Bundle Audit Committee 18 July 2024

1 PRELIMINARY MATTERS

1.1 09:30 - AC24.88 Apologies for absence
Sjef Molmans (BCUHB - Finance)

1.2 09:31 - AC24.89 Declarations of Interest

1.3 09:32 - AC24.90 Unconfirmed minutes of the meeting held on 7th May 2024
AC24.90 - Draft Minutes AC 07.05.24 - Public session NC V0.4docx

1.4 09:37 - AC24.91 Action Log and matters arising not covered on the agenda
AC24.91 - Public Session - Audit Committee - Action Log

1.5 09:42 - AC24.92 Notification of matters referred from other Committees

1.6 09:44 - AC24.93 Items considered in Private Audit Committee
Pam Wenger, Director of Corporate Governance
Recommendation - The Committee is asked to note the report.
AC24.93 - Private session items reported in public

2 GOVERNANCE

2.1 09:46 - AC24.94 Effective Governance – Integrated Health Community (IHC) Central - Final Internal Audit Report
Libby Ryan-Davies - Integrated Health Community Director (central) in attendance.
Please see Agenda item AC24.101 - Appendix 6 to view the Final Internal Audit Report.

2.2 10:08 - AC24.95 To receive a report from NHS Shared Services Partnership on 23/24 Annual Procurement Assurance
Russel Caldicott, Interim Executive Director of Finance
Wyn Owens - NWSSP, Head of Operational Procurement & National Sourcing, in attendance to present.
Recommendation - The Audit Committee is asked to discuss the content, and to note the report.
AC24.95a -NHS Wales Shared Services Partnership -Annual Assurance Report (Procurement)2324
AC24.95b - NHS Wales Shared Services Partnership - Annual Assurance Report (Procurement) 2324

2.3 10:30 - AC24.96 Risk Management
Pam Wenger, Director of Corporate Governance/Nesta Collingridge, Head of Risk Management
Recommendation -
The Audit Committee is asked to endorse:
1. The management response of Internal Audit report.
2. The recommendations made around the Risk Scrutiny Group and key updates and changes to the Risk Framework and Procedures.
3. The Corporate Risk Register.
AC24.96a - Risk Report and Corporate Risk Register July 24 v1
AC24.96b- Appendix 1 BCUHB Final Internal Audit Report Risk Management
AC24.96c - Appendix 2 Corporate Risk Register 19 June v1 PW
AC24.96d - Appendix 3 RM01 - Risk Management Framework - July Edits v3 for AC
AC24.96e - Appendix 4 RM02 - Risk Management Procedures July Edits

2.4 10:35 - AC24.97 Breaches of SFIs and Scheme of Delegation
Russel Caldicott, Interim Executive Director of Finance - Verbal update.

2.5 10:45 - AC24.98 Standards of Business Conduct
Pam Wenger, Director of Corporate Governance
Recommendation - the Audit Committee are asked to:
· Note the Internal Audit and its findings
· Note the actions proposed to address the issues raised
AC24.98a - Audit Committee - Paper on SOBC IA - V1.0
AC24.98b - Appendix B - Final Internal Audit Report Standards of Business Conduct

2.6 10:55 - COMFORT BREAK

3 FINANCIAL FOCUS

3.1 11:05 - AC24.99 To receive an annual report from NHS Shared Services Partnership on Post Payment Verification 2023/2024
Russel Caldicott, Interim Executive Director of Finance
Recommendation - The Audit Committee is asked to review, note and seek assurance that the Post Payment Verification cycle is being managed appropriately.

AC24.99 - NHS Wales Shared Services Partnership-Post Payment Verfication Annual Assurance Report 2324

3.2 11:20 - AC24.100 SFI Conformance Report - Quarter 1 24/25
Russel Caldicott, Interim Executive Director of Finance
Recommendations - the Audit Committee is asked to:
1. To note and discuss the below elements of performance
· Purchase orders that are non-compliant with SFI's
· E-Waiver System Developments and Single Waivers
· Receivables and conformance with payroll procedures
· Payables and conformance with Public Sector Payment Policy (PSPP)
2. Approve the Losses and Special Payments (April to June 2024)

AC24.100 SFI - Audit Committee - Conformance Report Q1 2024-25

4 INTERNAL AUDIT

4.1 11:35 - AC24.101 To receive the Internal Audit Progress Report
Pam Wenger, Director of Corporate Governance
Dave Harries, Head of Internal Audit, CMIIA, QiCA
Nicola Jones, Deputy Head of Internal Audit, CMIIA
Recommendations - The Audit Committee is asked to:
Receive the progress report.
Approve changes to the plan for the Grievance Management and Business Cases: Capital and Revenue reviews.
Please note: to view;
· Appendix 2: Risk Management report - please refer to Agenda Item Ref: AC24.96b
· Appendix 4: Standards of Business Conduct - Declarations of Interest, Gifts and Hospitality report - please refer to Agenda Item Ref: AC24.98

AC24.101a - IA Progress Report Cover Sheet July 24FC
AC24.101b - Appendix 1 - BCUHB Audit Committee progress report July 2024
AC24.101c - Appendix 3 - BCUHB Final Internal Audit Report Health and Safety
AC24.101d - Appendix 5 - BCUHB Final Internal Audit Report_Budgetary Control_2324
AC24.101e - Appendix 6 - BCUHB Final Internal Audit Report - Governance IHC Central
AC24.101f - Appendix 7 - BCUHB Final Internal Audit Report Discharge Arrangements D2RA
AC24.101g - Appendix 8 - BCUHB Final Internal Audit Report Operating Model

4.2 11:55 - AC24.102 Internal / External Audit Tracking Progress Report - Report
Pam Wenger, Director of Corporate Governance
Recommendations - the Audit Committee is asked to:
· Approve the changes to the proposed new processes around the introduction of new External and Internal Audit Reports to the Health Board.
· Approve the changes to the proposed new audit recommendation closure approval process.
· Note the current position with regards to no' and 'limited' assurance recommendations, and all open recommendations.
· Note the Audit recommendations proposed for closure.
· Note the update on next steps.

AC24.102a Audit Committee 18.07.2024 v0.05fc
AC24.102b - Appendix 1 - Closure summary table v0.01

5 EXTERNAL AUDIT

5.1 12:15 - AC24.103 Audit & Risk Committee Update - Report
External Audit Lead to present.

AC24.103 - BCU Audit Committee Update 03072024

5.2 12:35 - AC24.104 National audit reports for information
External Audit Lead to present.

AC24.104a - BCUHB Discharge Planning Local Report for HB - FINAL
AC24.104b - NW Regional Report - Managing Flow out of Hospital_FINAL (1)

6 CLOSING BUSINESS

6.1 12:55 - AC24.105 Agree Items for referral to Board / other Committees
Chair

6.2 12:56 - AC24.106 Chairs Assurance Report
To agree items for inclusion in the report;
To agree any items for escalation/referral to Board/Committees

6.3 12:57 - AC24.107 Review of Meeting Effectiveness

6.4 13:02 - AC24.108 Date of Next Meeting - 2.9.24

6.5 13:03 - AC24.109 Exclusion of press and public

Betsi Cadwaladr University Health Board (BCUHB)
Draft Minutes of the Audit Committee

7 May 2024, Boardroom, Carlton Court, St Asaph

Present	
Name	**Title**
Karen Balmer	Independent Member (IM), Chair
Urtha Felda	Independent Member
Dyfed Jones	Independent Member - Via VC Link
Rhian Watcyn Jones	Independent Member - Via VC Link
In attendance	
Andrea Hughes	Interim Director of Finance
Andrew Doughton	Audit Lead, Audit Wales
Dave Harries	Head of Internal Audit
Dyfed Edwards	Health Board Chairman
Jody Evans	Corporate Governance Officer – Secretariat
Karl Woodward	Head of Counter Fraud
Matt Edwards	Audit Lead, Audit Wales
Nesta Collingridge	Head of Risk Management
Nicola Jones	Deputy Head of Internal Audit - Via VC Link
Pam Wenger	Director of Corporate Governance
Paolo Tardivel	Director of Transformation & Improvement *(Part Meeting)*
Philippa Peake Jones	Head of Corporate Affairs
Russell Caldicott	Interim Executive Director of Finance
Sjef Molmans	Local Counter Fraud Specialist

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Agenda item	Action
AC24.57 PRELIMINARY MATTERS	
AC24.57.1 Welcome, introductions and apologies for absence AC24.57.2 The Chair of the Committee welcomed everyone to the meeting, including the newly appointed Committee Member: Independent Member (RWJ) AC24.57.3 Apologies received from Nick Lyons – Executive Medical Director. AC24.57.4 – The Chair acknowledged the Head of Counter Fraud upon his upcoming retirement and long term membership on the Committee. The members and attendees expressed appreciation.	
AC24.57.2 Declarations of interest on current agenda AC24.57.2.1 No declarations of interest were made at the meeting.	
AC24.57.3 Minutes of previous meeting for accuracy AC24.57.3.1 **RESOLVED**: That; accordingly, the Minutes of the last meeting held on 15th March 2024 were confirmed as a correct record, subject to the change of the word *"review"* to *"conclude"* in the reference: AC24.44.1.3.	JE
AC24.57.4 Action Log and matters arising not covered on the agenda AC24.57.4.1 **RESOLVED**: That; updates to the summary action log be recorded therein. It was agreed to combine the actions in relation to the internal audit tracker and to keep this on the log until the Audit Committee were satisfied of the progress. AC24.57.4.2 The Director of Corporate Governance summarised the new approach to populate the Action Log, in advance of each Committee meeting. AC24.57.4.3 A brief discussion followed, with regards to Committee Chair oversight, communication and perspectives within the Health Board between the Committees.	

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AC24.57.5 Notification of matters referred from other Committees AC24.57.5.1 There were no matters referred from other Committees noted at the meeting. AC24.57.5.2 Chair expressed the need for clarity, to the agenda item title. The Director of Governance clarified the approach with regards to Committee Chair oversight.	
AC24.57.6 To note the items considered in the In-committee Audit Committee on 15th March 2024 AC24.57.6.1 **–** The Committee noted the items considered at the Private Audit Committee session held on 15th March 2024. AC24.57.6.2 The Director of Corporate Governance reported at future Committee Meetings, there would be a brief written report, listing the agenda items taken in "Private Session" to follow the stance of other Health Boards. AC24.57.6.3 It was agreed to update the terminology from "In committee" to "Private" in all Board and Committee Minutes and Agendas for consistency. AC24.57.6.4 It was further noted that the Counter Fraud Report was to be considered for incorporation within the public meeting in future where appropriate.	PW/PPJ PW/PPJ

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AC24.57.7 Audit Tracker: progress recommendations against External & Internal Audit Reports AC24.57.7.1 The Director of Corporate Governance presented the report, and it was agreed the way in which the tracking report was presented to the Committee was too complex and therefore, as part of refining and simplifying the approach, the report was the first iteration and invited comments from members of the Audit Committee. It was recognised that the system was evolving and it was confirmed that there was a standard operating procedure under development to simplify the system. AC24.57.7.2 The Director of Corporate Governance also reiterated the need for Executive Directors to have oversight and accountability, with regards to recommendations and timescales to provide updates to responses and closures. AC24.57.7.3 The Committee recognised the work underway and the frustration of the Internal Audit Team, in terms of updates and closures to recommendations. AC24.57.7.4 Feedback was invited from the Committee attendees and members. AC24.57.7.5 External Audit Leads emphasised the need for a clearer process for monitoring timeliness, performance, and principles on a case-by-case basis. It was agreed that the process for financial audits needed to be different to the proposal in 2.1 of the report. They acknowledged the challenges of an informal process and the need for tighter timescales, which would be raised with the Committee Finance Leads. AC24.57.7.6 The Head of Internal Audit expressed satisfaction with the standard operating procedure development, which could also strengthen engagement and facilitate escalations. The Committee also noted the lack of engagement from officers therein the past year, with regards to various outstanding recommendations. AC24.57.7.7 An Independent Member (IM – RWJ) informed the committee of her interest with regards to the process, in relation to the reporting of audit recommendations and the content of the report. The IM also raised concerns relating to the report appendices' small print and format. The Committee agreed to review the report for future reporting, in terms of accessibility. AC24.57.7.8 The Health Board Chair expressed satisfaction with the upcoming simplified process, whilst acknowledging the ongoing work and dangers of non-implementation of actions. The Committee agreed that relevant Executives should be held accountable for overdue recommendations and called to Committee as and when required.	AD-RC/AD PW

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AC24.57.7.9 The Director of Corporate Governance recognised and agreed the points raised, in relation to the historic format and position statement overview. It was confirmed that the Director and the Head of Internal Audit had discussed the system and format of the report content, along with the direction of travel. A brief overview was provided in terms of the updated report format, which was under review. The Director invited questions in relation to the closure of the recommendations presented. AC24.57.7.10 The Chair acknowledged the ongoing work and the streamlined approach. It was agreed for Chair and the Director of Corporate Governance to agree the flow of live recommendations in relation to Appendix 7 in the form of a simple table and for increased time upon agendas for reporting of updates. AC24.57.7.11 The Head of Internal Audit apologised for the backlog of closures and the Committee acknowledged the high level of limited assurance reports generated at year end. It was recognised that a reduction of recommendations was demonstrated, but severity of findings had increased. The importance of embedding governance of policies and procedures was raised for future reporting compliance. AC24.57.7.12 The Health Board Chair acknowledged the steep learning curve and the emphasis to close off historic actions. The Interim Executive Director of Finance expressed the importance of current Executive Leads engagement and new timeframes. An Independent Member (DJ) also commented upon the need for clear reporting and of the format being updated. AC24.57.7.13 The Head of Internal Audit confirmed the Team was open to discussion with Executive Leads, on mitigation controls and reasonable closures of recommendations. The Committee agreed that the focus was on reducing outstanding recommendations to improve the system of internal control. ***RESOLVED: The Committee*** ○ Considered the proposed new processes around the introduction of new External and Internal Audit Reports, along with the new audit recommendation closure approval process and development of a Standard Operating Procedure. ○ Noted the current position regarding open recommendations and those proposed for closure, and limited assurance recommendations. ○ Approved the closure of the January recommendations approved for closure by Internal Audit. ○ Approved for closure those recommendations which did not fall within the audit charter for internal audit approval. ○ Noted the Audit recommendations proposed for closure - to be presented to Internal Audit for review. ○ Noted current positions of overdue audit recommendations.	KB/PW

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AC24.57.8 Special Measures Update Paolo Tardivel - Director of Transformation & Improvement presented the update to the Committee. AC24.57.8.1 The Director summarised the overview of activity, and transition from the initial Stabilisation Phase and development of the longer-term plan. AC24.57.8.2 The overview also provided an update on the Special Measures response, Annual Planning Cycle, as part of the development of the 3-year plan, as agreed at the March Health Board Meeting. AC24.57.8.3 The Committee also received a summary update, against the Independent Reviews and conclusion of the discovery phase. AC24.57.8.4 The Director of Governance commented upon tracking of Special Measures though Committees, in relation to the context of the Annual Plan. A discussion took place and it was agreed to review the tracking process through the Committee structures in order to maintain oversight. **RESOLVED:** *The Committee* noted and received acceptable assurance for the Special Measures update and its transition into the Annual Delivery Plan, in terms of reporting, and the update regarding Independent Reviews.	PW/PT
AC24.58 RISK MANAGEMENT (including Board Assurance Framework)	

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AC24.58 Risk Management ***Pam Wenger, Director of Corporate Governance*** ***Nesta Collingridge, Head of Risk Management*** AC24.58.1 The Head of Risk Management presented the report and updated the Committee on the Chairs Assurance from the Risk Management Group held on the 9th April 2024, where the group reviewed the Board Assurance Framework (BAF) and Corporate Risk Register (CRR) along with the emerging risks. AC24.58.2 The Committee noted 2 key changes to the BAF; which included a scoring of 20, in relation to an Estates risk report, based on Annual Plan Deliverables. In addition, the Leadership risk aligned to the Annual Plan Deliverables was reduced to 12, which had been based on achievements to the milestones. Attention was also drew to risk ref CRR24-16 - Leadership, which was to remain at a 16. AC24.58.3 Members and attendees also noted the update in relation to the CRR; "Safeguarding" and a reduction in scoring from 16 to 12. It was noted that risk would continue to be monitored. AC24.58.4 The Committee were informed of a forthcoming Risk Management workshop, to include Board Members in identifying BAF risks and objectives. It was also noted that Committees continue to review assurance updates, as aligned to their sphere of activity and monitoring oversight. AC24.58.5 The Director of Governance drew attention to the progress of Risk Management and the plans in alignment to the Risk Management Framework and BAF. It was noted and agreed to; establish the requirement to review the reporting updates of the Risk Management Group, through to Executive Team Meetings. The frequency in relation to reporting of BAF and CRR at Committees, was taken as an action for review. AC24.58.6 A discussion took place in relation to oversight and function of the controls and updates to Committee Meetings. It was noted that discussions would continue at the Board Workshop, in order to discuss and review format and contents. AC24.58.7 Emphasis was raised on defining objectives, and setting expectations of the strategic objectives and measurement at year end, by the Head of Internal Audit. The Director of Corporate Governance acknowledged the point, that the long-term strategy and goals of the BAF include the review of the definitions, to ensure that they are SMART in nature.	PW/NC

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AC24.58.7.1 Following comment made by the Interim Executive Director of Finance, it was agreed to update the relevant Finance Risks 24.05 and delivery to the financial plan. It was noted that financial sustainability visibility was also under review, in relation to being placed upon the risk register. AC24.58.8 An Independent Member (UF) drew attention to item ref CRR24-01 – requiring to be updated to 16 not12. The Independent member also expressed support to the Head of Internal Audit, in relation to the definitions of objectives and the requirement for clarification. AC24.58.9 The Chair expressed again that the Health Board Committees should not be utilised as a line of assurance, the Committee agreed. Attention was also raised in relation to SP14 and the due date, in relation to capital. It was agreed for existing due dates to be left extant, along with updated due dates therein. It was agreed that the additional controls should be linked through to the Actions necessary to mitigate the risks. The Chair requested that all additional controls were carried through to actions as some were not, and to ensure that narratives were accurate, citing "a vacancy" was not a control but recruiting to a vacancy was. The Chair also expressed concern regarding a target risk score of 1 in planned care. This had was also been noted by the Head of Risk Management and the intention was to revise the target risk, which had been discussed with the relevant lead. AC24.58.10 The Health Board Chair commented upon risk, in relation to education to mitigate, along with ownership and how the Health Board progress risks to completion and delivery. A discussion ensued with regards to trends and ownership in relation to Audit Tracking. **RESOLVED:** *The Committee* noted and received assurance for: ○ The Chair's Assurance Report from the Risk Management Group held on the 10th April 2024. ○ The Board Assurance Framework, Corporate Risk Register, Divisional Risk Registers, and emerging risks. ○ Endorsing the changes around the Board Assurance Framework and realigningment to the objectives of the Health Board, recently approved at the March Board Meeting. ○ Endorsed the closure of the 23/24 BAF noting that the development of the 24-27 BAF will be an iterative process. ○ Support of the approach to consider the frequency on the reporting of the Board Assurance Framework, as part of a Board Development Session on Risk Management.	RC NC
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AC24.59 Breaches of SFIs and Scheme of Delegation AC24.59.1 No update received. Item taken within Private Session.	

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AC24.59.2 23/24 Annual Conformance Report **(1 April 23 - 31 March 24)** ***Russell Caldicott - Acting Executive Director of Finance*** ***Andrea Hughes - Interim Director of Finance*** AC24.59.2.1 The Interim Director of Finance introduced the report, and provided the verbal overview of the key items. AC24.59.2.2 The Committee noted the year-end report relating to the performance figures. The Committee also discussed items of non-compliance in relation to Purchase Orders with Standing Financial Instructions, the E-Waiver System Developments and Single Tender Waivers. AC24.59.2.3 Receivables and conformance with payroll procedures had also been noted, along with Payables and conformance in relation to the Public Sector Payment Policy. The Committee Chair also discussed with the Interim Director or Finance the consequential loss of £1,519.08, pending final repair works. The Interim Executive Director also commented upon areas where queries arose. AC24.59.2.4 An Independent Member (RWJ) referred to compliance with procedures in terms of financial instructions and procurement, and acknowledged that movement was in the right direction. AC24.59.2.5 The Independent Member also queried overpayments being created via the payroll system. The Interim Executive of Finance confirmed that overpayments had been made as a result of the staff member not having been removed from the system. It was highlighted for termination documentation to be timely upon departure, in order to prevent further payments being made. AC24.59.2.6 The Head of Internal Audit and Chair of the Committee referred to outliers in relation to Purchase Order (PO) breaches. The Interim Executive of Finance provided an overview into the circumstances and reduction in compliance with policies and procedures, which was being raised within the wider leadership teams in relation to training and development. AC24.59.2.7 The Chair and Interim Director of Finance briefly discussed payables and the comparison of the detail, value and volume, to the previous year end, it was agreed for the Interim Executive Director to communicate the detail to the Chair following the meeting. AC24.59.2.8 Chair also queried a losses and special payment item from the year 2008/9 relating to the resolution. It was confirmed that the item was “open” in status.	RC

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AC24.59.2.9 The Director of Corporate Governance acknowledged the new e waiver system and the significant reductions, The Interim Executive Director of Finance confirmed that the details of approvals were incorporated therein the report within appendix 1, which allowed for oversight and assurance. AC24.59.2.10 The Health Board Chair thanked the Finance Team for their significant work, and emphasised the importance of learning and development in the future. AC24.59.2.11 The Chair of the Committee also drew attention to the e waiver system and noted that there were some concerns raised in a previous Internal Audit report. The Head of Internal Audit clarified that the review had been undertaken in October 2023 and progress had been made since the report had taken place. The Head of Internal Audit stated that the expectations of the system was being tested in due course for assurance by Internal Audit accordingly, in order to mitigate risks aligned to the system processes. AC24.59.2.12 Following discussion, the Interim Executive Director of Finance strongly advised the committee that the Health Board would not revert back to the paper based system. The Committee agreed. AC24.59.2.13 An Independent Member (RWJ) referred to the table of debts, it was suggested to brief the Committee within Private Section, in response to the repayment system. AC24.59.2.14 Chair raised a final query in relation to the table showing the payable balances over 6 months old, with regards to a debt due within the 2022/2023 financial year. It was confirmed that additional correspondence detail in the further action column was to be included within a Quarter 1 update report to the Committee to provide evidence of progress. **RESOLVED:** The Committee noted and discussed: ○ Non-compliance of Purchase orders with Standing Financial Instructions. ○ The E-Waiver System Developments and Single Tender Waivers. ○ Receivables and conformance with payroll procedures. ○ Payables and conformance with Public Sector Payment Policy. ○ The Committee approved the Losses and Special Payments Report from (January to March 2024) and the Committee approved a consequential loss of £1,519.08.	RC

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AC24.59.3 Agree the content of the Annual Accounts meeting of the Audit Committee (Meeting to be held on 21 May 2024) AC24.59.3.1 The Committee discussed and agreed the draft end of year content for the Private Meeting scheduled for 21 May 2024. It was confirmed that it was not a Workshop or Development Session. AC24.59.3.2 It was agreed for the Draft Annual Governance Statement (AGS) be provided in advance of the meeting, to Internal and External Audit for comment. It was also agreed to provide the full submission of the AGS to the July 2024 Committee Meeting. AC24.59.3.3 The Head of Counter Fraud informed the Committee that the Functional Standard Fraud Return was to be approved by the Committee Chair and Interim Executive Director of Finance by 31st May. Due to the Chairs leave the Chair needed to approve the return by 21st May 2024. It was agreed for the item to be included within the 21 May Committee meeting for wider discussion. .	PPJ/PW KW
AC24.60 INTERNAL AUDIT	

