subject to review annually, as part of the Audit Wales Structured Assessment process. The risk management framework draws from best practice standards ISO31000, policy, and legislative instruction such as the National Health Service (Wales) Act 2006, the Health and Safety at Work Act 1974 and the Management of Health and Safety at Work Regulations 1999. The Health Board understands that risk is inherent in every business and is committed to ensuring full compliance.

This document should be read in conjunction with the 'Risk Management Procedures' (RM02) and 'Risk Training Procedures' (RM03) which are supportive of this Framework and outline all the procedural requirements for managing a risk operationally through to escalation.

Appendix 1

RISK APPETITE

The Board set their risk appetite in a developmental session on the 27 August 2025 and is subject to annual review. The appetite session referenced the Good Governance Institute Appetite Risk Matrix for Sensitive Decision Making, for risk types in order to score appetite.

The output of the session detailed appetite across five risk types:

Quality Risk: There was willingness to be 'open' and consider all potential delivery options and choose while also providing an acceptable level of reward (and VfM). We are prepared to accept the possibility of short-term, managed risks to quality or safety where there is strong evidence that the change will deliver long-term improvement in patient outcomes. We will embed investigation and learning into all decisions, ensuring the duty of candour remains central to our approach. <15

Financial Risk: There was an agreed consensus on an 'open' appetite and consider all potential delivery options and choose while also providing an acceptable level of reward (and VfM). There was an agreed consensus to invest for return and minimise the possibility of financial loss by managing the risks to a tolerable level. Value and benefits considered (not just cheapest price). Resources allocated in order to capitalise on opportunities. <15

Regulatory/Compliance Risk: There was an agreed consensus supporting an 'open' risk appetite to consider all potential delivery options and choose while also providing an acceptable level of reward (and VfM). Challenge would be problematic but we are likely to win it and the gain will outweigh the adverse consequences. <15

Reputational Risk: There was an agreed consensus to 'seek' some reputational risks and an eagerness to be innovative and to choose options offering potentially higher business rewards (despite greater inherent risk). We are willing to take bold decisions that may attract significant scrutiny if they are in the best interests of patient safety and service improvement. Reputation is actively managed through transparent, values-based communication, and we view public interest as an opportunity to demonstrate leadership. <20

Innovation: There was a clear consensus to 'seek' innovation, with eagerness to be forward-thinking and to pursue options offering potentially higher business rewards. We actively pursue innovations that challenge current practice while implementing controls to minimise risks to patient safety, where there is strong potential for substantial improvement in outcomes. Controlled trials, pilot programmes, and transparent stakeholder engagement remain integral to this approach. <20

Score tolerances are communicated for each risk domain and risks should be managed throughout the Health Board in line with domain scores.

EQUALITY IMPACT ASSESSMENT

The Health Board has undertaken an Equality Impact Assessment on the implementation of the Risk Management Framework and procedures to ensure that

it is inclusive and does not discriminate against any protected characteristics. The assessment has highlighted an equality impact concern regarding the availability of the documentation in a format to address any visual impairment disabilities. Any RAG ratings in Datix and other documents will have descriptors for those with colour blindness and RM01-03 will be available in Welsh as well as all risk training. Further support to understand the document is also available through bespoke support and training through the corporate risk team. Any other challenges to implement or apply these Risk Management documents can be communicated to the corporate risk team in order to ensure the Health Board to positively meet its responsibilities under the equalities and human rights legislation.

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Included a desktop review of Welsh Health Boards Risk Frameworks

Teitl adroddiad: <i>Report title:</i>	Corporate Risk Register Report			
Adrodd i: <i>Report to:</i>	Audit Committee			
Dyddiad y Cyfarfod: <i>Date of Meeting:</i>	Tuesday, 21 October 2025			
Crynodeb Gweithredol: <i>Executive Summary:</i>	<p>The Committee is asked to receive assurance and endorse the updated corporate risk register:</p> <p>Following two informal Executive Committee Development sessions to review the Corporate Risk Register, held on the 16th July and 20th August, it was decided that the current Corporate Risk Register would benefit from consolidation of the current 26 risks to a more strategic Corporate Risk Register for presentation to the Board and oversight at relevant committees.</p> <p>The proposed revised, draft Corporate Risk Register (see appendix 1) comprises of 11 strategic risks with a selection of the more operational Corporate Risks de-escalated to be managed operationally at Director level.</p> <p>The Committee is asked to provide any further feedback on each of the Corporate Risks prior to approval by Board.</p>			
Argymhellion: <i>Recommendations:</i>	<p>The Committee is asked to:</p> <ol style="list-style-type: none"> 1. Provide any feedback or receive assurance and endorse the updated corporate risk register. 			
Arweinydd Gweithredol: <i>Executive Lead:</i>	Pam Wenger, Director of Corporate Governance			
Awdur yr Adroddiad: <i>Report Author:</i>	Nesta Collingridge Head of Risk Management			
Pwrpas yr adroddiad: <i>Purpose of report:</i>	<p>I'w Nodi <i>For Noting</i></p> <p><input type="checkbox"/></p>	<p>I Benderfynu arno <i>For Decision</i></p> <p><input checked="" type="checkbox"/></p>	<p>Am sicrwydd <i>For Assurance</i></p> <p><input checked="" type="checkbox"/></p>	
Lefel sicrwydd: <i>Assurance level:</i>	<p>Arwyddocaol <i>Significant</i></p> <p><input type="checkbox"/></p> <p>Lefel uchel o hyder/tystiolaeth o ran darparu'r mecanweithiau / amcanion presennol</p>	<p>Derbyniol <i>Acceptable</i></p> <p><input checked="" type="checkbox"/></p> <p>Lefel gyffredinol o hyder/tystiolaeth o ran darparu'r mecanweithiau / amcanion presennol</p>	<p>Rhannol <i>Partial</i></p> <p><input type="checkbox"/></p> <p>Rhywfaint o hyder/tystiolaeth o ran darparu'r mecanweithiau / amcanion presennol</p>	<p>Dim Sicrwydd <i>No Assurance</i></p> <p><input type="checkbox"/></p> <p>Dim hyder/tystiolaeth o ran y ddarpariaeth <i>No confidence / evidence in delivery</i></p>

	High level of confidence/evidence in delivery of existing mechanisms/objectives	General confidence / evidence in delivery of existing mechanisms / objectives	Some confidence / evidence in delivery of existing mechanisms / objectives
<p>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: <i>'Partial' Escalated to Chief Operating Officer</i></p>			
<p>Cyswllt ag Amcan/Amcanion Strategol:</p> <p><i>Link to Strategic Objective(s):</i></p>	<p>Detailed in the BAF report and how the CRR aligns to the revised BAF</p>		
<p>Goblygiadau rheoleiddio a lleol:</p> <p><i>Regulatory and legal implications:</i></p>	<p>It is essential that the Board has robust arrangements in place to assess, capture and mitigate risks, as failure to do so could have legal implications for the Health Board.</p>		
<p>Yn unol â WP7, a oedd EqIA yn angenrheidiol ac a gafodd ei gynnal?</p> <p><i>In accordance with WP7 has an EqIA been identified as necessary and undertaken?</i></p>	<p>Not applicable for this report</p>		
<p>Yn unol â WP68, a oedd SEIA yn angenrheidiol ac a gafodd ei gynnal?</p> <p><i>In accordance with WP68, has an SEIA identified as necessary ben undertaken?</i></p>	<p>Not applicable for this report</p>		
<p>Manylion am risgiau sy'n gysylltiedig â phwnc a chwmpas y papur hwn, gan gynnwys risgiau newydd (croesgyfeirio at y BAF a'r CRR)</p> <p><i>Details of risks associated with the subject and scope of this paper, including new risks(cross reference to the BAF and CRR)</i></p>	<p>The Board Assurance Framework has been updated and links of both have been referenced in both strategic risk registers.</p>		
<p>Goblygiadau ariannol o ganlyniad i roi'r argymhellion ar waith</p> <p><i>Financial implications as a result of implementing the recommendations</i></p>	<p>The effective and efficient mitigation and management of risks has the potential to leverage a positive financial dividend for the Health Board through better integration of risk management into business planning, decision-making and in shaping how care is delivered to our patients thus leading to enhanced quality, less waste and no claims.</p>		
<p>Goblygiadau gweithlu o ganlyniad i roi'r argymhellion ar waith</p> <p><i>Workforce implications as a result of implementing the recommendations</i></p>	<p>Failure to capture, assess and mitigate risks can impact adversely on the workforce.</p>		
<p>Adborth, ymateb a chrynodeb dilynol ar ôl ymgynghori</p> <p><i>Feedback, response, and follow up summary following consultation</i></p>	<p>Corporate risks descriptions presented informally to the Board during the risk appetite session 27 August 2025. Reviewed on two occasions by Risk Scrutiny Group and Executive Committee Sept and Oct 2025.</p>		

<p>Cysylltiadau â risgiau BAF: (neu gysylltiadau â'r Gofrestr Risg Gorfforaethol)</p> <p>Links to BAF risks: (or links to the Corporate Risk Register)</p>	<p>See the individual risks for details of the related links to the Board Assurance Framework.</p>
<p>Rheswm dros gyflwyno adroddiad i fwrdd cyfrinachol (lle bo'n berthnasol)</p> <p>Reason for submission of report to confidential board (where relevant)</p>	<p>Two private risks removed and to be presented in private Committee</p>
<p>Camau Nesaf:</p> <p>Next Steps:</p> <ol style="list-style-type: none"> 1. Revised Corporate Risks presented to Board for assurance and endorsement. 2. Approved Corporate Risks to be monitored as business as usual by senior risk leads, Executives, the Risk Scrutiny Group and the Executive Committee 	
<p>Rhestr o Atodiadau:</p> <p>List of Appendices:</p> <p>Appendix 1 – Revised Corporate Risk Register Heat Map – September 2025</p> <p>Appendix 2 – Revised Corporate Risk Register – September 2025</p>	

Revised Corporate Risk Register Dashboard – September 2025

Lead	Ref	Risk Title	Current Score (Impact x Likelihood)	Risk Target Score	Appetite Main Risk Type Appetite Level	Lead Board Committee	Action Progression			Risk Management Commentary
							Total	Completed	Delayed or Overdue	
COO	CRR25-01	Timely Patient Access to Safe and Effective Care	5x4 20	12	Quality (<15) Above Tolerance	Performance, Finance and Information Governance Committee	5	2	0	
EDoW	CRR25-02	Future Demand & Sustainable Workforce	4x4 16	8	Quality (<15) Above Tolerance	People & Culture Committee	8	1	0	
EDoPH	CRR25-03	Population Needs	4x4 16	12	Quality (<15) Above Tolerance	Quality, Safety and Experience Committee	13	0	2	
CDIO	CRR25-04	Modernising our Infrastructure	5x4 20	12	Quality (<15) Above Tolerance	Planning, Population Health & Partnership Committee	9	1	0	*Removed from report, in separate private report
EDoTSP	CRR25-05	Strategic Change – Impacting Care and Staff Delivery	4x3 12	8	Quality (<15) In Tolerance	Planning, Population Health & Partnership Committee	6	0	0	
EDoF	CRR25-06	Value Delivery and Financial Sustainability	5x4 20	12	Financial (<15) Above Tolerance	Planning, Population Health & Partnership Committee	8	3	0	
EDoW	CRR25-07	Leadership and Operating Model	4x4 16	8	Quality (<15) Above Tolerance	People & Culture Committee	5	0	0	
DCG	CRR25-08	Non-Compliance with Regulatory and Legislative Requirements	4x4 16	8	Regulatory (<15) Above Tolerance	Quality, Safety and Experience Committee	8	1	0	
DoE	CRR25-09	Safe Environment	4x5 20	12	Regulatory (<15) Above Tolerance	Performance, Finance and Information Governance Committee	3	0	0	

DoE	CRR25-10	Health and Safety	4x4 16	8	Regulatory (<15) Above Tolerance	Performance, Finance and Information Governance Committee	8	0	1	
CDIO	CRR25-11	Cyber	5x4 20	15	Quality Above Tolerance	Planning, Population Health & Partnership Committee	9	4	2 (revised dates)	*Removed from report, private. Target score remains high.

Corporate Risk Register Report

1.0 Purpose

The purpose of this report is to provide an update to the Committee on the Corporate Risk Register.

1.1 Key Highlights

All risks have been reviewed and updated by the relevant services and approved by Executives.

The dashboard has been updated for 2025. In 2024 we documented 104 actions completed which are not displayed in the dashboard due to the revisions of the descriptions and consolidation. From August to October 12 actions have been completed.

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

- CRR24-06 Value Delivery and Financial Sustainability (September)

The following risks are scheduled to undergo a deep dive at the November 2025 Risk Scrutiny Group following the October Risk Scrutiny Group being stood down as not quorate:

- CRR25-09 (former CRR24-06) Safe Environment
- CRR25-10 (former CRR24-15) Health and Safety

1.2 Changes in Score

11 Operational Risks to be managed as operational risks in particular 8 to have further oversight and scrutiny by the COO at the Operational Senior Leadership Meeting.

Risk Ref	Reduced Risks	Lead Exec Director	Previous Risk Score	Current Risk Score
	<i>None</i>			

1.3 New Risks

The risk(s) added to the Corporate Risk Register since the last update are:

Risk Ref	New Risks	Lead Exec Director	Current Risk Score (and IxL)
	<i>2025 All 11 risks presented refined and consolidated</i>		

1.4 Overdue/Delayed Actions

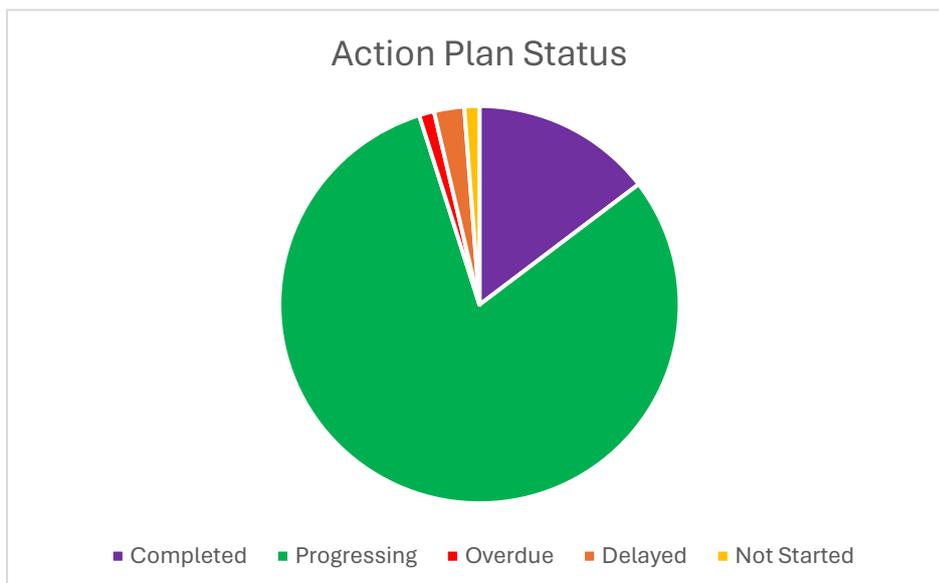
The corporate risk register was revised during September 2025 which did note 1 action as 'overdue'. Several actions are noted for being due end of November 2025. With 2 actions currently 'delayed'.

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

1.5 Risks above Health Board 24/25 appetite

In 2024 the HB had eight risks reported to committee score **above** the tolerance range set in the appetite. Although some of these are now being managed operationally and remain above appetite. Ten corporate risks above tolerance are for the oversight of the Committees and Board.

1.6 Action Plan status of Corporate Risks



Of the 11 Corporate Risks, 82 actions have been developed to mitigate the risks 12 actions have been completed, 66 actions are progressing and on track, 1 action is overdue, 2 delayed actions (rationale detailed within action update) and 1 action not started.

Next steps

1. Revised Corporate Risks presented to Board for assurance and endorsement.
2. Corporate Risks to be updated and monitored as business as usual by senior risk leads, Executives, the Risk Scrutiny Group and the Executive Committee

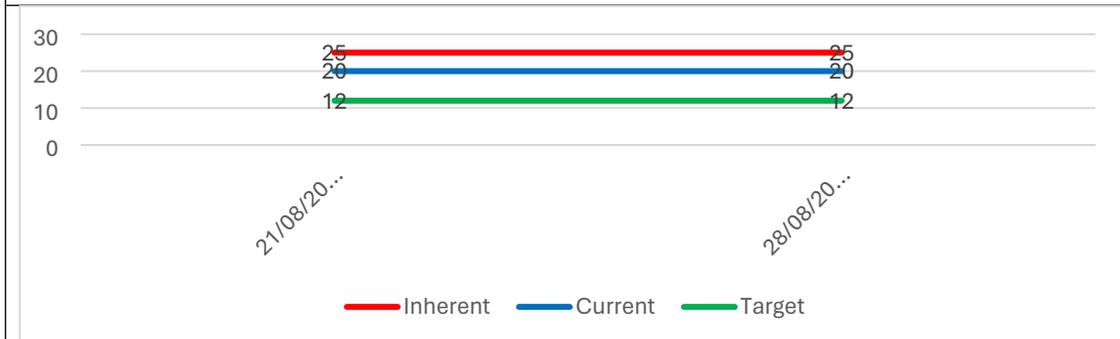
Appendix 1 – Revised Corporate Risk Register Heat Map – September 2025

Corporate Risk Register Heat Map Oct 25							
Impact	Catastrophic	5				<p>Extreme</p> <ul style="list-style-type: none"> Timely Patient Access to Safe and Effective Care Modernising our Infrastructure Value Delivery and Financial Sustainability ICT Failure and Cyber 	Extreme
	Major	4				<ul style="list-style-type: none"> Future Demand & Sustainable Workforce Population Needs Leadership and Operating Model Non-Compliance with Regulatory and Legislative Requirements Health and Safety 	<p>Extreme</p> <ul style="list-style-type: none"> Safe Environment
	Moderate	3				<ul style="list-style-type: none"> Strategic Change – Impacting Care and Staff Delivery 	
	Minor	2					
	Negligible	1					
			1	2	3	4	5
			Rare	Unlikely	Possible	Likely	Almost Certain
			Possibility				

Appendix 2 – Revised Corporate Risks – September 2025.

CRR 25-01	Risk Title: Timely Patient Access to Safe and Effective Care		Date Opened: 21/08/2025 <i>(version 2 refined from 2023)</i>	
	Assuring Committee: Quality, Safety and Experience Committee		Date Last Committee Review: New Risk	
Date Last Reviewed: 25/09/2025	Director Lead: Chief Operating Officer	Link to BAF: BAF24-07	Target Risk Date: 30/06/2026	
<p>There is a risk that patients may not receive timely access to the care they need, which could lead to deterioration in health, poor patient experience, and poorer outcome.</p> <p>This may be caused by lack of oversight of waiting lists, harm occurring on waiting lists, insufficient communication with clinicians, poor patient experience, and difficulties recruiting to specialist posts.</p> <p>This may lead to extended waiting lists, patient harm due to delays, and reputational or regulatory consequences.</p>				
Mitigations/Controls in place			Additional Controls required	
<ol style="list-style-type: none"> 1. System Resilience Hub in place with hospital full protocols and winter/festive plans 2. 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. 3. Winter Resilience Plan complete evaluation and lessons learnt. 4. Revised Access policy to ensure standardised practice across the Health Board 5. SICAT and GPOOHs joint model providing 24/7 triage and advice 6. Same Day Emergency Care (SDEC) services established at all acute sites 7. Routine clinical prioritisation of patients by risk in line with RTT guidance 8. Weekly corporate access meetings and specialty-level access monitoring 9. Outsourcing of radiology reporting and insourcing of CT, MRI, ultrasound 10. Diagnostic QMS accreditation system embedded 11. Welsh Gov short-term ND funding to support longest waiters, agency staff, overtime 			<ol style="list-style-type: none"> a. Fragility of UEC and specialist workforce posts, reliance on temporary/secondments b. Fragility of social care provision causing delayed discharge and stranded patients c. Need for demand and capacity modelling and specialty-level trajectories d. Inadequate ND capacity to manage waiting list e. Outdated diagnostic IT systems 	
Actions			Action Owner	Due Date
<p>a Complete recruitment of clinical leads and project management capacity to deliver sustainable specialty models</p> <p>UEC clinical lead appointed to for 4 sessions a week commencing 1st October 2025 until March 2026.</p> <p>Winter plan approach/self-assessment agreed at PPHP September 2025.</p> <p>Reiew of daily and weekly activities to improve flow through ED and deliver 45 minute handover requirements with weekly oversight by CEO, vice chair and chair.</p>			Chief Operating Officer	30/03/2026
				Progression Analysis
				Progressing

<p>b Complete demand and capacity analysis across Planned Care to inform forward activity planning complete for Q2 and look ahead for Q3</p> <p>As part of the planned care programme and major change programme. The Transformation improvement team have provided an allocation of project management and pathway re-design support to the planned care programme to be used flexibly across its delivery. Planned care deployment lead in place 1 August 2025 to March 31 2026 driving additional capacity through national programme for outpatient insourcing</p>	Chief Operating Officer	31/03/2026	Progressing
<p>d Implement new prudent ND assessment process to streamline and reduce wait times (ND Waiting List) Prudent assessment developed and agreed, to be rolled out across the teams from October 2025. Prudent assessment has been launched last week in September 2025</p>	Louise Bell / Fiona Wright	31/07/2025	Completed
<p>d Stratify ND waiting list to identify and prioritise high-risk children. Work undertaken to stratify the waiting list and identify high risk children. Stratification of Waiting Lists has taken place</p>	Louise Bell / Fiona Wright	30/09/2025	Completed
<p>e Update Failure to act on Diagnostics Procedure to be presented at divisional meeting for discussion on the 10/10/2025</p>	David Fletcher, North Wales Managed Clinical Services	20/10/2025	Progressing



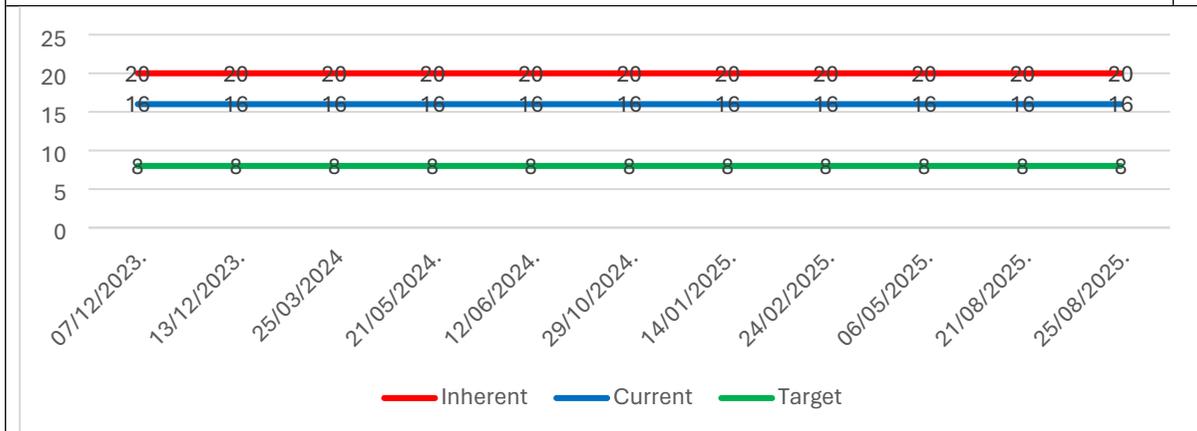
	Impact	Likelihood	Score
Inherent Risk Rating	5	5	25
Current Risk Rating	5	4	20
Target Risk Score	4	3	12
Risk Appetite	Quality <15		Not in Tolerance

	Position & Intended Outcome for Risk
	The number of Prevention of Future Death (PFD) / Regulation 28 Notices issued to BCUHB since February 2023 currently stands at 32. The Health Board saw a large number issued in 2023/24 (23) which was a significant outlier compared to previous years and other NHS Wales bodies. However, 5 were received in 2024/25 (to date), a significant reduction compared to the number issued in same period of the prior year and more in-line with the average of previous years and other NHS Wales bodies. 9 cases directly related to the impact of delays in the health and social care system on the timeliness of responses by the Welsh Ambulance Service. Goal to be in line with WG targets.

CRR 25-02	Risk Title: Future Demand & Sustainable Workforce		Date Opened: 21/08/2025 <i>(version 2 refined from 2023)</i>
			Date Last Committee Review: 12/062025
Date Last Reviewed: 25/08/2025	Assuring Committee: People & Culture Committee	Link to BAF: BAF24-04	Target Risk Date: 31/03/2026
Director Lead: Executive Director of People and Organisational Development			
<p>There is a risk that the organisation will not have a sustainable workforce to meet future patient demand. This may be caused by ongoing recruitment challenges (particularly in specialist roles), limited workforce planning to match future service needs, and increasing operational pressures across teams and departments. This may lead to staff burnout, reduced morale and retention, and an inability to consistently deliver safe, high-quality care placing additional strain on services and impacting patient outcomes.</p>			
Mitigations/Controls in place		Additional Controls required	
<ol style="list-style-type: none"> 1. Strategic Recruitment Team supporting senior leadership, medical and dental consultant posts (CRR24-01, Deputy DoPOD). 2. Local IHC resourcing teams delivering recruitment activity against divisional priorities (CRR24-01). 3. Recruiting Well / Joining Well programmes and recruitment campaigns (CRR24-01). 4. Nurse Retention Lead and retention plan (CRR24-01). 5. All-Wales Flexible Working policy implemented (CRR24-01). 		<ol style="list-style-type: none"> a) Limited integrated workforce planning across the system (CRR24-01). b) Medical and Dental workforce engagement and management not fully effective (CRR24-01). c) Fragile workforce pipelines in specialist services (ophthalmology, vascular, orthodontics, ND, diagnostics) (cross-theme). d) Retention measures not yet delivering consistent impact (CRR24-01). 	