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AC24.60.1 To receive the Internal Audit Progress Report and Internal Audit Reviews Limited/No Assurance Reports in Full AC24.60.1.1 The Head of Internal Audit provided the report to the Committee and informed the attendees of an error on the agenda stating a surname of *Thomas* which should have read *Jones*. AC24.60.1.2 The Committee were informed of the shorter reporting period within the report timeline. An overview of data within the report was presented. The Head of Internal Audit drew attention to the main oversight of reports (draft and complete), which had been issued for the year 2023/24 relating to the key themes of compliance, governance and risk management and reporting. The image also provided the levels current assurance, and attention was drawn to the number of limited and unsatisfactory audits for the period. AC24.60.1.3 The Head of Internal Audit also provided a detailed overview with regards to assurance ratings over the last 5 years. The Committee noted the assurance levels reported therein the report. AC24.60.1.4 The Committee then received an update in relation to the Executive Summaries. It was reported that the Special Measures Audit had had been taken through the relevant Committees, along with the Management Response. It was recognised that the report was now within the public domain. It was noted that there had been areas of concerns, however there had been movement to progress the actions required. It was recognised that a follow up would take please within October 2024. AC24.60.1.5 The Deprivation of Liberty Safeguards (DoLS) Limited Assurance report was also received, the Committee acknowledged the amount of excellent engagement by the Team, which had been recognised by the Head of Internal Audit. The Committee had been presented with the details of the management response. Chair commented upon the excellent feedback on the engagement of the DoLS Team. The Director of Corporate Governance informed the Committee that the report was also discussed at the Mental Health Act and Compliance Committee. AC24.60.1.6 The Work in Progress summary was presented to the Committee. Chair expressed disappointment to see a seeming lack of progress on Health & Safety and the Operating Model reviews. The Director of Corporate Governance acknowledged the actions, and confirmed that work had been followed up in relation to both Health & Safety and the Operating Model. It was agreed for the responses to be submitted to Internal Audit, along with the Chair of Audit Committee as soon as possible. AC24.60.1.7 The Head of Internal Audit drew attention and expressed disappointment to the request for the deferment of the Contracted patient	PW

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services: Quality and safety arrangements (Follow up) review from the 2024/25 to the 2025/26 plan. It was explained that the follow up review had recently been agreed by the Executive team and subsequently at the March 2024 Audit Committee. The Chair reminded the Committee of the no assurance report that had been received in May 2023. AC24.60.1.8 A discussion took place with regards to quality, safety and commissioned services. The Director of Corporate Governance provided an overview of the service elements and progression of the work. The Interim Executive Director of Finance explained that the opportunity to embed the newly approved framework would require time to implement, which was to allow the follow up to take place, by the end of the 2024/2025. 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 Quality, Safety and Experience Committee of this decision to defer by 6 months and for the QSE committee to drive progress on recommendations from the May 23 report. AC24.60.1.9 Performance indicators to report turnaround time was noted as green in status. However, the Head of Internal Audit envisaged and alerted the Committee that the status could reduce to Amber. It was explained that the response time for BCUHB was a 20 day ruling, as opposed to 15 for other Health Boards and Shared Services. The Chair agreed to retain the 20 days at present, but that the Committee would keep this under review expecting this to revert to 15 once the backlog of recommendations was cleared. AC24.60.1.10 An Independent Member (RWJ) referred to Limited Assurances relating to the Lessons Learnt Report dated July 2023, and the follow up progress to date. It was confirmed that the Internal Audit Tracker would provide the updates against relevant due dates. The Independent Member envisaged Impact Assessments being undertaken, it was noted that the pathway to gaining insight into the recommendations would progress in the usual manner. It was noted that the Chair of Audit Committee would raise within the Health Board Chairs Meeting, as an emerging topic. The Head of Internal Audit confirmed that the date of the follow up report would be undertaken following the risk assessment outcome. AC24.60.1.11 The Health Board Chair commented upon the areas of work undertaken, whilst acknowledging the need to follow procedures, and also to provide a wider message out to staff, in relation to efforts and challenges in getting things right. The Interim Executive Director of Finance also commented upon the number of limited assurance reports and delivery of assurance in relation to progression and visibility of the tracker system. ***RESOLVED:*** *The Committee:*	PPJ KB

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○ Received and noted the progress report, along with details pertaining to reports issued in draft and work in progress. ○ Noted the backlog of closures relating to audit recommendations. ○ Approved a 6 month deferment of the Contracted patient services: Quality and safety arrangements (follow up review) but on the basis that this would take place in the latter part of the current financial year.	
AC24.61 EXTERNAL AUDIT	

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AC24.61.1 Audit & Risk Committee Update AC24.61.1.1 The Audit Wales Lead (ME) provided the routine update to the Committee (for noting), in relation to External Audit pertaining to the Committee. AC24.61.1.2 The summary report provided the status and update of current and planned accounts, performance, and the status of current and planned audits. AC24.61.1.3 The Audit Wales Lead informed the Committee of the link to the good practice website therein the report, and informed the Committee of an awareness event in Cardiff along with a subsequent session in the Autumn in North Wales. Committee members were encouraged to attend the event in North Wales. AC24.61.1.4 It was also noted that the BCUHB Draft Annual Accounts had been received and work was in progress, along with Charitable Funds accounts being signed by the Auditor General. AC24.61.1.5 The Audit Lead (AD) then presented a report in relation to performance, and addressed detail in relation to the Financial Efficiencies Review and the informal feedback provided. It was also noted that the Workforce Planning Report had been finalised and presented to the relevant Committee, along with the Unscheduled and Planned Care review which had also been noted and was in the process of being completed. AC24.61.1.6 The Committee acknowledged the ongoing work and the positive partnership working. A discussion ensued with regards to the performance with regards to unscheduled care; it was confirmed that the Audit Lead (AD) would update Chair accordingly. It was also noted that the Corporate Governance Director would share the draft reports with members. **RESOLVED:** • Noted the update from External Audit in relation to the accounting and performance work.	AD PW

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AC24.61.2 Structured Assessment for 2023 AC24.61.2.1 The Audit Wales Lead (AD) provided the summary overview to the Committee. AC24.61.2.2 The review included a focus on corporate governance Arrangements, along with planning, financial strategy, delivery and board effectiveness. Key points and positive challenges since 2023 were highlighted. 8 Recommendations had been noted, and attention was drawn to the recommendations from previous years. It was noted that not all Audit Wales recommendations from 2023 had been added to the audit tracker. AC24.61.2.3 A query was raised by the Chair in relation to tracking of recommendations, along with systems to manage the process. A discussion ensued, it was agreed that progress against tracking of recommendations and regulatory reports would be provided to the Audit Committee, by the Director of Corporate Governance. It was also explained that the Health Board are reviewing other systems in relation to tracking systems. The deadline of the 31st July was raised. AC24.61.2.4 An Independent Member (RWJ) suggested that completion dates be provided therein the reports, against historical recommendations where they had not been complete. It was agreed that the Director of Corporate Governance would provide an update to the historical recommendations at a future meeting. AC24.61.2.5 Chair also raised a question with regards to the measurement of recommendations and impacts as noted in sections 68 – 72 of the report and recommendation 4. Priorities and areas for review were discussed and it was suggested to pilot an area to demonstrate recommendation impacts. AC24.61.2.6 The Director of Corporate Governance confirmed that the Board had received a copy of the draft Structured Assessment report, and it was agreed that the Annual Audit Letter would be provided as an appendix to the document at the next Health Board Meeting. It was also agreed to include the Structured Assessment bi monthly on the Audit Committee Cycle of Business to ensure the delivery of recommendations.	PW PW PW

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AC24.61.3 Workforce Planning Report AC24.61.3.1 The Audit Wales Lead (AD) provided the report to the Committee and confirmed that it had been presented to the People and Culture Committee on the 11th April 2024. AC24.61.3.2 As Chair of the People and Culture Committee, Independent Member (DJ) informed the Audit Committee of the productive discussion with regards to the report taken at the recent Meeting, along with the positive approach to progress the recommendations. A discussion took place with regard to the high level overview with relating to tracking of progress, against the report and the recommendations made along with Executive and Officer oversight. **RESOLVED**: • The Committee noted the final report, which provided detail into the reviews, key findings and recommendations.	

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AC24.61.4 Audit Plan 2024

AC24.61.4.1 The Audit Wales Lead (ME) presented the Detailed Audit Plan for the year 2024, which provided the Audit Committee with key detail into the forthcoming Audit Plan for the year, in relation to the accounts audit, fees, key dates and performance.

AC24.61.4.2 Key areas of focus had been summarised by the Audit Lead, in relation to significant financial statement risks, along with planned responses with regards to finance. The Audit Lead drew attention to Exhibit 1 and 2 within the report and associated risks were noted.

AC24.61.4.3 Attention was also raised in relation to the Annual Audit Fee, and it was confirmed that the fee rates for 2024-25 had increased by 6.4%, as a result of inflation to all organisations. The Committees attention was also drawn to the breakdown of audit fees.

AC24.61.4.4 Within the report, core members of the External Audit Team was also highlighted upon and reference had been made to junior member's relations with the Health Board, It was confirmed that any mitigations relating to the risk had been mitigated and would be monitored.

AC24.61.4.5 The Chair of the Committee acknowledged the update and expressed her duty in accordance with the Audit Committee Handbook to ensure value for money from the service. The fee rate increase was discussed in detail.

AC24.61.4.6 The Audit Wales Lead (AD) then presented the performance related elements of the report, along with key dates for delivery. The Audit Lead referred to the structured assessment approach, along with value for money and investment approaches into reviews and delivery of planned outputs. The scoping relating to the areas of the work and planned timescales were provided.

AC24.61.4.7 The Interim Executive Director of Finance expressed the need to review benefits verses realisation, whilst consideration to resources, along with the careful management to the financial stability of the Health Board. The Audit Wales Lead (AD) outlined the different approaches available to undertaking the work plans (e.g. past, present and future models). It was also discussed of the need for visibility and clear planning to the approach in terms of quality governance.

AC24.61.4.8 The Chair of the Committee queried the monetary value against the All Wales Thematic Review of Urgent and Emergency Care, and how the offset had been made. It was noted that the value would be classed as a refund.

DRAFT

AC24.61.4.9 The Interim Executive of Finance referred to Material costs, in relation to the low threshold position and asked the Committee to be aware of the low materiality threshold status. **RESOLVED:** The Committee received the Detailed Audit Plan for 2024.	
AC24.61.5 To receive a verbal update on : **AC24.61.5.1 National Audit Reports -** An External Audit Lead (AD) summarised the high level review relating to the From firefighting to future-proofing – the challenge for Welsh public services | Audit Wales Report, which was published in February 2024. **AC24.61.5.2 National Accounts update for information -** An External Audit Lead (MJ) referred to a letter issued in February 2024, with regards to the Accounts Audit Approach. It was agreed to circulate to the Audit Committee for information. **AC24.61.5.3** The Interim Executive Director of Finance also referenced a potential pension benefits reduction, and referred to figures within a recent update taken at a recent Remuneration and Terms of Service Committee.	MJ
AC24.62 COUNTER FRAUD	

DRAFT

AC24.62.1 Local Counter Fraud - Verbal Report ***Karl Woodward Head Of Local Counter Fraud Services, Finance*** AC24.62.1.1 The Head of Counter Fraud thanked the Chair of the Audit Committee for the opportunity to provide the verbal update to the Committee. AC24.62.1.2 It was reported that the NHS Counter Fraud Authority would undertake a national exercise on Procurement Fraud. AC24.62.1.3 It was also reported that the Annual Report in relation to Counter Fraud was scheduled for presenting at the July 2024 Audit Committee. AC24.62.1.4 The Committee also acknowledged that the F03 BCUHB Counter Fraud Policy was due to be periodically reviewed and approved by August 2024. The approval process was discussed and it was agreed to include upon the Audit Committee Agenda in September. AC24.62.1.5 The Head of Counter Fraud informed the Committee of new legislation in Failing to Prevent of Fraud, which would be in effect by the end of the year. It was noted that the Counter fraud policy needed to be updated in relation to this. AC24.62.1.6 The Head of Counter Fraud also reiterated to the Committee of the Counter Fraud Functional Standard return, which was due for submission by the 31st May 2024. AC24.62.1.7 A discussion took place with regards to the Committee being provided with a written report in future at Public Session. It was agreed to discuss within Private session, in terms of the items for inclusion. AC24.62.1.8 In recognition of the imminent retirement of the Head of Counter Fraud, the Chair expressed the Committees appreciation and thanks for the service provided by him to the Committee and the Health Board over many years and wished him well for his retirement. **RESOLVED:** ○ The verbal update was provided and it was again highlighted of the requirement to update the Local Counter Fraud, Bribery and Corruption Policy. The approval route was noted and it was agreed to consider the Policy for final approval at the Committee in September along with the Annual Report relating to Counter Fraud. ○ It was agreed to provide a written report with regards to Counter Fraud to future Committee Meetings.	Agenda Item Sept 2024 PW/KW

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CLOSING BUSINESS	
AC24.63.1 Agree Items for referral to Board / other Committees Chair - for information **AC24.63.1.1** Items for referral to other Committees were agreed as follows: *It was discussed to include;* Board Assurance Framework, Corporate Risk Register items, Audit Tracker reporting, and Contracting of Patient Services review and follow up. A discussion also ensued with regards to elements with regards to health and safety, risk oversight, tracking and annual accounts processes. **RESOLVED:** It was agreed to refer the relevant items to other Committees accordingly.	PPJ
AC24.63.2 Chairs Assurance Report **AC24.63.2.1** The items for inclusion were agreed. **RESOLVED:** The Items for the Chairs assurance Report would be included.	
AC24.63.3 Review of Meeting Effectiveness AC24.63.3.1 The Members and attendees discussed the effectiveness of the meeting. It was agreed that the sound quality was inadequate in parts of the meeting, along with inaccessibility of some documents. It was agreed that the quality of discussion had been good. The Chair requested that going forward the timings on the agenda take account of the appropriate length of time required for matters requiring a more in depth discussion. It was noted that agenda timings today did not reflect the actual time taken to discuss such matters. **RESOLVED:** The discussion and suggestions were noted.	
AC24.63.4 Date of Next Meetings AC24.63.4.1 - 21st May 2024 – Private Session. AC24.63.4.2 - 18th July 2024 – Full Committee Meeting.	

DRAFT

AC24.64 Exclusion of Press and Public **Resolution to Exclude the Press and Public –** "That 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."	

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Audit Committee - Public - Action Log

Open Actions						
Action No.	**Minute Ref.**	**Date**	**Agreed Action**	**Lead**	**Timescale**	**Status**
10.	**AC23. 93**	13/01/2024	**National Audit Report for information** - The Acting Board Secretary to add digital inclusion to the Exec agenda and update the Audit Committee through the matter arising.	Associate Director of Governance	Nov 2023	**Proposed for closure.** 7.5.24 - Proposed to close this action but to **update the Committee at the Audit Committee in July 2024.** Acting Board Secretary updated the Executive Team work plan - for inclusion by end of November 2023 **05.03.24** Tabled at the Executive Team (ET) Meeting of the 13 March 2024. *Proposed for closure* – Acting Board Secretary to confirm item is agreed at ET. **15.03.24** Item not agreed for closure - Closure of this item is dependent upon the work plan being agreed at the Executives Meeting. **16.04.24** – Item to be kept open – To continue to monitor and focus on historical data in relation to learning and progression. Associate Director of Governance (PM) has met with CDIO (DR) and agreed that this will be tabled at Informal Exec Team agenda for 15 May or 29th May 24 **22.5.24** - Associate Director to Governance to clarify closure detail.

Open Actions						
Action No.	**Minute Ref.**	**Date**	**Agreed Action**	**Lead**	**Timescale**	**Status**
11.	AC24. 16.1 & 2	11/01/2023	Lessons Learnt 'Make it safe reviews' system. The Interim Executive Director of Finance suggested the development be sighted in the Executive Team Meeting and that QSE has sight of the quality of the system.	Interim Executive Director of Finance	March 2024	**Proposed for closure.** **Action items Aligned together (Jan 23 and March 24) Items 11 and 2.** Update to the action to be provided at the 15 March Committee. 15.03.24 Item to be kept open – The development of the "make it safe reviews" system was yet to be sighted at Executive Team Meeting, with onwards progression to the Quality, Safety Experience Committee. 05.03.24 Minor amendment to reflect EDOF agreement to propose alignment to Action 2 07.05.24 The Interim Executive Director of Finance confirmed that the action was moving forwards and being shared via Operational Teams. The Integrated Concern of Policy and Framework was being developed and would be taken through to the July 2024 Board Meeting. It was also stated that the Quality Management System will also be taken to Board in May 2024 22.05.24 – Item requested for sharing. 12.06.24 - There is a new Integrated Concerns Policy; which is due at Board in July - Final Copy to be provided to the Committee thereafter. It was also confirmed that the Quality Management System was taken to the last Health Board

Open Actions						
Action No.	**Minute Ref.**	**Date**	**Agreed Action**	**Lead**	**Timescale**	**Status**
						Meeting.
2.	AC24. 39.8	02/03/2024	The Committee discussed the repository of learning. It was agreed to share the paper.	Item ref 2: March 2024 Deputy Executive Director of Nursing	May 2024	**Proposed for closure.** **Action items Aligned together (Jan 23 and March 24) Items 11 and 2.** 23.04.24 Associate Director of Governance contacted Deputy Exec Dire of Nursing to check complete. 26.04.24 Feedback received via Deputy Director of Quality. The specification and "wireframe" for the app has been designed and a prototype is in place. The next and current phase is to begin testing the app, which will be done with the MHLD Division. This user testing will help further refine the app through identifying any bugs or technical issues and inform enhancements from practical use by front line clinicians, prior to wider roll-out. This testing will take place over the coming quarter. 07.05.24 Action to be followed up. 22.05.24 – Item requested for sharing. 12.06.24 – Item to be kept open – further detail requested by the Director of Corporate Governance. 26.06.24 – Confirmed that there is no paper but the detail of the repository will be covered in the Quality Paper to the Board.

Open Actions						
Action No.	**Minute Ref.**	**Date**	**Agreed Action**	**Lead**	**Timescale**	**Status**
13	AC24. 45.12	02/03/2024	The current Health & Safety Policy is overdue for review. It was agreed to follow up the urgency to update the out of date Policy.	Associate Director of Governance	May 2024	**To be kept open.** 23.04.24 Head of H&S contacted on 23.4.24 Note action owner is Assistant Director of Occupational Health and Safety. Update as follows - The responsible officer agreed an extension on this for 6 months (that lasts until June 2024). This will enable the new Exec responsibilities to be defined, as the policy has to be rewritten as the accountabilities are changing. The version is drafted ready for confirmation of accountabilities. 22/05/24 – The Director of Corporate Governance reported that the Health & Safety Policy is being revised and it is expected to be considered by the Board in July 2024. 03/07/24 – Update provided to the People and Culture Committee. Health Board Policy scheduled for the meeting of the People and Culture in August and Board approval in September 2024.
1.	AC24. 57.3.1	07/05/2024	To update the draft minutes to edit the word *"review"* to *"conclude"* in the reference: AC24.44.1.3.	Secretariat	May 2024	**Proposed for closure.** 20.5.24 – Item complete. The confirmed minutes

Open Actions						
Action No.	**Minute Ref.**	**Date**	**Agreed Action**	**Lead**	**Timescale**	**Status**
						are now available on the Public Web Site: Audit Committee - Betsi Cadwaladr University Health Board (nhs.wales).
2.	AC24. 57.6.2	07/05/2024	Brief written report, listing agenda items taken in "Private Session" to be provided.	The Director of Corporate Governance Head of Corporate Affairs	May 2024	**Proposed for closure.** Complete – written summary to be provided at each meeting
3.	AC24. 57.6.3	07/05/2024	Terminology change - from "In committee" to "Private" in all Board and Committee Meetings for consistency.	Director of Corporate Governance Head of Corporate Affairs	May 2024	**Proposed for closure.** Complete – terminology changed
4.	AC24. 57.7.5	07/05/2024	Audit Tracker - progress recommendations against External & Internal Audit Reports - The need for a clearer process for monitoring timeliness, performance, and principles on a case-by-case basis was raised. It was agreed that the process for external audits needed to be different to the proposal in 2.1 of the report.	Interim Exec Director of Finance/Interim Director of Finance	July 2024	**To be kept open.** **03/07/24** – Process to be developed and agreed with External Audit following the end of year accounts process is concluded.

Open Actions						
Action No.	**Minute Ref.**	**Date**	**Agreed Action**	**Lead**	**Timescale**	**Status**
5.	AC24. 57.7.7	07/05/2024	Audit Tracker Report format to be reviewed for future reporting, in terms of accessibility.	Director of Corporate Governance	July 2024	**Proposed for closure.** 10.06.2024 - The update at the May Audit Committee was to provide Members with an overarching view of the progress since January 2024. The level of detail provided in the annexes has been reviewed.
6.	AC24. 57.7.10	07/05/2024	Audit Tracker Report - It was agreed for the flow of live recommendations in relation to Appendix 7 be reviewed.	Chair/ Director of Corporate Governance	July 2024	**Proposed for closure.** 10.06.2024 - Future reports to the Audit Committee will ensure that there is clearer alignment in terms of the recommendations that are closed.
7.	AC24. 57.8.4	07/05/2024	Tracking of Special Measures - It was agreed to review the tracking process through Committee Structures, in order to maintain oversight.	Director of Corporate Governance	July 2024	**Proposed for closure.** 10.06.2024 - The tracking of Special Measures will be integrated into the performance reporting at the Board and Committees. First report will be considered by the Board in July 2024.
8.	AC24. 58.5	07/05/2024	Progress of Risk Management. It was agreed to; • Establish the requirement to review the reporting updates of the Risk Management Group, through to Executive Team Meetings. • To review frequency in relation to reporting of BAF and CRR at Committees.	Director of Corporate Governance / Head of Risk Management	July 2024	**Proposed for closure.** 10.06.2024 - Proposal to be discussed at the Board Development in July and report to be presented to the Audit Committee in July before the Board at the end of July.

Open Actions						
Action No.	**Minute Ref.**	**Date**	**Agreed Action**	**Lead**	**Timescale**	**Status**
9.	AC24.58.7.1	07/05/2024	Risk updates – To update Financial Risks 24.05 and delivery to the financial plan.	Interim Executive Finance Director	May 2024	**Proposed for closure.** 24.06.2024 - The Corporate Risk relating to the 24/25 Financial Plan has been fully updated and has been shared with the Risk Management Group – see CRR24-05.
9.1	AC24.58.9	07/05/2024	It was agreed for existing due dates to be left extant, along with updated due dates therein. Additional controls should be linked through to the Actions necessary to mitigate the risks. Target risk score of 1 in planned care. Head of Risk Management to revise the target risk, which had been discussed with the relevant lead.	Head of Risk Management	May 2024	**Proposed for closure.** 17.6.24 - Risks have been further quality assured by the risk team to ensure gaps in controls follow as actions and this has been communicated to corporate risk leads. The target score for planned care was subsequently amended by the risk lead.
10.	AC24.59.2.7	07/05/2024	Conformance Report - The Chair and Interim Director of Finance briefly discussed payables and the comparison of detail, value and volume, to the previous year end. Interim Executive Director to communicate the detail to the Chair.	Interim Executive Director	May 2024	**Proposed for closure.** 26.06.2024 - Conformance Report (comparison of PSPP (payables) Data) – Non NHS invoices paid by number 94.5% (22/23 95.0%) and by value 97.0% (22/23 96.8%)
11.	AC24.59.2.14	07/05/2024	Quarter 1 Conformance Report update to be provided to the Committee to provide evidence of	Interim Executive Director	July 2024	**Proposed for closure.** 26.06.2024 - The Q1 Conformance Report will include additional details on the progress made to

Open Actions						
Action No.	**Minute Ref.**	**Date**	**Agreed Action**	**Lead**	**Timescale**	**Status**
			progress in relation to payable balances over 6 months old in relation to 22/23 financial year.			obtain payment of receivables >6months old.
12.	AC24. 59.3.2 AC24. 59.3.3	07/05/2024	Content of Annual Accounts Meeting – 21/05/24 • Draft Annual Governance Statement (AGS) be provided in advance of the meeting, to Internal and External Audit for comment. It was also agreed to provide the full submission of the AGS to the July 2024 Committee Meeting. • It was agreed that the Functional Standard Fraud Return be included within the 21 May Committee meeting for wider discussion.	Director of Corporate Governance Head of Corporate Affairs	May 2024 and July 2024	**Proposed for closure.** Completed – agenda planning has taken place.
13.	AC24. 60.1.6	07/05/2024	Internal Audit update - Work in Progress summary - Lack of progress on Health & Safety and the Operating Model reviews was raised. It was agreed for the responses to be submitted to Internal Audit, along with the Chair	Director of Corporate Governance	June 2024	**Proposed for closure.** Completed – reports finalised, agreed to receive the reports at the meeting in July 2024

Open Actions						
Action No.	**Minute Ref.**	**Date**	**Agreed Action**	**Lead**	**Timescale**	**Status**
			of Audit Committee as soon as possible.			
14.	AC24.60.1.8	07/05/2024	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.	Head of Corporate Affairs to inform the Quality, Safety and Experience Committee (QSE)	May 2024	Refer to QSE Committee.
15.	AC24.60.1.10	07/05/2024	Limited Assurances relating to the Lessons Learnt Report dated July 2023, and the follow up progress to date. Chair to raise within the Health Board Chairs Meeting, as an emerging topic.	Chair	July 2024	To be raised at the next meeting in August 2024 as part of feedback from Audit Committee Chair.
16.	AC24.61.1.6	07/05/2024	External Audit Update - The Committee acknowledged the ongoing work and the positive partnership working. With regards to the performance with unscheduled care; it was confirmed that the Audit Lead would update Chair	Audit Wales Lead / Corporate Governance Director	July 2024	**Proposed for closure.** 10/06/2024 – Detail confirmed and forwarded to Committee Members.

Open Actions						
Action No.	**Minute Ref.**	**Date**	**Agreed Action**	**Lead**	**Timescale**	**Status**
			accordingly. It was also noted that the Corporate Governance Director would share the draft reports with members.			
17.	AC24. 61.2.3	07/05/2024	Structured Assessment – Tracking of recommendations, along with systems to manage the process – The progress against tracking of recommendations and regulatory reports would be provided to the Committee.	Corporate Governance Director	July 2024	**Proposed for closure.** 10/06/2024 - All recommendations from Structured Assessments since 2019 are now included on the Audit Tracker, with a report on progress to the Audit Committee.
18.	AC24. 61.2.4	07/05/2024	Structured Assessment - An Independent Member suggested that completion dates be provided therein the reports, against historical recommendations where they had not been complete. The Director of Corporate Governance would provide an update to the historical recommendations at a future meeting.	Corporate Governance Director	Future report/agenda item to be confirmed	**Proposed for closure.** **03/07/24** - To be included on the July agenda as part of the audit tracking report and a report on progress against the Structured Assessment would be reported in September 2024.
19.	AC24. 61.2.6	07/05/2024	• It was agreed that the Annual Audit Letter would be provided as an appendix to the draft assessment at the next Health Board Meeting. • It was also agreed to include the	Corporate Governance Director	May 2024	**Proposed for closure.** Completed.

Open Actions						
Action No.	**Minute Ref.**	**Date**	**Agreed Action**	**Lead**	**Timescale**	**Status**
			Structured Assessment bi monthly on the Audit Committee Cycle of Business to ensure the delivery of recommendations.		Bi Monthly - CoB	
20.	AC24. 61.5.2	07/05/2024	National Accounts update - letter issued in February 2024, with regards to the Accounts Audit Approach. It was agreed to circulate to the Audit Committee for information.	Audit Wales Lead/ Audit Committee Secretariat	May 2024	**Proposed for closure.** 20/05/2024 – Item Circulated to all Audit Committee Members and Attendees.
21.	AC24. 62.1.4	07/05/2024	F03 BCUHB Counter Fraud Policy is due for review – to be and approved by August 2024. (Audit Committee Agenda in September).	Counter Fraud Lead	Sept 2024	**To be kept open.** 20/05/2024 - Item now on CoB for September 2024. 26.06.2024 - Counter Fraud Policy F03, is in the process of being reviewed by the team and will be placed out for wider consultation in July.
22.	AC24. 62.1.7	07/05/2024	Counter Fraud - Written reports to be provided at Public Session going forwards. (Non-confidential items only).	Counter Fraud Lead	July 2024	**Proposed for closure.** 26.06.2024 - Future Counter Fraud Quarterly Update Reports will be written for the Public Session, with only sensitive issues being reported to the Private Session.
23.	AC24. 63.1.1	07/05/2024	Items for referral to other Committees were agreed as follows: Board Assurance Framework, Corporate Risk Register items, Audit	Head of Corporate Affairs	May/June 2024	**Proposed for closure.** Completed. Also the Integrated Governance Advisory Group receives the items that have been referred to Committees.

Open Actions						
Action No.	**Minute Ref.**	**Date**	**Agreed Action**	**Lead**	**Timescale**	**Status**
			Tracker reporting, and Contracting of Patient Services review and follow up. A discussion also ensued with regards to elements with regards to health and safety, risk oversight, tracking and annual accounts processes.			
Closed Actions						
Action No.	**Minute Ref.**	**Date**	**Agreed Action**	**Lead**	**Timescale**	**Status**

Cyfarfod a dyddiad: **Meeting and date:**	Audit Committee
Cyhoeddus neu Breifat: **Public or Private:**	Public
Teitl yr Adroddiad **Report Title:**	Summary of business considered in private session to be reported in public
Cyfarwyddwr Cyfrifol: **Responsible Director:**	Pam Wenger, Director of Corporate Governance
Awdur yr Adroddiad **Report Author:**	Philippa Peake-Jones, Head of Corporate Affairs
Craffu blaenorol: **Prior Scrutiny:**	None
Atodiadau **Appendices:**	None

Y/N to indicate whether the Equality/SED duty is applicable	**N**

Argymhelliad / Recommendation:

The Committee is asked to note the report.

Ar gyfer penderfyniad /cymeradwyaeth For Decision/ Approval		**Ar gyfer Trafodaeth For Discussion**		**Ar gyfer sicrwydd For Assurance**		**Er gwybodaeth For Information**	✓

Sefyllfa / Situation:

To report in public session on matters previously considered in private session.

Cefndir / Background:

Standing Order 6.5.3 requires the Board to formally report any decisions taken in private session to the next meeting of the Board in public session. This principle is also applied to Committee meetings.

Asesiad / Assessment

The Committee considered the following matters in private session:

7 May 2024

- Details of Breaches of SFIs, Scheme of Delegation and SOs

- Independent Review Management Response (Contract Procurement Review)
- Local Counter Fraud Report
- Development of the Annual Governance Statement 2023/24

Teitl adroddiad: ***Report title:***	**NHS Wales Shared Services Partnership – Annual Assurance Report (Procurement) 2023/24**			
Adrodd i: ***Report to:***	Audit Committee			
Dyddiad y Cyfarfod: ***Date of Meeting:***	Thursday, 18 July 2024			
Crynodeb Gweithredol: ***Executive Summary:***	NHS Wales Shared Services Partnership present this inaugural Annual Assurance Report (Procurement) for 2023/24 to the Committee which updates on key national procurement initiatives and outcomes that have had a direct bearing on Health Board and a summary of the procurement activity undertaken on its behalf. The areas covered in this report are: 1. Overview of National Initiatives 2.Savings Position 3. Tendering position (Awarded and in process) 4. Quotations (Awarded) 5. Waivers position (Issued, awarded & avoided) 6. Robotics Project progress 7. Transactional KPIs 8. Actionpoint activity 9. Customer Service & Transactional activity 10. Welsh Government Policy Progress updates 11.Procurement Training for Health Board Staff			
Argymhellion: ***Recommendations:***	The Audit Committee is asked to discuss the content, and to note the report.			
Arweinydd Gweithredol: ***Executive Lead:***	Russel Caldicott, Interim Executive Director of Finance			
Awdur yr Adroddiad: ***Report Author:***	NHS Wales Shared Services Partnership: Jonathan Irvine, Director of Procurement Services Wyn Owens, Head of Operational Procurement & National Sourcing Sian Owens, Assistant Head of Operational Procurement Health Board Lead: Andrea J Hughes, Interim Finance Director - Operational			
Pwrpas yr adroddiad: ***Purpose of report:***	I'w Nodi *For Noting* ☒	I Benderfynu arno *For Decision* ☐	Am sicrwydd *For Assurance* ☒	
Lefel sicrwydd: ***Assurance level:***	Arwyddocaol *Significant* ☐	Derbyniol *Acceptable* ☒	Rhannol *Partial* ☐	Dim Sicrwydd *No Assurance* ☐
	Lefel uchel o hyder/tystiolaeth o ran darparu'r	Lefel gyffredinol o hyder/tystiolaeth o ran darparu'r	Rhywfaint o hyder/tystiolaeth o ran darparu'r	Dim hyder/tystiolaeth

	mecanweithiau / amcanion presennol *High level of confidence/evidence in delivery of existing mechanisms/objectives*	mecanweithiau / amcanion presennol *General confidence / evidence in delivery of existing mechanisms / objectives*	mecanweithiau / amcanion presennol *Some confidence / evidence in delivery of existing mechanisms / objectives*	o ran y ddarpariaeth *No confidence / evidence in delivery*

Cyfiawnhad dros y gyfradd sicrwydd uchod. Lle bo sicrwydd 'Rhannol' neu 'Dim Sicrwydd' wedi'i nodi uchod, nodwch gamau i gyflawni sicrwydd 'Derbyniol' uchod, a'r terfyn amser ar gyfer cyflawni hyn: ***Justification for the above assurance rating. Where 'Partial' or 'No' assurance has been indicated above, please indicate steps to achieve 'Acceptable' assurance or above, and the timeframe for achieving this:***	
Cyswllt ag Amcan/Amcanion Strategol: ***Link to Strategic Objective(s):***	Standing Orders, Standing Financial Instructions and the Scheme of Reservation and Delegation are designed to ensure that expenditure is committed in line with stipulated governance and incurred on the intended purpose.
Goblygiadau rheoleiddio a lleol: ***Regulatory and legal implications:***	Public procurement law regulates the purchasing by public sector bodies and certain utility sector bodies of contracts for goods, works and services.
Yn unol â WP7, a oedd EqIA yn angenrheidiol ac a gafodd ei gynnal? ***In accordance with WP7 has an EqIA been identified as necessary and undertaken?***	Not applicable
Yn unol â WP68, a oedd SEIA yn angenrheidiol ac a gafodd ei gynnal? ***In accordance with WP68, has an SEIA identified as necessary been undertaken?***	Not applicable
Manylion am risgiau sy'n gysylltiedig â phwnc a chwmpas y papur hwn, gan gynnwys risgiau newydd (croesgyfeirio at y BAF a'r CRR) ***Details of risks associated with the subject and scope of this paper, including new risks(cross reference to the BAF and CRR)***	BAF: 2.3 & CRR 24-05 – Delivery of the Annual Financial Plan.
Goblygiadau ariannol o ganlyniad i roi'r *argymhellion ar waith* ***Financial implications as a result of implementing the recommendations***	Management of financial risk of not achieving value for money.
Goblygiadau gweithlu o ganlyniad i roi'r argymhellion ar waith ***Workforce implications as a result of implementing the recommendations***	None
Adborth, ymateb a chrynodeb dilynol ar ôl ymgynghori ***Feedback, response, and follow up summary following consultation***	Not applicable
Cysylltiadau â risgiau BAF: (neu gysylltiadau â'r Gofrestr Risg Gorfforaethol) ***Links to BAF risks:*** *(or links to the Corporate Risk Register)*	BAF: 2.3 & CRR 24-05 – Delivery of the Annual Financial Plan.
Rheswm dros gyflwyno adroddiad i fwrdd cyfrinachol (lle bo'n berthnasol)	

Reason for submission of report to confidential board (where relevant)	Not applicable
Camau Nesaf: **Gweithredu argymhellion** ***Next Steps:*** ***Implementation of recommendations*** • The report is for discussion and noting.	
Rhestr o Atodiadau: ***List of Appendices:*** 1. NHS Wales Shared Services Partnership – Annual Assurance Report (Procurement) 2023/24	

PROCUREMENT SERVICES ANNUAL ASSURANCE REPORT
BETSI CADWALADR UNIVERSITY HEALTH BOARD

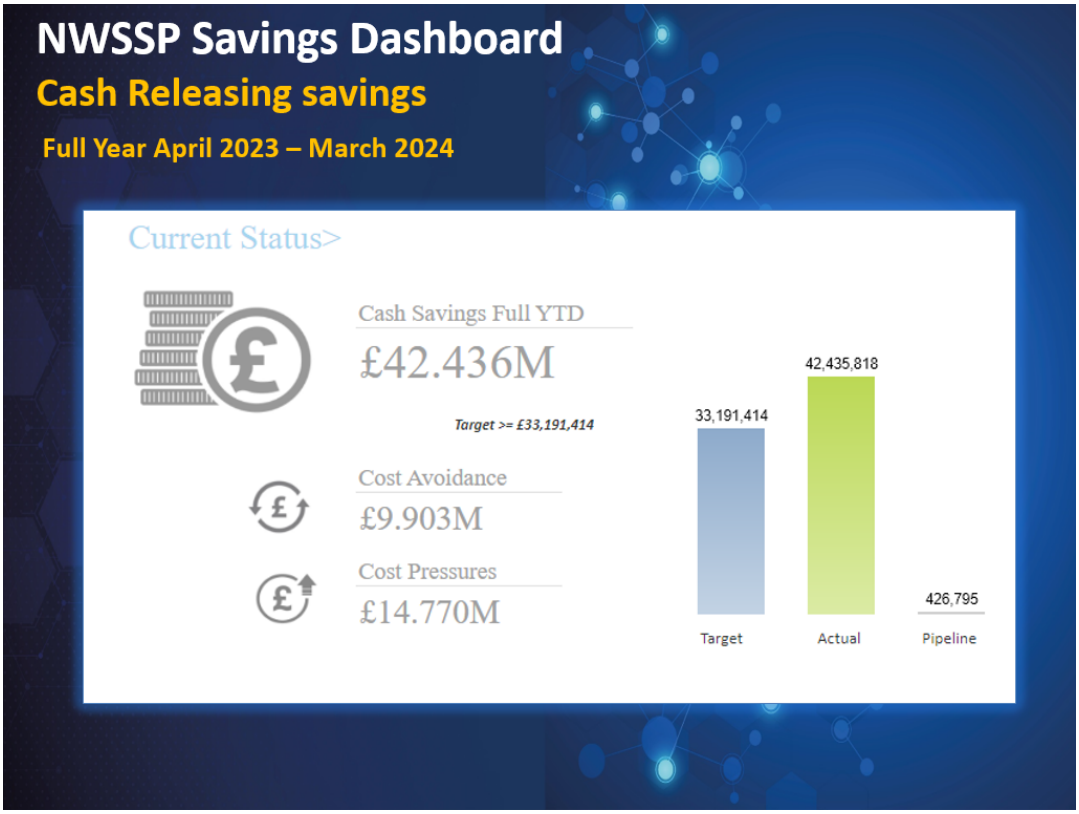
FOREWORD

I am delighted to have this opportunity to introduce the NWSSP Procurement Services Annual Assurance Report for BCUHB. May I firstly thank all Board staff for their productive engagement with our teams across Wales in relation to local and national procurement operations. In particular, the engagement with our Procurement and Logistics teams here in north Wales continues to demonstrate the benefits of a positive collaborative working relationship, many of which are outlined in this report. I also recognise the very significant challenges that NHS Wales faces on many fronts, not least the testing financial environment and the criticality of addressing waiting lists – areas in which procurement can and will continue to make a constructive contribution in relation to your Board's response to these challenges.

I believe this is a suitable point to outline some of the key national procurement initiatives and outcomes that we have been involved with during 2023/24, all of which will have had a direct bearing on the Health Board.

NHS Wales Value and Sustainability Board

NWSSP Procurement Services was a key contributor to the work and output of the Value and Sustainability Non-Pay and Procurement Workstream and presented progress on the national non-pay savings position to the Value and Sustainability Board at regular sessions throughout the year. The outturn position for 2023/24 is represented below;

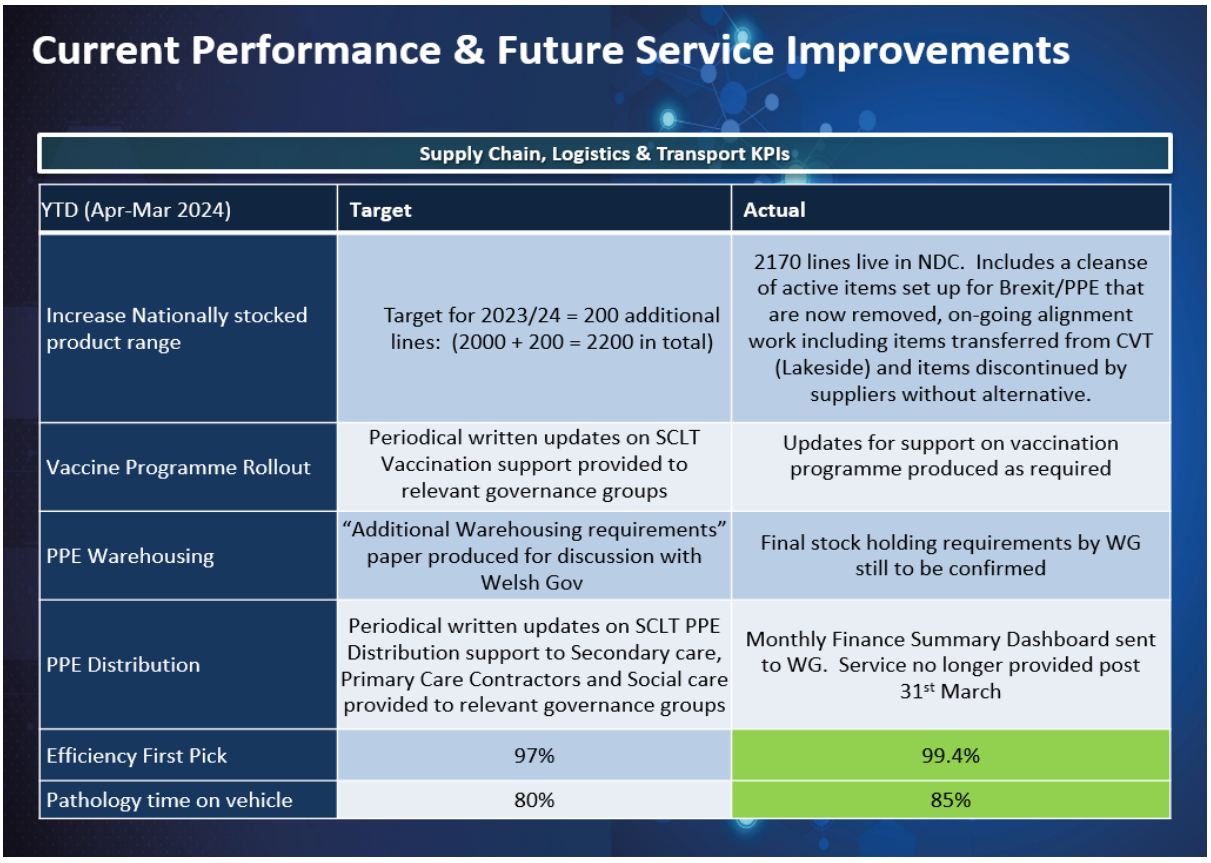


The over-delivery of cash releasing savings against target was a significant achievement in the midst of an inflationary market for goods and services. It is recognised however that more can be achieved with the removal of clinical variation and further consolidation of the supply base which will improve our national negotiating position leading to downward pressure on prices. This work will be a feature of the workplan for 2024/25 and engagement with the National Clinical Networks has already started to identify opportunities for standardisation of key product areas.

National Distribution Centre

The nationally stocked product range sited across our warehousing network has grown over the year by just under 10% to 2,170 individual product lines. The ambition is to further extend the range of products stocked to allow opportunities for volume purchase, standardisation and reduced prices to be realised. This work is ongoing with our National Sourcing Teams working closely with Supply Chain and Logistics colleagues to identify suitable products and make best use of the increasingly limited space available.

The following table summarises the other key activities supported by our service through the national warehousing and distribution network with ongoing management of PPE and support to the national vaccination programme. We are increasingly being recognised by Welsh Government as an enabler for national programmes requiring procurement and logistics support and we continue to work closely with them to understand and deliver on future requirements. Within 2024/25 we expect to be pivotal to the plans for national influenza vaccination procurement, storage and dispensing and delivery into primary and secondary care settings across Wales.