<p>6. Speak Out Safely MDT and Work in Confidence platform in place for staff concerns (CRR24-01).</p> <p>7. Workforce reviews underway in challenged specialties (ophthalmology, vascular, orthodontics, ND, diagnostics) (cross-theme from CRR24-21, 23, 22, 27, 13).</p>	<p>e) Absence and sickness management requires stronger controls (linked to new Absence risk created Feb 2025, CRR24-01).</p>		
Actions	Action Owner	Due Date	Progression Analysis
<p>Reintroduce Medical Staffing function within People Services (CRR24-01)</p> <p>The first stage of this is to recruit a new Band 7 Medical Staffing Policy and Practice specialist who will support key workstreams through the Value & Sustainability program and Medical Workforce Group. The individual starts in BCU on 1st October 2025. Any further implementation of a medical staffing resource will be dependent on the Foundations for the Future Program</p>	Steven Gregg-Rowbury	30/06/2025	Completed
<p>Deliver “Recruiting Well, Joining Well, Leaving Well” programme across staff journey (CRR24-01)</p> <p>Due to resource being allocated to the Foundations for the Future programme, the remaining workstreams within this action will continue to be worked on but the expected completion is delayed until later in 2025</p> <ul style="list-style-type: none"> a. The leaving well booklet b. Improving shortlisting timescales c. Advertising well in recruitment 	Steven Gregg-Rowbury	31/03/2026	Progressing
<p>Targeted management of sickness absence, linked to new Absence risk (CRR24-01)</p> <p>The Healthy Workforce group is in place and is overseeing the action plan to target reducing sickness absence rates, in line with the Welsh Government requirements by March 2026</p>	Steven Gregg-Rowbury	31/03/2026	Progressing

<p>Workforce modelling and specialty service plans for Ophthalmology, Vascular, ND and Orthodontics (CRR24-21, 23, 27, 22)</p> <p>Workforce planning templates have been issued out to services and engagement is underway to support the completion. Vascular services are so far further along with this, having held an away day on 3rd September. There are challenges in service leads having time/capacity to work on their workforce plans</p>	<p>Nick Graham, Workforce & Organisational Development</p>	<p>31/03/2026</p>	<p>Progressing</p>
<p>Develop Vascular workforce strategy and Phase 2 Business Case (CRR24-23)</p>	<p>Jo Flannery, Vascular Services</p>	<p>31/03/2026</p>	<p>Progressing</p>
<p>Recruitment and workforce model development for Orthodontics Academy model (CRR24-22; ongoing 2025, COO)</p>	<p>Chief Operating Officer</p>	<p>Ongoing</p>	<p>Progressing</p>
<p>ND workforce business case approval via Executive Team. Business case submitted to the Executive Team, decision on the case deferred pending a broader review of funding priorities</p>	<p>Fiona Wright, C&YP</p>	<p>31/12/2025</p>	<p>Progressing</p>
<p>Establish revised Radiology workforce model (CRR24-13) Updated operational Diagnostic risk to be presented at divisional meeting to discuss on the 10/10/2025.</p>	<p>David Fletcher, Diagnostics</p>	<p>20/10/2025</p>	<p>Progressing</p>



	Impact	Likelihood	Score
Inherent Risk Rating	4	5	20
Current Risk Rating	4	4	16
Target Risk Score	4	2	8
Risk Appetite	Quality <15		Not in Tolerance

Position & Intended Outcome for Risk

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

Overall Vacancy rate of 8.8%, risen from 8.2% since the last report. All staff groups have seen slight increases since last month.

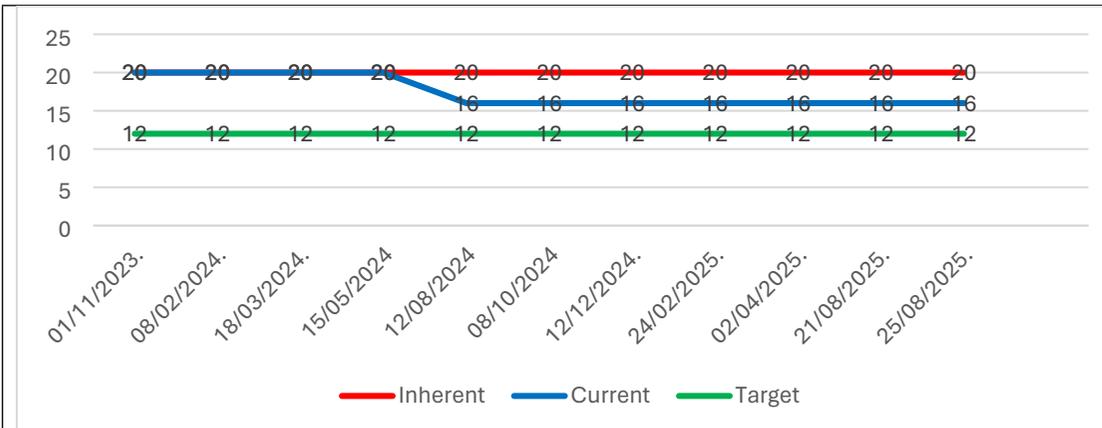
	<p>Although, the overall trend for Nursing are showing a positive downturn in vacancy rates compared to this time last year with effective international recruitment campaigns contributing.</p> <p>Turnover remained the same for March 25 compared to last month, maintaining a steady downward trend, currently our lowest score since January 2022, at 7.9% and down 0.6% in the last 12 months. Additional clinical services, AHPs and Healthcare scientists reporting increased turnover in the last 12 months. This is mirrored by a steady improvement in staff retention over the previous 12 months.</p> <p>Rolling sickness absence spiked in December 2024 and has reduced in the last three consecutive months to 5.6%. Stress, anxiety and depression continues as the highest reported reason despite also showing a reduction in time lost.</p> <p>KPIs to monitor how well our people are being treated; There has been a decline in the number of emergency salary payments in the past 12 months. Furthermore, E-rosters approved within policy timescales has improved in the last we months but work still needs to be done to meet the 80% KPI.</p>
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CRR 25-03	Risk Title: Population Needs		Date Opened: 21/08/2025 <i>(version 2 refined from 2023)</i>
	Assuring Committee: Planning, Population Health & Partnership Committee		Date Last Committee Review: 03/07/2025
Date Last Reviewed: 25/08/2025	Director Lead: Executive Director of Public Health	Link to BAF: BAF24-06/07	Target Risk Date: 31/03/2028
<p>There is a risk that the organisation will fail to meet the health needs of the population and will not enable good health and wellbeing of the population.</p> <p>This may be caused by a failure to take appropriate health prevention responses in areas such as immunisation, outbreak management and screening, failure to deliver interventions that improve people's health, increasing pressures in primary care, rising demand for chronic condition management, and insufficient capacity in children's, dental, and mental health services.</p> <p>This may lead to unmet health needs, preventable and communicable diseases, poorer health outcomes and widening inequalities for the North Wales population.</p>			
Mitigations/Controls in place		Additional Controls required	

<ol style="list-style-type: none"> 1. Recurrent funding secured for Healthy Weight / Healthy Wales programmes (from CRR24-08, DPH) 2. Diabetes “Case for Change” (from CRR24-08, DPH/MD) 3. Healthcare Public Health programmes support the integration of population health approaches within patient pathways 4. Approved Communicable Disease Plan in place with supporting procedures in place for some communicable diseases. (CRR 18) 5. Primary Care Board and subgroups (dental, community pharmacy, optometry, GMS) provide cluster-level governance (from CRR24-09, COO/DPH) 6. CHC teams and community escalation frameworks in place (from CRR24-19, COO) 7. Welsh Government ND transformation programme funding to support longest waiters (from CRR24-27, COO) 8. National referral pathways in orthodontics and DESI / Tier 2 provision (from CRR24-22, COO/Dental) 	<ol style="list-style-type: none"> a) Limited system-wide prevention leadership and prevention not consistently prioritised (from CRR24-08) b) Inconsistent commissioning approach across community and primary care services (from CRR24-19, CRR24-09) c) The plan in place for the management of communicable disease outbreaks (in and out-of-hours) within BCUHB requires testing / simulation and socialising to ensure effectiveness d) Diabetes Programme support to establish cross cutting delivery plan e) Insufficient digital integration for community and ND services (from CRR24-19, CRR24-27) f) Fragility of ND workforce and reliance on temporary funding (from CRR24-27) g) Lack of restorative dentistry service and workforce pipeline (from CRR24-22) h) Evidence to support the Health Inclusion offer
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Actions	Action Owner	Due Date	Progression Analysis
Complete Population Needs Assessment which informs the development and focus of Health Board Strategy	Gwyneth Page, Public Health	31/03/2026	Progressing
Identify population health focused priorities for Health Board delivery	Gwyneth Page, Public Health	31/03/2026	Progressing
Development of Population Health Management data and intelligence to ensure that Health Board is intelligence-led Delayed due to recruitment controls	Gwyneth Page, Public Health	31/03/2026	Delay
Develop a plan which addresses recommendations from the BCUHB Weight Management Service review	Gwyneth Page, Public Health	31/03/2027	Progressing
Communicable disease outbreak management plan is embedded within services with an agreed schedule of simulation events and schedule of review by the Board	Sam Lauder,	31/03/2026	Progressing

	Public Health		
Contribute to co-design Prevention Framework for North Wales as part of the Regional Partnership Board	Gwyneth Page, Public Health	31/03/2026	Progressing
Achieve the ministerial priority BCUHB Integrated Vaccination & Immunisation Service – Increase vaccination rates against targets	Gwyneth Page, Public Health	31/03/2026	Progressing
Implement plan to target resources for the most vulnerable groups (e.g. – those experiencing homelessness, Gypsy, Roma and Traveller communities) which will contribute to reducing inequalities in healthy life expectancy	Gwyneth Page, Public Health	31/03/2026	Progressing
Establish Diabetes Change Programme providing programme management, milestones and delivery plan – in order to meet the Ministerial priorities (increasing the % receiving all 8 NICE Care processes) <i>Delayed as clinical lead cover required and programme development</i>	Gwyneth Page, Public Health	31/03/2026	Delay
Develop a Community and CHC Strategic Plan with Local Authorities (from CRR24-19) this is being taken forward as part of the regional commissioning board (subgroup of the RPB)	Jane Trowman, CHC	31/03/2026	Progressing
Implement surge and escalation plans with Local Authority partners for community flow (from CRR24-19)	Jane Trowman, CHC	Ongoing	Progressing
Management of CYP needs, ND workforce business case submitted to the Executive Team, decision on the case deferred pending a broader review of funding priorities	Fiona Wright, Child & Adolescent Health	31/12/2025	Progressing
Undertake a dental diagnostic deep dive to inform strategy (from CRR24-09)	Rachael Page (amended from Gareth Evans)	31/03/2026	Progressing
	Impact	Likelihood	Score



Inherent Risk Rating	4	5	20
Current Risk Rating	4	4	16
Target Risk Score	4	3	12
Risk Appetite	Quality <15		Not in Tolerance

Position & Intended Outcome for Risk

Life expectancy / healthy life expectancy is declining, and there are worsening health inequalities. This has significant impact on demand for services and potentially on the wider community due to the loss of people from the workforce, and through the subsequent economic impacts on our communities. Worsening health outcomes, increasing ill health and widening inequalities directly affects the Health Board's ability and capacity to deliver excellent healthcare services, meaning the Health Board's purpose must retain clear focus on prevention and early intervention to improve the health and wellbeing of the population

CRR 25-05	Risk Title: Strategic Change – Impacting Care and Staff Delivery	Date Opened: 21/08/2025 <i>(version 2 refined from 2023)</i>
	Assuring Committee: Planning, Population Health & Partnership Committee	Date Last Committee Review: 03/07/2025

Date Last Reviewed: 01/10/2025	Director Lead: Executive Director of Transformation and Strategic Planning	Link to BAF: BAF24-02	Target Risk Date: 31/03/2026
<p>There is a risk that patients may not benefit from planned improvements in care, access, and outcomes if the HB does not effectively implement or develop its strategic change programmes.</p> <p>This may be caused by a lack of momentum in delivering change, unclear or underdeveloped clinical strategy, competing ministerial priorities, and inconsistent transformation efforts across clinical services.</p> <p>This may lead to inefficiencies, missed opportunities to modernise care, continued misalignment between service delivery and patient needs, and increased frustration or disengagement among staff tasked with delivering change.</p>			
Mitigations/Controls in place		Additional Controls required	
<ol style="list-style-type: none"> 1. Scrutiny and oversight of strategy development work by the Strategic Planning and Service Change Group (SP&SC Group a sub-group of the Executive Committee), Planning Population Health and Partnerships (PPHP) Board Committee and the Health Board to ensure robust governance arrangements and timely escalation; which are important for enabling foundations for successful delivery of strategic change and co-production of the 1) Strategic Intent for North Wales with partners, 2) 10 Year Strategy for the Health Board, 3) Clinical Services Plan 2. Priority change programmes in place for the organisation 1) Major Change Programmes (Planned Care; Urgent and Emergency Care; Value and Sustainability; and Foundations For The Future), 2) Key Programmes (grouped into: Mental Health; Llandudno Planned Care hub; Improving safety, efficiency and effectiveness through digitisation; Diagnostics improvement; and Health and Well-being Hubs), 3) Challenged Services (Dermatology, Ophthalmology, Vascular, Urology, Oncology, Plastics, Orthopaedics, Orthodontics). 3. Change programmes controls in place and monitored by the Transformation and Improvement team to ensure they are run consistently and best practice project, programme and portfolio management is applied. As well as providing an objective and independent assessment of progress and areas of risk. 4. Oversight and scrutiny of the Major Change Programmes tracking progress, risks, and dependencies by the Executive Committee, relevant Board Committee and Health Board. The Key Programmes reports into SP&SC Group, PPHP and Health Board. 5. The Challenged Services report into SP&SC Group for review and oversight, QSE and Health Board. 		<ol style="list-style-type: none"> a. Completion of the strategy development work, moving into the execution phase. b. Continued development of the portfolio management and reporting approach for all priority change programmes, including monthly monitoring of high risks across all priority programmes. c. Mobilisation of the Challenged Services oversight group that will report into the SP&SC Group. d. Organisational approach to change management to be developed and implemented. 	

<p>6. External oversight and scrutiny is provided by Welsh Government via IQPD and JET as well as quarterly Challenged Services review meetings.</p> <p>7. Terms of References for all groups with clear routes to escalation.</p> <p>8. Legal and policy compliance including adherence to WG service change guidance.</p>				
Actions	Action Owner	Due Date	Progression Analysis	
Complete Strategic Intent for North Wales with partners, presenting to Health Board for approval	Kamala Williams, Transformation & Strategic Planning	31/01/2026	Progressing	
Complete the diagnosis phased of the Health Board's 10 Year Strategy, including an implementation plan for the remaining programme of work	Kamala Williams, Transformation & Strategic Planning	31/03/2026	Progressing	
Complete preparations for phase 2 of the Clinical Services Planning work, including an implementation plan	Kamala Williams, Transformation & Strategic Planning	31/03/2026	Progressing	
Implement changes to portfolio management and reporting based on feedback on early iterations of reporting across all the priority programme areas, including monthly monitoring of high risks across all priority programmes.	Geraint Parry, Transformation & Strategic Planning	31/12/2025	Progressing	
Mobilise the Challenged Services oversight group that will report into the SP&SC Group	Geraint Parry, Transformation & Strategic Planning	31/12/2025	Progressing	
Organisational approach to change developed as one of the enabling products within Foundations For The Future programme	Geraint Parry, Transformation & Strategic Planning	31/03/2026	Progressing	
		Impact	Likelihood	Score



Inherent Risk Rating	4	4	16
Current Risk Rating	4	3	12
Target Risk Score	4	2	8
Risk Appetite	Quality <15		In Tolerance

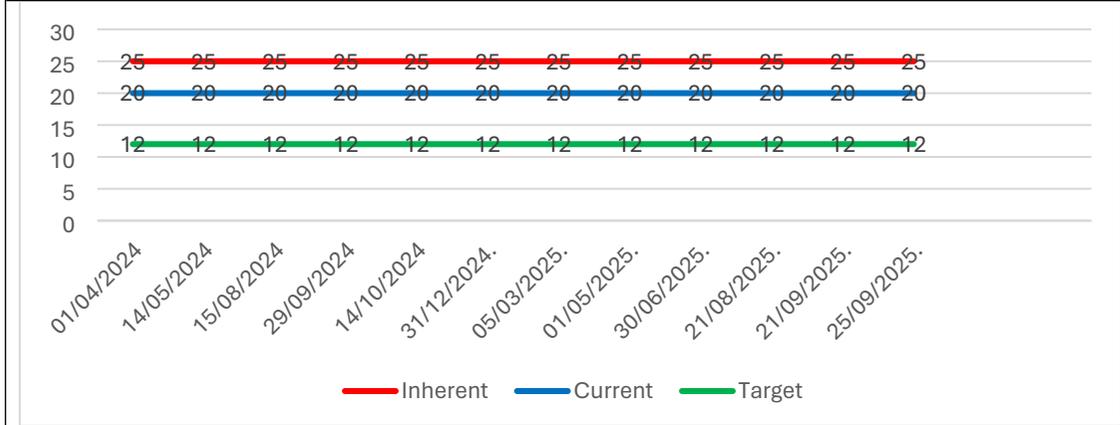
Position & Intended Outcome for Risk

	Assuring Committee: Performance, Finance and Information Governance Committee		Date Last Committee Review: 25/06/2025
Date Last Reviewed: 25/09/2025	Director Lead: Executive Director of Finance	Link to BAF: BAF24-03	Target Risk Date: 31/03/2026
<p>There is a risk that the Health Board is unable to secure current non-recurrent (one off) allocations in future financial years, these allocations conditional on attainment of financial plans. If this resource is not secured then services will be required to deliver within a reduced envelope of funds and as a consequence patients may experience reduced access to high-quality, timely and innovative care. The objective is to achieve long-term financial sustainability or maximise value from its spending.</p> <p>The key risks centre upon cost overruns from out of area referrals for mental health patients and patient flow out of the Hospital resulting in cost exposure from requiring additional capacity areas to remain open and additional costs within Emergency Care front of house, combined with an inability to deliver savings plans, reduced investment in transformation.</p>			
Mitigations/Controls in place		Additional Controls required	
<ol style="list-style-type: none"> 1. Core Savings targets for IHCs, Non-IHC Directorate and Corporate functions have been issued and performance to be challenged at Integrated Performance Executive Delivery Group – chaired by the Chief Executive. 2. Value and Sustainability programme approach to 2025/26 savings has been endorsed by the Executive and Board. Executive Leads have been assigned and a flow chart issued setting out the governance process for sharing of costed savings opportunities and Divisional delivery. 3. Accountability Agreements to be issued to the budget managers for sign off in support of funding and deliverables required for each financial year. The signing off for these agreements monitored for review by Internal Audit and performance reported through Committees of the Health Board 4. Continuation of the Enhanced Establishment Control Group (executive approval before advertising) to review all requests for A&C posts and all Band 7+ posts, moratorium on requests for Permanent recruitment to Band 8B and above where potentially affected by Foundations for the Future but excluding any clinical posts and minimising interim staff appointments. 5. Expansion of EEC to be utilised for acting up and any increase in hours to be managed through the Enhanced Establishment Control process. 6. Cease use of agency in line with Ministerial Actions by end September 2025 7. Implementation of exceptionality sign off by Executive Director of Nursing for all Agency nursing requests beyond 31 October for all areas excluding Mental Health. Mental Health to be included from December 2025. 8. Non-Pay – all discretionary, non-catalogue, non-clinical expenditure directed to the office of the Executive Director of Finance for scrutiny prior to approval 9. Internal scrutiny by Central Finance Team, of the Divisional financial assumptions, overspends and forecasts. 		<ol style="list-style-type: none"> a. Prior year and current year financial performance material deterioration and therefore additional actions are required to control the run rate and reduce the deficit to a balanced position. These have been previously endorsed for implementation through the Integrated Performance – Executive Delivery Group. b. Health Board delegation to Executive to produce a recovery plan, Health Board working group formed to provide Board oversight with Performance, Finance and Information Governance Committee to mitigate against the year-to-date deficit and risk to attainment of target break even whilst assessing impact on patient safety and quality c. Performance is reported and scrutinised through the IP-EDG monthly meetings where officers are held to account for delivery. A 1% cost benefit and savings ask delivery is required as a minimum d. Gaps in delivery of savings targets are to be mandated to be met on a recurrent basis e. Escalation meetings where improvements are not realised will continue to be held with leadership teams by the Chief Executive. In these forums support is offered to improve performance and trajectories supported for improvement. 	

<p>10. Financial reporting throughout the Health Board and to Welsh Government on a monthly basis, the Monthly Monitoring Return.</p> <p>11. Early identification of emerging issues through horizon scanning and trends in run rate and alerting Operational Management to changes to regularity requirements.</p> <p>12. Monitoring the adequacy and effectiveness of internal control, accuracy and completeness of financial reporting and forecast, compliance with laws and timely remediation of deficiencies through conformance reporting to Audit Committee and reporting through local finance reports to services</p> <p>13. Reviewing of SORD in place in September 2025 which was implemented in October 23 with a view to providing clarity of authority moving towards earned autonomy</p>	<p>f. Ongoing prioritisation exercise involving £42m transformation funding received on a conditionally recurrently basis to the end of 2025/26</p>
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Actions	Action Owner	Due Date	Progression Analysis
<p>Health Board receiving a report on need for additional financial oversight, delegating Executive to develop a recovery plan building on the measures deployed and key asks of officers from the Integrated performance executive Delivery Group. A representation of the Health Board to support development of the recovery plan and Performance, Finance and Information Governance Committee to provide Health Board oversight</p>	<p>Director of Finance (DoF)</p>	<p>30/11/2025</p>	<p>Progressing</p>
<p>The Integrated Performance – Executive Delivery Group (IP-EDG) endorsed implementation of expenditure controls within the areas and directorates (from November 2024) as a measure to cease the run rate deterioration above plan and recover the year to deficit, to attain the forecast control total deficit for the financial year as agreed with Welsh Government.</p> <p>These measures were expanded to cover controls over expenditure discretionary expenditure (non-patient related) in January 2025 within IP-EDG. In 2025/26, a further target 1% reduction of total spend has been provided to services in September 2025 with a view to reduce the year to date overspend and mitigate any further movement of the financial position. The total target is c£20m</p>	<p>DoF</p>	<p>31/10/2025</p>	<p>Progressing</p>
<p>Enhanced ‘Check and Challenge’ discussions with Chief Finance Officers, on a monthly basis, to ensure the forecast expenditure is robust. Escalation of Out of Area Mental Health Placements, through the Chief Executive Officer. Maintain increased controls.</p>	<p>DoF</p>	<p>31/03/2026</p>	<p>Progressing</p>
<p>Continued oversight and holding to account via the Integrated Performance Executive Delivery Group, and holding to account against expenditure control reductions identified for the remainder of the financial year.</p>	<p>Chief Executive Officer (CEO) / DoF</p>	<p>Monthly</p>	<p>Progressing</p>
<p>Strengthen application of SORD decision-making framework across all directorates /Decision Making Framework to be approved</p>	<p>DoF / Director of Corporate Governance</p>	<p>31/10/2025</p>	<p>Complete</p>
<p>Programme of work initiated to review how the Health Board spends its money, visibility of IHC performance and national benchmarks to ensure value outcomes (Patient Related Outcome Measures) are developed to support Allocative Efficiency moving forwards (cost / activity / outcomes)</p>	<p>DoF</p>	<p>30/09/2025</p>	<p>Complete / Ongoing</p>

Examine and explain clinical variation with a view to benchmarking opportunities internally initially with a view to ensuring financial sustainability	DoF	30/09/2025	Complete / Ongoing
<p>Directorate teams to review medical devices capital replacement plans.</p> <p>Directorate teams are linking with Capital to update their replacement plans.</p>	Susan Brierley-Hobson, Therapies & Health Science	15/12/2025	Progressing



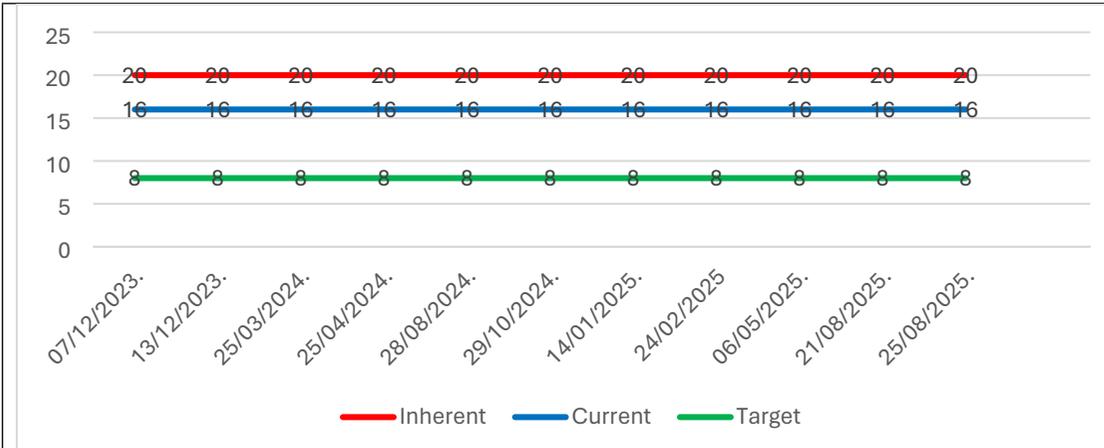
	Impact	Likelihood	Score
Inherent Risk Rating	5	5	25
Current Risk Rating	5	4	20
Target Risk Score	4	3	12
Risk Appetite	Financial/vfm <15		Not in Tolerance

Position & Intended Outcome for Risk

CRR25-07	Risk Title: Leadership and Operating Model	Date Opened: 21/08/2025 <i>(version 2 refined from 2023)</i>
	Assuring Committee: People & Culture Committee	Date Last Committee Review: 12/06/2025