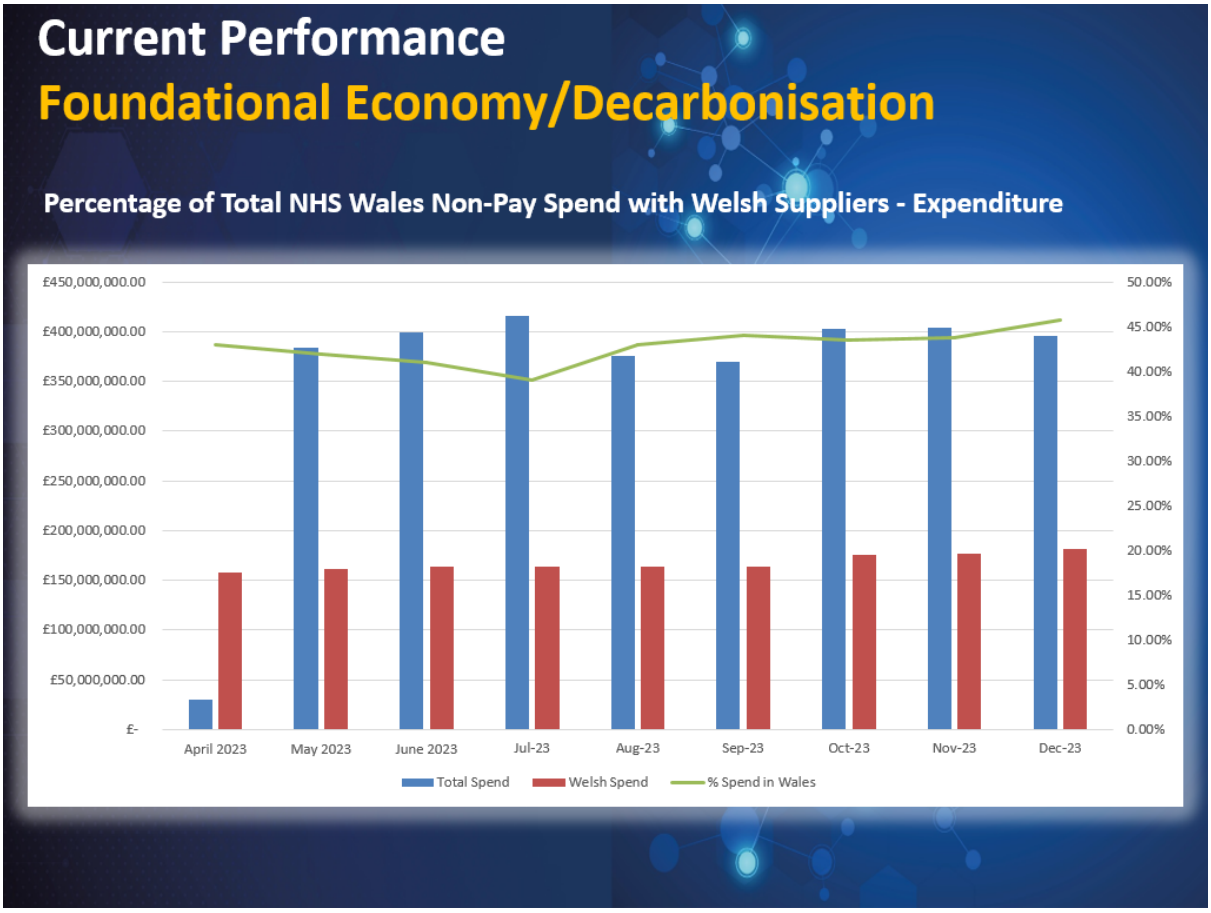
Foundational Economy and Decarbonisation in the Supply Chain

Work continues at a local and national level to maintain and improve on the position within NHS Wales in relation to the level of NHS Wales expenditure within the local economy and to reduce the

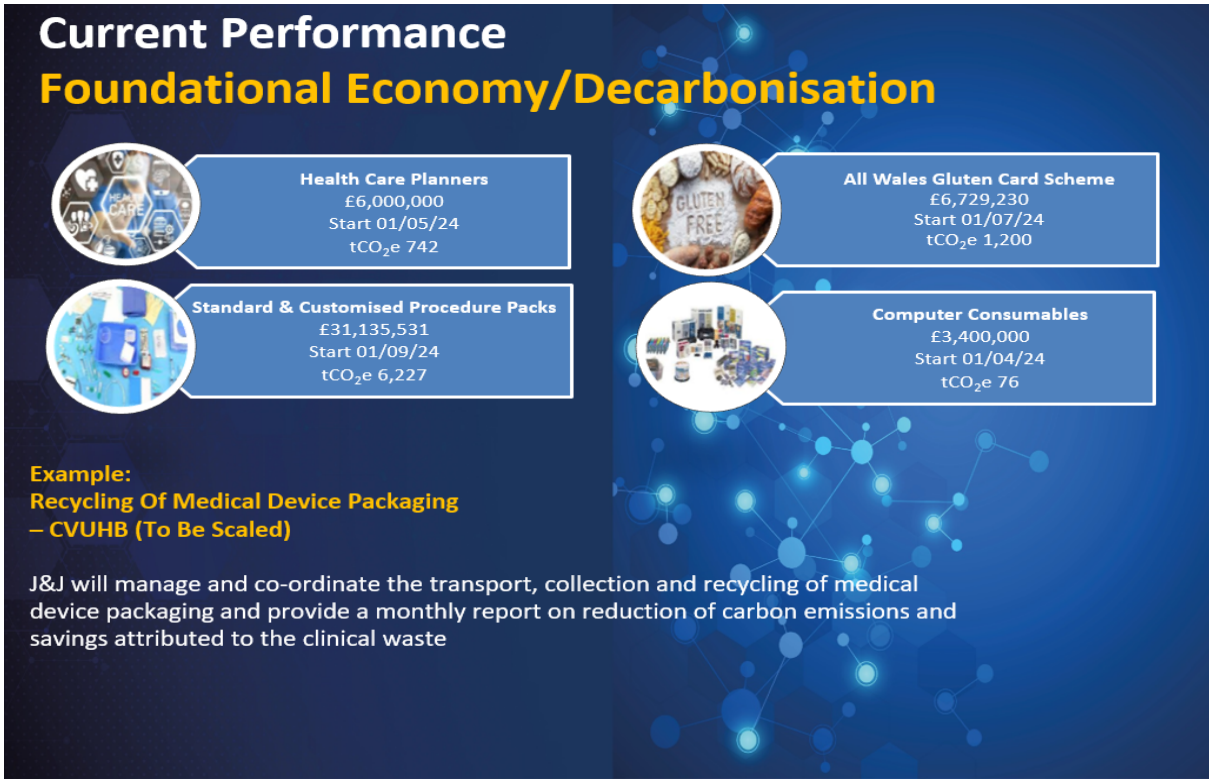
carbon footprint of supply chain activity which is acknowledged to account for approximately 60% of the total NHS Wales carbon footprint.

Throughout the year our dedicated Sustainability and Net Zero team has been working closely with all local and national procurement teams to record, identify and support opportunities within the national and local procurement plans to deliver improvements in foundational economy expenditure and carbon reduction. Extensive engagement has also been undertaken with the supply base to maximise the prospects of local suppliers securing new business with NHS Wales organisations.

The following graph illustrates that the level of non pay expenditure within the local economy is stabilising at approximately 45% of total expenditure. As a national procurement organisation we believe that this figure can be increased and we are now actively targeting national contracts which can be switched from “non Welsh” to Welsh based supply through active procurement interventions in the market.



Similarly with decarbonisation we are applying a targeted approach to the procurement workplans across Wales to achieve greatest return on our efforts. The following summary provides an example of how the workplan is being analysed and procurement targets identified as part of a much wider national programme.



In conclusion, I wish to acknowledge the hard work and commitment of my teams across Wales, including the local North Wales Integrated Partnership Team for BCUHB in providing you with professional procurement support across a wide number of areas. This dedication to upholding the highest standards has enabled NWSSP Procurement Services to retain its Customer Service Excellence accreditation for 2024 alongside our existing accreditations for the ISO9001 & 140001 Quality Standards. We recognise the challenges ahead and I believe that continuing to work in partnership with your Health Board at local and national levels will be key to delivering benefits next year and thereafter.

Diolch

Jonathan Irvine
NWSSP Director of Procurement Services

BCUHB ANNUAL ASSURANCE REPORT

This report is intended to provide the Operational Finance Director with an update on Procurement activity conducted on behalf of the Health Board during financial year 2023/24, the areas covered in this report are:

1. Savings Position
2. Tendering position (Awarded and in process)
3. Quotations (Awarded)
4. Waivers position (Issued, awarded & avoided)
5. Robotics Project progress
6. Transactional KPIs
7. Actionpoint activity
8. Customer Service & Transactional activity
9. Welsh Government Policy Progress updates
10. Procurement Training for Health Board Staff

1. Savings Position at end Q4

The HB savings target of £2.2m full year effect cash releasing savings (equating to £1.1m in year effect) was agreed with the HB Finance & Performance Lead in February 2023. The monthly savings returns for both Local and National Sourcing activity are sent to the HB Savings Accountant at the beginning of each calendar month, with the information subsequently being shared with each relevant HB Chief Finance Officer to analyse the financial impact on their localities.

BCUHB Procurement Savings	
	Actual
Cash Releasing (Revenue)	**£3,102,110.09**
Cost Avoidance (Capital & Revenue)	**£1,571,774.03**
Cost Pressures	**£2,537,000**
Energy Savings (Gas/Electricity)	**£6,300,502.69**

We are pleased to report that the Integrated Partnership Team exceeded its annual 'in year' savings target for the HB of £1.1m cash releasing savings by the end of Q3 and exceeded its full year savings target of £2.2m by the end of Q4. This is particularly pleasing given that the HB continues to experience significant inflationary pressures in an extremely challenging financial environment.

2. Tenders (Savings, Service delivery and governance)

Tendering activity is undertaken when expenditure for the procurement of goods & services required by Health Board Departments exceeds £25,000. All opportunities to bid for Health Board contracts over £25,000 are posted via the procurement e-tender portal 'Bravo'.

Suppliers interested in bidding for NHS Wales contracts should be directed to the 'Sell to Wales' website whereby they can register their interest in receiving alerts for any relevant opportunities to supply Welsh Public Sector organisations.

Tenders awarded

There has been significant tendering activity across the Health Board since April 23, with **118** tenders being awarded thus far with a cumulative value of just over £27m as shown in the table below. A further breakdown of the tenders awarded during the financial year is provided in Appendix A.

No. Of Tenders Awarded Q1	Value of Tenders awarded Q1	No. Of Tenders Awarded Q2	Value of Tenders Awarded Q2	No. Of Tenders Awarded Q3	Value of Tenders Awarded Q3	No. Of Tenders Awarded Q4	Value of Tenders Awarded Q4
19	£1,304,717	23	£8,775,828	34	£11,839,536	42	£5,450,335

Tenders in process during Q4

At financial year end tendering activities for the year reached a peak with **18** tenders at various stages of completion, with a wide variety of projects underway (see Appendix A).

Business Quality Internal Audit Programme

Each year, NWSSP Procurement Services Business Quality Team arranges a series of Internal Audit reviews to ensure that each Procurement Team across Wales is complying with the internal Policies & Procedures which cover all of the organisations procurement activities. Any 'non conformances' are flagged to the relevant Head of Procurement for action, with re-audits taking place within a 3 month period to check on the team's progress against its improvement plan. The recently launched 'Document Management System' has led to a delay in some of the Internal Audits taking place during the last few months. However, we have been advised that a series of Internal Audits will be carried out during Q2 of the 24/25 financial year on the team in north Wales, with results being fed back to the Head of Procurement. We will ensure that the results of these audits are included in future reports to the Audit Committee.

3. Multi Quote

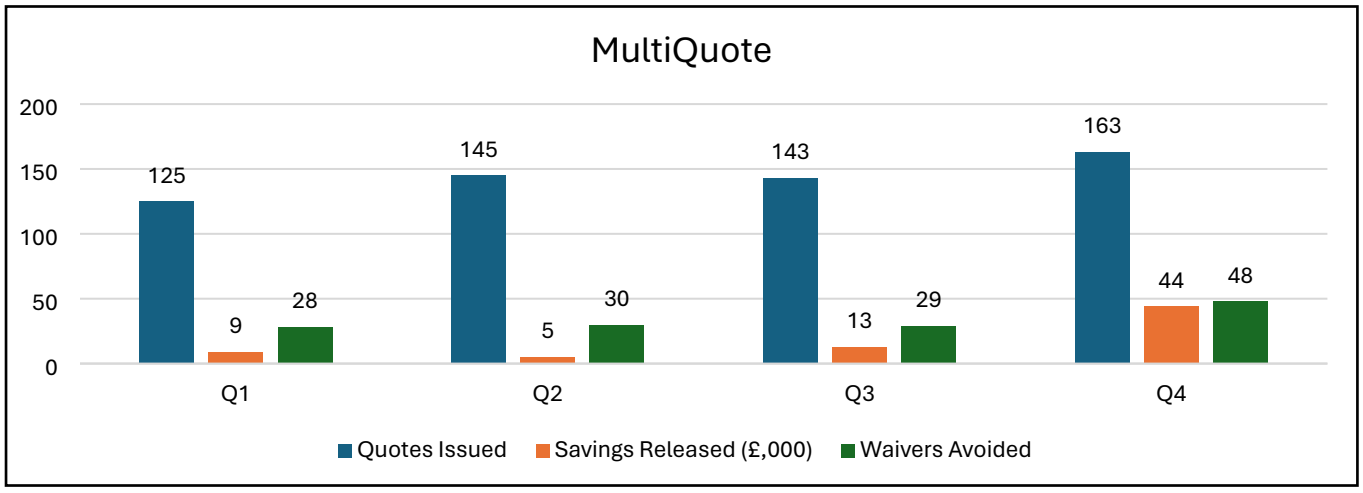
It is normal practice to obtain three quotes for items of expenditure between £5,000 and £25,000 which aren't covered by an existing contract or framework.

Multiquote is an electronic portal used by Procurement Staff to post opportunities which invite prospective suppliers to quote for the supply of goods and services up to the value of £24,999 in line with SFIs.

The table below provides a summary of quotes issued during financial year 2023/24 whilst these procurement exercises have delivered some savings, the process undertaken has more often been to confirm/refute the single supplier argument thus negating the need for a Single Quote Waiver with a total of **135** waivers avoided during the same period.

	Q1	Q2	Q3	Q4
Quotes issued	125	145	143	163
Savings realised	£9,285	£5,225	£13,871	£44,762
Waivers Avoided	28	30	29	48

The graph below shows the year-to-date upward trend in quotes issued, the increase in the number of quotation exercises conducted contributed to a further reduction in the number of requests to waive SFIs (demonstrated in the next section) during Q4 which is also reflective of our ongoing engagement with Health Board staff.



4. Requests to waive Standing Financial Instructions & Breaches

It is normal practice to obtain three quotes for items of expenditure between £5,000 and £25,000, where this is not possible then a single quote waiver should be obtained and approved ahead of expenditure being committed.

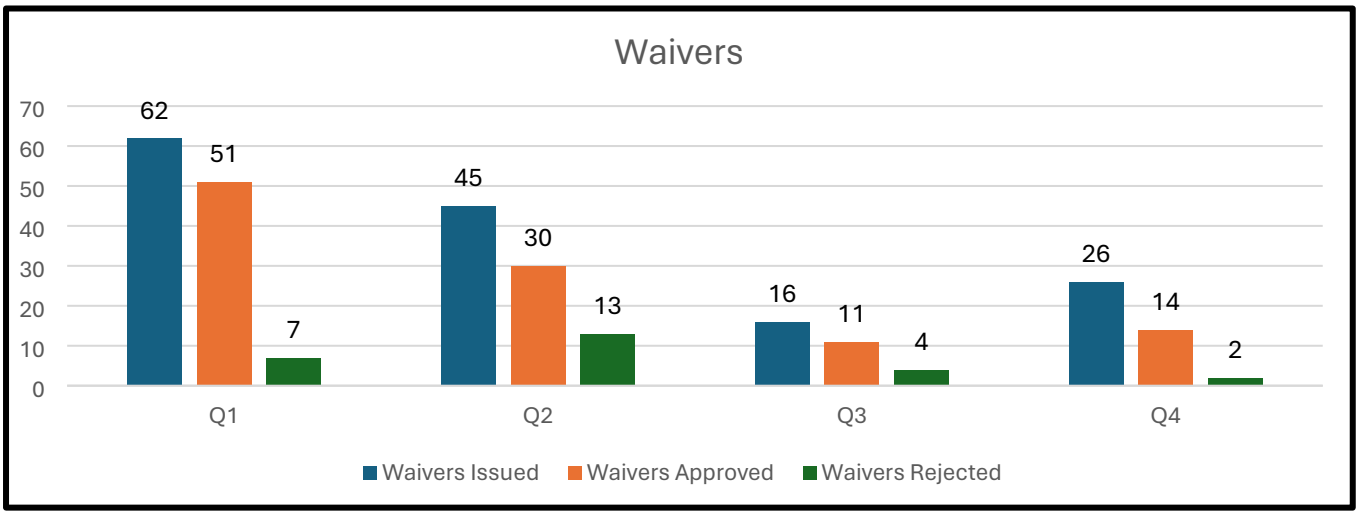
For items of expenditure above £25,000 it is normal practice to request bids from multiple suppliers via the procurement e-tender portal 'Bravo'. Where this is not possible, a single tender waiver should be obtained and approved ahead of expenditure being committed. Allowable rationale for a single tender waiver are:

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

The table below provides a summary of waiver activity for the period April 2023 to March 2024.

	Q1	Q2	Q3	Q4
Waivers Issued	**62**	**45**	**16**	**26**
Waivers Approved	**51**	**30**	**11**	**14**
Waivers Rejected	**7**	**13**	**4**	**2**

It is pleasing to note that there has been a significant reduction in the number of approved waivers during the period April 2023 to March 2024, the chart below provides a quarterly profile of the waiver activity for the period.



Waivers issued to Health Board staff during 2023/2024 are detailed in the accompanying excel reports (STWs /SQWs).

Breaches of SFIs/Scheme of Delegation

There have been two recent instances where HB SFIs have been breached via the retrospective award of contracts to suppliers that have not been through a compliant procurement process. One of these breaches (Idox Ltd) related to a contract that had been signed by a member of HB staff who did not have the delegated authority to approve the level of spend associated with this purchase. Procurement Services have taken the following actions to ensure such instances do not occur in the future:

- Implementation of 'File Notes' to capture and record instances of retrospective spend across the HB. This will allow Procurement Services to report such instances to BCUHBs Audit Committee and will also enable targeted intervention for repeated offenders;
- All Transactional Procurement Staff have undertaken training to enable them to spot instances of retrospective expenditure/contract awards and how to deal with them. Staff are already aware of the 'File Note' process as this is already used across our other stakeholder organisations; and
- The subject of retrospective expenditure is covered in the Procurement training sessions that have been carried out across the HB in collaboration with colleagues from BCU Finance. The training emphasises the importance of compliance with HB SFIs/SORD and how breaches of either process will be reported to the HB's Audit Committee for further action as necessary. The training has helped the Transactional Team to feel empowered to challenge any attempts to breach HB SFIs, regardless of how senior the HB member of staff may be. This is an extremely important point as often there can be significant pressure put upon the Transactional Team to simply 'get the order processed'.

5. Project Progress - Supply X / Scan for Safety

There are two national initiatives led by Procurement Services on behalf of Welsh Health Boards, being Supply X and Scan for Safety(S4S).

Eluned Morgan, Minister for Health and Social Services commented:
"Patient safety is at the heart of the NHS Wales Scan4Safety programme. The introduction of barcode scanning and the automation of the link between uniquely identified products, places and people, provides real-time data at the point of care and instant traceability of implanted medical devices should a product or patient recall be required. The investment in this Once for Wales initiative will also deliver significant financial savings, improved stock management, removal of time-consuming administrative tasks from clinical staff at the same time as safeguarding our patients from avoidable harm."

BCUHB, over recent years has introduced SupplyX, an inventory management solution, across wards and some theatres in support of the materials management function. Omnicell's SupplyX is active across all

BCUHB District General Hospitals with a total of over 200 wards linking product to place. The majority of theatres/POC also have their inventory managed with a combination of Omnicell cabinetry and SupplyX handsets.

During the first part of the year the inventory management capability extended to the following BCUHB areas:
A further 9 YG Wards
Llandudno Orthopaedics
Wrexham Maelor Theatres
Community hospitals across Denbigh, Ruthin, and Holywell
Multiple Abergele Wards
Usage data will also be reviewed to optimise stock levels and deliver further cost avoidance savings across the existing network e.g. 42 YGC wards, 34 YG wards and 56 WM wards.

BCUHB cost avoidance savings since 2019 through the inventory management phase of the S4S programme have yielded over £800k.

Progress made in Q4

In Q4 work is progressing between the S4S national team and BCU in relation to BCU server migration to National to allow BCU systems to be upgraded from V.23.5. A Test environment has been created as a key starting point.

SupplyX V.25 has been successfully tested in YGC as part of the phased upgrade. User training is being planned as we progress towards V.28.

Omnicell rollout continues along with recommissioning of Wrexham Maelor Theatre A cabinetry.

Actions outstanding at the end of Q4

Scan for Safety, however, is far more than just inventory management, the solid foundations established within BCUHB provide an ideal launch pad for extending the use of SupplyX in the data capture and linkage across patient pathways. To facilitate that product patient linkage DHCW have successfully developed (currently in non-live version) a feed from BCUHB Patient Administration System (PAS) to Omnicell's SupplyX inventory management system

BCU to continue to work with Shared Services to progress the already built, patient feed, to be tested and switched on to 'live' to allow products to be scanned to patients.

Key benefits of product to patient linkage

- Ability to track products to patients.
- Ability to swiftly remove 'recalled' products.
- Ability to quickly identify patients that have a recalled product (days of clinical effort reduced to <1hr)
- Ability to flag product alerts at point of use.
- Reduction of 'never' events and improved patient outcomes
- Automated device information linkage to patient records
- Fewer cancelled procedures due to product unavailability
- Increased access to information for clinicians to support decision making.
- Increased confidence of having the right product for the right patient
- Learning process augmented by data and insights.
- Gateway to further S4S use cases e.g. patient tracking.

6. Transactional Activity Performance Indicators

These data sets relate to the All Wales KPIs for transactional activity undertaken by both Health Board (requisitioners) and Procurement staff when committing expenditure on behalf of the Health Board.

Requisitions are requests raised by Health Board staff and are categorised as either Catalogue or Non-Catalogue requests.

- Catalogue requests are predominantly 'on-contract' items used within NHS Wales which have been pre-loaded into Oracle for ease of ordering. Requests for these items automatically generate a purchase order once the requisition has passed through the approval hierarchy within Oracle.
- Non-Catalogue requisitions require buyer intervention either via the conducting of a multiquote exercise or further investigation and comparison with contracted lines available from other suppliers.

Catalogue coverage continues to increase steadily with 88% of expenditure via Oracle Purchase Order now automated due to increased contract coverage in relation to non-pay expenditure.

Whilst the KPI target for No PO No Payment is being achieved the monthly report issued by Accounts Payable highlight the pressing need for action on the number of aged invoices without a Purchase Order which has consistently hovered at over 2,000 invoices for much of the financial year.

Retrospective Purchase Orders have seen significant increase in Q4, a breakdown of retrospective orders per month can be viewed in the chart below and are reported by Finance colleagues to the Audit committee. Procurement staff are working with service users to educate them as to best practice and to re-emphasise the SFI requirements of Purchase Order in advance of commitment to expenditure.

KPI Title	Definition/Target	Jan	Feb	March
Catalogue Coverage	*Increase catalogue coverage to meet All Wales target of 80%*	88%	90%	87%
No PO No Payment	*Reduction in the number of manual invoices paid where it has been agreed to raise a PO, target 80%*	89%	89%	84%
Retrospective Orders	*Reduce the number of retrospective orders raised*	625	463	653
Requisitions	*Requisitions turnaround within 3 days All Wales target of 90%*	90%	74%	64%
Requisitions returned	*Requisitions returned due to lack of information or item was a catalogue line*	197	212	174

In the later part of Q4 requisition turnaround has fallen well below the All-Wales target of 90%, this figure has been heavily influenced by the additional non-pay controls implemented across the Health Board during February and March.

Procurement & Finance 'Procure to Pay' (P2P) Meetings

Procurement Services have attended regular P2P Meetings with BCU Finance colleagues to address a number of common themes across both organisations, including:

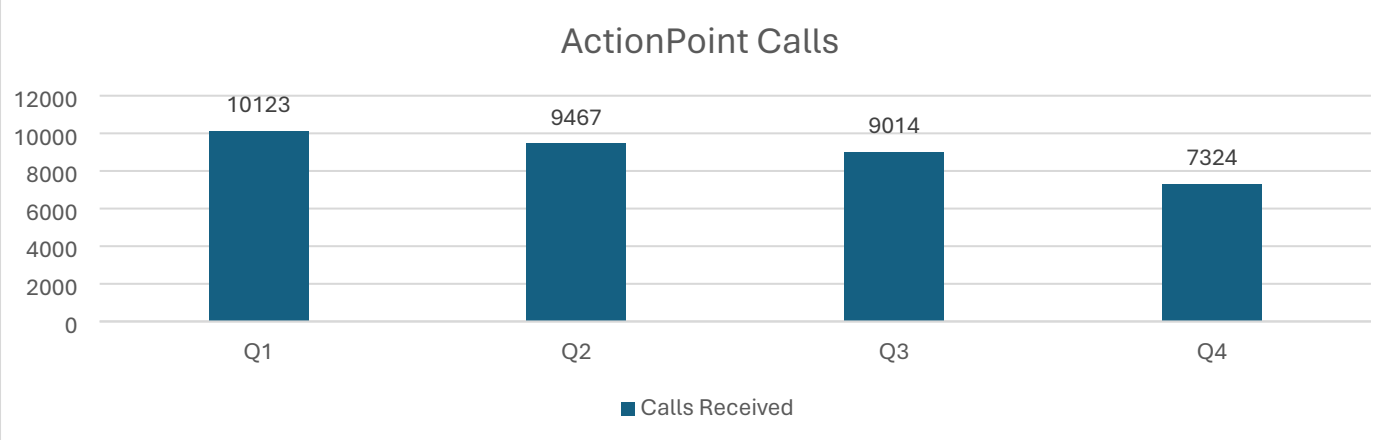
- Clearing historical Invoice on Hold (IOH) backlog;
- Implemented process improvements in relation to Home Delivery of Diabetes Products, which will have a direct impact on number of manual purchase orders raised and reduction of IOHs;
- Working with BCU Systems colleagues and BCU Dental staff to move towards automation of their ordering processes;

- Established a Task & Finish Group to explore requirements for Out of Ours orders of Bariatric Beds & Equipment, which will be added as a separate Lot in a forthcoming tender process later this year;
- Refreshed and updated the Budget Managers Handbook and Procurement Guide alongside BCU Finance colleagues; and
- Supported introduction of Financial 'Grip & Control' measures within Oracle at Financial year end in order to reduce unnecessary expenditure.

7. Action point customer calls received / responded to.

ActionPoint is the Procurement Teams customer service portal through which much of our communication with day-to-day service users is conducted. The portal is manned Monday to Friday and provides Health Board and Procurement Staff alike with an auditable trail on the incoming requests received by the team in terms of responsiveness and advice provided. The portal typically receives between 3,000 and 4,000 calls per month from our service users as is demonstrated in the table below. Calls fell slightly at the end of Q4 in part as Financial Year end crossed with the Easter Holiday break.

Q1	Q2	Q3	Q4
10,123	9467	9014	7324



The team aim to resolve most calls within 24 – 48hrs dependent on the nature of the incoming enquiry, the exception being calls requiring additional information from requestors and suppliers which can often take up to 5 working days to resolve. All calls were addressed and closed by the end of each quarter.

The table below provides a summary of the Top 5 enquiry types by volume of calls received, most of the PO queries received in the later part of Q4 related to requisitions that were pending action due to the change controls in place.

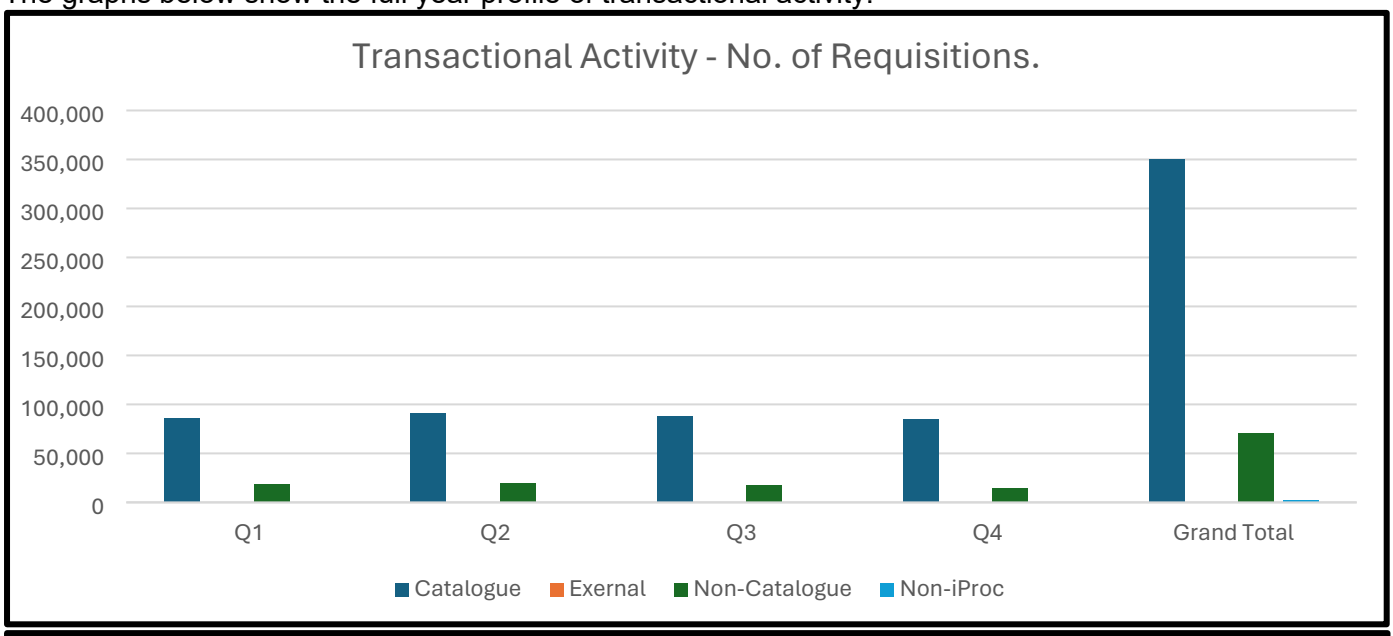
Enquiry Type	Q1 (APR - JUN)	Q2 (JUL - SEP)	Q3 (OCT - DEC)	Q4 (JAN-MAR)
	No. of calls	No. of calls	No Of Calls	No Of Calls
Purchase Order Query	6224	5880	4040	3804
Supplier Set Up	146	138	154	163
General PO Query	1235	1232	2147	629
Product Enquiry	1694	1542	1671	1701
Delivery Issue (non-stock)	18	30	177	336
Grand Total	9643	9194	8832	7324

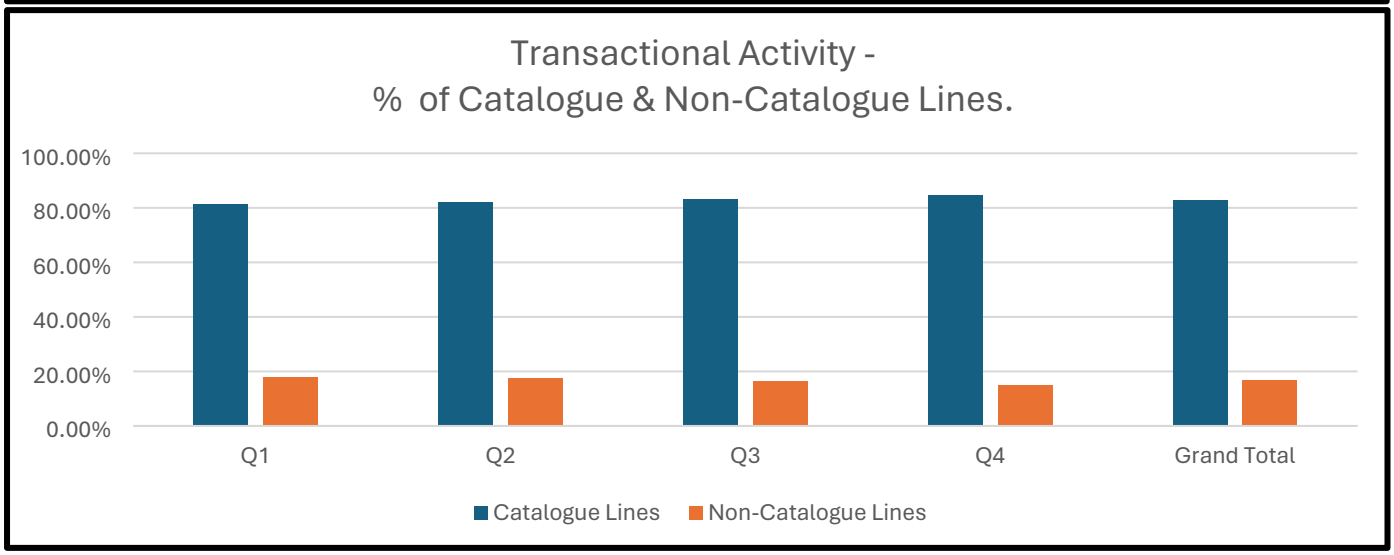
8. Customer Service & Transactional Activity

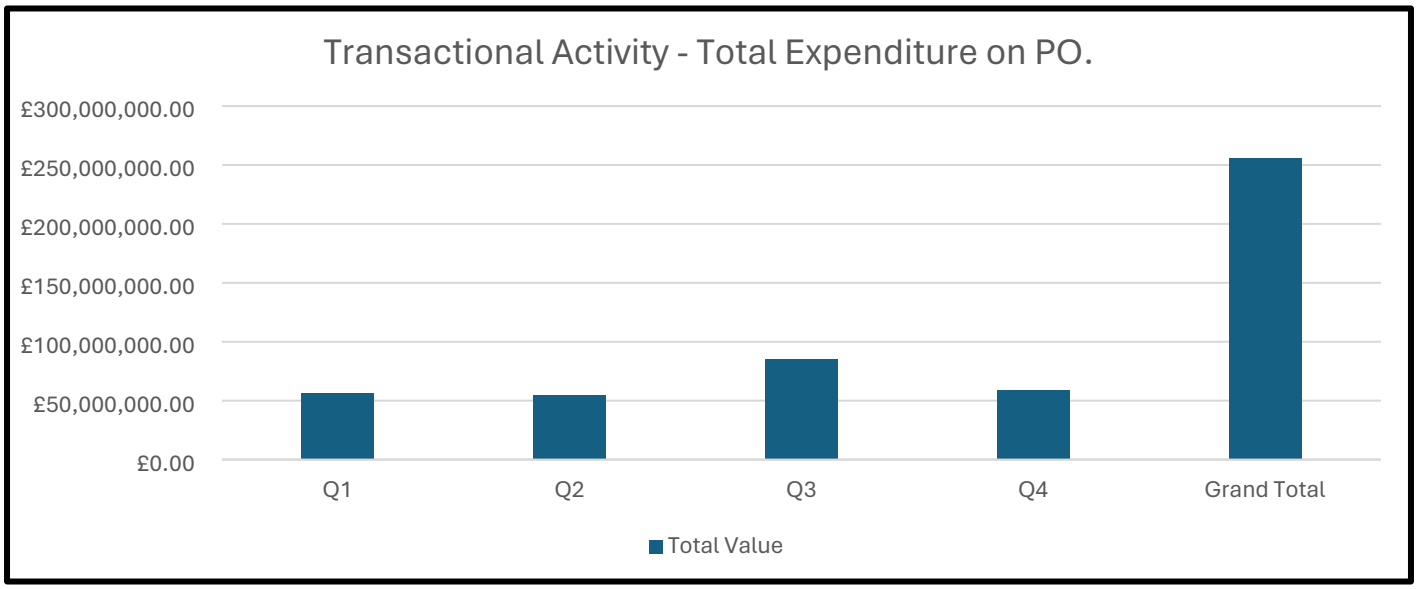
Transactional activity is predominantly activity undertaken in relation to non-catalogue requisitions received which require manual intervention by our buyers. Procurement services are working towards increased automation of purchase orders across the health board, the table below demonstrates that the percentage of non-catalogue lines fell to 15% in the final quarter of 2023/24, this figure is expected to continue to fall as our focus moves towards educating our service users with regards to alternative or similar items available on the existing catalogues and contracts.

	No. of Requisitions	No. of lines	% of Catalogue lines	% of non-catalogue lines	No. of Purchase Orders	No. of Suppliers	Total Expenditure on PO
Q1	23,431	105,858	81%	17%	42,960	1964	£56,677,598
Q2	23,797	110,791	82%	18%	42,878	1939	£54,854,345
Q3	23,146	106,521	83%	16%	41,500	1937	£85,091,795
Q4	22,254	100,925	85%	15%	39,002	1826	£58,921,822

The graphs below show the full year profile of transactional activity.







9. Welsh Government Policy Progress Update

NWSSP is responsible for ensuring that Welsh Government's key policy areas are considered during all of our day-to-day procurement activity for BCUHB. This includes policies such as the Well Being of Future Generations, Foundational Economy, Sustainability, Social Value and Decarbonisation. This information is reported into Welsh Government monthly.

The table below provides the Health Board with brief headlines on projects linked to the delivery of the above policies affecting procurements conducted on behalf of the Health Board.

WG Policy	Progress update
Foundational Economy	**19** contracts awarded to Welsh Suppliers – total value £1,864,392.75
Decarbonisation	BCUHB Re-Fit tender currently at CARR but will look at providing energy reduction and alternative energy schemes to the Health Board.

10. Procurement Training for Health Board Staff

Procurement Services in collaboration with BCU Finance colleagues have commenced the delivery of a rolling programme of Procurement Awareness Sessions across the Health Board.

At the start of Q3 we supported the delivery of awareness sessions to Finance colleagues across the Health Board with a specific focus on early procurement engagement and the alignment of procurement processes with the Health Boards SFIs.

In early 2024 we further embarked on a rolling programme of Procurement awareness sessions for both the Executive Team and Senior budget managers delivering at least one session to each of the 3 IHCs in East, West and Central by the end of Q4.

Feedback has been positive overall with several speciality areas approaching Procurement staff outside of the sessions for further support with planning their future procurements.

11. Procurement Actions following NWSSP Audit Services' Contract & Procurement Review of BCUHB

Procurement Services has worked alongside colleagues in BCU Finance and NWSSP Audit & Assurance Services to respond to the recommended actions following the Contract & Procurement Review. Some of

these were joint actions to be addressed by both BCU Finance and Procurement Services, while some were specific to Procurement Services. The table below shows the relevant Audit recommendations and the relevant actions taken to address them:

Recommendation Reference	Recommendation Detail	Action Taken
AR-03	All Wales Procure to Pay Manual to be reviewed to ensure content is accurate and up to date	Manual has been reviewed as part of launch of NWSSP 'Document Management System'. Plans are also in place to refresh the manual when new Procurement Regs have been implemented.
AR_13	Review escalation routes within the HB for the Head of Procurement	Quarterly Procurement highlight report has been resurrected and will include details of any areas of concern for escalating within the HB.
AR-14	Blank email/fax details on purchase orders to be reviewed regularly	In agreement with colleagues in Accounts Payable, a regular report will be provided to the AW P2P Forum around management of the Supplier Database and progress with cleansing any missing data from supplier accounts.
AR-17	Supplier Header data in eCM not consistent with data held in Oracle	As part of Procurement Services tender processes, suppliers are reminded of their obligations to keep their details updated in both systems. NWSSP have no control over supplier details in eTenderWales system as this is managed by an external provider on behalf of Welsh Public Sector.
AR-18	Annual Assurance Report – Director of Procurement Services ensures that all policies, procedures and guidance documents are up to date in line with SFIs.	The recently launched 'Document Management System' incorporates the most up to date guidance for Procurement and HBs. The system will also be refreshed regularly to ensure that information is accurate and current.
AR-19	Annual Assurance Report – Identify forum for Procurement Services to present report	Meeting scheduled with Exec DOF, Operational DOF and representatives from Procurement Services on 28th June
AR-20	Procurement Bill – Procurement Services to ensure NHS Wales is ready for any changes to procurement legislation and provide updates to HBs around impacts of any changes.	All Procurement Services staff are undertaking training during Summer '24 in readiness for the launch of the new Procurement Regs in the Autumn. Training will be provided to HB Exec Teams and Staff once full impact of changes is known.
AR-21	SQA/STW applications to be scrutinised to ensure compliance with SFI 11.13.3 and reject if criteria not met	E-Waiver System upgrade has been completed and complies with SFI 11.13.3. Procurement Services has seen a significant

		decrease in the number of waiver requests during last few months and this number is expected to decrease further over time.
AR-22	NWSSP to provide information to HB on services provided to other HBs/Trusts	HOP met with peers across Wales to discuss additional services offered to other HBs/Trusts, with information subsequently shared with BCU Finance colleagues for information purposes. In summary, any additional services provided by other Procurement Teams are funded directly by their relevant HB.

Report Produced for Betsi Cadwaladr University Health Board

Report prepared on behalf of NWSSP Procurement Services by;

Jonathan Irvine, Director of Procurement Services

Wyn Owens, Head of Operational Procurement & National Sourcing

Sian Owens, Assistant Head of Operational Procurement

Appendix A – Tenders Awarded and Tender in Progress (Quarter 4)

Awarded To	Award Date	Board Approval	Contract Value £000	Source Of Funding	Purchase of goods/Lease/Staff
JRS MECHANICAL SERVICES LTD	04/01/2024	NO	£131,631.01	CAPITAL	PURCHASE
ARCHUS	23/02/2024	NO	£52,740.00	CAPITAL	PURCHASE
A E & A T LEWIS LTD	08/02/2024	NO	£64,489.08	CAPITAL	PURCHASE
PREMIER COMPLIANCE UK	18/03/2024	NO	£21,682.50	CAPITAL	PURCHASE
COLEMAN ELECTRICAL LTD	01/02/2024	NO	£22,000.00	CAPITAL	PURCHASE
CAE TECHNOLOGY LTD	25/01/2024	YES	£1,015,502.36	CAPITAL	PURCHASE
CENTERPRISE INTERNATIONAL LTD	30/01/2024	NO	£355,807.50	REVENUE	SERVICE
MPH CONSTRUCTION LTD	22/01/2024	NO	£189,432.54	CAPITAL	PURCHASE
INSIGHT DIRECT LTD	24/01/2024	NO	£34,756.32	REVENUE	PURCHASE
PREMIER COMPLIANCE	07/03/2024	NO	£60,883.05	REVENUE	SERVICE
BLOCK SOLUTIONS LTD	27/02/2024	NO	£323,192.12	REVENUE	PURCHASE
DELL COMPUTER CORPORATION LTD	31/01/2024	NO	£17,263.46	CAPITAL	PURCHASE
RAFFERTY SPECIALIST ACCESS SERVICES LTD	01/03/2024	NO	£50,595.00	REVENUE	PURCHASE
SOFTCAT	01/02/2024	NO	£30,643.80	REVENUE	PURCHASE
CDW LTD	01/02/2024	NO	£5,023.38	REVENUE	PURCHASE
GARTNER UK LTD	01/02/2024	NO	£55,150.00	REVENUE	LEASE
CENTERPRISE INTERNATIONAL LTD	04/03/2024	NO	£442,638.50	CAPITAL	PURCHASE
SOFTCAT	14/03/2024	NO	£79,945.05	REVENUE	PURCHASE
MPH CONSTRUCTION LTD	06/02/2024	NO	£172,947.90	REVENUE	PURCHASE
PETER T GRIFFITHS LTD	06/02/2024	NO	£30,730.50	REVENUE	PURCHASE
PETER T GRIFFITHS LTD	07/02/2024	NO	£32,461.62	REVENUE	PURCHASE

SGC HOLDINGS LTD	09/02/2024	NO	£462,389.76	REVENUE	PURCHASE
CINOS COMMUNICATIONS LTD	04/03/2024	NO	£116,298.41	CAPITAL	PURCHASE
MPH CONSTRUCTION LTD	21/02/2024	NO	£128,945.84	CAPITAL	PURCHASE
MPH CONSTRUCTION LTD	21/02/2024	NO	£77,183.57	CAPITAL	PURCHASE
SP NETWORKS	21/02/2024	NO	£138,342.20	CAPITAL	PURCHASE
MPH CONSTRUCTION LTD	21/02/2024	NO	£10,287.78	CAPITAL	PURCHASE
MPH CONSTRUCTION LTD	21/02/2024	NO	£19,895.99	CAPITAL	PURCHASE
PETER T GRIFFITHS LTD	21/02/2024	NO	£11,030.51	CAPITAL	PURCHASE
PETER T GRIFFITHS LTD	21/02/2024	NO	£13,281.30	CAPITAL	PURCHASE
COMPUTACENTER (UK) LTD	05/03/2024	NO	£45,735.97	CAPITAL	PURCHASE
ATKINS REALISS	23/02/2024	NO	TBC	CAPITAL	PURCHASE
SOFTCAT PLC	26/02/2024	NO	£31,769.47	CAPITAL	PURCHASE
SGC HOLDINGS LTD	01/03/2024	NO	£30,000.00	CAPITAL	PURCHASE
MPH CONSTRUCTION LTD	04/03/2024	NO	£7,367.64	CAPITAL	PURCHASE
GLEEDS ADVISORY LIMITED	04/03/2024	NO	£39,408.00	CAPITAL	PURCHASE
PETER T GRIFFITHS LTD	07/03/2024	NO	£44,988.35	CAPITAL	PURCHASE
CDW LTD	14/03/2024	NO	£42,940.07	CAPITAL	PURCHASE
MPH CONSTRUCTION LTD	20/03/2024	NO	£65,409.53	CAPITAL	PURCHASE
IDOX SOFTWARE LTD	14/03/2024	NO	£208,433.99	CAPITAL	PURCHASE
PETER GRIFFITHS LTD	27/03/2024	NO	£74,838.30	CAPITAL	PURCHASE
PEN Y BRYN JOINERY LTD	29/01/2024	NO	£692,273.38	CAPITAL	PURCHASE

Tenders in process during Q4

Tender Ref	Contract Title	Department	Duration	Total Contract Value	Governance, Service or Savings	Current Status
BCU-MIN-55076	BCUHB RE-FIT	CORPORATE	One Off	£5,000,000.00	Savings	At evaluation - Can't confirm final costs until winning bidder undertakes surveys and proposals.
BCU-MIN-54485	ENLLI ITU WARD UPGRADE PHASE 3	CAPITAL PLANNING	One Off	TBC	Governance	CARR in progress.
BCU-ITT-54230	YSBYTY GWYNEDD PATHOLOGY PHASED REVITALISATION	CAPITAL PLANNING	One Off	TBC	Governance	In discussion to re-phase the works due to capital budgets.
BCU-MIN-54633	ELECTRONIC PRESCRIBING & MEDICINES ADMINISTRATION (EPMA) SYSTEM	ICT	5 Years (2 Year Optional Extension)	TBC	Service	Notification of standstill sent.
BCU-MIN-54842	6 FACET SURVEYS ACROSS BCUHB	ESTATES	One Off	£500,000.00	Governance	Pending post-tender clarifications.
BCU-ITT-55121	PROVISION OF GMS CONTRACT SERVICES IN BETWSY COED, NORTH WALES	PRIMARY CARE	GMS - Indefinite	£0.00	Governance	At evaluation stages.
BCU-OJEU-55140	BCUHB EDUCATION AND TRAINING PROGRAMME	PRIMARY AND COMMUNITY CARE	1 Year (1 Year Optional Extension)	£400,000.00	Service	At evaluation stages.
BCU-ITT-55209	LLANDUDNO ORTHOPAEDIC - ENABLING WORKS	CAPITAL PLANNING	One Off	£5,782,764.30	Governance	Pending Welsh Gov post-approvals.