Date Last Reviewed: 25/08/2025	Director Lead: Executive Director of People and Organisational Development	Link to BAF: BAF24-01	Target Risk Date: 31/03/2026		
<p>There is a risk that patients may experience delays, reduced quality of care, or fragmented services if the organisation does not have an operational model to deliver its strategic objectives This may be caused by fragile management structures, workforce shortages, leadership capabilities and competence and rising demand in high-need areas. This may lead to diminished organisational resilience, reduced capability to deliver foundations for the future, low staff morale, and risks to safe, high-quality care.</p>					
Mitigations/Controls in place			Additional Controls required		
<ol style="list-style-type: none"> 1. Strategic Recruitment team for senior leadership, medical and dental consultant posts (from CRR24-01, Deputy DoPOD) 2. Local IHC resourcing teams driving recruitment priorities (from CRR24-01) 3. Recruiting Well and Joining Well programmes (from CRR24-01) 4. Nurse Retention Lead and retention plan in place (from CRR24-01) 5. All-Wales Flexible Working policy implemented (from CRR24-01) 6. Speak Out Safely MDT and Work in Confidence platform for staff to raise concerns (from CRR24-01) 7. Organisational Culture Change Plan and Behaviours Framework approved by Board (from CRR24-16) 8. Integrated Leadership Development Framework (ILDF) with measurement metrics (from CRR24-16) 9. Leadership conferences, networking and masterclasses held (3 so far, >750 attendees) (from CRR24-16) 10. Compassionate leadership pledge signed (from CRR24-16) 			<ol style="list-style-type: none"> a) Need for further embedding of workforce planning function (from CRR24-01) b) Leadership development pathways not fully integrated (from CRR24-16) c) Engagement and operational effectiveness with Medical and Dental workforce inconsistent (from CRR24-01) d) Absence management requires stronger controls (from CRR24-01,) e) Compassionate leadership adoption requires measurable indicators across organisation (from CRR24-16) 		
Actions			Action Owner	Due Date	Progression Analysis
<p>Implement Employee Engagement Plan with suite of indicators (from CRR24-01)</p> <p>The actions underway listed below are part of the 2025-26 plan for culture and engagement. The 2025 staff survey result will be used to assess the impact these actions have had. It is expected the result will be available in early 2026.</p> <ul style="list-style-type: none"> • Embedded new engagement listening approach including staff stories being shared at People and Culture Committee, Local Partnership Forum and more widely to support organisational understanding and learning • Refreshed reward and recognition activity to introduce monthly recognition awards 'Seren Betsi' with Executive involvement, improved annual staff achievement awards event (26.9.25) 			Katie Sargent - Corporate Office	31/03/2026	Progressing

<p>and currently reviewing approach to the celebration of long serving colleagues while holding ceremonies for those who have reached 25 years service in October 2025</p> <ul style="list-style-type: none"> Involved local teams and introduced new local responsibility for actions in response to the 2024 NHS Wales Staff Survey to prepare the ground for the 2025 survey (goes live 6.10.25) As of August 2025, two members of staff joined the team, bringing additional capacity to proceed with work to further develop and deliver employee engagement and experience-related improvements which will include mechanisms for both improving engagement and measuring engagement such as Pulse surveys 				
<p>Further embed ILDF and measure effectiveness (from CRR24-16)</p> <p>HEIW will release a Management Competency Framework due to be launched September 25. This will be used to inform the mid-level management ILDF leadership courses / resources design.</p>	<p>Rebecca Testa Workforce & Organisational Development</p>	<p>31/03/2026</p>	<p>Progressing</p>	
<p>Roll out Compassionate Leadership resources and embed into development programmes (from CRR24-16)</p>	<p>Director of People and Organisational Development</p>	<p>Ongoing</p>	<p>Progressing</p>	
<p>Deliver Culture Change Plan with Comms and Engagement rollout (from CRR24-16)</p> <p>The synthesis report has been submitted to the Executive Committee (EC) and pulls together the findings from the Discovery phase of the Culture & Leadership Programme and staff feedback from other sources including the NHS Wales Staff Survey 2024 and the Foundations for the Future programme engagement work. This report includes a series of proposals for the EC to agree that will form the work program to improve culture and leadership in the organisation,</p>	<p>Nia Thomas Workforce & Organisational Development</p>	<p>31/12/2025</p>	<p>Progressing</p>	
<p>Quarterly Culture, Leadership & Engagement Plans finalised and monitored (from CRR24-16)</p>	<p>Nia Thomas Workforce & Organisational Development</p>	<p>Ongoing</p>	<p>Progressing</p>	
<p>Additional actions to be included in next iteration on FftF (what will reduce the above risk-key actions in the next 6 months if any).</p>				
		<p>Impact</p>	<p>Likelihood</p>	<p>Score</p>



Inherent Risk Rating	4	5	20
Current Risk Rating	4	4	16
Target Risk Score	4	2	8
Risk Appetite	Quality <15		Not in Tolerance

Position & Intended Outcome for Risk

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

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

PADR compliance showed improvement increasing to 9.6%

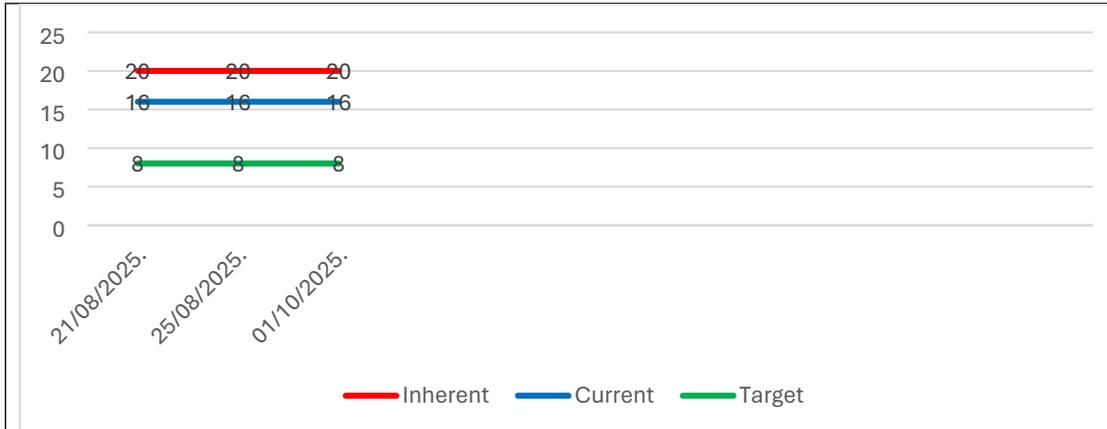
The number of Grievance cases has dropped in the previous three months to 3, from a spike of 17 in July 2024.

The percentage of stress & anxiety absences remains high at 1.6% although has dropped 0.2% since January. Avoidable turnover has dropped from 5.9% to 4.5% compared to January 2023.

Speak out safely cases have dropped from 9 to 6 since the last report in January 2025

CRR 25-08	Risk Title: Non-Compliance with Regulatory and Legislative Requirements		Date Opened: 21/08/2025 <i>(version 2 refined from 2023)</i>		
	Assuring Committee: Quality, Safety and Experience Committee		Date Last Committee Review: New Risk		
Date Last Reviewed: 01/10/2025	Director Lead: Director of Corporate Governance	Link to BAF: BAF24-01	Target Risk Date: 30/06/2026		
<p>There is a risk that the organisation may fail to comply with regulatory and legislative requirements, which could directly or indirectly impact the safety, quality, and accessibility of patient care.</p> <p>This may be caused by inefficiencies in managing regulatory complexities, insufficient policy management, managing changes in legislation at pace, insufficient operational assurance across estates, health and safety, and medical devices, and failure to deliver climate/net zero requirements.</p> <p>This may lead to enforcement action, financial penalties, and loss of public and stakeholder confidence.</p>					
Mitigations/Controls in place			Additional Controls required		
<ol style="list-style-type: none"> 1. Training, induction and mandatory requirements for staff for highlights legislation and compliance. 2. Various groups exist such as: Medical Devices Governance & Assurance Group oversees procurement, selection, risk management and safety comms Estates and Health & Safety Committee oversee areas of non-compliance and tracking of action plans. Pharmacy Technical Services and monitoring of compliance in relation to Controlled Drugs 3. Various External peer review programmes e.g. Finance, Counter Fraud, Pharmacy, Imaging and Pathology reporting areas of non-compliance with legislation. 4. Regulatory compliance around Health Inspectorate Wales and Care Inspectorate Wales reported to QSE, and to Audit Committee (via the Statutory Compliance Report) 			<ol style="list-style-type: none"> a) Governance and regulatory Executive Delivery Group (EDG) group to be in place to ensure HB wide oversight of all other groups (not just clinical) and tracking non-compliance and a clear route for escalation to the EDG. b) Creation of an electronic system to capture all legislative and regulatory requirements, to capture information in relation to accountability and responsibility for the different elements, to enable the sharing of information, monitoring of progress and production of monitoring reports as necessary c) The QMS system is yet to be fully embedded and will highlight external peer reviews which cite any areas of non-compliance for better oversight by the EDG. d) Lack of consistent medical device training and local governance (from CRR24-14) e) Inadequate workforce capacity in Pharmacy aseptic units; >80% capacity utilisation (from CRR24-28) f) Quality assurance and regulatory compliance gaps in Pharmacy services (from CRR24-28) g) Net zero / climate compliance delivery plan not embedded (consolidated) 		
Actions			Action Owner	Due Date	Progression Analysis
A) Governance and regulatory EDG to be set up to oversee non-compliance (strategic actions from this to be added here going forward)			Glesni Driver,	01/12/2025	Progressing

	Corporate Office		
B)Creation of an electronic system to capture legislative and regulatory information and requirements. Not started due to resource constraints anticipated start date Q1 25/26.	Glesni Driver, Corporate Office	01/11/2026	Not Started
D)Complete audit of medical devices readiness of services. Post-market surveillance audit completed August; three services who make or modify devices need support to ensure compliance. Meetings scheduled with those services, Head of Clinical Engineering and ADAHPS in September / October to facilitate next steps. The audit was circulated widely across the Health Board, prioritising services/pathways most likely to make or modify devices. As there may be other services who fit these criteria, the engagement team have supported ongoing communication into the organisation for awareness. National benchmark audit completed June 2025. Benchmark summary received August 2025. Head of Clinical Engineering working with services to progress improvements. The National audit remains live so we can update as required.	Susan Brierley-Hobson, Therapies & Health Science	16/12/2025	Progressing
A)Review local medical devices groups governance & membership. A proposal was written re these groups being reformed in April 2025. EDAHPHS Teresa Owen and COO Tehmeena Ajmal in discussion re way forward.	Susan Brierley-Hobson, Therapies & Health Science	16/03/2026	Progressing
E)In order for compliance in pharmacy (aseptic production, QA and regulatory staff) Workforce Expansion is required. The delay in initial progress has been due to annual leave in July and August, responding to external audit findings and responding to out of specification environmental monitoring results. Work has restarted but completion will be delayed until end of Nov 2025.	Lois Lloyd , Corporate Office	31/11/2025	Progressing
E) Strengthen pharmacy QMS and regulatory compliance roles	Lois Lloyd , Corporate Office	31/05/2025	Completed
A)Prevent Fraud legislation. Compliance task and finish group to be set up with risk leads appointed to ensure compliance across the HB. Areas of non-compliance or not progressing in a timely manner to be monitored by Finance and EDG.	Danielle Timmins, Finance	31/12/2025	Progressing
Review and update business continuity plans for Pharmacy Technical Services. The Cancer Division have set up a working group to develop and implement a demand and capacity SACT Dashboard, multi-disciplinary group meeting monthly.	Lois Lloyd, Corporate Office	31/12/2025	Progressing
	Impact	Likelihood	Score



Inherent Risk Rating	4	5	20
Current Risk Rating	4	4	16
Target Risk Score	4	2	8
Risk Appetite	Regulatory/Compliance <15		Not in Tolerance

Position & Intended Outcome for Risk

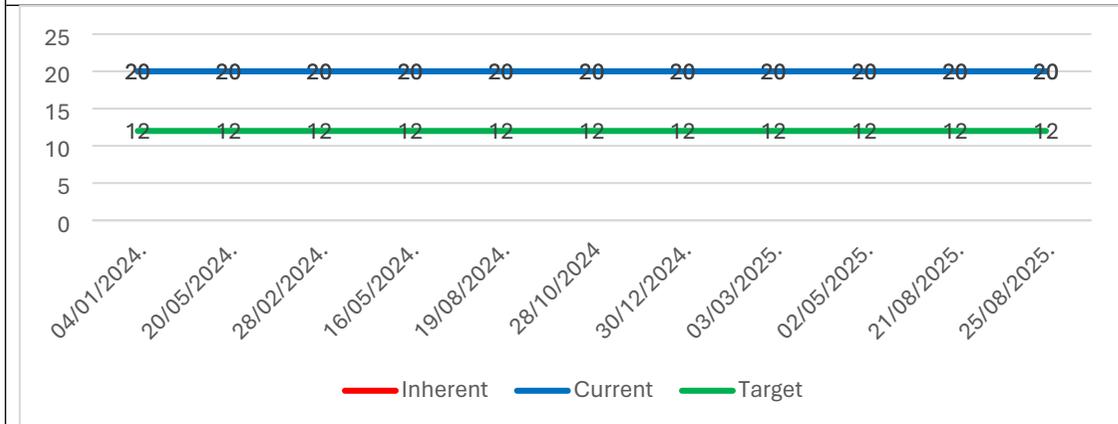
Governance and regulatory EDG to be set up to oversee non-compliance and all operational aspects. This risk to be developed to be more strategic following the group and to report areas of non-compliance to the Executive Committee. Compliance to be tracked and risks mitigated.

CRR 25-09	Risk Title: Safe Environment		Date Opened: 04/01/2024
	Assuring Committee: Performance, Finance and Information Governance Committee		Date Last Committee Review: 25/06/2025.
Date Last Reviewed: 25/08/2025	Director Lead: Director of Environment and Estates	Link to BAF: BAF 24-03	Target Risk Date: 31/03/2026 (10 year capital investment requests aligns with the capital prioritisation form that will submitted to Welsh Government – completion target date 2035)
<p>There is a risk that patients may be exposed to unsafe, uncomfortable, or unsuitable care environments if the organisation's estates and infrastructure are not maintained to appropriate standards.</p> <p>This may be caused by ageing estate, backlog maintenance, and gaps in fire safety, health and safety compliance, and alignment with the estates strategy.</p> <p>This may lead to safety incidents, non-compliance with statutory duties, and barriers to service modernisation.</p>			
Mitigations/Controls in place		Additional Controls required	
<ol style="list-style-type: none"> 1. Estates Strategy developed and approved by the Health Board in January 2023. 2. Internal Governance for capital allocation in place within the Health Board. 3. Business Cases to Welsh Government to resolve major infrastructure issues in line with the Estates Strategy 4. Priority bids against Welsh Government Estates Funding Advisory Board (EFAB) for the allocation and prioritisation of funding in relation to infrastructure funding, decarbonisation, fire and Mental Health and Learning Disability. 5. Discretionary Capital Allocation of £17m for 25/26 approved by Welsh Government with an allocation of approximately £3.45m aligned to improvements within the Estates. Prioritisation is based on Operational Estates Risk Register 6. Regular Welsh Government /Health Board Capital Meetings – which provides a direct link with Welsh Government to raise concerns regarding the funding available to effectively manage the condition of the estate and ensure safety of patients and staff. 7. Operational Estates Safety Groups in place to provide assurance, the safety groups are as detailed below and oversee risks relevant to the groups: 8. Fire Management 9. Asbestos Management 		<ol style="list-style-type: none"> a) 6 facet survey to be undertaken to obtain an updated report of the condition of the Estate' this will inform the risk status by site, which will be assessed against the controls currently in place. Additional mitigation or strengthening of controls will also be considered. b) Standardised approach by the Health Board in relation to management of Estates and Capital between the Integrated Health Community IHC's) and other services and the Estates/Capital teams – linked to the changes to the Operating Model. c) Ensure that the Health Board has an Estates rationalisation programme in place that will support the capital prioritisation programme and reduce backlog maintenance. d) Internal Audit review of Fire Safety – Agreed Management Action Plan being implemented and being managed through the Fire Safety Management Group e) Timely progression of major Capital Schemes which address Estates Safety such as Wrexham Maelor Continuity Plan – Phase 	

10. Water Safety,
11. Ventilation Safety
12. Electrical Safety
13. Welsh Government Capital Resource Meetings in place to provide route for escalation.
14. Estates and Facilities Performance Management System (EFPMS) reporting template and recording of backlog maintenance
15. Capital Allocation from Welsh Government – additional capital funding of allocated to the Health Board to focus on Backlog Maintenance
16. The Health Board submitted the Major Capital prioritisation plan to Welsh Government (WG) to identify required investment. The end date is dependant of how much capital investment is provided to the Health Board from WG. The 10 year capital investment requests aligns with the capital prioritisation form that we will submit to Welsh Government.
17. Updated agreed protocol for use of Annual Discretionary Slippage in place for developing Business Justification Cases (BJC) for essential estates works and discretionary capital schemes that could be aligned with in-year additional Capital Funding provided by WG.
18. Review of Reinforced Autoclaved Aerated Concrete (RAAC) completed by the Health Board’s approved structural engineers – Curtins and a report will be presented at the Strategic Occupational Health and Safety Group
19. Targeted Estates Funding (TEF) approved by Welsh Government and allocation of £15.390m awarded over a 2-year period (2025-2026 / 2026/2027) to progress the national programme of capital schemes for Fire, Infrastructure, Decarbonisation, Mental Health, Infection Prevention Control and Decontamination
20. Assurance around the Capital Prioritisation Plans that it is aligned with both the Estates strategy and the Clinical strategy. This forms part of the T.O.R of the Capital Investment Group

Actions	Action Owner	Due Date	Progression Analysis
Undertake action to deliver a Health Board Estates Rationalisation Programme. Estates Rationalisation Programme being developed and in draft format. This will be finalised in conjunction with the new Director of Environment, once in post. The Draft will be submitted to a multi-disciplinary group for initial comment, with a final version to be ratified by Capital Investment Group. Health	Arwel Hughes, Estates	31/03/2026	Progressing

<p>Board Rationalisation Programme to be presented to CIG on 12th September 2024. Estate’s rationalisation plan is being reviewed and updated taking into account disposals that have been approved in 2024-2025 and opportunity for disposals in 2025-2026 as part of rationalisation of our estates that supports the Caledfryn Project.</p>			
<p>Undertake actions to deliver a 6 facet survey across the Health Board over the next 5 years. The 6 Facet survey contract is currently being procured through the SBS framework via mini-competition, the contract is due to be awarded by January 2025. A Phase 1 approach for the Acute Hospitals, is expected to be completed by 30/09/26. The completion of the full survey has been brought forward from the original 5 year time frame to a 2 year programme. A review of the 6 facet survey programme has been undertaken with support from Director of Environment and Estates and a plan has been agreed to utilise Ysbyty Gwynedd as a pilot site to conduct a 6-facet survey, it is anticipated that the pilot will be completed by 31st March 2026</p>	<p>Arwel Hughes, Estates</p>	<p>31/03/2027</p>	<p>Progressing</p>
<p>Develop a standardised Terms of Reference to be considered and endorsed by Capital Investment Group. <u>New Terms of Reference for IHC Capital Groups</u> will be reviewed as part of the Foundation for the Future Programme.</p>	<p>Arwel Hughes, Estates</p>	<p>31/03/2026</p>	<p>Progressing</p>



	Impact	Likelihood	Score
Inherent Risk Rating	4	5	20
Current Risk Rating	4	5	20
Target Risk Score	3	4	12
Risk Appetite	Regulatory/Compliance <15		Not in Tolerance
Position & Intended Outcome for Risk			
<p>Current Risk score of 20 aims to be reduced to a 12 by April 2035. Backlog maintenance is the cost to bring estate assets that are below acceptable standards (either physical condition or compliance with mandatory fire safety requirements and statutory</p>			

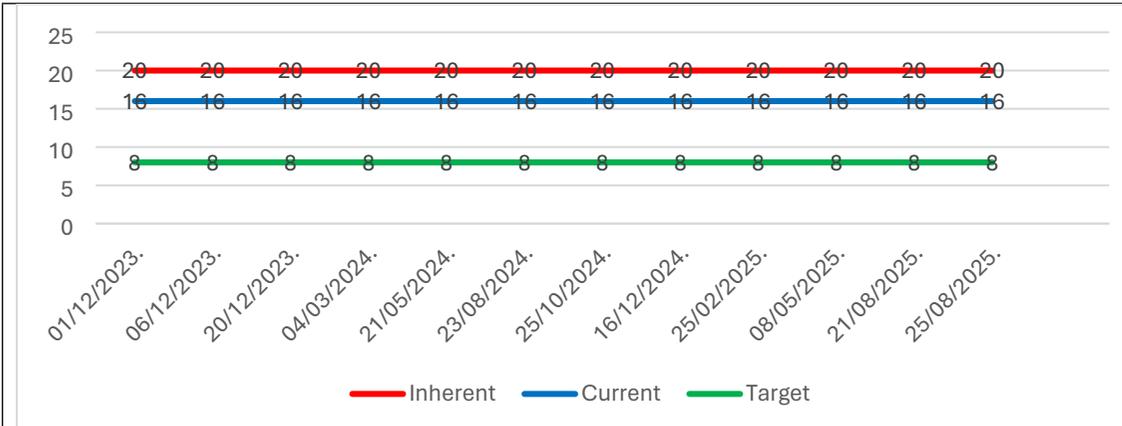
safety legislation) up to an acceptable condition. Total 2021/22 backlog costs for all BCUHB properties was £348.4m. Cost to achieve physical condition B is c. £213m. Cost to achieve condition B for fire and safety statutory compliance is c. £136m. Total risk adjusted backlog is c. £240m. The majority (73%) of backlog relates to the 3 acute hospitals. Backlog for MH&LD, Community and Local Hospitals, and Community Facilities each comprise c.10% of total backlog.

The estate is facing significant risks and challenges and severe limitations on expected future funding. The current estate is not sustainable or viable in the long term and will not support the implementation of key BCUHB strategies and is a significant risk to the Board.

To aid with supporting a Capital Programme the Health Board will commence with a programme to deliver a 6 facet survey for the Estates, these surveys will commence in 2024 focussing on Acute sites and then community hospitals with a target to complete within 2 years. This will be a significant part of the estates portfolio and backlog maintenance cost. As sites are completed the cost associated with backlog maintenance will be identified and capital funding requested. The end date is dependant of how much capital investment is provided to the Health Board from Welsh Government. The 10 year capital investment requests aligns with the capital prioritisation form that we will submit to Welsh Government.

In addition, significant works have been undertaken on the fire project at Ysbyty Gwynedd which will result in approx £2M being invested and works completed by March 2025. Wrexham Resilience Programme has undertaken a risk-based approach to address key findings of the original Business Case. The Health Board has disposed of 2 sites (Ala Road and Cilan) this financial year which were vacated as 'not being fit for purpose', approval has also been received to dispose of Rossett HC and Ruthin HC which have been vacated due to condition of the Estate and these are expected to progress to auction in early 2025. Both sites are currently being disposed of with Ruthin HC awaiting completion of contract.

CRR 25-10	Risk Title: Health and Safety		Date Opened: 21/08/2025	
	Assuring Committee: Performance, Finance and Information Governance Committee		Date Last Committee Review: 25/06/2025	
Date Last Reviewed: 25/08/2025	Director Lead: Director of Environment and Estates	Link to BAF: BAF24-03	Target Risk Date: 31/03/2026	
<p>There is a risk that the organisation will not maintain a safe environment for staff and patients in line with health and safety legislation. This may be caused by inadequate oversight of health and safety risks, gaps in estates and equipment compliance, and insufficient resources to address safety priorities.</p> <p>This may lead to patient and staff harm, enforcement action, reputational damage, and increased legal claims</p>				
Mitigations/Controls in place		Additional Controls required		
<ol style="list-style-type: none"> 1. Three-year Occupational Health, Safety and Security strategy. 2. Health and Safety Policies report into the Strategic Occupational Health & Safety Group (SOSHG). 3. Health and Safety eLearning and short courses in place. 4. Gap Analysis has been reviewed. Strategy and plan to March 2026. 5. Health and Safety Policies and Procedures are on BetsiNet. 6. Programme of Health and Safety Reviews are in place. 7. Programme of Health and Safety Self-Assessments are in place for completion twice yearly. 8. Health and Safety presentation delivered to Board members in February 2025, to raise awareness of requirements. 		<ol style="list-style-type: none"> a) NHS Employer Health and Safety Standards are being developed b) A review of resources required following the internal audit. c) BCUHB Executive Team and Board of Directors to complete health and safety training. d) The business model aligned to the NHS Manual Handling Passport Scheme to be reviewed e) Investment in training venues is required for manual handling training delivery. f) Senior Leaders to nominate staff to support with Divisional delivery of manual handling refresher training. g) Review of health and safety policies within the next 12-24 months. h) A Health and Safety Risk Assessment and Management Framework needs developing. i) A pan BCUHB Health, Safety and Security Training Needs Analysis is required. j) Utilise the Violence Prevention and Reduction Standards to provide a framework for a safer environment. k) Intranet pages for Health, Safety and Security Services require development. 		
Actions		Action Owner	Due Date	Progression Analysis
A new approach is required supplemented by a clear strategy and framework.		Lynne Bushell, Workforce &	31/12/2025	Progressing



Target Risk Score	4	2	8
Risk Appetite	Regulatory/Compliance <15		Not in Tolerance

Position & Intended Outcome for Risk

There is an inherent risk that the failure of Health & Safety management systems could lead to RIDDOR Reportable. Specified Injuries to Workers. Patient mismanagement, long-term effects. Death or significant irreversible harm which will result in prosecution by the Health and Safety Executive consequently leading to loss of reputation and financial penalties. The risk is extenuated by Non-compliance with national standards with significant risk to patients/public. An unacceptable level or quality of treatment/service. Gross failure of patient safety leading. Inquests and Coroners reports. Low staffing level that reduces the service quality. Low staff morale. Poor staff attendance for mandatory/key professional training. Uncertain delivery of key objective/ service due to lack/loss of staff within the Health and Safety team. Structural changes implemented in summer 2024, with Health and Safety moving from Workforce Directorate to a new role of Director of Environment, reporting directly to CEO.