BCU-ITT-55266	PROVISION OF MUSIC INTERVENTION THERAPY	CAMHS	2 Years (1 Year Optional Extension)	£62,000.00	Service	CARR with Finance.
BCU-ITT-55278	FIRE ALARM UPGRADES - BRYN BERYL HOSPITAL AND PENRHOS STANLEY HOSPITAL	ESTATES	One Off	TBC	Governance	Pending post-tender clarifications.
BCU-ITT-55282	FIRE ALARM UPGRADES - ERYRI HOSPITAL	ESTATES	One Off	£50,494.76	Governance	To be Awarded.
BCU-OJEU-55283	COMMUNITY DENTAL IT SOLUTION	ICT/DENTAL	4 Years (2 Year Optional Extension)	TBC	Service	At evaluation stages.
BCU-ITT-55494	LEVEL 3 WEIGHT MANAGEMENT SERVICE	DIETETICS	2 Years	TBC	Service	At evaluation stages.
BCU-OJEU-55488	PROVISION OF BRANDED MERCHANDISE FOR NORTH WALES CHILD & ADOLESENT MENTAL HEALTH (CAMH) SCHOOL IN-REACH SERVICE	CAHMS	2 Years (2 x 1 Year Optional Extensions)	TBC	Governance	At evaluation stages.
BCU-DCO-55516	PROVISION OF ABORTION CARE SERVICES	COMMISIONING	TBC	TBC	Service	Pending end users for way forward.
BCU-ITT-55630	PROVISION OF C-CARD SCHEME IN NORTH WALES FOR AGES 13-25	PROFESSIONAL SERVICES	3 Years	TBC	Service	At evaluation stages.
BCU-DCO-55896	BCU FUEL CARDS	FLEET/TRANSPORT	TBC	TBC	Service	SLA agreement awaiting HB signoff

BCU-MIN-55942	PROVISION OF CISCO UNIFIED COMMNICATIONS ENDPOINTS FOR VARIOUS SITES	ICT	One off	TBC	Governance	At evaluation stages.

END OF DOCUMENT

Teitl adroddiad: ***Report title:***	Risk Report & Corporate Risk Register
Adrodd i: ***Report to:***	Audit Committee
Dyddiad y Cyfarfod: ***Date of Meeting:***	Thursday, 18 July 2024
Crynodeb Gweithredol: ***Executive Summary:***	The purpose of this standing agenda item is to provide an update position of the Corporate Risk Register, June Internal Audit report and Risk Management arrangements and role of Risk Management Group proposal. The June Internal Audit report on Risk Management arrangements across the Health Board notes Limited Assurance and management response (Final report Appendix 1). The body of this report draws out one of the recommendations from the Internal Audit report around reviewing the role of Risk Management Group and proposes a 3 x a year Risk Forum and a monthly Risk Scrutiny Group. This paper further presents the corporate risk dashboard and report highlighting risks and updates following review of the individual risks. Of the 17 Corporate Risks, 139 actions have been developed to mitigate the risks 29 actions have been completed, 104 actions are progressing and on track and 6 actions are overdue. Appendix 3 & 4 outlines key updates to our organisation's risk framework and procedures. The changes reflect approved changes at the Executive Team Meeting 20/06/24 and Risk Appetite Board Development Session 27/06/24. Appendix 1 - Internal Audit Report and Recommendations Appendix 2 - Full corporate risk register as of June 2024. Appendix 3 - Risk Management Framework - highlights key updates and changes. Appendix 4 - contains the Risk Management Procedure and highlights key updates and changes.
Argymhellion: ***Recommendations:***	The Committee is asked to **endorse**: 1. The management response of Internal Audit report. 2. The recommendations made around the Risk Scrutiny Group and key updates and changes to the Risk Framework and Procedures. 3. The Corporate Risk Register.
Arweinydd Gweithredol:	Pam Wenger, Director of Corporate Governance

Executive Lead:				
Awdur yr Adroddiad: ***Report Author:***	Nesta Collingridge Head of Risk Management			
Pwrpas yr adroddiad: ***Purpose of report:***	I'w Nodi *For Noting* ☐	I Benderfynu arno *For Decision* ☒	Am sicrwydd *For Assurance* ☒	
Lefel sicrwydd: ***Assurance level:***	Arwyddocaol *Significant* ☐ Lefel uchel o hyder/tystiolaeth o ran darparu'r mecanweithiau / amcanion presennol *High level of confidence/evidence in delivery of existing mechanisms/objectives*	Derbyniol *Acceptable* ☒ Lefel gyffredinol o hyder/tystiolaeth o ran darparu'r mecanweithiau / amcanion presennol *General confidence / evidence in delivery of existing mechanisms / objectives*	Rhannol *Partial* ☐ Rhywfaint o hyder/tystiolaeth o ran darparu'r mecanweithiau / amcanion presennol *Some confidence / evidence in delivery of existing mechanisms / objectives*	Dim Sicrwydd *No Assurance* ☐ Dim hyder/tystiolaeth o ran y ddarpariaeth *No confidence / evidence in delivery*
Cyfiawnhad dros y gyfradd sicrwydd uchod. Lle bo sicrwydd 'Rhannol' neu 'Dim Sicrwydd' wedi'i nodi uchod, nodwch gamau i gyflawni sicrwydd 'Derbyniol' uchod, a'r terfyn amser ar gyfer cyflawni hyn: ***Justification for the above assurance rating. Where 'Partial' or 'No' assurance has been indicated above, please indicate steps to achieve 'Acceptable' assurance or above, and the timeframe for achieving this: N/A***				
Cyswllt ag Amcan/Amcanion Strategol: ***Link to Strategic Objective(s):***	Detailed in the BAF report and how the CRR aligns to the revised BAF			
Goblygiadau rheoleiddio a lleol: ***Regulatory and legal implications:***	It is essential that the Board has robust arrangements in place to assess, capture and mitigate risks, as failure to do so could have legal implications for the Health Board.			
Yn unol â WP7, a oedd EqlA yn angenrheidiol ac a gafodd ei gynnal? ***In accordance with WP7 has an EqlA been identified as necessary and undertaken?***	Not applicable for this report			
Yn unol â WP68, a oedd SEIA yn angenrheidiol ac a gafodd ei gynnal? ***In accordance with WP68, has an SEIA identified as necessary ben undertaken?***	Not applicable for this report			
Manylion am risgiau sy'n gysylltiedig â phwnc a chwmpas y papur hwn, gan	Board Assurance Framework due for review			

gynnwys risgiau newydd (croesgyfeirio at y BAF a'r CRR) ***Details of risks associated with the subject and scope of this paper, including new risks(cross reference to the BAF and CRR)***	
Goblygiadau ariannol o ganlyniad i roi'r *argymhellion ar waith* ***Financial implications as a result of implementing the recommendations***	The effective and efficient mitigation and management of risks has the potential to leverage a positive financial dividend for the Health Board through better integration of risk management into business planning, decision-making and in shaping how care is delivered to our patients thus leading to enhanced quality, less waste and no claims.
Goblygiadau gweithlu o ganlyniad i roi'r argymhellion ar waith ***Workforce implications as a result of implementing the recommendations***	Failure to capture, assess and mitigate risks can impact adversely on the workforce.
Adborth, ymateb a chrynodeb dilynol ar ôl ymgynghori ***Feedback, response, and follow up summary following consultation***	Quality assurance by Corporate Risk Management Team and some have been updated and presented to Risk Management Group. Some risks were delayed and since updated by leads for this paper so not seen at the Risk Management Group, however, presented at Executive Team on the 19th June 2024.
Cysylltiadau â risgiau BAF: (neu gysylltiadau â'r Gofrestr Risg Gorfforaethol) ***Links to BAF risks:*** *(or links to the Corporate Risk Register)*	See the individual risks for details of the related links to the Board Assurance Framework.
Rheswm dros gyflwyno adroddiad i fwrdd cyfrinachol (lle bo'n berthnasol) ***Reason for submission of report to confidential board (where relevant)***	**N/A** **Cyber risk CRR24-17 excluded from the paper**
Camau Nesaf: ***Next Steps:*** 1. Risk Scrutiny Group and recommendations from Internal Audit to be progressed.	
Rhestr o Atodiadau: ***List of Appendices:*** • Appendix 1 - Internal Audit Report and Recommendations • Appendix 2 - Full corporate risk register as of June 2024.	

- Appendix 3 - Risk Management Framework and highlights key updates and changes.
- Appendix 4 - Risk Management Procedure and highlights key updates and changes.

RISK MANAGEMENT REPORT – AS AT END JUNE 2024

1. PURPOSE

The purpose of this report is to provide the Audit Committee with the recent internal audit report, provide a proposal for some of the recommendations and to present the corporate risk register.

2. INTERNAL AUDIT RISK MANAGEMENT – 'LIMITED ASSURANCE'

Internal Audit have undertaken the planned annual audit of arrangements of risk management noting limited assurance. During the last 12 months significant work has been undertaken to make improvements to the management of risk. This is recognised but the Board and the commentary in the Internal Audit Report are reflective of that progress. The Executive Team recognise that progress made and support the actions outlined to address the 'Limited Assurance' Internal Audit Report.

There are actions in which the corporate Risk Management team need to improve quality assurance of all risks and monitor risks which are overdue. It is recommended that corporate risks need to be better scrutinised, and the role of risk management should be reviewed. For assurance to the Executive Team several actions are already underway by the corporate risk team. A summary of findings is provided in Table 1 below.

Table 1

Matters which require management attention
The content and quality of the Operational risk registers varies. Risk dates were overdue for almost a quarter (23%) of risks reviewed.
Whilst there has been an improvement in the scrutiny arrangements within the Corporate Risk Team, there is not consistent scrutiny of risks across operational areas.
The Corporate Risk Register has been reviewed and consolidated, however further work is required to ensure information on controls, actions and lines of assurance are captured in sufficient detail to provide assurance to the Health Board.
Whilst the Risk Management Group brings together representatives from across the Health Board, the membership is wide, and the agenda is large, so there is often not sufficient scrutiny of corporate or operational risk registers

The full management response is attached at **Appendix 1**.

2.1 Role of Risk Management Group Proposal

The Risk Management Group has provided a mechanism for the detailed consideration of risk registers in BCUHB. However, it has appeared on times to provide confusion in relation to the

accountability and responsibility for Risk Management in the organisation. Each Directorate is responsible for the management of risks and the framework in place should allow for the escalation and monitoring of operational risks through the governance structures, such as the IHC Board.

Any risks that require escalation should be considered by the IHC Board and form part of the overarching governance arrangements, and will also be monitored through the Health Board Performance Management Framework.

There is a need to ensure the appropriate escalation and management of risks have appropriate scrutiny before they are considered by the Executive Team and the current role of the Risk Management Group confuses this accountability and therefore it is proposed to integrated the processes through the normal governance arrangements and frameworks already in place. The following therefore outlines the approach that is recommended.

Table 1 - Summary of Proposal

Summary of Proposal
1. IHC and Corporate Functions will be required to provide a monthly exception report which will highlight any critical risks for consideration on the CRR and/or de-escalation. 2. Risk Management Team would support and review the production of this information ahead of a Risk Scrutiny Group. 3. A monthly Leadership Team will need to consider risk exception reports before an Executive Lead sign off along with the rationale for the risk escalation. 4. This would be a feedback loop process. It is equally important that feedback from Risk Scrutiny Group is reported back to IHC's, Directorates/Services and Functions. 5. Risk Scrutiny Group to meet once a month, to prior to a monthly Executive Team meeting. *6.* The Risk Scrutiny Group (supported by the Risk Management Team) would approve a monthly Corporate Risk Register to the Executive *Team (Terms of Reference drafted for review at the first meeting 09/07/24 and subsequent approval at the following* Executive *Team meeting).* 7. Corporate Risk Register would be considered and approved at Executive Team on a monthly basis. This would result in a definitive Executive Team approved monthly Corporate Risk Register. 8. This would then be reported to the Committees in their two monthly cycle (risks above tolerance or minimum quarterly) of and also received at the Board on a quarterly basis. 9. Risk Management Forum to meet 3 times a year to receive risk performance/governance reports and governance arrangements of risk management (for example, approval of Framework/Procedures).

A key element of these proposals is to facilitate a monthly discipline of risk scrutiny and escalation that supports a definitive monthly approved Corporate Risk Register that then informs Committee and the Board. The summary of which is outlined below

- Week 1- Risk Management Team works with IHC and Corporate Functions to prepare information for review.
- Week 2 – Risk Scrutiny Group meets (as scrutiny of any critical risks)
- Week 3 – Executive Team receives and considers Corporate Risk Register report
- Week 4 - 2 month cycle - A confirmed Corporate Risk Register informs Committees.
- Quarterly – The most recent confirmed Corporate Risk Register reported to Board

An outline of these proposals was presented at the Risk Management Group on the 11 June 2024 and approved at the Executive Team (19 June 2024) and membership of Risk Scrutiny Group agreed. Changes were also presented informally at the Risk Development Session for the Board (27 June 2024).

A Risk Scrutiny Group has been set up for the 9th July to review a draft Terms of Reference, Cycle of Business and Draft Risk Escalation report.

2.2 Risk Framework and Procedures Updates

The Risk Management Group has been stood down and replaced by a Risk Scrutiny Group and Risk Forum. This change emphasises critical review of strategic risks. Furthermore, The BAF reporting cycle to the Board has been modified from [previous frequency quarterly] to bi-annual, noting planning papers will be received by the Board quarterly. The updates are designed to strengthen our risk management practices and improve the efficiency of our reporting mechanisms. The revised framework ensures that we maintain robust risk oversight while optimising resource allocation. Committees will receive risks which are above the risk tolerance on a bi-monthly basis and for those in line or below tolerance on a quarterly basis [previous frequency quarterly]. We recommend a thorough review of the attached detailed document (Appendix 3 & 4) to fully understand the implications of these changes on existing processes and responsibilities.

2.3 Risk Appetite

The Board undertook the planned annual exercise on the 27th June 2024 to review the Risk Appetite and set the tolerance for 24/25. This has subsequently been updated in the Appendix of the Risk Framework.

Quality; Financial; Regulatory/Compliance: Open
Innovation; Reputation: Seek

24/25 Risk Appetite

Quality Risk: There was willingness to be '**open**' and accept the possibility of a short-term impact on quality outcomes with potential for longer-term rewards, supporting

innovation. Broad learning from events influence improvement. Efforts to promote openness and transparency are on a risk basis by repercussion.

Financial Risk: There was an agreed consensus on an '**open**' appetite to be prepared to invest for return but **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.

Compliance/Regulatory: There was an agreed consensus supporting an '**open**' risk appetite to accept the possibility of some regulatory challenge as long as we can be reasonably confident we would be able to challenge this successfully.

Innovation Risk: There was an agreed consensus to **'seek'** and innovation is to be pursued with the desire to 'break the mould' and challenge current working practices. New technologies viewed as a key enabler of operational delivery. High levels of devolved authority – management by trust rather than tight control.

Reputational Risk: There was an agreed consensus to '**seek**' with a willingness to take decisions that may bring scrutiny of BCUHB but where potential benefits outweigh the risks. New ideas seen as potentially enhancing reputation of organisation.

2.4 Strategic Risk Management Training

In the Risk Management Training Plan Strategic Risk Management Training is recommended to the Board every two years. Training was delivered virtually to the Board on the 24.06.24 at the all Board members had attended the training or later watched the recording.

2.5 Next Steps

Work has started to develop enabling documents that would allow for this approach to be implemented. It is proposed that these documents are developed by the Risk Management Team and received at Executive Team for approval on 17 July 2024 and then received at Audit Committee on 18 July 2024.

1. A clear escalation criteria that reflects the nature or risk management and escalation from 'floor to board'.
2. Terms of refence for Risk Scrutiny Group (and Risk Management Forum to follow) to include a clear escalation of risk between registers.
3. A programme/calendar setting out the review of Corporate Risks at Executive Team and when they are received and considered at Committees and Board**.**

3. CORPORATE RISK REGISTER REPORT – AS AT END JUNE 2024

3.1 Changes to the Corporate Risk Register

There are 17 consolidated Corporate Risks. The full details of these risks are highlighted in **Appendix 2** and include evidence of controls in place, assurances on those controls, additional controls required and actions with due dates.

There have been no changes in risks (escalation or de-escalation since the report to the Board at the end of May 2024). However, a number updates on progress in terms of the actions have been progressed although these have not resulted in any changes to the risk scores.

3.2 Key Highlights

Corporate Risks Dashboard highlights actions required by the Executive Team.

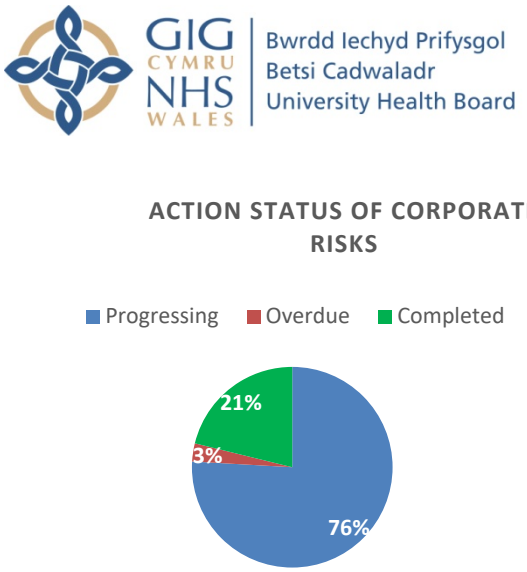
- CRR24-02 'Patient Safety – Falls' (risk score 20) – 4 Overdue actions. However this risk is to be revised to a Patient Safety risk, draft has now been completed and currently being reviewed by the Executive. **The updated risk will be reflected in the risk register reported to the Board at the end of July 2024.**

Out of the 17 corporate risks, 139 actions have been developed to mitigate the risks as opposed to the previously reported 89. 29 actions have been completed (previous 13), 104 actions are progressing and on track and 6 actions are overdue. However 14 actions have revised dates (risks CRR24 01-04 & 06).

The Risk Management Team met with available Executives w/c 10 June to gain updates on actions and some of these are reflected in the reports in Appendix 2. Despite the increase in the completed actions, there is no proposed changes to the risk score to report.

The 6 overdue actions span across 2 different corporate risks, with the Patient Safety - Falls (4) and Harm from the Medical Devices/Equipment (2).

However positive assurances include 75% of open actions being on track, and an increase in the number of closed actions from previous reports (increase from 13 to 29 closed actions) demonstrating management of the risks.



3.3 Management of Risk

Following the update provided to the Board at the end of May 2024, at the Board Development Session in June 2024, the Board agreed to a number of actions, these have been reflected in the attached Risk Management Framework and are summarised below:

- Remove the levels of assurance from the Risk Register as it is covered in the Board Assurance Framework;
- Changes to the Corporate Risk Register to include shorter number of actions linked to the Annual Plan (as agreed by the Board;
- Separate out the risk in relation to 'Challenged Services' in order that as progress is made, changes to the risks can be monitored; and
- Agree a number of 'principal' risks which will form the basis of the Board Assurance Framework, which will be reported to the Board in September 2024.

Next steps

1. Corporate Risks presented to relevant committees for assurance.
2. Continued scrutiny of the actions, controls and progress of all corporate risks by Executives and Executive Team.
3. Published and deploying revised Risk Framework and Procedures.
4. Terms of Reference of Risk Scrutiny Group to be approved.
5. Internal Audit Recommendations to be progressed.

Risk Management
Final Internal Audit Report

June 2024

Betsi Cadwaladr University Health Board

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

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

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Review reference:	BCUHB-2324-19
Report status:	Final
Fieldwork commencement:	11 March 2024
Fieldwork completion:	21 May 2024
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Committee:	Audit Committee

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

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

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Executive Summary

Purpose
To review the implementation and application of the Health Board's Risk Management process. We also assessed implementation of the management actions agreed as part of the limited assurance review in 2022/23.

Overview
We have issued limited assurance on this area.

There has been positive progress on risk management over the last year, however it is recognised there are areas still to progress to ensure risk management is fully embedded to a high quality across the Health Board.

The matters which require management attention include:

- The content and quality of the Operational risk registers varies. Risk dates were overdue for almost a quarter (23%) of risks reviewed.
- Whilst there has been an improvement in the scrutiny arrangements within the Corporate Risk Team, there is not consistent scrutiny of risks across operational areas.
- The Corporate Risk Register has been reviewed and consolidated, however further work is required to ensure information on controls, actions and lines of assurance are captured in sufficient detail to provide assurance to the Health Board.
- Whilst the Risk Management Group brings together representatives from across the Health Board, the membership is wide, and the agenda is large, so there is often not sufficient scrutiny of corporate or operational risk registers.

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

Report Opinion

		Trend
Limited	More significant matters require management attention. **Moderate impact** on residual risk exposure until resolved.	 2022/23

Assurance summary[1]

	Objectives	Assurance
1	The Risk Management Framework, and supporting documents, set out the risk management system within the Health Board, outline clear roles and responsibilities and provide guidance to staff on the requirements for risk management.	Substantial
2	Comprehensive operational risk registers are in place, actively monitored and scrutinised at an appropriate level.	Limited
3	The Corporate Risk Register is reviewed, actively monitored and scrutinised regularly.	Limited
4	There are clear and consistent processes in place for the identification, classification, scoring and escalation / de-escalation of risks throughout the Health Board.	Reasonable
5	The Risk Management Group is operating effectively and in line with the requirements of the Framework and Terms of Reference.	Limited
6	Management actions agreed as part of the 2022/23 Risk Management and Board Assurance Framework review have been progressed / implemented.	Reasonable

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

Key Matters Arising		Objective	Control Design or Operation	Recommendation Priority
1	There is still variation in the quality of the information included in operational risk registers, and the review and scrutiny arrangements across the Health Board.	2	Operation	High
2	The risks within the Corporate Risk Register have been consolidated and refined, however there is still further work to ensure all risks, controls, actions and assurances are appropriately documented.	3	Operation	High
3	The Risk Management Group provides a forum for useful discussion on risk, however it is not sufficiently scrutinising the detail of operational and corporate risks, as per its Terms of Reference. The escalation process for corporate risks includes the presentation of the risk at Risk Management Group, however as this meets bi-monthly, alternative arrangements should be considered.	4/5	Operation	High

1. Introduction

1.1 Effective risk management is a key component of corporate and clinical governance and is integral to the delivery of organisational priorities. Risk management consists of defined steps which help us understand risks and their impact. Good risk management awareness and practice at all levels is a critical success factor for any organisation and is integral to effective management.

The Health Board's Risk Management Framework and associated documentation has recently been revised, with work ongoing to develop strategic objectives for the Health Board, to inform the Board Assurance Framework.

1.2 Risks considered in the review were:

- Inconsistent management of risks across the Health Board;
- Failure to achieve objectives and strategic priorities; and
- Exposure to reputational damage due to inadequate identification, assessment and monitoring of risks.

1.3 The following risk areas were excluded from the scope of the review:

- Board Assurance Framework (BAF) – we recognise work is ongoing to agree Health Board strategic objectives that will inform the BAF.
- Training – work is currently being undertaken to revise risk management training.

Both these elements will be included in the 2024/25 review.