Teitl adroddiad: <i>Report title:</i>	CORPORATE GOVERNANCE REPORT			
Adrodd i: <i>Report to:</i>	Audit Committee			
Dyddiad y Cyfarfod: <i>Date of Meeting:</i>	Tuesday, 21 October 2025			
Crynodeb Gweithredol: <i>Executive Summary:</i>	<p>This report provides the Audit Committee with an update on key corporate governance matters, offering assurance on the Health Board’s compliance with its Standing Orders and broader governance responsibilities. It includes a summary of recent breaches in publication timelines, updates on declarations of interest, and business considered in private sessions now reported publicly, in line with transparency requirements.</p> <p>The report also outlines the Committee’s Forward Work Plan, which supports structured and timely oversight, and includes a placeholder for an update on Mental Health and Society.</p>			
Argymhellion: <i>Recommendations:</i>	<p>Members are asked to:</p> <ul style="list-style-type: none"> • NOTE the breaches to the Standing Orders; • NOTE the Declarations of Interests; • NOTE and COMMENT on the Draft Governance Improvement Plan 2025-27; • NOTE the Summary of business considered in private session to be reported in public on 25 August 2025; • NOTE the Forward Workplan; and • RECEIVE an update on the Mental Health and Society. 			
Arweinydd Gweithredol: <i>Executive Lead:</i>	Pam Wenger – Director of Corporate Governance			
Awdur yr Adroddiad: <i>Report Authors:</i>	Philippa Peake-Jones – Head of Corporate Governance			
Pwrpas adroddiad: <i>Purpose of report:</i>	I’w Nodi <i>For Noting</i> <input type="checkbox"/>	I Benderfynu arno <i>For Decision</i> <input checked="" type="checkbox"/>	Am sicrwydd <i>For Assurance</i> <input type="checkbox"/>	
Lefel sicrwydd: <i>Assurance level:</i>	Arwyddocaol <i>Significant</i> <input type="checkbox"/>	Derbyniol <i>Acceptable</i> <input checked="" type="checkbox"/>	Rhannol <i>Partial</i> <input type="checkbox"/>	Dim Sicrwydd <i>No Assurance</i> <input type="checkbox"/>

	<p>Lefel uchel o hyder/tystiolaeth o ran darparu'r mecanweithiau / amcanion presennol</p> <p><i>High level of confidence/evidence in delivery of existing mechanisms/objectives</i></p>	<p>Lefel gyffredinol o hyder/tystiolaeth o ran darparu'r mecanweithiau / amcanion presennol</p> <p><i>General confidence / evidence in delivery of existing mechanisms / objectives</i></p>	<p>Rhywfaint o hyder/tystiolaeth o ran darparu'r mecanweithiau / amcanion presennol</p> <p><i>Some confidence / evidence in delivery of existing mechanisms / objectives</i></p>	<p>Dim hyder/tystiolaeth o ran y ddarpariaeth</p> <p><i>No confidence / evidence in delivery</i></p>
<p>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:</p> <p><i>Justification for the above assurance rating. Where 'Partial' or 'No' assurance has been indicated above, please indicate steps to achieve 'Acceptable' assurance or above, and the timeframe for achieving this:</i></p>				
<p>Cyswllt ag Amcan/Amcanion Strategol:</p> <p><i>Link to Strategic Objective(s):</i></p>	<p>This work links to all strategic objectives of the Health Board as Corporate Governance is a key enabler for them.</p>			
<p>Goblygiadau rheoleiddio a lleol:</p> <p><i>Regulatory and legal implications:</i></p>	<p>The Health Board is required to act according to its Standing Orders. This report contains information to allow the Health Board to conform to this.</p> <p>It is essential that the Board has robust arrangements in place for Corporate Governance and failure to do so could have legal implications for the Health Board.</p>			
<p>Yn unol â WP7, a oedd EqIA yn angenrheidiol ac a gafodd ei gynnal?</p> <p><i>In accordance with WP7 has an EqIA been identified as necessary and undertaken?</i></p>	<p>This is not applicable for this report.</p>			
<p>Yn unol â WP68, a oedd SEIA yn angenrheidiol ac a gafodd ei gynnal?</p> <p><i>In accordance with WP68, has an SEIA identified as necessary been undertaken?</i></p>	<p>This is not applicable for this report.</p>			
<p>Manylion am risgiau sy'n gysylltiedig â phwnc a chwmpas y papur hwn, gan gynnwys risgiau newydd (croesgyfeirio at y BAF a'r CRR)</p>				

Details of risks associated with the subject and scope of this paper, including new risks(cross reference to the BAF and CRR)	
Goblygiadau ariannol o ganlyniad i roi'r argymhellion ar waith Financial implications as a result of implementing the recommendations	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 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 Feedback, response, and follow up summary following consultation	Not applicable
Cysylltiadau â risgiau BAF: (neu gysylltiadau â'r Gofrestr Risg Gorfforaethol) Links to BAF risks: (or links to the Corporate Risk Register)	BAF24-01 Building an Effective and Accountable Organisation CRR-16 – Leadership/Special Measures
Rheswm dros gyflwyno adroddiad i fwrdd cyfrinachol (lle bo'n berthnasol) Reason for submission of report to confidential board (where relevant)	Not applicable
Next Steps:	
<ul style="list-style-type: none"> To continue to improve and report on Corporate Governance 	
List of Appendices:	
Appendix 1 Draft Corporate Governance Improvement Plan 2025-26 Appendix 2 Audit Committee Forward Work Plan	

CORPORATE GOVERNANCE REPORT

1. INTRODUCTION

The purpose of this report is to provide the Committee with an update on key corporate governance matters.

2. BREACHES AGAINST THE STANDING ORDERS (7.43)

7.43 of the Standing Orders, require that Board members shall be sent an Agenda and a complete set of supporting papers at least 5 clear days before a formal Board meeting. This information may be provided to Board members electronically or in paper form, in an accessible format, to the address provided, and in accordance with their stated preference. Supporting papers may, exceptionally, be provided, after this time provided that the Chair is satisfied that the Board's ability to consider the issues contained within the paper would not be impaired.

In terms of the breaches against this requirement in the Standing Orders; there have been 4 instances whereby the full set of Board Papers was not available 5 calendar days before the meeting between the period April and September 2025.

As noted in the Accountability Report 2024/25 a particular focus for 2025/26 is on increasing compliance with the Standing Orders. The delays in the publication of these reports were as a result of further quality assurances to ensure they standards were at an appropriate level.

Board Members have highlighted in their feedback of the Board and Committee meetings that whilst progress has been made in the quality of report writing, there is further work to do. This is part of a programme of development being led by the Corporate Governance Directorate.

3. DECLARATIONS OF INTEREST

As part of the Standing Orders of the Health Board, via the Standards of Business Conduct Police, declarations of interest must be monitored, they are a critical governance mechanism that supports assurance, accountability, and ethical decision-making. Members and senior staff are required to declare any personal, financial, or professional interests that could influence or be perceived to influence their role in overseeing operations, finances, or strategic decisions. This process enables the Health Board to identify and manage potential conflicts of interest, ensuring that scrutiny and recommendations are based on objective evidence and free from bias. It also reinforces public confidence in the integrity of governance, aligning with national standards and best practice in public sector accountability.

Below are the two registers of interest shared publicly, the first is that of Board Members the second is that of Employees who are 8c and above as defined in the Standards of Business Conduct Policy as those who should declare.

Board Member Declarations can be found:

<https://bcuhb.nhs.wales/about-us/health-board-meetings-and-members/the-board/register-of-board-members-declarations-of-interest-2025-26-for-the-website-v40pdf/>

The current system of reporting declarations of interest and gifts and hospitality is an area of improvement that is highlighted in terms of the Governance Improvement Plan for 25/26. This information provides a link to the register and going forward, it will be monitored by the Corporate Governance Team reporting on any breaches to the policy.

Declarations for those 8c and above can be found:

<https://bcuhb.mydeclarations.co.uk/declarations>

Summary		Financial Year <input type="text" value="2025/26"/>		
Staff Type	Staff Count	Staff That Have Made A Declaration	Staff That Have Not Made A Declaration	Total Number of Declarations Made
All	25715	1896	23819	2060
Contracted	25708	1895	23813	2059
Non Contracted	7	1	6	1
Decision Makers	2589	1311	1278	1418
Non Decision Makers	23126	585	22541	642

4. GOVERNANCE IMPROVEMENT PLAN 2025-27

The Draft Governance Improvement Plan 2025–27 sets out a framework to strengthen governance across Betsi Cadwaladr University Health Board, aligned with Strategic Priority 1: **Building an Effective Organisation**. The plan responds to findings from internal and external assessments, including the Structured Assessment, Board Assessment, Internal Audit, and Audit Wales reviews.

The plan is structured around six key governance domains:

- Corporate Governance
- Standards of Business Conduct
- Risk Management
- Compliance (Reporting, Systems, Processes, and Policy Framework)
- Procurement and Financial Governance

Each action is assigned to accountable leads with clear timelines, ensuring progress is monitored and aligned with strategic transformation programmes. This plan reflects the Health Board’s commitment to continuous improvement, transparency, and delivering high standards of governance across all levels of the organisation. The Draft Plan is attached as an *Appendix 1*.

5. SUMMARY OF BUSINESS CONSIDERED IN PRIVATE

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.

The below items were considered in private at the meeting held on 25 August 2025:

- Local Counter Fraud Service Progress Report
- Final Internal Audit Report on Digital Procurement
- Historical Symphony Contract

6. COMMITTEE FORWARD WORK PLAN

The Forward Work Plan sets out the Committee’s priorities and scheduled business outside of the normal Cycle of Business, helping ensure a structured, timely, and transparent approach to

decision-making and oversight. It collates suggested referral items from other Committees and the Board.

7. MENTAL HEALTH AND SOCIETY

As reported to the Audit Committee the Health Board underwent a procurement to secure an independent review of the arrangements for the Centre For Mental Health and Society (CFMAHS) the successful bidder is now unable to proceed with the independent review due to personal reasons. An alternative provider of this service is now urgently being sought.

8. RECOMMENDATIONS

Members are asked to:

- **NOTE** the breaches to the Standing Orders;
- **NOTE** the Declarations of Interests;
- **NOTE** and **COMMENT** on the Draft Governance Improvement Plan 2025-27;
- **NOTE** the Summary of business considered in private session to be reported in public on 25 August 2025;
- **NOTE** the Forward Workplan; and
- **RECEIVE** an update on the Mental Health and Society.

GOVERNANCE IMPROVEMENT PLAN 2025-27

Strategic Priority 1: Building an Effective Organisation				
1A: Effective Systems of Governance				
Domain	Improvement Action	Lead	Timescale	Internal/External Report
Governance	<ul style="list-style-type: none"> To continue to improve meeting efficiency of the Board and Committees through the improvements in the paper quality through the introduction of refreshed standards for papers 	Director of Corporate Governance and all Directors	March 2026	Structured Assessment
	<ul style="list-style-type: none"> Continue to review and refine the business planning arrangements for Committees ensuring they are fit for purpose 	Director of Corporate Governance and all Directors	March 2026	Structured Assessment
	<ul style="list-style-type: none"> Through regular review of the Governance Framework; ensure that it is fit for purpose and is reviewed and refreshed as part of an annual review and as part of the Foundations for Future Programme 	Director of Corporate Governance	September 2026	Board Assessment
	<ul style="list-style-type: none"> Improve the focus of Board formal and informal meetings to ensure the balance of the time spent by the Board on strategic discussions 	Chair and Director of Corporate Governance	March 2026	Board Assessment
	<ul style="list-style-type: none"> Review and refine the Board Self-Assessment process ensuring it evolves as part of the feedback from the Board. 	Director of Corporate Governance	February 2026	Board Assessment
	<ul style="list-style-type: none"> Review induction process for all Board Members 	Director of Corporate Governance	March 2026	Board Assessment
	<ul style="list-style-type: none"> To continue to evolve the Executive Committee arrangements by formalising the 'sub' groups and ensure that they are operating effectively 	Director of Corporate Governance (working all Lead Directors)	March 2026	Structured Assessment
	<ul style="list-style-type: none"> To reflect on the Quality Governance reporting taking into consideration the recommendations from the Quality Governance Review by Audit Wales 	Clinical Executive Directors (supported by the Director of Corporate Governance)	June 2026	Audit Wales

GOVERNANCE IMPROVEMENT PLAN 2025-27

Strategic Priority 1: Building an Effective Organisation				
1A: Effective Systems of Governance				
Domain	Improvement Action	Lead	Timescale	Internal/External Report
	<ul style="list-style-type: none"> Review the Operational Governance Framework as part of any changes to the 'operating model' as part of Foundations for the Future Programme 	Director of Corporate Governance and Chief Operating Officer	March – June 2026	Foundations for Future and Internal Audit Report
Standards of Business Conduct	<ul style="list-style-type: none"> Ensure all Directors and monitoring arrangements are in place for ensuring staff at Band C and above are completing their declarations of gifts and hospitality, including where such gifts and hospitality are declined (in accordance with the Standards of Business Conduct Policy) 	Director of Corporate Governance and all Directors	March 2026	Internal Audit Report
	<ul style="list-style-type: none"> A series of guidance documents be circulated to all Board Members and Budget Holders in respect of key conduct matters such as declarations of interest and gifts and hospitality 	Director of Corporate Governance	December 2026	Internal Audit Report
	<ul style="list-style-type: none"> Progress recommendations made by Audit Wales (<i>Structured Assessment, Planned Care, Unscheduled Care etc.</i>) 	Executive Team (<i>through the lead Director</i>)	March 2026	Audit Wales Reports
	<ul style="list-style-type: none"> Review the Standing Financial Instructions to take into account the requirements of the Procurement Act 2023 and introduce a Procurement Guide for all Staff 	Executive Director of Finance and Director of Corporate Governance	March 2026	Internal Audit Report
Risk Management	<ul style="list-style-type: none"> Further embed risk management systems to ensure that risk is actively managed and demonstrable improvements in risk reduction are visible through the Corporate Risk Register 	All Directors	September 2026	Internal Audit Reports Structured Assessment

GOVERNANCE IMPROVEMENT PLAN 2025-27

Strategic Priority 1: Building an Effective Organisation				
1A: Effective Systems of Governance				
Domain	Improvement Action	Lead	Timescale	Internal/External Report
Compliance (Reporting, Systems, Processes and Policy Framework)	<ul style="list-style-type: none"> To simplify the Policy Management System and ensure improvements are made in terms of the reduction of overdue policies 	Director of Corporate Governance	March 2026	Structured Assessment
	<ul style="list-style-type: none"> Streamline and strengthen the reporting arrangements for Internal and External Audit Recommendations 	Director of Corporate Governance	June 2026	Structured Assessment

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
21.07.25	Action AC25/70.1 from Audit Committee 08.05.25	Pam Wenger	Clinical Audit Improvement Plan	Clinical Audit Plan to go to QSE in July and come back to Audit Committee to confirm progress.	Joanne Shillingford	Clara Day	16.12.25	Agreed with Pam and Clara to put forward to Dec 25 meeting
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 Nick Graham	Pam Wenger	16.12.25	Went to P&C 14.08.25, full report and action plan to go to P&C and AC in Dec 25
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 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	16.12.25	Further work required
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	16.12.25	Being discussed with the DDaT team how to take this forward
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	CLOSED Going to Comm in Oct 25
12.09.24	Action AC24/124.3 from Audit Committee	Audit Committee / Pam Wenger	June – Update on new process for policies 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	CLOSED Going to Comm in Oct 25
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	CLOSED Going to Comm in Oct 25
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 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 Russell Caldicott	Tehmeena Ajmal Russell Caldicott	19.08.25	CLOSED 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 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 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) Latest update from AH 21.11.24 policy won't be ready to go in Jan 25 so put forward for March 25.	<ul style="list-style-type: none"> Counter Fraud Policy to go to Committee. Draft Policy in development and being progressed by Head of Counter Fraud. 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



Teitl adroddiad: <i>Report title:</i>	Internal Audit Progress Report 1 August – 10 October 2025		
Adrodd i: <i>Report to:</i>	Audit Committee		
Dyddiad y Cyfarfod: <i>Date of Meeting:</i>	21 October 2025		
Crynodeb Gweithredol: <i>Executive Summary:</i>	<p><u>Progress report</u></p> <p>The progress report is produced in accordance with:</p> <ul style="list-style-type: none"> the requirements as set out within <i>Global Internal Audit Standard 11.3: Communicating Results</i>. the <i>Welsh Government NHS Wales Audit Committee Handbook – Section 4.5 Reviewing internal audit assignment reports</i>. <p>The progress report summarises four reviews finalised since the last Committee meeting in August 2025, with the recorded assurance as follows:</p> <ul style="list-style-type: none"> Reasonable assurance – two Limited assurance – one Assurance rating not applied/not applicable – one <p>The report also includes a request for the Committee to approve amendments to the 2025/26 internal audit plan.</p>		
Argymhellion: <i>Recommendations:</i>	<p>The Committee is asked to:</p> <ul style="list-style-type: none"> ➤ Progress report <ul style="list-style-type: none"> Receive the progress report. ➤ Plan <ul style="list-style-type: none"> Approve the following amendments to the internal audit plan for 2025/26: <ul style="list-style-type: none"> ○ Removal from the plan: <ul style="list-style-type: none"> Budgetary Control and Financial Reporting (BCU-2526-8). Outpatient Transformation (BCU-2526-12). Primary Dental Care (BCU-2526-21). Agency utilisation (BCU-2526-29). ○ Additions to the plan: <ul style="list-style-type: none"> Pharmacy Regulatory compliance (BCU-2526-40). Sickness Management (BCU-2526-41). Purchase Cards and Petty Cash (BCU-2526-42). 		
Arweinydd Gweithredol: <i>Executive Lead:</i>	Director of Corporate Governance		
Awdur yr Adroddiad: <i>Report Author:</i>	Dave Harries, Head of Internal Audit, CMIIA Nicola Jones, Deputy Head of Internal Audit, CMIIA		
Pwrpas yr adroddiad: <i>Purpose of report:</i>	I'w Nodi <i>For Noting</i>	I Benderfynu arno <i>For Decision</i>	Am sicrwydd <i>For Assurance</i>

	☒		☒		☒
Lefel sicrwydd: Assurance level:	Arwyddocaol Significant <input type="checkbox"/> Lefel uchel o hyder/tystiolaeth o ran darparu'r mecanweithiau / amcanion presennol <i>High level of confidence/evidence in delivery of existing mechanisms/objectives</i>	Derbyniol Acceptable <input type="checkbox"/> Lefel gyffredinol o hyder/tystiolaeth o ran darparu'r mecanweithiau / amcanion presennol <i>General confidence / evidence in delivery of existing mechanisms / objectives</i>	Rhannol Partial <input type="checkbox"/> Rhywfaint o hyder/tystiolaeth o ran darparu'r mecanweithiau / amcanion presennol <i>Some confidence / evidence in delivery of existing mechanisms / objectives</i>	Dim Sicrwydd No Assurance <input type="checkbox"/> Dim hyder/tystiolaeth o ran y ddarpariaeth <i>No confidence / evidence in delivery</i>	
Cyfiawnhad dros y gyfradd sicrwydd uchod. Lle bo sicrwydd 'Rhannol' neu 'Dim Sicrwydd' wedi'i nodi uchod, nodwch gamau i gyflawni sicrwydd 'Derbyniol' uchod, a'r terfyn amser ar gyfer cyflawni hyn:					
Justification for the above assurance rating. Where 'Partial' or 'No' assurance has been indicated above, please indicate steps to achieve 'Acceptable' assurance or above, and the timeframe for achieving this:					
The report details internal audit assurance against specific reviews which emanate from the corporate risk register and/or assurance framework, as outlined in the internal audit plan. The Health Board assurance ratings 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: Link to Strategic Objective(s):		N/A other than those relating to individual audit reviews / recommendations.			
Goblygiadau rheoleiddio a lleol: Regulatory and legal implications:		The progress report is required per the Welsh Government NHS Wales Audit Committee Handbook – Section 4.5 Reviewing internal audit assignment reports.			
Yn unol â WP7, a oedd EqIA yn angenrheidiol ac a gafodd ei gynnal? In accordance with WP7 has an EqIA been identified as necessary and undertaken?		The Equality duty is not applicable. This progress report is required per the Welsh Government NHS Wales Audit Committee Handbook – Section 4.5 Reviewing internal audit assignment reports. The associated public sector duties are not engaged (there are no associated impacts on any of the protected groups).			
Yn unol â WP68, a oedd SEIA yn angenrheidiol ac a gafodd ei gynnal? In accordance with WP68, has an SEIA identified as necessary been undertaken?		The Socio-Economic duty is not applicable. This progress report is required per the Welsh Government NHS Wales Audit Committee Handbook – Section 4.5 Reviewing internal audit assignment reports.			
Manylion am risgiau sy'n gysylltiedig â phwnc a chwmpas y papur hwn, gan gynnwys risgiau newydd (croesgyfeirio at y BAF a'r CRR) Details of risks associated with the subject and scope of this paper, including new risks (cross reference to the BAF and CRR)		N/A other than those relating to individual audit reviews/recommendations.			
Goblygiadau ariannol o ganlyniad i roi'r argymhellion ar waith Financial implications as a result of implementing the recommendations		The progress report may record issues/risks, identified as part of a specific review, which has financial implications for the Health Board.			
Goblygiadau gweithlu o ganlyniad i roi'r argymhellion ar waith		N/A other than those relating to individual audit reviews/recommendations.			

<p>Workforce implications as a result of implementing the recommendations</p>	
<p>Adborth, ymateb a chrynodeb dilynol ar ôl ymgynghori</p> <p>Feedback, response, and follow up summary following consultation</p>	<p>The Progress Report is produced independently of management.</p> <p>The Progress report has been shared with the Director of Corporate Governance.</p>
<p>Cysylltiadau â risgiau BAF: (neu gysylltiadau â'r Gofrestr Risg Gorfforaethol)</p> <p>Links to BAF risks: (or links to the Corporate Risk Register)</p>	<p>N/A other than those relating to individual audit reviews.</p>
<p>Rheswm dros gyflwyno adroddiad i fwrdd cyfrinachol (lle bo'n berthnasol)</p> <p>Reason for submission of report to confidential board (where relevant)</p>	<p>N/A</p>
<p>Next Steps: Implementation of recommendations</p> <p>The progress report is presented according to the Committee's cycle of business and in line with the requirements of the NHS Wales Audit Committee Handbook.</p>	
<p>List of Appendices:</p> <ul style="list-style-type: none"> • Appendix 1: Progress Report • Appendix 2: Progress Report: Internal Audit of Partnerships, Engagement and Communication (PEC) <p>Supporting Papers:</p> <ul style="list-style-type: none"> • Corporate Legislative Compliance - Civil Contingencies Act 2004 (BCU-2526-03) • Public Health: Prevention and Early intervention – Grant funded activity (BCU-2526-06) • Patient Experience (BCU-2526-10) • Consultant Job Planning follow up (BCU-2526-27) 	

Internal Audit Progress Report

Audit Committee

1 August to 10 October 2025

Betsi Cadwaladr University Health Board

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Introduction

This progress report provides an update to the Audit Committee in respect of the assurances, key issues, and progress against the Internal Audit (IA) Plan for 2025/26.

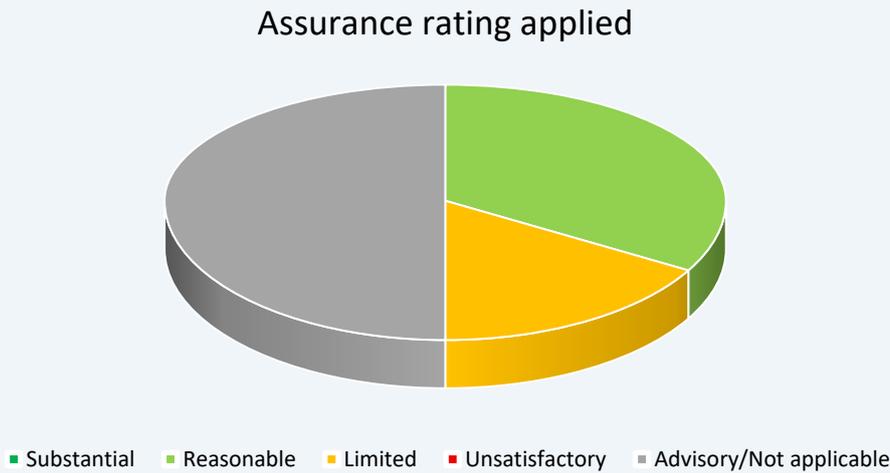
Reports Issued

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

Table 1: Summary of final reports issued

Review	Assurance rating	Key issues
Corporate Legislative Compliance - Civil Contingencies Act 2004 (BCU-2526-03)	Limited	The Health Board has made progress in strengthening its Emergency Preparedness, Resilience, and Response framework, but there are still significant areas needing improvement, including comprehensive business continuity plan coverage, timely testing, and learning from the tests to refine plans where needed.
Public Health: Prevention and Early intervention – Grant funded activity (BCU-2526-06)	Reasonable	The reliance on fixed-term posts due to grant funding may impact outcome delivery if positions become/are vacant. Oversight and monitoring arrangements for the Healthy Weight: Healthy Wales Whole System Approach (HWHW WSA) and Prevention and Early Years (PEY) grants are well-established, with regular reporting and documented progress updates.
Patient Experience (BCU-2526-10)	Reasonable	The review of the processes for capturing and utilising feedback to improve patient experience across the Health Board concluded with reasonable assurance, highlighting the need for better use of feedback to drive improvements at a local level, where this gap in assurance exists.
Consultant Job Planning follow up (BCU-2526-27)	Assurance not applicable	Only one high-risk issue has been fully closed, and another partially implemented, while the remaining six high-risk issues are outstanding. The Health Board's job planning compliance is at 43%, far from the 90% target set by the Welsh Government. The lack of a published policy/procedure, inadequate reporting, and no formal review of job plan sign-offs are significant concerns. Additionally, there is no evidence of directorate or specialty service objectives, and reporting on job plan performance is inadequate.

Image 1: Summary of final report assurance ratings issued as at 10 October 2025



Appendix A details the status of all reviews in the 2025/26 plan.

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 this financial year, with the outcomes noted in the table below concerning the latest actions reviewed.

Table 2 – Status of follow-up actions submitted for closure

Recommendation category by submission	Number of recommendations	Closed	Partially closed	Outstanding
Submitted for 1 st review	8	5 (63%)	3 (37%)	0

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 have met with Audit Wales to discuss recent issues and areas of emerging risks to the Health Board.

We have attended and observed the Risk Scrutiny and Executive Policy Oversight Groups in this reporting period coupled with also attending/observing the Health Board and its Committees.

We have met with the Director of Corporate Governance and Chief Executive (Accountable Officer) in this reporting period.

Delivering the plan

The status of the 2025/26 internal audit plan is detailed in image 2 (excluding proposed additions to the plan).

Image 2: Current status of plan delivery



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 Head of Internal Audit will consider the planned reviews against the emerging high-level risks.

The Audit Committee is requested to approve the changes to the audit plan outlined in Table 3.

Table 3: Changes to the 2025/26 internal audit plan

Audit Title	Reason for requesting deferral / removal from plan / adding to the plan
Budgetary Control and Financial Reporting (BCU-2526-8)	<p>We assigned reasonable assurance to this review in 2024/25 and not been advised of any amendments to the system of internal control in 2025/26, except for the on-going review and publication of finance policy and procedures.</p> <p>Recommendation: This review is deferred to be included in risk planning for the 2026/27 plan.</p>
Outpatient Transformation (BCU-2526-12)	<p>The Ministerial Advisory Group made a specific recommendation around outpatient referrals and associated management: <i>'Recommendation 1: All health boards should, within three months, develop a plan to reduce referrals to traditional outpatients in high volume specialities.'</i> The recommendation is being taken forward via the <i>'Planned Care Major Change Programme, specifically Workstream 2 – Referral Advice and Guidance'</i> (Source PF25.68 Progress against Planned Care Performance Targets – presentation Performance Finance and Information Governance Committee 26 August 2025).</p> <p>Our review would cut across the steps being taken by the Health Board through the major change programme and cannot be viewed in isolation where interdependencies exist with other planned care recommendations, some of which</p>

Audit Title	Reason for requesting deferral / removal from plan / adding to the plan
	<p>have a delivery timeline of six months, which fall outside our annual planning cycle.</p> <p>Recommendation: This review is deferred to be included in risk planning for the 2026/27 plan.</p>
Primary Dental Care (BCU-2526-21)	<p>A review of primary care dental services was completed in January 2025 by the Associate Director of Primary Care Strategy (ADPC).</p> <p>An Improvement and Development Plan has been produced and undertaking a review does not allow sufficient time for the embedding of agreed actions.</p> <p>Recommendation: This review is deferred to be included in risk planning for the 2026/27 plan.</p>
Agency utilisation (BCU-2526-29)	<p>Agency expenditure is less than in 2024/25 for April to June respectively and we note the <i>Welsh Government Remit Letter to the NHS Wales Executive 2025–26</i> sets explicit targets for the Health Board to achieve a reduction overall of 30% on the previous year out turn coupled with Healthcare Support Worker, Administrative & Clerical, and Estates & Ancillary staff use of agency to zero by 30th September 2025.</p> <p>As this is a specific focus for the Health Board to meet the required targets, we do not believe a review of agency controls will be of value for the Health Board.</p> <p>Recommendation: This review is deferred to be included in risk planning for the 2026/27 plan.</p>
Pharmacy Regulatory compliance (BCU-2526-40)	<p>During our review on Learning, we became aware of increased risk regarding pharmacy regulatory compliance. CRR25-08 <i>Non-Compliance with Regulatory and Legislative Requirements</i> records an additional required control of 'Quality assurance and regulatory compliance gaps in Pharmacy services.' Working with the Chief Pharmacist we will undertake a review of the process followed on receipt of regulatory notices.</p> <p>Recommendation: This review is added to the 2025/26 internal audit plan.</p>
Sickness Management (BCU-2526-41)	<p>Since March 2025 there has been an upward trend in sickness reported across the Health Board. We will review compliance with Health Board policy.</p> <p>Recommendation: This review is added to the 2025/26 internal audit plan.</p>
Purchase Cards and Petty Cash (BCU-2526-42)	<p>The Health Board has placed additional controls on procurement through the e-financials system however controls over the use of both purchase cards and petty cash remain extant. We will review expenditure processed through both payment systems to ensure compliance with expected controls.</p>

Audit Title	Reason for requesting deferral / removal from plan / adding to the plan
	Recommendation: This review is added to the 2025/26 internal audit plan.

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

For 2025/26, six reports have been issued as final, with three missing the response timeline.

Table 5 is reporting a positive status across all indicators except for plan delivery. We have experienced delays in management response to the request for evidence in two reviews. Figures are based on six reports issued as final for 2025/26.

Table 4: Performance Indicators

Indicator	Status	Actual	Target
Operational Internal Audit Plan agreed for 2025/26		4 March 2025	30 June
Total audit reviews reported against adjusted plan for 2025/26		7	9
Report turnaround: time from fieldwork completion to draft reporting [10 days]		96%	80%
Report turnaround: time taken for management response to draft report [20 days per Internal Audit Charter and Service Level Agreement]		60%	80%
Report turnaround: time from management response to issue of final report [10 days]		100%	80%

Key  v>20%  10%<v<20%  v<10%

Table 5: Core Plan 2025/26

Planned output	Status	Planned Committee Meeting ¹	Assurance rating
1. Risk Management and Board Assurance Framework (Assurance)	Not started.	April 2026	
2. Follow up	Work in progress.	On-going	
3. Corporate Legislative Compliance - Civil Contingencies Act 2004 (Assurance)	Final report.	October 2025	Limited
4. Standards of Business Conduct (Assurance)	Not started.	April 2026	
5. Executive and Operational Leadership Team Governance (Assurance)	Not started.	April 2026	

¹ Subject to change

Planned output	Status	Planned Committee Meeting ¹	Assurance rating
6. Public Health: Prevention and Early intervention – Grant funded activity (Assurance)	Final report.	October 2025	Reasonable
7. Value and Sustainability - improvements and savings delivery (Assurance)	Work in progress.	October 2025	
8. Budgetary Control and Financial Reporting (Assurance)	Recommended for deferral.		
9. Budget Setting (All Wales review) (Assurance)	Planning.	February 2026	
10. Patient Experience (Assurance)	Final report.	October 2025	Reasonable
11. Learning – Regulatory reporting (Assurance)	Draft report.	October 2025	
12. Outpatient Transformation (Assurance)	Recommended for deferral.		
13. Complaints (Assurance)	Work in progress.	December 2025	
14. Skills and Capabilities (Assurance)	Deferred.		-
15. Delivering successful change and benefits realisation (Assurance)	Draft report.	December 2025	
16. Non-Digital Data and Technology (DDaT) controlled IT (Assurance)	Planning.	February 2026	
17. Community Services (Assurance)	Draft report.	December 2025	
18. Productivity and Efficiency (Assurance)	Deferred.		-
19. Planned Care (Assurance)	Planning.	June 2026	
20. Urgent Emergency Care (Assurance)	Not started.	February 2026	
21. Primary Dental Care (Assurance)	Recommended for deferral.		-
22. Primary Medical Care (Assurance)	Work in progress.	December 2025	
23. Workforce Planning (Assurance)	Not started.	June 2026	
24. Compassionate Leadership (Assurance)	Planning.	February 2026	
25. Speaking Up Safely (Assurance)	Planning.	February 2026	
26. On-call arrangements (Assurance)	Planning.	February 2026	
27. Consultant Job Planning follow up	Final report.	October 2025	Assurance not applicable
28. NICE guidance compliance (Assurance)	Planning.	February 2026	
29. Agency utilisation (Assurance)	Recommended for deferral.		

Planned output	Status	Planned Committee Meeting ¹	Assurance rating
30. Challenged Care services (Assurance)	Not started.	April 2026	
31. Estate Management (Assurance)	Work in progress.	February 2026	
32. Statutory Compliance: Asbestos Management (Assurance)	Not started.	April 2026	
33. Capital Systems (Assurance)	Deferred.		-
34. Wrexham Maelor Hospital Engineering Infrastructure Programme (Assurance)	Deferred.		-
35. Integrated Regional Care Fund (IRCF) Projects (Assurance)	Not started.	June 2026	
36. Falls Management follow up	Final report.	August 2025	Assurance not applicable
37. Contract management and procurement – Digital Data and Technology (Advisory)	Final report.	August 2025	Advisory
38. Contract management and procurement – Executive and Director corporate functions (Assurance)	Work in progress.	December 2025	
39. Adult and Older Persons Mental Health Unit at Ysbyty Glan Clwyd (Assurance)	Not started.	June 2026	
40. Pharmacy regulatory compliance / controlled drugs	Recommended for inclusion.		
41. Sickness management	Recommended for inclusion.		
42. Purchase cards & Petty cash	Recommended for inclusion.		

Appendix A

Assurance Opinion

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

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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.

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.

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](https://www.nhs.uk/audit-and-assurance-services)

,Teitl adroddiad: <i>Report title:</i>	Progress Report: Internal Audit of Partnerships, Engagement and Communication (PEC)		
Adrodd i: <i>Report to:</i>	Audit Committee		
Dyddiad y Cyfarfod: <i>Date of Meeting:</i>	Tuesday, 21 October 2025		
Crynodeb Gweithredol: <i>Executive Summary:</i>	<p>The internal audit of Partnerships, Engagement and Communication (PEC) made recommendations in 2025 to strengthen governance, assurance, staff resources, operational oversight, and benefits realisation. A consolidated delivery plan has now been completed, bringing all actions into a single programme. Several recommendations are already closed, including improved assurance processes, embedding benefits realisation into plans, and strengthening evidence retention. The majority of remaining actions are on track for delivery by November 2025, supported by quarterly monitoring arrangements.</p> <p>Work is progressing well on the remaining recommendations relating to staff resources and operational oversight, with engagement workshops held, updated SOPs and policies in development, and enhanced escalation processes already in use. No high-risk delays have been reported, though there remains a need to embed changes consistently across teams. Risks are being mitigated through regular engagement, quarterly review, and senior oversight. The next steps are to complete staff resource-related SOPs and policies, ensure full adoption of revised escalation processes, and maintain ongoing monitoring to sustain assurance.</p>		
Argymhellion: <i>Recommendations :</i>	The Committee is asked to note progress and take assurance that implementation of the internal audit recommendations for Partnerships, Engagement and Communication remains on track, with no high-risk delays reported.		
Report presented by:	Helen Stevens Jones, Director Partnerships, Engagement and Communications		
Awdur yr Adroddiad: <i>Report Author:</i>	Helen Stevens Jones, Director Partnerships, Engagement and Communications		
Pwrpas yr adroddiad: <i>Purpose of report:</i>	I'w Nodi <i>For Noting</i> <input type="checkbox"/>	I Benderfynu arno <i>For Decision</i> <input type="checkbox"/>	Am sicrwydd <i>For Assurance</i>

				☒
Lefel sicrwydd: Assurance level:	Arwyddocaol <i>Significant</i> <input type="checkbox"/> Lefel uchel o hyder/tystiolaeth o ran darparu'r mecanweithiau / amcanion presennol <i>High level of confidence/evidence in delivery of existing mechanisms/objectives</i>	Derbyniol <i>Acceptable</i> <input checked="" type="checkbox"/> Lefel gyffredinol o hyder/tystiolaeth o ran darparu'r mecanweithiau / amcanion presennol <i>General confidence / evidence in delivery of existing mechanisms / objectives</i>	Rhannol <i>Partial</i> <input type="checkbox"/> Rhywfaint o hyder/tystiolaeth o ran darparu'r mecanweithiau / amcanion presennol <i>Some confidence / evidence in delivery of existing mechanisms / objectives</i>	Dim Sicrwydd <i>No Assurance</i> <input type="checkbox"/> Dim hyder/tystiolaeth o ran y ddarpariaeth <i>No confidence / evidence in delivery</i>

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

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

Cyswllt ag Amcan/Amcanion Strategol:

Link to Strategic Objective(s):

This work strengthens governance, assurance, and operational oversight, while supporting the Health Board's wider strategic objectives of building public trust through effective engagement, supporting staff, ensuring strong governance, and improving performance and outcomes.

Goblygiadau rheoleiddio a lleol:

Regulatory and legal implications:

Delivery of the internal audit recommendations for Partnerships, Engagement and Communication (PEC) strengthens compliance with the Health Board's Standing Orders,

	<p>Standing Financial Instructions, and Scheme of Delegation, and provides assurance to Internal Audit, Audit Wales, and Welsh Government that governance, accountability, and engagement processes are being applied consistently. There are no direct new legal obligations arising, but failure to implement the recommendations could expose the Health Board to regulatory scrutiny and reputational risk.</p>
<p>Yn unol â WP7 (sydd bellach yn cynnwys WP68), a oedd EqIA yn angenrheidiol ac a gafodd ei gynnal?</p> <p><i>In accordance with WP7 (which now incorporates WP68) has an EqIA been identified as necessary and undertaken ?</i></p>	<p>An EQIA is not required for this paper as it relates to internal governance and assurance processes only, with no direct impact on patients, staff, or communities..</p>
<p>Manylion am risgiau sy'n gysylltiedig â phwnc a chwmpas y papur hwn, gan gynnwys risgiau newydd (croesgyfeirio at y BAF a'r CRR)</p> <p><i>Details of risks associated with the subject and scope of this paper, including new risks (cross reference to the BAF and CRR)</i></p>	<p>There are no new risks for escalation to the BAF or CRR; however, there is a residual risk around the consistent embedding of revised SOPs and governance processes across PEC teams. This is being mitigated through engagement workshops, quarterly review, and senior oversight, and links indirectly to existing BAF risks relating to governance, assurance, and organisational reputation.</p>
<p>Goblygiadau ariannol o ganlyniad i roi'r argymhellion ar waith</p> <p><i>Financial implications as a result of implementing the recommendations</i></p>	<p>There are no direct additional financial implications arising from this progress update, as the internal audit recommendations are being implemented within existing PEC resources.</p>
<p>Goblygiadau gweithlu o ganlyniad i roi'r argymhellion ar waith</p> <p><i>Workforce implications as a result of implementing the recommendations</i></p>	<p>The internal audit recommendations include actions to strengthen staff resources, SOPs, and guidance to support consistent practice across PEC teams. While no additional posts are required, there is a need for sustained engagement and capacity within existing teams to embed the changes. This work should ultimately provide clearer</p>

	roles, improved oversight, and greater support for staff in delivering engagement and communication objectives.
Adborth, ymateb a chrynodeb dilynol ar ôl ymgynghori <i>Feedback, response, and follow up summary following consultation</i>	Not applicable
Cysylltiadau â risgiau BAF: (neu gysylltiadau â'r Gofrestr Risg Gorfforaethol) <i>Links to BAF risks:</i> <i>(Or links to the Corporate Risk Register)</i>	See above
Rheswm dros gyflwyno adroddiad i fwrdd cyfrinachol (lle bo'n berthnasol) <i>Reason for submission of report to confidential board (where relevant)</i>	Not applicable

Progress Report: Internal Audit of Partnerships, Engagement and Communication (PEC)

Audit Committee

1. Purpose

To provide the Committee with an update on progress against the internal audit recommendations relating to Partnerships, Engagement and Communication (PEC), following the most recent internal audit report.

2. Background

The internal audit report (2025) made a series of recommendations aimed at strengthening governance, assurance, operational oversight, staff resources, and benefits realisation within the PEC function. Management responses were agreed, with clear timelines for implementation, and progress has been monitored through the internal audit tracker.

3. Current position (as at 18 September 2025)

3.1 Overall progress

- A consolidated delivery plan has been completed, bringing together all outstanding improvement actions into a single, coherent programme.
- Several recommendations have now been completed, with evidence submitted and assurance confirmed.
- The majority of remaining actions are on track for delivery by November 2025, with no material delays reported.
- Quarterly review processes are now in place to ensure sustained monitoring.

3.2 Completed recommendations

- **Recommendation 1: Outstanding actions** – All improvement actions consolidated, expected outcomes defined, and the consolidated delivery plan signed off (August 2025).
- **Recommendation 2: Assurance to Board/Committees** – Evidence retention and impact assurance processes embedded. Q1 deliverables completed and evidenced in the consolidated plan.
- **Recommendation 5.1 & 5.2: Benefits Realisation** – Integration of benefits and evidence into PEC improvement plans completed, with quarterly review cycles established.

3.3 Recommendations in progress

- **Recommendation 3.1–3.5: Staff Resources** – Development and strengthening of governance, SOPs, and guidance to support staff in progressing actions.
 - Engagement workshops have been held.

- SOP/policy updates in progress and on track for end September 2025 completion.
- **Recommendation 4: Operational Oversight** – Escalation and oversight processes enhanced. Evidence of updates being recorded through team discussions and reflected in notes. Delivery remains on track for end September 2025.

4. Risks and issues

- No high-risk delays reported.
- Risk remains around embedding changes consistently across teams, particularly in relation to SOP adoption and sustained operational oversight.
- Mitigation: Regular engagement workshops, reinforced quarterly review, and senior oversight by the Director.

5. Next steps

1. Complete delivery of staff resource-related SOPs and policies by 30 November 2025.
2. Ensure all PEC teams fully adopt revised escalation and recording processes.
3. Maintain quarterly monitoring and evidence retention for ongoing assurance.

6. Appendix

Spreadsheet update provided to Head of Statutory Compliance, September 2025.

Audit Committee Update – Betsi Cadwaladr University Health Board

Date issued: October 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.

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About this document

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

Accounts audit update

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

Exhibit 1 – Accounts audit work

Area of work	Executive Lead	Focus of the work	Current status	Planned date for consideration
Audit of Accounts 2024-25	Russell Caldicott, Executive Director of Finance	Audit of Financial Statements Report including the Opinion on the Financial Statements.	Completed	June 2025
Audit of Awyr Las Accounts 2024-25	Russell Caldicott, Executive Director of Finance	Audit of Awyr Las Annual Report and Accounts.	Planning commenced	January 2026.

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	<p>This work follows on from the national report on tackling the planned care backlog. It considers:</p> <ul style="list-style-type: none"> the extent that health boards have achieved Welsh Government targets for recovering planned care services; the efficacy of local plans and activity to recover waiting lists; and Use of the additional Welsh Government financial allocations to improve waiting lists. 	Completed	August 2025
All Wales thematic work on Urgent and Emergency Care	Chief Operating Officer	<p>This work examines different aspects of the urgent and emergency care system in three parts:</p> <ul style="list-style-type: none"> Part One: Flow out of hospital. Part Two: accessing urgent and emergency care. 	<p>Part One: Completed</p> <p>Part Two: Completed</p>	<p>July 2024</p> <p>October 2025</p>

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.	In clearance	December 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	February 2026
Structured Assessment 2025 - core	Director of Corporate Governance / Board Secretary	<p>This work will review the following core areas:</p> <ul style="list-style-type: none"> • Board and committee effectiveness, cohesion, and transparency. • Corporate systems of assurance. • Corporate planning arrangements. • Corporate financial planning arrangements. <p>This work will also seek to provide an update on the Health Board's progress in addressing audit recommendations made in previous structured assessment reports.</p>	Fieldwork	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.	Fieldwork	February 2026
Thematic review of cancer services	To be confirmed	<p>Following on from our recent review of the national leadership arrangements for cancer services, this work will consider:</p> <ul style="list-style-type: none"> • The progress NHS bodies are making towards achieving Welsh Government targets and quality standards for cancer services; • The efficacy of local plans and associated actions to recover cancer waiting lists; and • Use of the additional Welsh Government financial allocations to improve cancer services. 	Not yet started	Spring/Summer 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.	Not yet started	Summer 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
<u>Temporary Accommodation, long-term crisis?</u>	July 2025
<u>Cost Savings Arrangements: A Checklist for NHS Board Members</u>	June 2025
<u>The Wales Infrastructure Investment Strategy</u>	May 2025
<u>No time to lose: Lessons from our work under the Well-being of Future Generations Act</u>	April 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
<u>Welsh Language Report 2024-25</u>	September 2025
<u>Annual Report and Accounts 2024-25</u>	June 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.

Urgent and Emergency Care: Arrangements for Managing Demand – Betsi Cadwaladr University Health Board

Date issued: July 2025

Document reference: 4989A2025

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We welcome correspondence and telephone calls in Welsh and English. Corresponding in Welsh will not lead to delay. Rydym yn croesawu gohebiaeth a galwadau ffôn yn Gymraeg a Saesneg. Ni fydd gohebu yn Gymraeg yn arwain at oedi.

Mae'r ddogfen hon hefyd ar gael yn Gymraeg. This document is also available in Welsh.

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Summary report

About this report

- 1 This report sets out the findings from the Auditor General's 2024 review of the arrangements for managing demand for urgent and emergency care at Betsi Cadwaladr University Health Board (the Health Board). The work is the second phase of a programme of work focused on several elements of the urgent and emergency care system in Wales. The first phase, which examined discharge planning and the impact of patient flow on urgent and emergency care, is reported separately.
- 2 Our approach recognises that the urgent and emergency care system is complex, with many different organisations needing to work together to provide urgent and emergency care and to ensure the wider system operates effectively and efficiently. The Welsh Government's [Six Goals for Urgent and Emergency Care Programme](#) (Six Goals Programme) launched in 2021, provides the context for our work. At the time of our work, the urgent and emergency care system in Wales continued to be under significant pressure.
- 3 Our work has examined the Health Board's arrangements for managing the demand for urgent and emergency care to reduce unnecessary pressure on the system. It has been undertaken to help discharge the Auditor General's statutory duties under Section 61 of the Public Audit (Wales) Act 2004 to be satisfied that the Health Board has proper arrangements in place to ensure the efficient, effective, and economic use of its resources.
- 4 We undertook our work during the 2024-25 financial year. The audit methods and criteria we used to deliver our work are summarised in **Appendices 1 and 2**.

Key facts and figures

Primary Care Services

809 Number of GP urgent and acute appointments¹ available per day per 100,000 head of GP population in March 2025 compared with the all-Wales average of 751. This is a reduction of 7.6% since March 2023.

901 Number of GP out-of-hours contacts per month per 100,000 head of GP population in July 2024 compared with an all-Wales average of 973.

341 Number of contacts per month at the Urgent Primary Care Centre per 100,000 head of GP population in March 2025 compared with an all-Wales average of 433.

Ambulance Services

100% Increase in Category A (red) ambulance calls between March 2019 and March 2025 compared with an all-Wales average of 127%.

48% Category A (red) ambulance calls responded to within eight minutes in March 2025, compared with the all-Wales average of 50% and a national target of 65%. This is a reduction of 37% from March 2019.

10% Patients handed over from ambulance crews to the emergency department within 15 minutes of arrival in March 2025, compared with the all-Wales average of 14% and a national target of 100%. This is a reduction of 125% from March 2019.

¹ Urgent and acute appointments are defined as appointments for urgent or acute conditions which have occurred over the short-term.

Hospital Services

9% Increase in the number of attendances at the Health Board's Emergency Departments between March 2019 and March 2025, compared with an all-Wales average increase of 8%.

3763 Number of people waiting more than 12 hours in the Health Board's Emergency Departments in March 2025. This is an increase of 79% since March 2019.

07:46hrs Average time spent in the Health Board's Emergency Departments in March 2025, compared with the all-Wales average of 5 hours, 27 minutes. This is an increase of 2 hours, 56 minutes since March 2019.

241 Number of attendances to the Same Day Emergency Care units per 100,000 head of population in March 2025 compared with an all-Wales average of 278.

Funding

£92.6m Additional monies allocated to the Health Board for the period 2022-25 to recover planned and urgent and emergency care over and above the Health Board's core funding.

£5.7m Additional in-year monies received by the Health Board in 2023-24, and 2024-25 to support delivery of the ambitions of the Six Goals Programme.

Key messages

Overall conclusion

- 5 Overall, we found that **whilst plans for managing urgent and emergency care demand continue to develop, performance remains extremely challenging and arrangements for managing risks, demonstrating the use of additional funding and patient and staff engagement need strengthening.**

Key findings

Planning arrangements

- 6 The Health Board is developing its planning approach for implementing the Six Goals Programme to better manage urgent and emergency care demand. Plans align with the requirements of the Six Goals Programme by setting out actions such as developing its Same Day Emergency Care units and further strengthening pathways for high volume demand such as breathing problems. However, whilst the Health Board has access to a range of operational data, plans do not show how data has been used to inform its strategic plans for urgent and emergency care services.
- 7 Plans identify key risks, including those related to workforce and resource challenges, as well as mitigating actions, although there is a need to ensure mitigating actions are sufficiently robust and that risks have identified owners and targets. However, plans are not sufficiently clear about how they will be resourced. Plans do not set out the required levels of staffing and lack clarity on how new models will be funded in the medium to longer term. There is also scope to ensure that actions taking place at more local Integrated Health Community (IHC) levels are aligned to the Health Board's corporate Six Goals Plan.

Accessing services

- 8 We found that the Health Board does not have a formal communications plan for its interaction with the public, staff, and stakeholders regarding urgent and emergency care. The Health Board does provide information to the public through its website and social media platforms. However, feedback during our review, as well as from Llais, indicates that there is a need to further strengthen public messaging of the purpose of services and how to access them. For example, we found scope to strengthen information available via the Health Board, GP and dental websites.
- 9 We also found inconsistent staff engagement regarding updates to service changes and delivery. Ambulance staff deal with lower rates of 999 and 111 calls across the Health Board remotely compared to other areas in Wales. There also

remain opportunities to identify further referral mechanisms that could direct patients to their required service in a more efficient manner. In addition, the Health Board does not currently have a mechanism to keep the Welsh Ambulance Services NHS Trust (WAST) directory of service up to date. However, paramedics treat higher rates in the community within the Health Board area than across Wales.