2. Detailed Audit Findings

This report is based upon the information provided by officers supporting our review. We have relied solely on the documents, information and explanations provided and, except where otherwise stated, we have not contacted or undertaken work directly to verify the authenticity of the information provided.

There has been a significant amount of work undertaken on Risk Management within the Health Board over the last year, with a full review of the process and rationalisation of risks, providing members with key risks that impact the achievement of Health Board priorities. This work is ongoing and it is recognised that it will take a period of time for training to be rolled out across the Health Board before risk management processes are fully embedded.

Due to a period of change in the Health Board through 2023/24, and issues with resource within the Office of the Board Secretary, the Head of Risk Management was often required to undertake other duties, affecting the time they were able to spend on progressing risk management. We have been advised this has now been resolved and the Head of Risk Management is now solely focusing on risk management.

Objective 1: The Risk Management Framework, and supporting documents, set out the risk management system within the Health Board, outline clear roles and responsibilities and provide guidance to staff on the requirements for risk management.

2.1 Documentation relating to risk management is available to staff via the Health Board intranet site, BetsiNet. The site includes links to three key documents:

Risk Management Framework (RM01)

The Risk Management Framework was approved by the Health Board in September 2023. This outlines the risk management philosophy and details the strategy for the Health Board. It includes roles, expectations, accountability and assurance arrangements, risk appetite and scoring.

Risk Management Procedures (RM02)

The Risk Management Procedures were approved by the Risk Management Group and the Executive Team in February 2023. The Procedures support the Risk Management Framework and provide detailed guidance to staff on the roles and requirements of risk management across the Health Board.

Risk Management Training Strategy (RM03)

The Risk Management Training Plan was approved by the Risk Management Group and the Executive Team in February 2023. The document sets out the Health Board's approach to risk management training, and how this will be delivered at various levels across the organisation.

2.2 In producing the above documents, there was wide consultation across the Health Board via attendance at key service meetings, senior leadership team meetings, quality groups and risk management groups.

Conclusion:

2.3 There is a Risk Management Framework, supported by detailed procedures, available for staff via BetsiNet. A training strategy is also in place, which will further communicate and contribute to embedding risk management across the organisation.

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

Objective 2: Comprehensive operational risk registers are in place, actively monitored and scrutinised at an appropriate level

2.4 The Risk Management Procedure (RM02) requires each service to maintain their own risk register within Datix. We were provided with copies of twenty-five operational risk registers. Following review of a sample of five risk registers, we noted:

- In general, risks and controls included a lot of detail, in some cases this was useful, for others it was a timeline of what had happened, rather than a

succinct summary of the risks and current controls.

- There were some examples of older risks that either had no actions stated or actions without dates against them.
- Target risks dates were overdue for 28 of the 120 risks reviewed (23%).
- Several actions were not SMART (Specific, Measurable, Achievable, Relevant, Timebound), with brief information included that did not provide detail of what actions were planned and how the target risk score would be achieved.

2.5 The Risk Performance report for Quarter 3 (Oct – Dec 2023), details that 251 risks are not yet live and (549) are noted as 'under review' (Live). The report also details findings from an analysis of risk registers.

2.6 The Risk Management Group (RMG) has received risk registers from twelve services / areas over the last three meetings. The Group do not scrutinise each risk register (see objective 5 for more detail on RMG content), but do provide the opportunity for services to share and discuss how risk management works within their areas and challenges faced.

2.7 The Risk Managers within the Corporate Risk Team review operational risks via Datix, and will liaise with areas / services to encourage regular review and update. They attend operational risk meetings regularly, which is captured on a tracker. Where meetings are stood down, or there is a lack of engagement, this is escalated to the Head of Risk Management. Evidence was received to confirm this.

2.8 Risk managers also complete an assessment, in conjunction with the services, on the quality of the information within the risk register. This is only undertaken for those areas presenting at the RMG, and is not formally undertaken regularly.

2.9 Through discussions with Risk Managers, a review of the assurance reports provided by the team to RMG (service specific), papers of a sample of operational risk meetings, and observation of the Risk Management Group meetings, our key observations of risk management at an operational level, are:

- Lack of regular review of risks, with a number overdue for review.
- Lack of SMART action plans.
- Lack of knowledge of the processes and how to update risks in Datix (noting if this is not undertaken regularly it is more difficult to complete).
- Competing operational pressures affecting the ability to ensure risks are reviewed within timescales.
- Lack of attendance at local risk management groups, or risk meetings stood down/not in place.

Conclusion:

2.10 A review of the information in local risk registers, extracted from Datix, highlights a high number of risks overdue for review, as well as action plans that are not SMART. There has been increased review and scrutiny of risk registers within the Corporate Risk Team, however this is usually focused on Tier 1 (high) risks.

Operational arrangements for review and scrutiny varies.

2.11 We are unable to evidence high quality risk registers and regular scrutiny and review of risks across operational areas. We recognise that once training has been undertaken by key staff involved in the risk process, and the assurance activities introduced into the Corporate Risk Team have been further embedded, the quality of operational risk registers and scrutiny/review is likely to improve.

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

Objective 3: The Corporate Risk Register is reviewed, actively monitored and scrutinised regularly.

2.12 The Head of Risk Management and Corporate Risk Team have been undertaking a review of all risks on the corporate risk register to consolidate these into the strategic risks facing the Health Board. These changes have been made via discussion with executives, review at the Risk Management Group and Executive Team meetings, and presentation to the relevant committees.

2.13 We reviewed the Corporate Risk Register (CRR) presented to the Audit Committee on 7 May 2024. We noted the following:

- In general, the information in the risk register is fully complete, with new updates highlighted. Each risk includes rationale for why it is considered a corporate risk, which is useful context.
- Actions are generally SMART, however further refinement is needed to ensure all actions are captured this way, for example:

Risk	Current wording	Suggested / revised wording
CRR 24-11 Planned Care	Senior Responsible Officer for Planned Care Board	Appoint a Senior Responsible Officer to the Planned Care Board, which is responsible for XX.
	Approval of the application of sustainability funds and authority to deploy in line with plan.	Receive XX (Welsh Govt/Health Board etc.) approval of application for sustainability funds to deploy in line with XX plan.
CRR 24-02 Patient Safety – Falls	Outcome of peer review pilot to be evaluated.	Outcome of XX peer review pilot to be evaluated by XX and future actions agreed.

- Whilst it is stated that action target dates have been revised, some risks do not include the original date, limiting the ability of members to challenge the timelines.
- Mitigations / controls in place are generally well worded, however some narrative against the 'additional controls required' section are worded as controls, for example:

Risk	Current wording	Suggested / revised wording
CRR24-04 Failure to Embed Learning	Internal reviews against External National Reports.	*Should be more specific i.e.* Internal Review against XX national report.

Risk	Current wording	Suggested / revised wording
CRR24-11 Planned Care	Chief Operating Officer vacancy.	Recruitment to Chief Operating Officer role to provide direction.
CRR24-08 Population Health	The current cost of living crisis will adversely affect those most at risk.	*This is a statement rather than a control.*

- For a number of risks, the lines of assurance require refinement to ensure assurance arrangements are clear. Some examples of this are:

Risk	Current wording	Suggested / revised wording
CRR 24-02 Patient Safety – Falls	1st line - Patient Safety Group	Monthly report on falls data is provided to the Patient Safety Group.
	2nd line – Quality, Safety and Experience Committee	Bi-monthly reporting on falls data, themes and actions is provided to the QSE committee.
CRR 24-05 2023/24 Financial Plan	1st line – Control total actions and monitoring of progress	Control totals are reviewed with budget holders on a monthly basis to determine progress and actions.
	2nd line – Performance, Finance and Information Governance Committee/ Audit Committee	Bi-monthly report on financial plans and control totals is provided to the PFIG committee.

Also, the Risk Management Group is often stated as first line assurance, whereas this should be second line as it is a function that is not responsible for the processes within services.

2.14 The Head of Risk Management and Corporate Risk Team scrutinise corporate risks prior to reporting and will address queries with risks leads in the relevant services as required. The Risk Register Dashboard, included in the CRR reports, provides a high level view of the risks on the CRR, with commentary from the Corporate Risk Team. These comments can include when the risk was added / escalated, the number of actions and those overdue, any changes in scoring, and other relevant information.

2.15 The Executive Team, Health Board and Committees all receive regular information on risk, with either the full risk register, relevant risks for the committee, or risk report presented. We reviewed the papers for the Health Board, Audit Committee, Quality, Safety and Experience (QSE) Committee, Performance, Finance and Information Governance (PFIG) Committee, Partnerships, People and Population Health Committee (PPPH) and Executive Team (formal) meetings from September 2023 to April 2024. The following information relating to risk was received at the meetings:

- Executive Team (formal meetings) – A Corporate governance report was received in November 2023, January, February, and April 2024 respectively. Papers on specific risks (Vascular, patient numbering) were also discussed.
- Health Board – Received risk framework for approval and agreed Board appetite for risk types in September. The full CRR was received in March 2024.
- Audit Committee – CRR or risk papers were received at each meeting, with

detailed discussion noted in the minutes, including follow up actions.

- QSE - CRR was received at each meeting with detailed discussions noted in the minutes.
- PFIG – CRR received at each meeting up to February 2024 (excluding March which was a review of the annual plan). Minutes note some detailed discussion and importance of risk ownership and risk management supported through robust learning and education process.
- PPPH – risk report presented at April 2024 Committee, minutes are not yet published.

Whilst there is detailed discussion on risk noted in the minutes of Committees, this is less evident in the minutes of the Executive Team and Health Board meetings. However, we do note that the RMG received papers at the 6 February 2024 and 9 April 2024 meetings providing feedback from Executive Team meetings in January and February, and the Health Board meeting on 24 January 2024.

It is noted that at the Executive Meeting on 10 April 2024, revised arrangements for reporting were agreed, and the Corporate Risk Register would in future be received monthly at the Executive Team and quarterly at the Board and it's Committees.

Conclusion:

2.16 Whilst there has been a significant amount of work undertaken in reviewing and consolidating corporate risks, there is further work required to ensure risks, controls and assurance mechanisms are appropriately reflected in the risk register. We recognise work is ongoing to get all risks captured to a high standard, as well as alignment with the Board Assurance Framework.

2.17 There is regular reporting of risks to the Health Board, it's Committees and the Executive Team. Information that has been received has varied between the full CRR, risk reports, reports from the RMG. The detail of discussion on risks also varies across the Health Board key meetings.

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

Objective 4: There are clear and consistent processes in place for the identification, classification, scoring and escalation / de-escalation of risks throughout the Health Board.

2.18 The Risk Management Procedures (RM02) set out in detail the responsibilities of staff in identifying and discussing risks, and the assurances required to the Corporate Risk Team. As detailed in objective 2 above, this is often inconsistent, and it is recognised that planned risk management training will likely increase compliance with this element of the procedures.

2.19 The Procedures include the Risk Scoring Matrix and Risk Tolerance Scoring Matrix, providing detailed guidance on the impact of different types of risks i.e. quality, finance, people, to guide staff when scoring risks.

2.20 We reviewed a sample of five risks from the Corporate Risk Register and five risks from operational risk registers to determine if the current risk score was appropriate and in line with the Risk Tolerance Scoring Matrix. All were appropriately scored, however some of the operational risks had not recently been updated. We also received examples of evidence to confirm the Corporate Risk Team and Head of Risk Management reviewed and challenged scores of corporate and operational risks.

2.21 The Corporate Risk Team review Tier 1 escalated risks, with the Risk Management Group receiving a report on risks that are escalated or de-escalated. This includes the number of Tier 1 risks de-escalated. It also includes corporate risks for escalation, and possible themes emerging that could form a corporate risk.

2.22 The process for the escalation of risks includes a review of the risk at the Risk Management Group. There were no corporate risks for escalation presented at the meetings in December 2023 or February 2024. There was a Digital, Data and Technology (DDaT) risk presented for escalation at the April 2024 meeting, however this was already included within the Corporate Risk Register. We are advised that this was not picked up due to staff absence.

Conclusion:

2.23 There are clear detailed procedures in place for the scoring and escalation / de-escalation of risks.

2.24 For the escalation of risks to the Corporate Risk Register, the process involves the risk being presented to the Risk Management Group. As this group meets bi-monthly, consideration should be given as to whether this step in the process is a required control, and if escalation via usual routes i.e. through Executive Team is sufficient.

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

Objective 5: The Risk Management Group (RMG) is operating effectively and in line with the requirements of the Framework and Terms of Reference.

2.25 The Risk Management Framework states the Risk Management Group "*reports to the Executive Team and advises on any risk management issues, including all significant risks arising from activities within the organisation. The Group is responsible for leading the implementation of the risk, control and assurance processes established within the organisation. The Group 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".*

2.26 There is a Terms of Reference in place for the Risk Management Group, dated April 2023. The stated purpose of the Group is "*…to work with a collective focus to manage, oversee and scrutinise the risk management process for the Health Board, to support the Chief Executive in fulfilling their accountability responsibilities".* We understand the remit of the group is currently under review, with the Terms of

Reference likely to change. A cycle of business for 2024/25 has been drafted, and includes items expected, including cyclical review of service / area risk registers.

2.27 Previously the RMG was not receiving regular reporting on risk performance, however the Group has been receiving quarterly performance reports on risk management since October 2023, as well as an annual report.

2.28 There are a wide range of attendees for the RMG meeting, which includes representation from areas across the Health Board. Whilst it is useful to have a wide membership, it does feel the group is too large to enable a focused discussion and demonstrate scrutiny of risk information. An analysis of attendance at meetings was provided by the Corporate Risk Team, which identified a number of areas with non-attendance.

2.29 We have attended the last three Risk Management Group meetings in an observational capacity. Whilst there is some useful discussion, our key views of the meetings are:

- There is often little discussion relating to agenda items, with the majority of the comments by the Chair or Corporate Risk Team. However some items do generate more discussion than others.
- The presentations from services / areas on their risks were well received, however the discussions focus on risk management arrangements and do not consider the detail of the risk registers, or scrutinise the information within them.
- There was some confusion on the process to escalate risks i.e. a DDAT risk was presented for escalation, however this was already included within the Corporate Risk Register. We are advised that this was not picked up due to staff absence.

2.30 A review of the formal Executive Team meeting agendas and minutes show that whilst the meeting is receiving risk updates, a *'RMG Assurance Paper'* was only provided in February 2024, covering the meeting on 6 February 2024. There were no assurance reports from the RMG to the Executive Team covering the meetings in December 2023 or April 2024.

2.31 Through our review, we are unable to confirm the RMG is fulfilling all its stated key objectives according to its Terms of Reference, noted as follows:

- Maintain operational oversight of the risk management systems and process.
- Provide scrutiny and oversight of the full Corporate Risk Register prior to review by Board.
- Review, scrutinise and challenge the effectiveness of proposed or current mitigations, and actions pertaining to risk register reports, including new risks that have been approved by Executive Directors for inclusion on the Corporate Risk Register/Tier 1.

Conclusion:

2.32 We believe the Risk Management Group is unable to demonstrate scrutiny of the full

corporate risk register and local risk registers. Whilst there is some useful discussion, a smaller, more focused group considering the detail of operational and corporate function risk registers would likely be more effective and consider the detail of risks.

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

Objective 6: Management actions agreed as part of the 2022/23 Risk Management and Board Assurance Framework review (BCU-2223-02) have been progressed / implemented.

2.33 We reviewed the evidence in place to support implementation of the actions agreed in the previous risk management report. There were five actions in total, however as one refers to the BAF, which is excluded from the scope of the review, we have reviewed four of these actions.

2.34 **Risk Management department duties.**

Completed

The previous audit found that there was no description of the Risk Management Department outlined in documentation.

The duties of the Risk Management Department have been included in the revised RM02 document.

2.35 **Oversight, scrutiny and challenge of CRR and BAF.**

In progress

The previous audit found that, due to the cancellation of several meetings within the Health Board, there was limited scrutiny and challenge of the risks within the Corporate risk register.

In relation to the Corporate Risk Register, the Health Board and Committees are receiving this on a regular basis, however there is limited evidence to demonstrate detailed scrutiny of risks (outside of the Corporate Risk Team). It is recognised the BAF is currently being revised, this element has not been reviewed.

2.36 **Escalation and De-escalation of Risks.**

Completed

The previous audit found the approval process for the escalation and de-escalation of risks was not clear.

The escalation process for risks is detailed in the revised Risk Management Procedures (RM02) document, however, as noted in objectives 4 and 5 above, there is opportunity to improve this process.

2.37 **Oversight and scrutiny of divisions / IHCs**

In progress

The previous audit found that there was inconsistent oversight and scrutiny of risk

management arrangements within divisions / IHCs by the Risk Management department.

Since the previous audit, the Risk Management Department put a *'Risk Meeting tracker'* in place, which captures the risk meetings that Risk Managers attend, and note whether any of these are stood down.

There is further review of the quality of service risk registers – see objective 2 for further details.

There remains further work within divisions / directorates to ensure risk registers are completed with sufficient information.

Conclusion:

2.38 The actions agreed in the 2022/23 report have either been completed or have progressed. There is further work required to demonstrate scrutiny of the CRR and divisional risks. These have been identified in the previous sections of the report, with appropriate recommendations.

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

Appendix A: Management Action Plan

Matter Arising 1: Operational risk registers (Operation)		**Impact**
Quality of operational risk registers The quality of Operational risk registers varies. A review of risk registers found the following: • Risk review dates overdue. • Action plans not SMART. • Risk dates were overdue for almost a quarter (23%) of risks reviewed. Scrutiny and oversight Scrutiny and oversight of risk registers is inconsistent across the Health Board. It is recognised that further assurance checks are in place within the Corporate Risk Team for the operational risk registers presented to the Risk Management Group (RMG), however this is not undertaken regularly (only in preparedness for the RMG).		Potential risk of: • Risks are not managed appropriately, increasing the likelihood of the risk, and associated detriment, materialising.
Recommendations		**Priority**
1.1	Health Board management are reminded of the importance of: • Reviewing risks and ensuring they are up to date, with appropriate actions and timescales. • The need for risk management to be embedded into governance structures through regular risk meetings and assurance to the appropriate leadership team *It is recognised that this is likely to improve following Risk Management Training.*	**High**
1.2	Head of Risk Management to consider the formal review of operational risks registers be undertaken by the Corporate Risk Team on a regular, cyclical basis.	**High**

Agreed Management Action		Target Date	Responsible Officer
1.1	Communication will be sent to all service leads reminding them of their responsibilities relating to maintaining up-to-date risk registers with appropriate actions and timescales. A system of sending automatic reminder to handlers and owners where risks need to be updated will be set up.	Target Date: Communication by 30 July 2024; Automated Monitoring and E-mail notification system to be launched in September	**Director of Corporate Governance (Head of Risk Management)**
1.2	The Corporate Risk Team will implement a rolling programme to formally review each service's operational risk register on a quarterly basis. All risks are to be quality assured before being live.	Rolling programme & Live Risks to be QA by Q3 2024/25	**Director of Corporate Governance (Head of Risk Management)**

Matter Arising 2: Corporate Risk Register (Operation)	**Impact**
Corporate risks are under review, and whilst there has been an improvement and refinement of wording, there are some areas that require review and consideration to ensure consistency and clarity of risks. The detail of corporate risks require review and updating to ensure the following is clear: • Lines of assurance • Controls • Future actions	Potential risk of: • Risks are not stated or assessed appropriately, resulting in inadequate assurance to the Health Board.

The Corporate Risk Register is scrutinised by the Head of Risk Management and Corporate Risk Team, however the Risk Management Group does not review this in detail. There is some evidence of detailed discussion within Committees. *It is noted that revised reporting arrangements have been agreed for the CRR from April 2024.*			
Recommendations			**Priority**
2.1	Head of Risk Management and Corporate Risk Team to review lines of assurance, controls and future actions of corporate risks.		**High**
Agreed Management Action		**Target Date**	**Responsible Officer**
2.1	All corporate risks to be reviewed and quality assured by corporate risk team	**30 August 2024**	**Director of Corporate Governance (Head of Risk Management)**

Matter Arising 3: Risk Management Group (Operation)	**Impact**
Whilst the Risk Management Group provides a useful forum for operational risk discussion, it does not meet the objectives stated in the Terms of Reference: • Maintain operational oversight of the risk management systems and process. • Provide scrutiny and oversight of the full Corporate Risk Register prior to review by Board. Review, scrutinise and challenge the effectiveness of proposed or current mitigations, and actions pertaining to risk register reports, including new risks that have been approved by Executive Directors for inclusion on the Corporate Risk Register/Tier 1. The process for the escalation of risks to the Corporate Risk Register involves the risk being presented to the Risk Management Group. As this group meets bi-monthly, consideration should be given to whether this step	Potential risk of: • Delay in escalating risks resulting in increased risk exposure for the Health Board. • Corporate and local risks are not scrutinised effectively, which could result in misinformation or incorrect statements, impacting the ability of the Health Board to manage risks.

in the process is considered an unnecessary control - Escalation could be progressed directly to the Executive Team who are responsible for managing risk, with the Chief Executive (Accountable Officer) ultimately accountable for effective risk management arrangements.			
Recommendations			**Priority**
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.		**High**
Agreed Management Action		**Target Date**	**Responsible Officer**
3.1	The role and remit of the Risk Management Group will be reviewed, and a paper has been drafted for discussion of 'the role and future of RMG' with proposed options at the June meeting. The proposals also notes the need to increase this meeting to monthly. Options will be further considered by the Executive Team for alternative arrangements to provide more effective, regular scrutiny of operational risks and corporate risks. The new arrangement will be approved by Executive Team and Audit Committee. A new arrangement will be established following approval in Q2. Any agreed changes will be reflected in a revised Risk Management Framework and supporting procedures. A terms of reference will be drafted for this meeting following establishment and review Q3 2024.	**New meeting established September 2024**	**Director of Corporate Governance (Head of Risk Management)**

Appendix B: Assurance opinion and action plan risk rating

Audit Assurance Ratings

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

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

Prioritisation of Recommendations

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

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

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

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Appendix 2 - Corporate Risks Dashboard – June 2024.