- 10 The Health Board has established Same Day Emergency Care (SDEC) units to provide urgent assessments and treatments without overnight admissions. Between April 2024 and March 2025, for those attending SDECs there are broadly high rates of discharge, which indicates effective use of the units. However, referrals to SDEC via ambulance crews is low, indicating lack of compliance with national SDEC referral criteria. The Health Board has also established Urgent Primary Care Centres (UPCCs) to treat patients with primary urgent needs and create additional capacity for GPs. Whilst the development of UPCCs has been welcomed in the Health Board, there remains opportunities to maximise contact rates, which are lower in the Health Board compared to the all-Wales rates.
- 11 Data shows that demand is increasing in relation to red calls to 999 as well as through attendances to Emergency Departments. Conveyance rates have remained largely static, which suggests that the Health Board's activity is maintaining performance levels despite increased demand. However a small proportion of patients are conveyed to Minor Injuries Units, with low visibility of this metric at a corporate level. Handover delays continue to be at unacceptably high levels, which is likely to be causing patient harm, both for the patients waiting to be transferred to the hospital, as well as for patients in the community who are awaiting an ambulance response. Data shows increasing levels of attendance to the Health Board's emergency departments, and subsequently longer waiting times for patients to be seen. Despite a general decrease in acuity levels for patients accessing emergency departments, the Health Board admit higher rates of patients than other regions in Wales, suggesting further opportunities to meet some patients needs through alternative services.

Scrutiny and monitoring arrangements

- 12 The Health Board has a wealth of information to enable it to track and report the use of urgent and emergency care services. Whilst the Health Board does seek some patient feedback, response rates are low which make the findings unreliable. It is also not clear how the Health Board uses this feedback to improve services. Furthermore, we found no evidence that the Health Board collects staff feedback.
- 13 There is regular operational and corporate oversight of performance and plan progress. However, there is a need to report on the use of additional funding more clearly within the Health Board.

Recommendations

- 14 **Exhibit 1** details the recommendations arising from our work. The Health Board's management response to our recommendations is summarised in **Appendix 3**.

Exhibit 1: recommendations

Recommendations

Identifying data used to inform plans for urgent and emergency care

- R1 To ensure that priorities reflect and align to up to date information such as service demand, service capacity and future demographic pressures, the Health Board should clearly indicate the data used to inform its plans for urgent and emergency care (**Exhibit 2**).

Risk management within plans

- R2 To strengthen risk management, the Health Board should ensure that all risks set out in urgent and emergency care plans have risk owners, clear scores and targets as well as robust mitigating actions (**Exhibit 2**).

Alignment between IHC and corporate urgent and emergency care plans

- R3 To ensure that the actions taking place within Integrated Health Communities align with the corporate vision of the Health Board, it should develop an implementation plan to ensure consistent implementation of the regional Six Goals Plan across each IHC area (**Exhibit 2**).

Resourcing urgent and emergency care plans

- R4 To provide clarity on how initiatives will be funded beyond the annual plan cycle, the Health Board should ensure its plans for urgent and emergency care clearly identify funding needs for current and future years, as well as identifying the sources of funding (**Exhibit 2**).
- R5 To support achievement of the ambitions of its urgent and emergency care plans, the Health Board should clearly set out the current and future workforce requirements (**Exhibit 2**).

Improving information on alternative services

- R6 To help guide patients to the most appropriate service for their needs, the Health Board's website should include advice on key urgent conditions, such as breathing difficulty, chest pain or rashes (**Paragraph 26**)
- R7 To help address demand for urgent care, the Health Board should ensure GP and dental practices provide clear, accessible information about urgent and emergency care services on their websites and conduct a future audit to ensure compliance (**Paragraph 28**).
- R8 To support staff and public understanding of the breadth of urgent and emergency services within the Health Board, and how to access them, the Health Board should develop a communications plan for urgent and emergency care services (**Paragraph 33**).
- R9 To help health and care staff adequately signpost and refer people to the right urgent and emergency care services, the Health Board should establish a mechanism to keep the WAST Directory of Services up to date, which includes the identification of an officer with lead responsibility for this task (**Paragraph 37**).

Maximising use of SDECs and UPCCs

- R10 To ensure compliance with the national SDEC referral criteria and guidance, the Health Board should conduct an audit of its SDEC data and report the results to the appropriate committee (**Paragraph 52**).
- R11 To ensure Urgent Primary Care Centres are being maximised, the Health Board should:
- 11.1 Work with key partners, including GPs and Emergency Department leads, to review the UPCC referral criteria.
 - 11.2 Ensure the UPCC referral criteria is well-communicated and accessible to relevant staff, once agreed (**Paragraph 56**)

Maximising use of Minor Injuries Units

- R12 To understand how well it is utilising Minor Injuries Units and to identify further opportunities to maximise this service, the Health Board should include metrics on attendance and conveyance rates to its minor injuries units and medical assessment units in reports to the Finance and Performance Committee (**paragraph 62**).

Improving staff and patient feedback

- R13 To ensure future plans for urgent and emergency care are informed by patient experience, the Health Board should clearly demonstrate within the narrative how it has considered patient feedback (**Exhibit 9**).

R14 To improve the understanding of how services are working, and identify potential weaknesses or learning from recent changes, the Health Board should introduce regular mechanisms for staff feedback on urgent and emergency care services. This should include feedback from key partners including primary care and WAST staff (**Exhibit 9**).

Reporting of expenditure of additional funding for UEC services

R15 To increase transparency and strengthen assurance that monies allocated to the Health Board for urgent and emergency care is being spent wisely, the Health Board should include information on its use of additional funding within regular finance reports to the Performance, Finance and Information Governance Committee. This should include the use of Six Goals, Further Faster and Regional Integration Fund monies (**Exhibit 10**).

Detailed Report

Planning arrangements

- 15 This section considers whether the Health Board has robust plans in place to manage the demand on urgent and emergency care services. We were specifically looking for evidence of plans:
- being informed by relevant and up to date information;
 - identifying and seeking to address key risks associated with urgent and emergency care services;
 - aligning with requirements of the Six Goals Programme, and clearly setting out how alternative clinical pathways will work; and
 - identifying the current and required levels of resource and staffing to achieve the intended ambitions.
- 16 We reviewed two versions of the Health Board’s draft Six Goals for Urgent and Emergency Care Delivery Plan 2024-25² (the Six Goals Plan), one which was developed in April 2024 and an updated version from November 2024. We also reviewed the Health Board’s Annual Plan 2024-25 and its winter resilience plan, both of which were approved by the Board (in March and November 2024 respectively).
- 17 We found that **whilst plans for managing demand continue to develop, the Health Board needs to strengthen its approach to managing risks and describing how it will resource its plans.**
- 18 The findings from our review of these plans are summarised in **Exhibit 2.**

Exhibit 2: approach to planning urgent and emergency care services.

Audit question	Yes/ No/ Partially	Findings
Are plans informed by relevant and up-to-date information?	Partially	Plans provide a snapshot of the regular data available to inform operational decisions. This snapshot shows evidence of good data at an operational level to inform day-to-day decision making and management of flow within hospitals, such as the ‘Patient Journey’ dashboard. However, there is little to no data included within plans to inform the strategic changes identified (Recommendation 1).

² At the time of our fieldwork, Betsi Cadwaladr University Health Board was the only health board in Wales without an approved Six Goals Delivery Plan.

Audit question	Yes/ No/ Partially	Findings
<p>Do plans identify and seek to address key risks associated with urgent and emergency care services?</p>	<p>Partially</p>	<p>The Health Board's plans identify a set of risks to the delivery of its Six Goals Programme. Risks listed include a lack of resource to deliver, specifically relating to leadership and ineffective use of investment funding. However, the risks we reviewed did not have risk scores, owners, or targets. Furthermore, some of the mitigating actions listed were undeveloped when the Health Board submitted the draft plan, with the narrative for several risks stating the Health Board would review processes or discuss further during the year (Recommendation 2).</p> <p>Strategic risks for urgent and emergency are better detailed. The Health Board's Board Assurance Framework and Corporate Risk Register have risks relating to the urgent and emergency care services more broadly. Risks include the Health Board's inability to meet demand leading to delays which could cause severe or catastrophic harm to patients. There are a range of mitigating actions in place for these risks which align to the Health Board's Six Goals Programme. However, the effectiveness of these mitigating actions is dependent on how well risks can be managed at the programme level.</p>
<p>Do plans align with requirements of the Six Goals for Urgent and Emergency Care Programme, and clearly setting out how the alternative clinical pathways will work?</p>	<p>Partially</p>	<p>The Health Board's plans align with the Six Goals Programme. The Health Board has combined the six goals into four workstreams.</p> <p>Plans set out a commitment to implementing alternative clinical pathways in line with the Six Goals Programme, including strengthening arrangements for its Same Day Emergency Care (SDEC) services, Urgent Primary Care Centres (UPCCs) and reducing handover delays.</p> <p>However, the Six Goals Plan we reviewed is high-level and largely provides an update on the current position of these pathways without setting clear expectations for how new clinical pathways will operate in future. This is in part due to the different structures and processes in place across the Health Board's three Integrated Health Communities (IHCs) which means that different models have been implemented.</p> <p>The Performance, Finance and Information Governance committee received separate reports from each of the three Integrated Health Communities (IHCs) during 2024 to provide assurance on performance, finance, and workforce issues within their areas, which included urgent and emergency care performance. The reports highlighted</p>

Audit question	Yes/ No/ Partially	Findings
		how different services and actions are in place across the Health Board reflecting the different IHC plans that are in place (Recommendation 3).
Do plans identify the current and required levels of resource and staffing to achieve the intended ambitions?	No	<p>The Health Board's draft Six Goals Plan was costed for 2024-25 but the figures quoted far exceeded the Health Board's £1.6m Six Goals funding allocation for 2024-25. The Six Goals Plan did not show where additional money for the identified costs would be sourced from, such as Further Faster or core funding. In addition, the plans did not set out how initiatives set out in the plan would be funded in future years (Recommendation 4).</p> <p>In addition, whilst the Six Goals Plan references a risk related to the lack of leadership and programme support, plans provide no detail on how the risk will be mitigated. None of the plans we reviewed clearly identified the current and future required levels of staffing to achieve their intended ambitions (Recommendation 5).</p>

Source: Audit Wales

Accessing services

19 This section considers whether the Health Board has robust arrangements in place to encourage and enable people to access the right care, in the right place, at the right time, and whether these are working. We were specifically looking for evidence of:

- effective signposting of patients to the urgent and emergency care services that best meets their needs;
- staff having good knowledge of, and information on the range of services available to patients; and
- changes to service delivery resulting in improvements in access to urgent and emergency care services.

20 We found that **urgent and emergency care performance remains extremely challenging, worsened by a lack of consistent engagement with staff and stakeholders to ensure reliable referrals and guide patients to the best service for their needs.**

Signposting of services to patients

- 21 We found that **there are some arrangements are in place to signpost services to the public, but arrangements are not strategic or consistent with feedback suggesting a need to improve public awareness of services.**

Communication plans

- 22 The Health Board does not have a standalone communications plan setting out how it communicates urgent and emergency care messages to the public, its staff, and other agencies.
- 23 The Health Board undertakes communications activity specific to its winter and summer plans. The winter resilience plan 2024-25 included a section on communication and engagement which commits to delivering the national 'Help Us to Help You' campaign by amplifying the national messaging on a local basis and working with regional partners to ensure consistent messaging. However, the plan did not set out how the Health Board would achieve this action.
- 24 More generally, the Health Board uses its social media pages to provide information on specific services, including the 'Mental Health 111 Press 2' service, and for potentially high-demand days, such as bank holidays. Whilst this approach allows flexibility, it also creates a significant risk that public messaging will not reach those without access to social media.

Public information

- 25 The first point of call for most patients with an urgent need may be their GP. Our review of available data suggests that, between April 2024 and March 2025, the Health Board's GP practices provided a level of urgent and acute appointments per day per 100,000 head of GP population that is in line with the all-Wales average (787 and 777 appointments per day respectively). The level of provision has decreased from 812 appointment per day in 2023-24, despite one of the Health Board's Six Goals workstreams providing cluster funding for additional urgent appointments at a full year cost effect of £600,000. These appointments are only available during the day, and in times of high demand and out of hours, patients need to be signposted to alternative services that can meet their urgent care needs.
- 26 The Health Board's website is not easy to navigate to access advice on how to best manage common illnesses. The website has a 'Health Advice' section, but this does not hold clear information relating to urgent care needs and mainly includes information around wellbeing and prevention. In December 2024, a section on seasonal information was added which provides useful advice on managing winter viruses, chest infections and information on the urgent dental service. However, the website does not have advice on several other key urgent conditions, such as breathing difficulty, chest pain or rashes (**Recommendation 6**).

27 We also considered what information is available to the public via GP and dental practices to assess whether there was clear signposting for patients if they have urgent or emergency care needs out of hours. **Exhibit 3** sets out the results of this work, which reviewed the websites and out of hours phone messages of 25 GP practices and 19 dental practices³.

Exhibit 3: results of the review of GP and dental practice information (October 2024)

Indicator	This Health Board	All-Wales position
% of GP practice websites with clear signposting	36.0	56.8
% of GP practice answer phone messages with clear signposting	80.0	89.5
% of dental practice websites with clear signposting	36.8	36.7
% of dental practice answer phone messages with clear signposting	78.9	86.7

Source: Audit Wales

28 The Health Board is broadly in line with the all-Wales position in terms of having clear signposting on its GP and dental phonelines. Whilst the Health Board is also in line with the all-Wales average in relation to clear signposting on dental websites, there appears to be scope to strengthen the signposting available through its GP and dental websites. This would help ensure the public can access relevant and up to date information on where they can access help when experiencing an urgent care need (**Recommendation 7**).

29 Across Wales, between 450,000 – 500,000 people access the 111 website each month. The Health Board has a lower rate of 111 calls per head of GP population, with 111 calls made by Health Board residents accounting for 18.4% of all calls in February 2024. The top five reasons for calls are set out in **Exhibit 4**.

³ The sample included a mix of NHS and private dental practices.

Exhibit 4: top five reasons for calling 111 (February 2024)⁴

This Health Board	% of all calls	All-Wales position	% of all calls
Dental problems	3.8	Dental problems	4.1
Abdominal pain	3.1	Abdominal pain	2.4
Chest pain	1.8	Chest pain	1.6
Cough	1.8	Cough	1.4
Rash	1.2	Rash	1.0

Source: Ambulance Services Indicators

30 Dental problems is the most common reason for contacting 111 in the region, though this is at a lower frequency than at a national level. The Health Board has a slightly higher number of dental contracts per 100,000 of population compared to the all-Wales figure (18.5 and 16.8 respectively) which is positive. As mentioned in **paragraph 26**, the Health Board's website holds useful information in relation to the urgent dental service. The rate of calls for abdominal pain, chest pain and rashes are slightly higher for the Health Board than at an all-Wales level, which reinforces the need for clear information on the website to provide patients with advice on a broader range of conditions.

Patient awareness

- 31 There are differences in urgent and emergency care services in place across the Health Board's three IHCs. These differences can make it more difficult for patients and staff to understand how to access services.
- 32 The Health Board does not collect feedback from patients to understand whether they have a good awareness of the availability of services. Feedback from Llais⁵ has also identified that there are further opportunities to strengthen public understanding of the urgent and emergency care system, so the public are better able to access the most appropriate provision for their needs.
- 33 As such, the Health Board would benefit from developing a communications plan for its urgent and emergency care services. A communications plan would support the Health Board to mitigate the risk of disjointed and confusing public messaging about the availability and access routes to urgent and emergency care services

⁴ Due to ongoing issues with the new 111 system implemented in April 2024, there has been no data on the 111-service reported since February 2024.

⁵ Llais is a national, independent body set up by the Welsh Government to collect and report the views and experiences of the public to influence decision-makers in the NHS and social care sector.

across the Health Board's footprint. It would also support the Health Board to identify gaps in information and hard-to-reach audiences, such as those with limited access to digital resources (**Recommendation 8**).

Staff awareness and ability to refer

- 34 We found that **despite good arrangements for ambulance staff to treat patients in the community, staff engagement on the range of alternative pathways for urgent and emergency care is inconsistent.**

Promoting staff awareness of services

- 35 In the absence of a communications plan, it is unclear how the Health Board engages its staff on plans to manage demand for urgent and emergency care. Interviews with a range of staff as part of this review indicated that the methods used are inconsistent.
- 36 Interviews also indicated that engagement between senior leaders within urgent and emergency care with key staff and partners, such as primary care and ambulance staff has been poor in the past. Lack of engagement has led to a lack of a shared understanding of the range of alternative services available to patients with urgent and emergency care needs. This was made worse by having numerous urgent and emergency care plans in place at IHC and Health Board levels which were both operational and strategic in nature. This historically has led to variation in the application of new models and services, as well as confusion about the services available for staff and key partners.
- 37 We often heard that information to capture the alternative pathways that are in place is also unreliable. WAST holds a directory of service for each Health Board area which holds details of referral pathways. The Health Board has responsibility for keeping the directory up to date. However, we heard from a range of staff that the information held in the directory of service is unreliable. Issues cited included listed services that were no longer available, new services missing and the directory not reflecting the differences in services across the IHC areas (**Recommendation 9**).
- 38 However, during our fieldwork we saw examples of the Health Board taking steps to improve its engagement with key stakeholders to inform its operational urgent and emergency care work. For example, following the re-draft of its Six Goals Plan in November 2024, the Health Board shared its plans with local authority partners via the Regional Partnership Board.

Referring to services

- 39 The Health Board consistently has a lower rate of patients that call 999 who are dealt with through 'consult and close' over-the-phone advice or signposting, compared to the all-Wales average (13.9% compared with 15.1% in April 2024). Of

those calls, the proportion that are directed to alternative services is in line with the all-Wales average (75% compared with 73%).

- 40 The 111 service is also directing a lower proportion of patients to alternative services. **Exhibit 5** sets out the extent to which the 111 service has been able to refer patients to other services.

Exhibit 5: referral to other services (February 2024)

Indicator	This Health Board	All-Wales position
% of 111 calls referred to GP out of hours	42.7	41.0
% of 111 calls referred to another health profession	2.9	2.4
% of 111 calls referred to dental services	13.3	9.9

Source: DHCW Urgent and Emergency Care Dashboard, Ambulance Services Indicators

- 41 During 2023-24, the rate at which 111 staff referred patients to GP out of hours and to other health professions has been broadly consistent with the all-Wales level. However, 111 staff have consistently referred higher proportions of calls to urgent dental care than the all-Wales average. This is in line with the data contained in **Exhibit 4** and shows a need to ensure sufficient access to dental pathways across the Health Board.
- 42 In addition, 5.2% of 999 calls within the Health Board area were transferred to the 111 service during 2023-24. However, 29% of these were returned from 111 back to the 999 phoneline to be considered for an ambulance dispatch. This is higher than the all-Wales average, which was 27.6% for the same period. This suggests that, although the triage software has identified that the caller has a less severe urgent care need and therefore does not require a 999-call response, there is an absence of a suitable alternative service for that patient, and they have needed to be diverted back to the emergency 999 service as a result.
- 43 Lack of a sufficient range of alternative pathways was a common concern expressed in our discussions with a range of professionals across the Health Board area. This included representatives from GP clusters who felt they had limited pathway options to refer patients to, meaning that they refer to the emergency department by default. Analysis of the top three incidents leading to conveyance across the Health Board identified that the most frequent incidents between April 2023 and August 2024 were due to falls, breathing problems, and chest pain. Lack of frailty pathways was a commonly cited area where there are insufficient available pathways. A focus on high impact pathways for both falls in the community and breathing problems is the main aim of workstream one under the Health Board’s Six Goals Delivery Board, although the Health Board’s Six

Goals Plan lacked clarity on timescales and specific actions for achieving these aims.

- 44 The extent to which ambulance crews however can 'see and treat' patients at scene within the Health Board area is higher than the all-Wales average (16.8% compared with 14.3% in March 2025). The 'see and treat' rate has consistently been higher than the all-Wales average for the past 12 months. In addition, the percentage of patients who were referred to alternative care services was higher than the all-Wales position in February 2025 (14.5.% compared with 11.9%).
- 45 In 2019, working collaboratively with the ambulance service, the Health Board implemented a clinical assessment service, SICAT (single integrated clinical assessment and triage). Under the model, GPs and Advanced Paramedic Practitioners work together to review 999 calls that are waiting to receive a response, gain further clinical history from the patient/patient's representative or carer and where safe and possible offer an alternative route than conveyance to hospital. A review at the end of the pilot period (June 2019) showed that the service had successfully directed 72% of its cases away from an emergency department to a more appropriate pathway of care. Whilst there have been no more recent reviews of the service, the staff we spoke to during our fieldwork said that this service has become a highly valued area of core business.

Services to help manage demand

- 46 We found that **expanded and new services are generally working well to help manage increased urgent and emergency care demand, although there is a need to ensure that SDECs and UPCCs are consistently used in line with referral criteria.**

Community pharmacy services

- 47 For 2023-24, the Health Board had a slightly lower number of community pharmacies per 100,000 head of GP population compared to the all-Wales position, at 20.2 (compared to 20.9 at an all-Wales level). 98% of the Health Board's community pharmacies had signed up to provide the common ailment scheme in 2023-24, which was slightly below the all-Wales average. This scheme allows pharmacists to assess and treat a common list of minor ailments⁶. However, should antibiotics be required, then patients would need to be referred to their GP. The number of common ailment consultations per 100,000 head of GP population for 2023-24 was above the all-Wales average (10,685 compared with 10,472). The most common ailments reported were conjunctivitis, hay fever, sore throat, and dermatitis.

⁶ [Common ailments scheme](#), 2021.

- 48 To supplement the scheme, some community pharmacies across Wales have also signed up to provide additional enhanced services, which further increases the ability of community pharmacists to respond to minor ailments. This includes providing the sore throat treat and test service, and the independent prescribing service. Both services enable the community pharmacist to prescribe antibiotics. In addition, community pharmacists can also provide the additional hours service, which allows them to extend their opening hours and provide bank holiday cover.
- 49 The uptake of these is set out in **Exhibit 6**.

Exhibit 6: uptake of enhanced services in community pharmacies (2023-24)

Indicator	This Health Board	All-Wales position
% of community pharmacies providing the sore throat treat and test service	89	79
% of community pharmacies providing the independent prescribing service	28	28
% of community pharmacies providing additional hours services	17	16

Source: StatsWales

- 50 As shown above, uptake of additional enhanced services in the Health Board’s community pharmacies is broadly in line with the all-Wales position. The Health Board has a higher percentage of community pharmacies that provide treat and test services for sore throats, increasing from 84% in the previous year. The uptake of community pharmacies providing independent prescribing services has also increased although fewer pharmacies are now providing additional hours services.

Same Day Emergency Care and Urgent Primary Care Centres

- 51 In line with the ambitions of the Six Goals Programme, the Health Board has established three Same Day Emergency Care (SDEC) units. The SDEC units are each co-located with the Health Board’s three main Emergency Departments. The principle of the SDEC is to provide same day assessments and treatment for patients needing urgent medical attention, without the patient needing admission into hospital overnight.
- 52 Between April 2024 and March 2025, the Health Board’s rate of attendance to its SDECs per 100,000 head of GP population was in-line with the all-Wales level (250 compared to 249). The Health Board’s rate has gradually decreased since October 2023.
- 53 GPs and staff from the Emergency Department can directly refer into SDEC units. The Health Board also told us that WAST staff (including remote clinicians and paramedics) can directly refer patients to the SDEC units. Data from WAST

indicates that the Health Board has extremely low rates of SDEC referrals from ambulance staff each month. We were told that, due to technical issues with the dedicated telephone, ambulance staff are unable to communicate with SDEC staff. As a result, they will revert to conveyance to the Emergency Department.

- 54 We also heard that SDEC staff are reluctant to accept referrals later in the day as it limits their ability to discharge before the service closes. In April 2022, Welsh Government issued an all-Wales policy⁷ to encourage direct paramedic referral to same day emergency care. The data above along with intelligence gathered through our fieldwork indicates that the Health Board is not currently adhering to this policy (**Recommendation 10**).
- 55 During our fieldwork, we found that staff working within SDEC felt it was an extremely valuable service that can successfully undertake rapid diagnostics and treatment. However, we also heard that when the Emergency Department becomes under pressure, patients are referred to the SDEC to alleviate that pressure. When this is the case, the SDEC often becomes full of unsuitable patients who can be difficult to discharge. This is poor use of the service which has a negative impact on patients and staff.
- 56 Good practice says that there should be high rates of discharge from SDEC units to ensure that they are used effectively and appropriately. Within the Health Board, the percentage of patients discharged from the SDEC units has been relatively stable, with an average rate of 84% between April 2024 and March 2025. This is in line with the all-Wales average, which was also 84% for the same period.
- 57 The Health Board has also set up Urgent Primary Care Centres, with four centres in place across the Health Board⁸. The centres are open between 9am and 6pm. The UPCCs in the West and East IHCs use a hub and spoke model⁹. UPCCs treat patients with urgent primary care needs on the same day, creating capacity to support GP surgeries and reducing unnecessary emergency department attendances.
- 58 The rate of UPCC contacts per 100,000 head of GP population in the Health Board has fluctuated since April 2022, ranging between a high of 386 and a low of 95. Between April 2024 and March 2025, the average number of monthly contacts to the Health Board's UPCCs per 100,000 head of GP population was lower than the all-Wales average (319 and 425 respectively). Patients access UPCCs via GP or emergency department referrals. Whilst many of the staff we spoke to, including representatives from primary and secondary care, felt there was significant

⁷ [Direct paramedic referral to same day emergency care: All Wales policy, April 2022](#)

⁸ Two UPCCs are co-located with the emergency departments at Ysbyty Gwynedd and Wrexham Maelor Hospital. There are also two community UPCC sites in both the east and west IHC areas.

⁹ The hub and spoke model (also referred to as Health Board managed) is staffed by a mix of professional staff and places a greater emphasis on managing demand away from out of hours services, emergency departments and minor injury units.

potential for UPCCs to alleviate pressure on emergency departments, we also heard concerns that current referral criteria are narrow and not well-communicated. This means GPs and other health professionals do not find it to be an easily accessible pathway (**Recommendations 11.1 and 11.2**).

Impact of service changes on urgent and emergency care performance

59 We found that **urgent and emergency care performance, particularly in the emergency departments, is still extremely challenged and is not yet showing improvement from service changes.**

Ambulance performance

- 60 Since the pandemic, 999 calls to the ambulance service across the Health Board have continued to rise and have now passed the level experienced by the service pre-pandemic. There was an average of 415 red calls per month between April 2018 and March 2019, compared to an average of 1,214 red calls per month between April 2024 and March 2025. Though still representing the bulk of calls to the 999 service, amber calls have declined slightly since prior to the pandemic with an average of 6,395 calls per month between April 2024 and March 2025, compared to 6,964 between April 2018 and March 2019.
- 61 The rate at which ambulance crews convey patients in the Health Board to hospital is consistent with pre-pandemic levels, with an average monthly rate of 63.3% between April 2024 and March 2025 compared to 66.1% between April 2018 and March 2019. Performance for the Health Board is in line with the all-Wales average (63.3% between April 2024 and March 2025). This shows that some of the work to avoid conveyance is enabling the Health Board to maintain performance despite increasing demand. **Exhibit 7** sets out further detail in relation to conveyance to hospital.

Exhibit 7: conveyance destination as a proportion of total conveyance (April 2024 – March 2025)

Indicator	This Health Board	Trend	All-Wales position
% of patients conveyed to major emergency departments	97.4		88.8
% of patients conveyed to minor injuries units	0.1		6.2
% of patients conveyed to major acute medical admissions unit	0.0		3.1

Indicator	This Health Board	Trend	All-Wales position
% of patients conveyed to other unit e.g. mental health or maternity unit	2.5		1.8

Source: Ambulance Services Indicators

- 62 Ambulance crews convey a higher percentage of patients to the Health Board’s Emergency Departments than the all-Wales average. Conveyance rates for minor injuries units (MIUs) within the Health Board are the lowest in Wales and there is no conveyance to a medical assessment unit within the Health Board, which would include SDEC units. This data shows that the Health Board could do more to treat patients in settings other than the emergency department, where appropriate (**Recommendation 12**).
- 63 Analysis of presentations to the Health Board’s Emergency Departments between July 2023 and June 2024 showed that the most frequent causes were due to minor head injuries, lower respiratory tract infections and urinary tract infections. Analysis showed that whilst demand for the Emergency Departments had increased by 3% during the same period, the complexity of cases had changed. The proportion of patients with high acuity had decreased with a correlating increase in patients with urgent but not life-threatening, or semi-urgent and not life-threatening issues. Whilst these patients require treatment, the data shows that there is further potential to treat them through MIUs, freeing up emergency department capacity.
- 64 There are issues with the availability of alternative services which deter paramedics from using alternatives to emergency departments. For example, paramedics told us that they will bypass MIUs to go directly to emergency departments. This is because the services available in, and the operating hours of, MIUs vary. The Health Board has nine MIUs, although seven were closed temporarily at the time of our fieldwork. Opening hours vary between 9 and 24 hours a day, with some open on weekends. There is also variation with the opening times of the X-ray departments within the units, which limit access for some conditions.
- 65 We also heard from some ambulance and MIU staff that, on occasion, the MIU has refused to receive patients from an emergency ambulance due to the unit being full of walk-in patients. Whilst there is no data to quantify how many times this has taken place, our interviews with staff indicated that this has happened numerous times in recent years. We heard that, in extreme cases, units have had to close temporarily because of a walk-in patient presenting with severe urgent care needs, including cardiac arrest. In these examples often the patient has chosen to present to the MIU due to fears about waits within the Emergency Department. However, MIUs are not staffed or equipped to treat patients with cardiac arrest, which means that staff must close the units to await arrangements to transfer the patient to an Emergency Department.

- 66 The Health Board has analysed a range of urgent and emergency care metrics from June 2024, termed the Summary Emergency Department Indiciary Table (SEDIT). This analysis has found several gaps in provision which was influencing how patients access urgent and emergency care across the Health Board. For example, it found that there are higher levels of ambulance conveyances to Ysbyty Glan Clwyd, crucially due to a lack of an MIU nearby. The data showed that just under half of the minor presentations to the Emergency Department at Ysbyty Glan Clwyd were from Rhyl postcodes, suggesting a need for increased minor injury provision in that area.
- 67 Data shows that ambulance handover delays across the Health Board continue to be at unacceptably high levels. The percentage of ambulance handovers completed within 15 minutes between April 2024 and March 2025 was just 10.8%, against a national target of 100%. This performance is the worst in Wales, set against an all-Wales average of 15.5%. Poor handover performance is resulting in a high number of lost hours due to handover delays. The Health Board lost on average 8,251 hours every month between April 2024 and March 2025. This equates to 687 12-hour shifts where patients were waiting in an ambulance outside of hospital for treatment and paramedics were unable to respond to other calls. In January 2025, Wrexham Maelor Hospital reported its highest number of lost hours on record (4,080), and Ysbyty Gwynedd reported its second highest number of lost hours (3,082).
- 68 A clinical review developed by the Association of Ambulance Chief Executives (AACE)¹⁰ discovered that the rate at which harm occurs for patients increases when their handovers take over an hour to complete. This review showed that the likelihood of a patient experiencing severe, or permanent, harm was 7% for handovers taking between an hour and an hour and a half, 10% for handovers taking between two and three hours, and 27% for handovers taking over four hours to complete. Data from March 2025 showed that 72% (2118) of handovers in the Health Board took over one hour to complete, and 26% (776) of handovers took over four hours to complete. Using the AACE model, it is possible that 201 Health Board patients came to severe harm following long handover delays during March 2025.
- 69 Handover delays also inhibit the ability of ambulance staff to respond to other urgent calls in the community. Ambulance response times continue to be challenging and below performance targets (**Exhibit 8**). The percentage of red calls responded to within eight minutes between April 2024 and March 2025 was in line with the all-Wales average but was significantly below the target of 65%. During the same period, the response time to amber calls was one hour 42 minutes, which was below the all-Wales average of one hour 52 minutes. The patients who waited the longest (that is, the 95% percentile of patients) waited an

¹⁰ ['Delayed hospital handovers: Impact assessment of patient harm'](#) Association of Ambulance Chief Executives, November 2021.

average of nine hours 17 minutes for a response against an all-Wales average of nine hours 57 minutes. This performance has deteriorated over the last 12 months.

Exhibit 8: red and amber call response times (April 2024 – March 2025)

Indicator	This Health Board	Trend	All-Wales position
% of red calls responded to within eight minutes	48.0		48.7
Median response to amber calls (minutes)	102		112

Source: Ambulance Service Indicators

Emergency Department performance

- 70 Within the Health Board, the rate of attendance at an emergency department per month per 100,000 head of GP population has increased during the past two years and is slightly higher than the all-Wales average (2,071 and 1,989 respectively).
- 71 Performance in relation to emergency department waiting times continues to be challenging. The percentage of patients spending less than four hours in the Health Board’s Emergency Departments deteriorated slightly during 2024-25 with an average monthly rate of 62.6%. Performance dipped to 57.2% in March 2025, the lowest rate since the pandemic with performance at Ysbyty Glan Clwyd and Wrexham Maelor Hospital the second lowest on record.
- 72 The percentage of patients spending less than 12 hours in the Emergency Departments has also deteriorated in recent months, with an average monthly rate of 84% between April 2024 and March 2025. The number of patients who spent longer than 12 hours in March 2025 (3,763) was the highest number on record for any Welsh health board. A [HIW Hospital Inspection Report](#), published in March 2025 found that some patients had spent over 36 hours at the Wrexham Maelor Hospital Emergency Department.
- 73 Once assessed, the rate of admission for the Health Board (27.0%) was higher than the all-Wales average (22.3%) between March 2024 and February 2025. As said in **paragraph 63**, data collected by the Health Board shows that whilst emergency department attendances have increased, acuity levels of patient needs have decreased. These higher levels of admission therefore suggest further opportunities for the Health Board to redirect or better signpost patients to more appropriate services for their needs.

Scrutiny and monitoring arrangements

- 74 This section considers whether the Health Board is doing enough to monitor the performance of its urgent and emergency care services, and applying lessons learnt to improve services further. We were specifically looking for evidence of:
- arrangements for monitoring the impact of alternative clinical pathways; and
 - effective oversight and scrutiny of the delivery of plans for urgent and emergency care.
- 75 We found that **while there is significant activity to monitor urgent and emergency care performance, there is an absence of staff and patient feedback and there is a need to provide assurance on the use of funding to improve services.**

Monitoring impact

- 76 We found that **the Health Board collects useful data relating to the use of alternative clinical pathways, however it is not using this data to drive improvements, and activity to collect and analyse staff and patient feedback is poor.**
- 77 The findings that have led us to this conclusion are summarised in **Exhibit 9.**

Exhibit 9: approach to monitoring impact on urgent and emergency care services.

Audit question	Yes/ No/ Partially	Findings
Is the Health Board tracking and reporting data to show whether patients are accessing urgent and emergency care services appropriately?	Partially	<p>The Health Board routinely collects a wealth of data to monitor demand and performance. This data provides insight into how existing services are used, such as its Emergency Departments, as well as new services, such as UPCCs and SDECs. The data includes the source of referrals for UPCCs and SDECs, as well as outcome data for UPCC patients. The data can be reported by IHC area and has the potential to provide valuable intelligence.</p> <p>However, whilst we could see that this data informs day-to-day decision-making, it is not clear how it is used to inform plans which aim to improve access and outcomes for urgent and emergency care (Recommendation 1).</p>

Audit question	Yes/ No/ Partially	Findings
Is regular patient feedback is being sought and used to inform and improve plans?	Partially	<p>The Health Board gathers some patient feedback on its urgent and emergency care services, including via a CIVICA¹¹ patient survey. The survey is specific to patient experiences within emergency departments and questions are scored according to the percentage of positive responses. However, response rates are very low which makes the findings unreliable. It is not clear what actions the Health Board is taking to increase participation for this survey.</p> <p>Whilst our review of the Health Board's Six Goals Delivery Board meeting papers did show that they routinely hear patient stories, the sample of papers we looked at did not clearly show how the Health Board was using this feedback to inform and improve plans (Recommendation 13).</p>
Is there regular staff feedback on the impact of changes to services and pilots to identify and apply lessons?	No	<p>Our review found no evidence of the Health Board proactively collecting staff feedback. Interviews with a range of staff showed a need for more regular mechanisms for feedback, such as between urgent and emergency care services and primary care services, to ensure service changes are working as intended (Recommendation 14).</p>

Source: Audit Wales

Oversight and scrutiny

- 78 We found that **while urgent and emergency care performance is routinely monitored, a lack of alignment between area plans and the Health Board vision, alongside poor financial oversight, undermines the effectiveness and sustainability of improvement initiatives**
- 79 The findings that have led us to this conclusion are summarised in **Exhibit 10**.

Exhibit 10: oversight and scrutiny of urgent and emergency care services.

¹¹ CIVICA is a software platform designed to measure patient feedback within healthcare organisations.

Audit question	Yes/ No/ Partially	Findings
<p>Is there effective oversight of urgent and emergency care performance operationally, including scrutiny and assurance on the effectiveness of plans and actions being taken to better meet demand?</p>	<p>Yes</p>	<p>There is regular operational oversight of urgent and emergency care performance. There are weekly urgent and emergency care reviews with IHCs which include representatives from WAST. At the time of fieldwork, the Health Board was renewing its Six Goals Programme Board to oversee plans and delivery in relation to urgent and emergency care and the Six Goals Programme. This group feeds into the Health Board's internal reporting structures directly to the Chief Executive, as well as externally to the Regional Partnership Board and the National Six Goals Programme Board.</p> <p>Corporately, the Health Board's Executive Finance and Performance Group monitors urgent and emergency care performance and progress against the relevant plans.</p>
<p>Is there effective oversight of urgent and emergency care performance at the committee and board level, including scrutiny and assurance on the effectiveness of plans and actions being taken to better meet demand?</p>	<p>Partially</p>	<p>The Performance, Finance, and Information Governance (PFIG) Committee routinely monitors urgent and emergency care performance. Urgent and emergency care has been an escalated performance measure for the PFIG Committee since February 2024. The reports highlight ongoing challenging performance and provide benchmark information for specific metrics with other Health Boards in Wales.</p>
<p>Are there arrangements in place for monitoring and oversight of economy, efficiency, and effectiveness of project investment from Welsh Government?</p>	<p>No</p>	<p>There is a need for better scrutiny on finance and to receive assurance that the Health Board spends money allocated for urgent and emergency care effectively. The PFIG Committee finance report includes reference to the £1.6 million provided through the Six Goals Programme to the Health Board. However, our review of papers found no clear reporting of how this money is being spent on improving urgent and emergency care. The Health Board also receives additional funding by way of the Regional Integration Fund and Further Faster funding, as well as contributing money from its core funding. However, there was also no reporting of</p>

Audit question	Yes/ No/ Partially	Findings
		this expenditure within reports to the committee or the Board (Recommendation 15).

Source: Audit Wales

Appendix 1

Audit methods

Exhibit 11 sets out the audit methods we used to deliver this work. Our evidence is limited to the information drawn from the methods below.

Exhibit 11: audit methods

Element of audit approach	Description
Documents	We reviewed a range of documents, including: <ul style="list-style-type: none">• Strategic and operational plans relating to urgent and emergency care services;• Performance reports;• Escalation protocols;• Referral criteria; and• Internal audit reports.
Interviews	We interviewed the following: <ul style="list-style-type: none">• Interim Chief Operating Officer;• Programme Director, Urgent and Emergency Care Improvement;• Assistant Director of urgent and Emergency Care;• Urgent and Emergency Care Lead;• Director of Communications;• IHC Directors (East, West and Central);• Director of Primary Care;• WAST Head of Service for the Health Board region;• Local Llais Lead;
Group discussions	We held group discussions with the following: <ul style="list-style-type: none">• Leads for Emergency Departments, Same Day Emergency Centres, Urgent Primary Care Centres and Minor Injuries Units; and• GP cluster leads and GP Out of Hours leads East;
Observations	We observed the following meeting(s): <ul style="list-style-type: none">• Performance, Finance, and Information Governance Committee.

Element of audit approach	Description
Data analysis	<p>We analysed data relating to urgent and emergency care services, using the following sources:</p> <ul style="list-style-type: none"> • Ambulance Services Indicators; • DHCW Urgent and Emergency Care Dashboard; • StatsWales; • Data provided by Welsh Government in relation to GP out of hours services; and • Monthly Monitoring Returns.
Website and practice reviews	<p>We reviewed the Health Board’s website and social media accounts relating to the provision of information to the public on accessing urgent and emergency care services.</p> <p>We also reviewed practice websites and phonelines for:</p> <ul style="list-style-type: none"> • a sample of 25 GP practices; and • a sample of 19 dental practices

All audit work has been delivered in accordance with the International Organisation of Supreme Audit Institutions (INTOSAI) audit standards.

Appendix 2

Audit criteria

Exhibit 12 sets out the audit criteria that we used to deliver this work.

Exhibit 12: audit criteria

Audit questions	Audit criteria
Does the Health Board have robust plans in place to manage the demand for urgent and emergency care services?	
Do plans seek to improve the management of demand through changes to service delivery in line with the six goals for Urgent and Emergency care?	<ul style="list-style-type: none">• Strategies and/or plans relating to urgent and emergency care:<ul style="list-style-type: none">– are based and grounded in rich and up-to-date information, informed by urgent and emergency care demand data (past and future), including peaks in activity at certain times/days and months, demographics, and conditions of patients.– identify and seek to address key risks associated with demand for urgent and emergency care services.– align with the requirements of the Welsh Government Six goals for Urgent and Emergency Care for better managing demand.– include documented information on alternative clinical pathways, including how and when they should be accessed.
Do plans identify the current and required levels of resource and	<ul style="list-style-type: none">• Strategies and/or plans detail the:<ul style="list-style-type: none">– resource requirements and identified funding to support any changes to service delivery included within the strategy/plan.

Audit questions	Audit criteria
staffing to achieve the ambitions?	<ul style="list-style-type: none"> – workforce and skills required to meet demand, including for changes in models of delivery such as winter peaks. The plan is clear about the required resources of clinical and non-clinical skills/staff.
<p>Are arrangements in place to encourage and enable people to access the right care, in the right place, at the first time, and are these working?</p>	
Is the Health Board effectively signposting urgent and emergency care services to the public, so they know how to access services appropriately?	<ul style="list-style-type: none"> • The Health Board provides clear information on available services and alternatives to emergency departments to the public through various avenues – websites, call handlers, posters/leaflets, advertisements, GP/dentist websites and phone lines, social media, videos etc. • Strategies and/or plans on public communication align to requirements of goals 2 and 3 of the WG Six goals for Urgent and Emergency Care (Right care, right place, first time) • There is evidence to suggest patients have a good understanding of how to access urgent and emergency care services that are appropriate to their needs
Do staff have good knowledge of, and access to, information regarding the range of other services available to their patients and at what times they are available?	<ul style="list-style-type: none"> • There is engagement between Health Boards and GP clusters / dentists / paramedics / pharmacists about alternative pathways in place and the future of urgent and emergency care services. Information on these pathways and services are accessible for staff. • Staff can refer directly / divert patients to more appropriate settings for their needs, including Urgent Primary Care Centres (UPCC) and Same Day Emergency Centres (SDEC).
Is there evidence that changes to service delivery are resulting in better demand management?	<ul style="list-style-type: none"> • Referrals into new service models are in line with the ambitions of the six goals for urgent and emergency care policy handbook. • WAST can refer at least 4% of cases to SDEC. • Calls to 111 are answered quickly and abandonment rates are low.

Audit questions	Audit criteria
	<ul style="list-style-type: none"> • Emergency ambulance response times, ambulance handover delays and waits within Emergency Departments and Minor Injury Units are improving. • Data shows decreasing volumes of patients with low acuity / minor complaints presenting at Emergency Departments. • Data indicates a good range of GP appointment availability. • Data indicates that calls diverted between 999 and 111/NHS Direct Wales are appropriate with low levels of calls diverted back and low numbers of re-contact rates.
<p>Is the Health Board doing enough to monitor the performance of its urgent and emergency care services and apply lessons learnt to improve the services further?</p>	
<p>Is the Health Board monitoring the effectiveness of alternative clinical pathways, including by seeking feedback from staff and service users?</p>	<ul style="list-style-type: none"> • The Health Board tracks and reports data to show whether patients are accessing urgent and emergency care services appropriately. • The Health Board can evidence that it seeks patient feedback regularly and uses it to inform and improve plans. • Regular feedback is sought from various staff on the impact of changes to services and pilots to identify and apply lessons
<p>Is there effective scrutiny and assurance in relation to delivering plans for urgent and emergency care and alternative clinical pathways?</p>	<ul style="list-style-type: none"> • There is effective oversight of urgent and emergency care performance operationally and at the committee and board level. This includes scrutiny and assurance on the effectiveness of the plans and actions being taken to better meet demand. Oversight and scrutiny are informed by comparative benchmarking and learning from other bodies where appropriate. • There are arrangements in place for monitoring and oversight of economy, efficiency, and effectiveness of project investment from Welsh Government. This includes establishing value for money and what difference the project has made.

Appendix 3

Management response to audit recommendations

Exhibit 13 sets out the Health Board’s management response to the recommendations made because of this audit.

Exhibit 13: management response

Recommendation	Management response	Completion date	Responsible officer
<p>Identifying data used to inform plans for urgent and emergency care</p> <p>R1 To ensure that priorities reflect and align to up to date information such as service demand, service capacity and future demographic pressures, the Health Board should clearly indicate the data used to inform its plans for urgent and emergency care (Exhibit 2).</p>	<p>The 6 Goals Delivery Plan includes specific benefits and measures to monitor the progress against the priorities for the 4 UEC workstreams. A number of Power BI dashboards have also been established to support access to a range of live data across UEC, enabling oversight of activity across acute and community sites, any emerging pressures and monitoring delayed patients. UEC data will be reviewed within the IHC local governance structures for UEC, the UEC programme board and UEC internal focus group to continue to inform plans and priorities.</p>	<p>Q3 2025-26</p>	<p>UEC Programme Director</p>

Recommendation	Management response	Completion date	Responsible officer
<p>Risk management within plans</p> <p>R2 To strengthen risk management, the Health Board should ensure that all risks set out in urgent and emergency care plans have risk owners, clear scores and targets as well as robust mitigating actions (Exhibit 2).</p>	<p>The 4 UEC workstreams have RAID logs that are either developed or in development that include risks, actions, issues, decisions which are reviewed during each workstream meeting that are held regularly with standard agendas.</p> <p>A Health Board corporate risk CRR25-01 (Timely Patient Access to Safe & Effective Care) includes mitigating actions and controls across UEC as well as wider services.</p>	<p>Q4 2025-26</p> <p>Q1 (2026-27)</p>	<p>UEC Programme Director / other relevant risk leads</p>
<p>Alignment between IHC and corporate urgent and emergency care plans</p> <p>R3 To ensure that the actions taking place within Integrated Health Communities align with the corporate vision of the Health Board, it should develop IHC delivery plans to implement the vision of the corporate Six Goals Plan which sets out a consistent approach to track performance of the overarching urgent and emergency care plan delivery across each IHC area (Exhibit 2).</p>	<p>The 6 Goals transformation programme and delivery plan is a single regional plan which will be delivered within each of the IHCs (as the current service configuration) to ensure consistency of approach. This will include a detailed deployment / implementation plan across different sites and services rather than having three additional locality-based plans. The rationale for this is to ensure development of a single model for the Health Board to drive out unwarranted variation.</p>	<p>Q4 2025-26</p>	<p>UEC Programme Director</p>
<p>Resourcing urgent and emergency care plans</p> <p>R4 To provide clarity on how initiatives will be funded beyond the annual plan cycle, the Health Board should ensure its plans for urgent and emergency</p>	<p>Additional 6 Goals funding has been made available nationally, which is contingent on a detailed financial plan and which has been submitted to the national</p>	<p>Q4 2025-26</p>	<p>UEC Programme Director</p>

Recommendation	Management response	Completion date	Responsible officer
<p>care clearly identify funding needs for current and future years, as well as identifying the sources of funding (Exhibit 2).</p> <p>R5 To support achievement of the ambitions of its urgent and emergency care plans, the Health Board should clearly set out the current and future workforce requirements (Exhibit 2).</p>	<p>NHS P&I team. As regional service models are developed, resource implications will be integrated into annual financial plans and within the IMTP.</p> <p>Workforce requirements will be assessed as part of the development of a regional model for urgent and emergency care and to support requirements of R4.</p>	<p>Q4 2025-26</p>	<p>UEC Programme Director</p>
<p>Improving information on alternative services</p> <p>R6 To help guide patients to the most appropriate service for their needs, the Health Board’s website should include advice on key urgent conditions, such as breathing difficulty, chest pain or rashes (Paragraph 26)</p> <p>R7 To help address demand for urgent care, the Health Board should ensure GP and dental practices provide clear, accessible information about urgent and emergency care services on their websites and conduct a future</p>	<p>The Health Board publishes a regular schedule of advice and information about how to access urgent care appropriately and where more information about services and checking symptoms can be found. This is part of a year-round approach to help improve public understanding of services and influence behaviour when people need urgent care and support. This local activity is supported by national campaigns, such as the ‘Help Us Help You’ campaign.</p> <p>The BCU website includes information about local primary care services; including access to dental and GP services that includes a page with a directory of information of all GP practices in NW as a core part of seasonal campaigns to sign post to information.</p>	<p>Q3 2025-26</p> <p>Q3 2025-26</p>	<p>Director of Communication</p> <p>Associate Director of Primary Care / Corporate Comms</p>

Recommendation	Management response	Completion date	Responsible officer
<p>audit to ensure compliance (Paragraph 28).</p> <p>R8 To support staff and public understanding of the breadth of urgent and emergency services within the Health Board, and how to access them, the Health Board should develop a communications plan for urgent and emergency care services (Paragraph 33).</p> <p>R9 To help health and care staff adequately signpost and refer people to the right urgent and emergency care services, the Health Board should establish a mechanism to keep the WAST Directory of Services up to date, which includes the identification of an officer with lead responsibility for this task (Paragraph 37).</p>	<p>A GMS sustainability action plans includes a focus on public comms, including identification of relevant items for communication and work is ongoing with corporate comms team to agree a communications plan including how community pharmacies can support.</p> <p>The website also includes a link to NHS 111 providing information and a point of signposting which includes all directories for primary care services and is the single point of contact in terms of supporting the public with decisions on these services.</p> <p>The Health Board publishes a regular schedule of advice and information about how to access urgent care appropriately and where more information about services and checking symptoms can be found. This is part of a year-round approach to help improve public understanding of services and influence behaviour when people need urgent care and support. This local activity is supported by national campaigns, such as the ‘Help Us Help You’ campaign</p> <p>A clinical lead has been identified to roll out our Single Point of Access model, which includes an accurate and up to date directory of services to support referral into appropriate services. This will initially be supported by the 6 Goals project team. The lead role will be designated following the reconfiguration of services.</p>	<p>Q4 2025-26</p> <p>Q4 2025-26</p>	<p>Clinical lead for UEC</p>

Recommendation	Management response	Completion date	Responsible officer
<p>Maximising use of SDECs and UPCCs</p> <p>R10 To ensure compliance with the national SDEC referral criteria and guidance, the Health Board should conduct an audit of its SDEC data and report the results to the appropriate committee (Paragraph 52).</p> <p>R11 To ensure Urgent Primary Care Centres are being maximised, the Health Board should:</p> <p>11.1 Work with key partners, including GPs and Emergency Department leads, to review the UPCC referral criteria.</p> <p>11.2 Ensure the UPCC referral criteria is well-communicated and accessible to relevant staff, once agreed (Paragraph 56)</p>	<p>As part of the 6 Goals programme a review will be undertaken to evaluate the SDEC models currently in place on each of the 3 acute sites in North Wales, including an analysis of utilisation by WAST and ED to support streaming, and outcomes for patients. The NHS P&I team are conducting an assurance review of the SDEC units during October 2025.</p> <p>BCUHB is currently working with the Performance and Improvement Team to pilot a test of concept for an Urgent Treatment Centre in Wrexham Maelor. It is likely that the current UPCC model will change significantly and key clinicians will be involved in this process.</p>	<p>Q4 2025-26</p> <p>Q1 (2026-27)</p>	<p>Clinical lead for UEC</p> <p>UEC Programme Director / workstream lead / clinical lead</p>
<p>Maximising use of Minor Injuries Units</p> <p>R12 To understand how well it is utilising Minor Injuries Units and to identify further opportunities to maximise this service, the Health Board should include metrics on attendance and conveyance rates to its minor injuries units and medical assessment units in reports to the Finance and</p>	<p>A power BI dashboard is established that includes a suite of reports for MIU performance data including number of attendances, time to triage & clinician / number of breaches. UEC data will be reviewed and scrutinised within the UEC programme board and other relevant forums as agreed with the COO to inform the development of plans and priorities.</p>	<p>Q3 2025-26</p>	<p>COO</p>

Recommendation	Management response	Completion date	Responsible officer
Performance Committee (paragraph 62).			
<p>Improving staff and patient feedback</p> <p>R13 To ensure future plans for urgent and emergency care are informed by patient experience, the Health Board should clearly demonstrate within the narrative how it has considered patient feedback (Exhibit 9).</p> <p>R14 To improve the understanding of how services are working, and identify potential weaknesses or learning from recent changes, the Health Board should introduce regular mechanisms for staff feedback on urgent and emergency care services. This should include feedback from key partners including primary care and WAST staff (Exhibit 9).</p>	<p>The UEC programme board receives a patient story as a standing item on the agenda. A review of complaints and compliments is routinely undertaken by IHCs respectively. As part of the focused work within UEC workstream 4, Discharge Improvement Groups have been established in each of the 3 IHCs to review discharges that are considered to provide learning, identify themes and trends.</p> <p>Targeted work has been done with care homes and actions to improve the patient experience which is included within care home awareness seminars.</p> <p>Follow up audits have been undertaken in the 3 ED departments specifically for attendances from care homes into the EDs. This has included engagement with staff from care homes & EDs. Learning from this has been incorporated into the ongoing care home awareness webinars that are being rolled out across NW within a rolling programme of awareness raising and training</p>	Q3 2025-26	COO
Reporting of expenditure of additional funding for UEC services			

Recommendation	Management response	Completion date	Responsible officer
<p>R15 To increase transparency and strengthen assurance that monies allocated to the Health Board for urgent and emergency care is being spent wisely, the Health Board should include information on its use of additional funding within regular finance reports to the Performance, Finance and Information Governance Committee. This should include the use of Six Goals, Further Faster and Regional Integration Fund monies (Exhibit 10).</p>	<p>The UEC (6 goals) programme board approved the 6 Goals financial plan that is aligned to the 6 Goals programme plan prior to submission to WG earlier this year. The UEC / 6 Goals programme board will receive regular finance reports on UEC / 6 Goals and wider Further Faster / RIF funding as a standing item which includes review with LA partners.</p>	<p>Q3 2025-26</p>	<p>UEC Programme Director / CFO</p>

Source: Audit Wales



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.

National Fraud Initiative 2024-25: update for Betsi Cadwaladr University Health Board

About the National Fraud Initiative

- 1 The National Fraud Initiative (NFI) is a biennial UK-wide counter-fraud exercise. It helps prevent and detect fraud by electronically sharing and matching data sets. **Appendix 1** provides further information on how the NFI works.
- 2 In Wales, the NFI operates under the Auditor General's statutory powers. Participation is mandatory for unitary local authorities, NHS bodies, police forces, and fire and rescue authorities. Participating on a voluntary basis in the latest exercise are the Welsh Government, some Welsh Government arm's length bodies (Natural Resources Wales, Arts Council of Wales, Sport Wales, National Library of Wales, Transport for Wales), and South East Wales Corporate Joint Committee.
- 3 This briefing note provides an update on the latest NFI 2024-25 exercise at a national level and as at 31 July 2025. It also provides some local level data for your organisation, although we are encouraging those charged with governance to seek further local detail from lead officers.

Data submission for 2024-25

- 4 The NFI 2024-25 exercise is underway. Participants submitted data for the biennial batch data matching exercise in October 2024. This included data on housing benefits, housing tenants and waiting lists, blue badge parking permits, licences, and various payments such as creditor payments, payroll, and pensions.
- 5 The UK Public Sector Fraud Authority released most data match reports to participants by the end of December 2024. Council tax and electoral register data are submitted annually. The most recent deadline for submitting this data was February 2025.
- 6 Supplementary data runs take place during the exercise to process new, incomplete or missing data submissions. For example, progress is being made to amend the Public Audit (Wales) Act 2004 through a Legislative Reform Order which will enable the NFI to resume the matching of adult social care data during the NFI 2024-25 exercise.

National update

Data matches and investigation

- 7 To date, almost 440,000 data matches have been identified for the Welsh NFI 2024-25 exercise participants. **Exhibit 1** shows that most of these matches are for unitary authorities and health bodies.

Exhibit 1: NFI 2024-25 Welsh participant data matches by type of organisation, at end of July 2025

Type of organisation	Number of data matches	% of data matches
Unitary authority	373,114	84.9
Health	50,409	11.5
Police	2,641	0.6
Fire and rescue	740	0.2
Other	12,749	2.9
Total	439,653	100.0

Source: Audit Wales analysis of NFI web-application data

Note: % total does not match the sum of the parts due to rounding.

- 8 Data matching identifies potentially fraudulent or erroneous claims and payments. No assumption can be made about whether there is fraud, error, or another explanation until an investigation is carried out. There can, for example, be false positives around creditor payments if bodies are deliberately making staged payments of the same amount.
- 9 We recognise it is not practical to investigate all data matches, particularly for bodies with large numbers of matches. Bodies are encouraged to take a risk-based approach to assessing data match reports and deciding what type of, and how many, data matches they review.
- 10 By the end of July 2025, five participating bodies had not yet closed any data matches. Some participants are making good progress with reviewing NFI 2024-25 data matches, while others have made limited progress.
- 11 **Exhibit 2** shows the total number of data matches for each data match area. It also shows the number of data matches closed in a data match area, along with the number of participants that have matches in that area.

The absence of closed matches indicates that the participant has not reviewed any matches in that area.

Exhibit 2: NFI 2024-25 Welsh participant data matches processed and closed, at end of July 2025

Data match area	Data matches	Data matches closed	Participants with data matches	Participants with no closed statuses for their matches
Council tax single person discount	198,146	5,385	22	11
Creditors	187,228	19,791	48	16
Council tax reduction scheme	16,578	3,547	22	1
Blue badges	10,377	5,849	22	3
Payroll	8,150	1,705	46	6
Housing waiting lists	6,359	1,392	18	5
Housing tenants	4,636	879	11	2
Pensions	2,962	1,098	12	4
Resident parking	2,405	2,368	8	1
Procurement	1,985	400	42	28
Housing benefit	826	483	22	2
Taxi drivers	1	1	1	0
Total	439,653	42,898	49	5

Source: Audit Wales analysis of NFI web-application data

Note: After risk assessing data match reports and any subsequent investigations, each data match should be 'closed' and given a match status. There are a range of 'closed' statuses. Matches not investigated should be given the status 'Closed – Not selected for investigation'. Assigning match statuses to data matches can be done individually or by bulk selection.

Outcomes

- 12 Welsh participants recorded outcomes of £4.7 million for the period 1 April 2024 to 31 July 2025. **Exhibit 3** shows which matching process the outcomes relate to.

Exhibit 3: Welsh participant reported NFI outcomes, 1 April 2024 to 31 July 2025

NFI exercise	Outcomes (£s)
NFI 2024-25 biennial exercise	1,719,037
Late savings from the NFI 2022-23 biennial exercise	867,157
Annual council tax data matching exercises	2,080,831
Total	4,667,025

Source: Audit Wales analysis of NFI web-application data

Note: Outcomes are made up of (i) actual amounts participants have recorded as fraud or error; and (ii) estimated elements which seek to capture the value of loss from a fraud or error detected, and the value of any future losses that bodies may have incurred without intervention following an NFI match. Most datasets have a methodology to calculate estimated savings. All methodologies are reviewed by the Cabinet Office's NFI Governance Board and approved by the Cabinet Office's Fraud Prevention Panel.

Local update

- 13 Data matches are released in data match reports. Each report has a different purpose and compares data from two or more datasets. The reports are broken down into dataset types: for example, housing benefit, payroll, or creditors.
- 14 An organisation's risk assessment of the data match reports should determine the types and numbers of data matches to be investigated. To aid risk assessment, the NFI web application flags some data match reports as 'key reports' with historically high success rates in identifying fraud or error. Also, most individual data matches are assigned a fraud risk score.
- 15 **Exhibit 4** shows the total number of data matches identified for Betsi Cadwaladr University Health Board, along with those recorded in key reports. **Appendix 2** provides some further analysis of these data matches by fraud risk score.

Exhibit 4: Betsi Cadwaladr University Health Board's NFI 2024-25 data matches, at end of July 2025

Data match area	Data matches in all reports	Data matches in key reports with historically high success rates
Creditors	2,892	1,674
Payroll	601	355
Procurement	118	118
Total	3,611	2,147

Source: Audit Wales analysis of NFI web-application data

Note: Council tax single person discount data match reports are not formally designated as 'key reports' but are treated as such in practice.

- 16 Various factors can influence which data match reports are reviewed and when this takes place. For example, an organisation may prioritise looking at data match reports linked to areas where it has concerns about internal controls or where there is a history of fraud or error. Also, local resourcing will dictate the pace of progress. For these reasons, this general update does not provide further detail on where processing work and outcomes are recorded by your organisation at this stage.
- 17 The NFI web application features a dashboard and provides various reports on outcomes and processing activity. We encourage those charged with governance to seek more detailed updates on processing work and outcomes recorded from their NFI Senior Responsible Officer and NFI Key Contact.

Future Audit Wales work

- 18 For this NFI exercise we will carry out a high-level assessment of participants' governance and follow-up arrangements. We will engage with bodies over the autumn/early winter to consider issues covered in our [NFI self-appraisal checklist](#).¹ We will also analyse the risk assessment and data match processing work carried out, and the outcomes recorded by participants, as reflected in the NFI web application.
- 19 This work will help us understand the factors influencing the outcomes reported by individual bodies and the variations between them. Findings from this assessment will inform our next national report in autumn 2026.

¹ In December 2024, we shared the updated checklist with NFI senior responsible officers and key contacts. We encouraged all bodies to complete it and share it with those charged with governance.

Appendix 1 – The National Fraud Initiative

The NFI uses data matching to detect and prevent fraud. It electronically compares sets of data against other records held by the same and other bodies, to see to what extent they match.

The data matching flags anomalies or inconsistencies that indicate potential fraud or error. Indicators of potential fraud are reported to the participants, who are responsible for following up these matches.

The effectiveness of the NFI depends on the thoroughness of the assessment and investigation of matches and recording of outcomes.

Bodies record the outcomes in the NFI web application. Each participant body has a nominated Senior Responsible Owner and Key Contact for the NFI, who in some cases may be the same individual.

The UK Public Sector Fraud Authority, part of the UK Government's Cabinet Office and HM Treasury, oversees the NFI across the UK. Audit Wales leads the exercise in Wales under the Auditor General's powers in the Public Audit (Wales) Act 2004. The Auditor General's Code of Data Matching Practice summarises the key legislation, and controls, governing the exercise in Wales.

We published a report on the outcomes from the 2022-23 NFI exercise in October 2024. Reports on the NFI for other parts of the UK are produced by the Public Sector Fraud Authority, Audit Scotland, and the Northern Ireland Audit Office.

There is no direct cost to participants for taking part in the exercise. Audit Wales receives funding, through the Welsh Consolidated Fund, to pay for bodies to participate in the NFI. This covers the central data matching processing for the biennial exercise, as well as the annual exercise for council tax and electoral register datasets. This remained the case for the NFI 2024-25 exercise. The main costs to participants are, therefore, the resources used to submit data and conduct follow-up work once data matches are released.

Appendix 2 – Analysis of data matches by fraud risk score for Betsi Cadwaladr University Health Board

The NFI assigns a fraud risk score of very high risk, high risk, or medium risk to most, but not all, data matches. This risk score is based on a combination of two factors:

- Risk logic – a set of criteria for each dataset combination that, when met, indicates a fraudulent outcome is more likely to occur.
- Footprint score – the number of times an individual in a match appears at the address across all NFI data. It is an indicator of whether that person resides at that address.

Exhibit 5 and **Exhibit 6** provide further analysis of Betsi Cadwaladr University Health Board's data matches by risk score for data matches in all data match reports and those in key reports. This analysis builds on **Exhibit 4** in the main body of this briefing note. Not all data matches are formally assigned a risk score. Council tax single person discount data matches and matches in key reports that are not formally assigned a risk score should generally be treated as 'very high risk' in practice.

Exhibit 5: Betsi Cadwaladr University Health Board's NFI 2024-25 data matches by risk score for data matches in all reports, at end of July 2025

Data match area	All data matches	Very high risk	High risk	Medium risk	No risk score
Creditors	2,892	339	2,553	0	0
Payroll	601	69	243	145	144
Procurement	118	0	0	0	118
Total	3,611	408	2,796	145	262

Source: Audit Wales analysis of NFI web-application data

Exhibit 6: Betsi Cadwaladr University Health Board's NFI 2024-25 data matches by risk score for data matches in key reports, at end of July 2025

Data match area	All data matches	Very high risk	High risk	Medium risk	No risk score
Creditors	1,674	337	1,337	0	0
Payroll	355	57	54	106	138
Procurement	118	0	0	0	118
Total number of data matches	2,147	394	1,391	106	256

Source: Audit Wales analysis of NFI web-application data



Teitl adroddiad: <i>Report title:</i>	PUBLIC - Local Counter Fraud Service Q2 Report 2025/2026			
Adrodd i: <i>Report to:</i>	Audit Committee			
Dyddiad y Cyfarfod: <i>Date of Meeting:</i>	Tuesday, 21 October 2025			
Crynodeb Gweithredol: <i>Executive Summary:</i>	<p>This report provides a Q2 2025/26 update on Local Counter Fraud Service activity.</p> <p>Reactive Work: 16 cases were concluded in Q2, with 19 remaining open at the end of the quarter. Progress was made on a number of cases with two interviews under caution taking place and 6 referrals made to regulatory or enforcement agencies. No cases were referred to NHS CFS Wales in Q2. Sanctions included disciplinary action and voluntary recovery.</p> <p>Proactive Work: Staff engagement continued to progress via intranet content and a successful second counter fraud clinic at Ysbyty Glan Clwyd. A Local Proactive Exercise (LPE) was completed on Travel Expenses and two further LPE's commenced.</p> <p>Training: Compliance remains high at 90.32%</p>			
Argymhellion: <i>Recommendations:</i>	The Audit Committee is asked to consider and note the contents of the report.			
Arweinydd Gweithredol: <i>Executive Lead:</i>	Mr. Russell Caldicott – Interim Executive Director of Finance			
Awdur yr Adroddiad: <i>Report Author:</i>	Mrs Danielle Kerr-Timmins – Head of Local Counter Fraud Service			
Pwrpas yr adroddiad: <i>Purpose of report:</i>	I'w Nodi <i>For Noting</i> <input type="checkbox"/>	I Benderfynu arno <i>For Decision</i> <input type="checkbox"/>	Am sicrwydd <i>For Assurance</i> <input checked="" type="checkbox"/>	
Lefel sicrwydd: <i>Assurance level:</i>	Arwyddocaol <i>Significant</i> <input type="checkbox"/> Lefel uchel o hyder/tystiolaeth o ran darparu'r mecanweithiau / amcanion presennol <i>High level of confidence/evidence in delivery of existing mechanisms/objectives</i>	Derbyniol <i>Acceptable</i> <input checked="" type="checkbox"/> Lefel gyffredinol o hyder/tystiolaeth o ran darparu'r mecanweithiau / amcanion presennol <i>General confidence / evidence in delivery of existing mechanisms / objectives</i>	Rhannol <i>Partial</i> <input type="checkbox"/> Rhywfaint o hyder/tystiolaeth o ran darparu'r mecanweithiau / amcanion presennol <i>Some confidence / evidence in delivery of existing mechanisms / objectives</i>	Dim Sicrwydd <i>No Assurance</i> <input type="checkbox"/> Dim hyder/tystiolaeth o ran y ddarpariaeth <i>No confidence / evidence in delivery</i>
Cyfiawnhad dros y gyfradd sicrwydd uchod. Lle bo sicrwydd 'Rhannol' neu 'Dim Sicrwydd' wedi'i nodi uchod, nodwch gamau i gyflawni sicrwydd 'Derbyniol' uchod, a'r terfyn amser ar gyfer cyflawni hyn:				

Justification for the above assurance rating. Where 'Partial' or 'No' assurance has been indicated above, please indicate steps to achieve 'Acceptable' assurance or above, and the timeframe for achieving this:	
Cyswllt ag Amcan/Amcanion Strategol: Link to Strategic Objective(s):	Building an Effective Organisation
Goblygiadau rheoleiddio a lleol: 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 EqlA yn angenrheidiol ac a gafodd ei gynnal? In accordance with WP7 has an EqlA been identified as necessary and undertaken?	No Equality Assessment is not required to be carried out, as this report is administrative in nature and reports the quarterly progress relating to Fraud, Bribery and Corruption. <u>Gweithdrefn ar gyfer Asesu Effaith ar Gydraddoldeb WP7</u> <u>WP7 Procedure for Equality Impact Assessments</u>
Yn unol â WP68, a oedd SEIA yn angenrheidiol ac a gafodd ei gynnal? In accordance with WP68, has an SEIA identified as necessary been undertaken?	No Socio-economic Impact Assessment is not required to be carried out, as this report does not deal with Health Board's strategic decisions. <u>Gweithdrefn WP68 ar gyfer Asesu Effaith Economaidd-Gymdeithasol.</u> <u>WP68 Procedure for Socio-economic Impact Assessment.</u>
Manylion am risgiau sy'n gysylltiedig â phwnc a chwmpas y papur hwn, gan gynnwys risgiau newydd (croesgyfeirio at y BAF a'r CRR) Details of risks associated with the subject and scope of this paper, including new risks(cross reference to the BAF and CRR)	CRR 25-08 Non-Compliance with Regulatory and Legislative Requirement
Goblygiadau ariannol o ganlyniad i roi'r argymhellion ar waith Financial implications as a result of implementing the recommendations	No recommendations
Goblygiadau gweithlu o ganlyniad i roi'r argymhellion ar waith Workforce implications as a result of implementing the recommendations	No recommendations

<p>Adborth, ymateb a chrynodeb dilynol ar ôl ymgynghori</p> <p><i>Feedback, response, and follow up summary following consultation</i></p>	<p>The paper has been subject to Executive review and sign off.</p>
<p>Cysylltiadau â risgiau BAF: (neu gysylltiadau â'r Gofrestr Risg Gorfforaethol)</p> <p><i>Links to BAF risks:</i> <i>(or links to the Corporate Risk Register)</i></p>	
<p>Rheswm dros gyflwyno adroddiad i fwrdd cyfrinachol (lle bo'n berthnasol)</p> <p><i>Reason for submission of report to confidential board (where relevant)</i></p>	<p>N/A</p>
<p><i>Next Steps:</i></p> <p>The Committee is required to note the contents of the Q2 Local Counter Fraud Service Progress Report.</p>	
<p><i>List of Appendices:</i></p> <p><i>Appendix A – Counter Fraud Progress Dashboard Q2 25/26</i> <i>Appendix B – Local Proactive Exercise – Travel Expenses Home to Base</i></p>	

Local Counter Fraud Service Progress Report Q2 2025-26

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 Work

2.1 Cases

	Q3 24/25	Q4 24/25	Q1 25/26	Q2 25/26
Open Cases at close of Q	38	22	27	19
Cases closed during Q	16	8	17	16

Reactive counter fraud work is ongoing, with 19 open cases remaining at the end of Q2. Of these, 67.67% have shown significant progress since the last Audit Committee update which is an improvement from 30% in Q1.

During Q2, 16 cases were concluded.

A dashboard detailing the progress of cases is provided in Appendix A.

3. Proactive Counter Fraud Work

Engagement:

Engagement efforts continued during Q2, with several posts published on the intranet focusing on education and deterrence. Articles included information articles on salary overpayments, secondary employment and petty cash, a deterrence article relating to a GP Practice Manager convicted of fraud (salary diversion) and a psychiatrist convicted of fraud relating to false qualifications, and scam alerts affecting staff.

These generated a significant increase in staff interaction, with site views rising from 235 in Q4 2024-25 to 1,644 in Q1 and 1,785 in Q2 2025-26.

A second 'Counter Fraud Clinic' took place at Ysbyty Glan Clwyd on the 10th of September 2025. We were pleased to engage with 301 attendees, who received QR code cards and informative leaflets on how to report fraud. The second event of this financial year was a great success with requests made by managers for targeted training which will be arranged in the coming months.

Training:

Training compliance remains strong, with 90.32% of staff compliant with the mandatory e-learning. Additionally, two presentations were delivered to staff during the period. The main counter fraud awareness presentation has seen a substantial update to ensure it remains current, engaging, and better suited to staff needs.

Proactive Exercises:

In Q2, a Local Proactive Exercise was completed relating to travel expense claims across the organisation, with a focus on home-to-base mileage and high-value general mileage claims.

A further two Local Proactive Exercises were opened in Q2 focusing on private patients being treated on BCUHB premises and opportunities for fraud in high-risk roles whilst working from home.

A summary report for all reactive and proactive work completed during Q2 has been provided in Appendix A.

4. Other

4.1 Direct Payments for Personal Health Budgets:

The Counter Fraud Team is assisting Finance colleagues in identifying any fraud related risks and necessary prevention for Welsh Government's intention to introduce direct payments for Personal Health Budgets for continuing healthcare. Training has been offered by the NHS Counter Fraud Authority which has been shared with finance and CHC colleagues. The All-Wales Counter Fraud Leads Group will nominate a member to ensure the recommendations are made on an all-Wales level to help inform policy.

4.2 Failure to Prevent Fraud, Economic Crime and Corporate Transparency Act 2023:

The Failure to Prevent Fraud offence is now in place as of the 1st September 2025. BCUHB has a solid governance framework and cultural commitment to countering fraud which would provide sufficient evidence for a defence from prosecution. Some critical gaps remain, especially relating to the incomplete organisational fraud risk assessment and lack of resourcing for proactive fraud prevention.

The need for additional staffing resource for Counter Fraud has been highlighted as a factor to address the risk. The risk relating to the Failure to Prevent Fraud Offence has been added to Datix (Risk ID 5630).

In order to address the gaps, the following measures are being taken:

- Following advice from the Head of Risk Management, a programme of work is being led by the Head of Local Counter Fraud to facilitate a task and finish group to ensure a full organisational fraud risk assessment is completed and continually reviewed. The group will consist of representatives from across the organisation who will act as risk owners for fraud risks in their area of responsibility, and will work with the Counter Fraud Team to score and identify current control measures and further mitigation required to address risks.
- The Chief Finance Officer for Corporate Services has been tasked with identifying opportunities for funding within the Finance Budget to address the feasibility of additional staffing within the Counter Fraud Team.

4.3 Controlled Document Fraud Review

To ensure greater oversight of controlled document fraud proofing in future, the Head of Local Counter Fraud is now a standing member of the Executive Policy Oversight Group.

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 Q2 25-26

Cases Under Investigation

19

Referrals Received

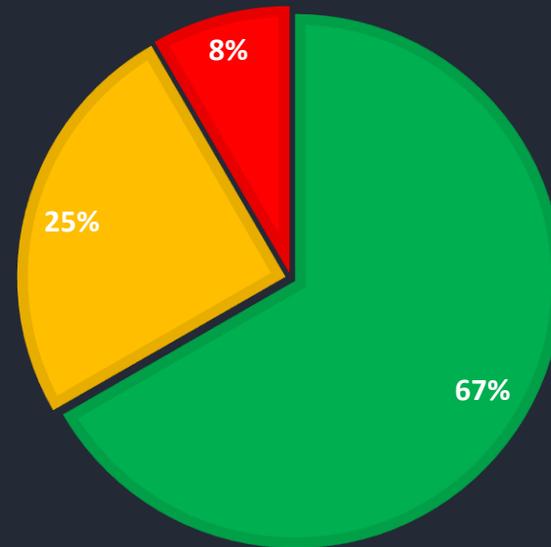
8

Interviews Under Caution

2

PROGRESS SINCE LAST UPDATE

■ Good ■ Acceptable ■ None



Subtype	Cases
Timesheet/overtime fraud	7
Working Whilst Sick	6
Employee Fraud - Other	4
NHS Patients - Misuse of services	2
Post contract fraud - Invoicing fraud	2
Dispensing fraud - Patient services	1
Employee declaration	1
Employee insider issues	1
GP Practice - Diversion of global sum	1
GP Practice - Prescribing	1
GP Practice staff - diversion of funds	1
Identity Fraud	1
NHS Patients - Charge evasion	1
Staff Collusion - Breach of procurement rules	1
Staff collusion - Bribery	1



Investigation Outcomes – Q2 25-26

Cases Closed

16

Referrals to Other Agency

6

Loss Identified

£12,789.25

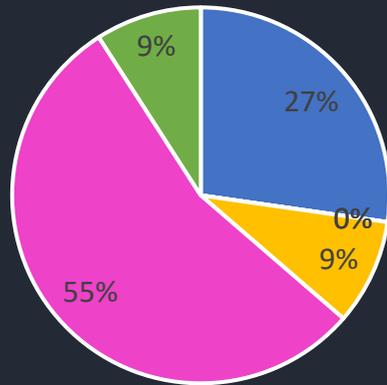
Loss Recovered

£91.95

Loss Prevented

£56,339.86

SANCTIONS/OUTCOMES



- Disciplinary
- Criminal Prosecution
- Caution/ Community Resolution
- Civil Recovery
- Referral to Other Agency
- DoI Requested

Fraud Identified in
35.29%
Of Cases

Sanctions/Outcomes
Applied
10

Average Days to Investigate
242



Proactive Work – Q2 25-26

E-Learning Training Compliance

90.32%

Risk Reviews

11

Presentations

4

Media Reports

28

System Weakness
Reports Completed

4

Local Proactive
Exercises Completed

1

Local Proactive
Exercises in Progress

2

Engagement Events
(People Seen)

323