Lead	Ref	Risk Title	Current Score (Impact x Likelihood)	Risk Target Score	Appetite Main Risk Type / Appetite Level	Lead Board Committee	Risk Management Commentary
EDoW	CRR24-01	People, Culture and Wellbeing	4 x 4 = 16 ⟷	8	Quality Open 15-19	People & Culture Committee	Opened Dec 23. 6 actions identified, 1 completed, 5 progressing, **with 2 revised due dates**. QA comments have been addressed by the lead and included in this bundle but **Awaiting Executive approval**
EDoN	CRR24-02	Patient Safety-Falls	4 x 5 = 20 ⟷	12	Quality Open 15-19	Quality, Safety and Experience Committee	Opened Dec 23. 7 actions identified, 1 completed, 1 revised date, **4 overdue**, 1 progressing. Risk to be downgraded to be managed as an operational risk and broader patient safety risk to be presented back for approval. **Not yet received a corporate risk on patient safety.**
EDoN	CRR24-03	Safeguarding	4 x 3 = 12 ⟷	8	Regulatory Seek 20-25	Quality, Safety and Experience Committee	Opened Dec 23. 8 actions identified, 1 completed, 7 progressing, highlighted, some, action deadlines have all been extended to Sept 2024. Scored reduced 18/04/24 from 16 to 12. . Minor Quality Assurance comments sent to the service lead around gaps in controls which will need to be further refined into controls as opposed to statements. Associate Director of Governance met AW on 11 June 2024 and reviewed dates for some actions which would not be delivered on original timescale. (now Sept)
EDoN	CRR24-04	Failure to Embed Learning	5 x 4 = 20 ⟷	5	Quality Open 15-19	Quality, Safety and Experience Committee	Opened Dec 23, 10 actions identified, 2 completed (rolled into QMS action), 8 progressing. March 2024 **highlighted action deadlines have all been extended** to April-June 2024. The current risk score remains at 20. Some actions delayed due to reliance on NHS Executive National team. Associate Director of Governance met AW on 11 June 2024 and reviewed dates for some actions which would not be delivered on original timescale. (now July)

Lead	Ref	Risk Title	Current Score (Impact x Likelihood)	Risk Target Score	Appetite Main Risk Type / Appetite Level	Lead Board Committee	Risk Management Commentary
EDoF	CRR24-05	Financial Sustainability	4 x 5 = 20 ⟷	12	Financial Open 15-19	Performance, Finance and Information Governance Committee	Risk score has remained at 20 since opened in March 2023, updated to reflect current Financial year. 2 actions identified and progressing. **Risk Score above tolerance set in risk appetite.**
EDoF	CRR24-06	Suitability and Safety of Sites	4 x 5 = 20 ⟷	12	Quality Open 15-19	Performance, Finance and Information Governance Committee	Opened March 24, 7 actions identified, 2 completed, 5 progressing, 2 revised dates. Backlog maintenance costs **£348m**. **Risk Score above tolerance set in risk appetite.**
CDIO	CRR24-07	Availability and Integrity of Patient Information	4 x 5 = 20 ⟷	12	Quality Open 15-19	Planning, Population Health & Partnership Committee	Opened Dec 23, 7 actions identified, 1 completed, 6 progressing. The inherent and current risk scores are both high at 20, indicating the existing controls are not adequate to control the risk. **Risk Score above tolerance set in risk appetite.**
EDoPH	CRR24-08	Population Health	4 x 5 = 20 ⟷	12	Reputational Seek 20-25	Planning, Population Health & Partnership Committee	Redrafted to be more strategic Nov 2023, **No change in score**, 17 actions identified, 0 completed, 17 progressing. 2026 target date. However, the **inherent and current risk scores are both 20**, so the controls are not reducing the risk. Work has been completed to add short term SMART actions however there are still some QA comments around gaps in controls which have been sent to the lead and Executive 13.06.24 to review.
EDoO	CRR24-09	Primary Care	4 x 5 = 20 ⟷	12	Quality Open 15-19	Quality, Safety and Experience Committee	Opened Feb 24, 6 actions identified, 3 completed, 3 progressing. The **inherent and current risk scores are both 20**, indicating the controls are not yet reducing the risk. This risk has been revised and now only reflects primary care and not community. A separate community risk is being drafted.

Lead	Ref	Risk Title	Current Score (Impact x Likelihood)	Risk Target Score	Appetite Main Risk Type Appetite Level	Lead Board Committee	Risk Management Commentary
							Risk Score above tolerance set in risk appetite.
EDoO	CRR24-10	Urgent and Emergency Care	4 x 5 = 20 ⟷	12	Quality Open 15-19	Performance, Finance and Information Governance Committee	Opened Feb 24, 10 actions identified, 7 progressing. **Risk Score above tolerance set in risk appetite.**
EDoO	CRR24-11	Planned Care	5 x 4 = 20 ⟷	8s	Quality Open 15-19	Performance, Finance and Information Governance Committee	Newly developed strategic risk Feb 24, 8 actions identified, 5 progressing, 3 completed. Risk Management Team discussed that the target score should be 12. This will need to be approved by the Executive owner. **Risk Score above tolerance set in risk appetite.**
EDoO	CRR24-12	Areas of Clinical Concern (encompasses ophthalmology and dermatology)	5 x 3 = 15 ⟷	12	Quality Open 15-19	Quality, Safety and Experience Committee	Opened Feb 24, 6 actions identified, 0 completed, 6 progressing. Further work will be done to separate this risk to the key areas of clinical concern.
EDoTH	CRR24-13	Timely Diagnostics	5 x 4 = 20 ⟷	5	Reputational Seek 20-25	Quality, Safety and Experience Committee	Opened Feb 24, 5 actions identified, 0 completed, 5 progressing. **Risk Score above tolerance set in risk appetite.**

Lead	Ref	Risk Title	Current Score (Impact x Likelihood)	Risk Target Score	Appetite Main Risk Type / Appetite Level	Lead Board Committee	Risk Management Commentary
EDoTH	CRR24-14	Harm from the Medical Devices/Equipment	4 x 4 = 16 ⟷	8	Quality Open 15-19	Quality, Safety and Experience Committee	Opened Feb 24, 6 actions identified, 0 completed, 4 progressing, **2 overdue**. Overdue actions escalated to Chair of Medical Devices committee but need to be addressed. **Risk Score above tolerance set in risk appetite.**
EDoW	CRR24-15	Health and Safety	4 x 4 = 16 ⟷	8	Regulatory Seek 20-25	People & Culture Committee	Opened Feb 24, 14 actions identified, 0 completed, 14 progressing. Work has been completed by the lead to strengthen the action plan and also reflect the recent Internal Audit report recommendations however there remain to be some quality assurance comments sent to the service lead around controls, gaps in controls and dates of **all actions being Dec 24**. **Awaiting Executive approval**
EDoW	CRR24-16	Leadership/Special Measures	4 x 4 = 16 ⟷	8	Reputational Seek 20-25	People & Culture Committee	Opened Dec 23. 7 actions identified, 4 completed, and 3 progressing. QA comments have been addressed by the lead and included in this bundle but **Awaiting Executive approval**.
CDIO	CRR24-17	ICT Failure and Cyber	5 x 4 = 20 ⟷	15	Reputational Seek 20-25	Planning, Population Health & Partnership Committee	Opened Feb 24, 7 actions identified, 4 completed, 3 progressing. Target score of 15 not in line with appetite.

Committee	
Performance, Finance and Information Governance Committee	PFIGC
Quality, Safety and Experience Committee	QSE
People & Culture Committee	P&C
Audit Committee	AC
Planning, Population Health & Partnership Committee	PPHP

Trend	
No trend/Score remains the same	⟷
Increase	⬆
Decreased	⬇

Executive Lead	
Executive Director of Workforce	EDoW
Executive Director of Nursing & Midwifery	EDoN
Executive Director of Finance	EDoF
Chief Digital Information Officer	CDIO
Executive Director of Operations	EDoO
Executive Director of Therapies and Allied Health Professions	EDoTH

Full Corporate Risk Register

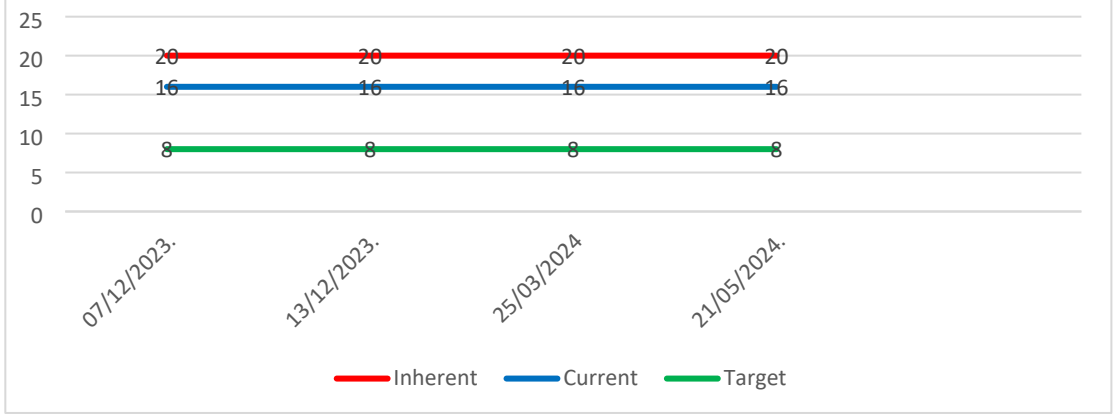
CRR 24-01	**Risk Title:** People, Culture and Wellbeing		**Date Opened:** 07/12/2023
	Assuring Committee: People & Culture Committee		**Date Last Committee Review:** 13/06/2024
Date Last Reviewed: 12/06/2024	**Director Lead:** Deputy Director of Workforce	**Link to BAF**: SP12	**Target Risk Date:** 31/03/2025

There is a risk that BCU do not have a **highly skilled**, engaged and **motivated** workforce which could impact on safe delivery of care. This could be caused by **staffing shortfalls**, organisational reputation and staff not feeling psychologically safe which could lead to burnout. This could lead to the inability to attract and retain high quality and skilled people.

Mitigations/Controls in place	Lines of Assurances	Additional Controls required
1. People Committee oversee delivery of the People Services agenda 2. Local IHC & Pan Services People & Culture Committees in place 3. The Strategic Recruitment team in place to oversee efficient and effective professional recruitment for all senior leadership and medical & dental consultant appointments across the Health Board 4. Local IHC Resourcing Teams are in place across all IHC/Pan Services to drive forward recruitment and staffing priorities. 5. The Recruiting well and Joining Well programmes in place 6. Organisational Retention lead in post for BCU linked with national retention work through HEIW 7. Dedicated Nurse Retention Lead in place to deliver the Nurse Retention Implementation Plan for the organisation 8. New All Wales Flexible working policy has been ratified and is in place 9. Staff feedback conjunction with the NHS Wales Staff Survey in place. Development of Pulse surveys to ensure staff have a voice across the organisation 10. Speak out Safely MDT in place 11. Work in Confidence platform for staff to safely raise concerns. 12. Workstreams associated with this risk which links into the Special Measures Framework are monitored via the governance of the Framework and reported to Executive Team and Board 13. An Agreed scope to the operating model review is underway	**1st** – eg. Operational: 1. Organisational Development Steering Group 2. People Services Senior Leadership Team **2nd** – eg. Risk and Compliance: 1. Risk Management Group 2. Executive Team oversight **3rd** – eg. Independent: 1. Internal Audit 2. Welsh government through quarterly IQPD meetings with executive team 3. HEIW through National Retention programme meetings	1. The programme of work through the Education and Learning Committee to be finalised 2. Increased measures on employee engagement 3. Development of a programme of work to ensure line manager's full involvement in employee engagement 4. Feedback from the HEIW Nurse retention tool.

14. A range of employee engagement tools have been agreed at the OD steering group in March 2024 15. The Culture Change Plan, which incorporated the results from the Staff Survey, was agreed at People & Culture Committee in March 2024 16. Staff facing version of the Learning Organisation Framework developed for use in work-based learning contexts		

Actions	Due Date	Progression Analysis
REF Gaps in controls; A. Education and Learning Committee is being established as a control measure	31.07.24	Progressing
REF Gaps in controls; B. NHS Staff Survey action plan to be developed and implemented across 24/25. The corporate action plan has been developed, the next steps is to take it forward at IHC level. This work is scheduled to be completed by end of June	30.06.24	Progressing
REF Gaps in controls; C. Findings from the wider review of the 2022 Operating Model restructure presented via an appropriate Executive governance process and next steps agreed. A full report of the findings is due to be submitted by Ararna by the end of May. The Findings will determine what the next steps will be, therefore they cannot be agreed until the full report has been received. The findings will inform the PID for the Operating Model which is one of BCUHB's 3 major transformation programmes of work.	30/06/24	Revised Date 2 weeks (Progressing)
Clinical engagement: Progress demonstrated in the part of the OD plan relating to clinical engagement field work conducted in previous cycles. Recommendations made were reviewed by the Organisational Development Steering Group on 5.2.24. As agreed there, further work is being undertaken to understand the barriers to engagement of clinicians, which will inform proposals for the development of a broader corporate engagement offer. A draft OD Plan was presented to the Steering Group on 4.3.24 for feedback before being finalised.	29/02/2024	Complete
REF Gaps in controls; B. Revisit the values of the organisation: Views on the existing values and suggestions for modifications presented to Exec Team prior to scheduling for review at Board. Previously collected staff feedback on the existing values to be analysed and proposals of methods of co-production with the staff including comms and engagement plans to be submitted via an appropriate Executive governance process. Culture World Café to take place at Leadership Conference 04.06.24. The revised date for the culture world café is scheduled for 4th June, the feedback will be collated and available by the end of June 2024	**30/06/2024**	Revised Date from April (Progressing)
REF Gaps in controls; D. The Recruiting Well, Joining Well, Leaving Well Programme is being developed to ensure we recruit, support and retain a skilled motivated workforce. The programme for Recruiting Well, Joining Well, Leaving Well will now be incorporated into the **Staff Journey** programme of work. An illustrative map is currently being developed showing all areas within People Services and OD that employees typically encounter, from Hire to Retire'. Work in being undertaken to identify gaps in each of the services with regards to policies and procedures. This will enable the Staff journey programme plan, which will include timescales, to be drafted.	30/06/2024	Progressing



	Impact	Likelihood	Score
Inherent Risk Rating	4	5	20
Current Risk Rating	4	4	16
Target Risk Score	2	4	8
Risk Appetite	People		4 - Seek

Rationale for Corporate Risk

This is a corporate risk due to the current position across the Health Board with high turnover rates across certain key staff groups. Staff engagement score at 72%, comparable with all Wales average of 73%.

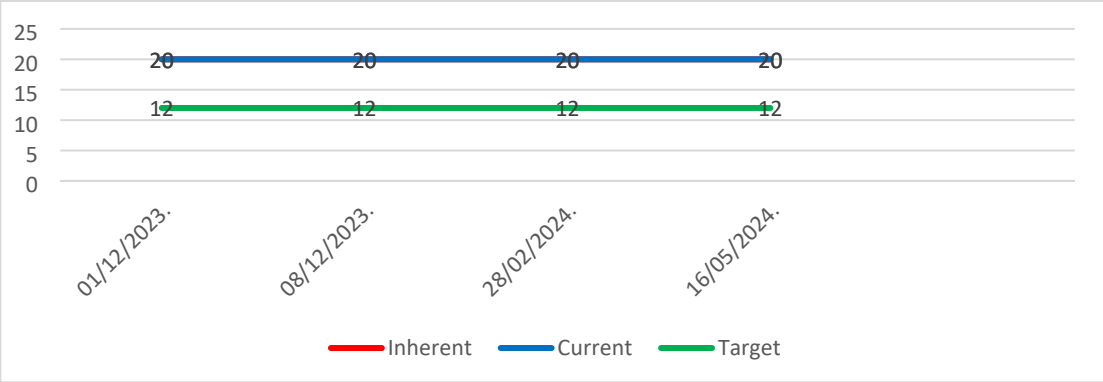
CRR 24-02	**Risk Title:** Patient Safety - Falls		**Date Opened:** 01/12/2023
	Assuring Committee: Quality, Safety and Experience Committee		**Date Last Committee Review:** 06/06/2024
Date Last Reviewed: 16/05/2024	**Director Lead:** Executive Director of Nursing and Midwifery	**Link to BAF**: N/A	**Target Risk Date:** 30/10/2024

There is a risk to patient safety, in particular harm, as a result of slips, trips and **falls** within Secondary Care acute sites. This may be caused by patients acuity/clinical condition/frailty alongside contributory factors such as **reduced staffing**, segregated areas and **premises** which do not allow for ease of oversight, compliance with **manual handling training,** compliance of falls risk assessment and subsequent implementation of mitigating actions. This could result in poorer patient health outcomes, extended hospital stay, regulatory non-compliance and litigation and associated financial impact.

Mitigations/Controls in place	Lines of Assurances	Additional Controls required
1. Mandatory E learning modules (1a and 1b) for Falls Prevention launched and monitoring in place for completion via the Strategic Inpatient Falls Group. Health Board compliance currently 1a 93.83%, 1b 94.55%. 2. Manual Handling training 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. 3. Welsh Nursing Care Record (WNCR) has been implemented which has an electronic version of the Falls and Bone Health Multifactorial Assessment (FBHMA) that is identified on the dashboard if not completed and monitored for compliance by the Ward Manager. 4. How to /good practice guide developed and implemented to support with completion and quality of FBHMA across all Adult Inpatient wards: 5. Peer review process in place for 3 months to improve quality of the FBHMA across adult inpatient wards. 6. Falls review groups in place across the Health Board with exception reporting, updating of improvements to Strategic Inpatient Falls Group.	**1st** – eg. Operational: 1. Strategic Inpatient Falls Group - Integrated Health Community (IHC) and Divisional falls review groups report to the falls leads who report to the strategic group. 2. Ward accreditation metrics 3. Ward accreditation review process 4. Peer reviews 5. Patient Safety Group **2nd** – eg. Risk and Compliance: 1. Risk Management Group 2. Executive Team Meeting **3rd** – eg. Independent: 1. Internal Audit 2. HSE 3. Regulatory inspections and investigations – HSE, HIW, CIW, PSOW 4. WG performance monitoring and assurance 5. Welsh Government Reviews	1. Falls prevention and management policy to be ratified and relaunched - has been updated to include a clear step by step approach to completion of the Falls and Bone Health Multifactorial Assessment (FBHMA) and post falls management and currently under review with Patient Safety Group. 2. Assurance and training of agency workers. 3. Improved compliance with manual handling training. 4. Sustained improvement in the quality of completion of FBHMA.

Actions	**Due Date**	**Progression Analysis**

New updated and revised Falls Prevention and Management Policy NU06 reviewed in BCUHB Patient Safety Group to be ratified and re-launched. Policy approved at Patient Safety Group, disseminated and uploaded to Betsinet	30/12/2023	Completed
Audit of Ward Managers induction for agency/temporary staff to ensure falls training has been completed. A review of the checklist is underway to make it more user friendly and compliance is being reported in the strategic falls group a question on compliance is being added to the ward accreditation audit	30/08/2024	Progressing (revied date from April 2024)
Capacity within the Manual Handling training team to be optimised with focused recruitment drive for Band 6 posts (x3) supported by workforce	30/04/2024	Overdue
Manual Handling corporate team to progress contract arrangements for external training facilities to support capacity	30/04/2024	Overdue
Outcome of peer review pilot to be evaluated Peer reviews discussed at strategic falls group and quality of risk assessments have shown some improvement. Review of quality of risk assessments need to form part of business as usual and this is part of the ward metrics. The patient safety team are conducting spot checks of the Risk Assessments on the acute wards. Some areas are also conducting spot checks via the Weekly Harms Meetings and chairs of the groups know 'what good looks like'. Plans to embed as part of Board Round process to be discussed with Senior Nurses – New action created	30/04/2024	Completed
Future enhancement to the Welsh Nursing Care Record on an all-Wales basis. still no progress from All Wales group	31/05/2024	Overdue (Revised date from April)
Embed sample review of Falls Risk Assessment at Board Rounds	31/07/2024	New action



N.B. Inherent and Current score lines stacked as both are 20.

	Impact	Likelihood	Score
Inherent Risk Rating	4	5	20
Current Risk Rating	4	5	20
Target Risk Score	4	3	12
Risk Appetite	Quality		3 - Open

Rationale for Corporate Risk

This is in line with the Falls Internal Audit limited assurance report. Disproportionate high number of avoidable falls across the Health Board compared to other NHS providers.

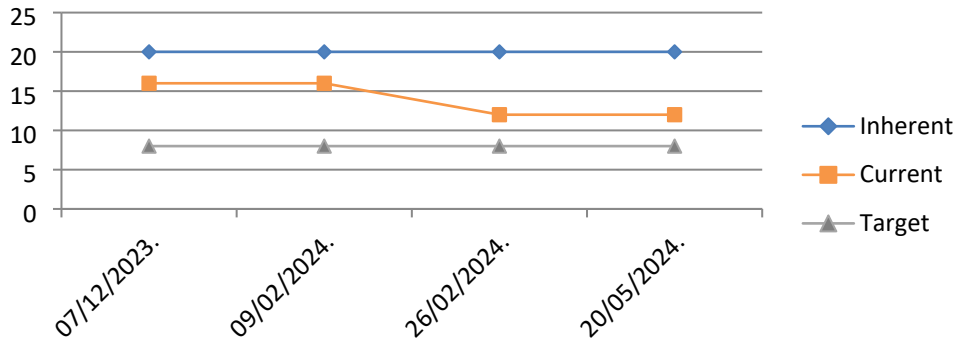
CRR 24-03	**Risk Title: Safeguarding**		**Date Opened:** 07/12/2023
	Assuring Committee: Quality, Safety and Experience Committee		**Date Last Committee Review:** 06/06/2024
Date Last Reviewed: 20/05/2024	**Director Lead:** Executive Director of Nursing and Midwifery	**Link to BAF**: N/A	**Target Risk Date:** 31/03/2025

There is a risk that BCU may fail in its statutory duties to protect **vulnerable** groups from harm. This could be caused by gaps in **safeguarding governance**, **insufficient** workforce **training** and engagement, complexity of legal frameworks, and lack of resources to manage growing demand. The impact may result in harm to at-risk adults, children or young persons, victims of violence/abuse, patients unlawfully detained, financial penalties, reputational damage and non-compliance with Safeguarding legislation which includes but is not exclusive to the Social Services and Wellbeing (Wales) Act 2014, the Deprivation of Liberty Safeguards, and the Mental Capacity Act.

Mitigations/Controls in place	Lines of Assurances	Additional Controls required
1. Standardised formal reporting and escalation of activity, mandatory compliance and exception reports are presented in line with Health Board Governance and Reporting Frameworks. 2. Audit findings and data are monitored and escalated. Risk Management has been embedded into the processes of the reporting framework. 3. BCUHB mandatory safeguarding training is in place for all staff. 4. Welsh Government interim monies has supported temporary the implementation of additional Mental Capacity Act (MCA) training, the completion of Deprivation for Liberty (DoLS) applications, and strengthened the implementation of Court of Protection DoL for 16/17-year-olds. 5. BCUHB local work programmes are in place and aligned to the National Strategies which are regularly reported to Welsh Government. 6. Safeguarding support the Sexual Abuse Referral Centre (SARC) implementation, compliance and accreditation but the accountability remains with the Central Integrated Health Community (IHC). 7. Fully engaged and supporting the Single Unified Safeguarding Review led by Welsh Government and the Home Office/Central Government for the re-write of Safeguarding and Homicide Reviews.	**1st** – eg. Operational: **17.** The risks is monitored monthly and reviewed at the Safeguarding Governance and Performance Group **2nd** – eg. Risk and Compliance: 1. Risk Management Group 2. Executive Team **3rd** – eg. Independent: 1. Mental Capacity Act training compliance and the DoLS backlog is monitored and reported into Welsh Government. 2. This risks are regularly monitored and reviewed by the statutory engagement with the North Wales Safeguarding Board. 3. BCUHB are fully engaged in National and Regional Forums to provide assurance of the implementation of legislation.	1. New legislation and statutory guidance driven by case law, UK and Welsh Government impacts upon the organisation and the date of implementation is not within BCUHB control. 2. The increase in safeguarding activity with enhanced complexity has resulted in the delay of the implementation of strategic and operational interventions. 3. Local Authorities frequently develop independent local guidance which requires duplication of implementation across BCUHB. This is time consuming and can result in reduced compliance. 4. The rise in the number of DoLS assessments has resulted in a backlog. Current post holders work additional hours, weekends and evenings. There are local and national staffing challenges with regard to the recruitment of Safeguarding, MCA and DoLS specialist staff. This is recognised by Public Heath Wales and WG. We support flexible working arrangements within the team to ensure staff retention. Reduced

		leadership team capacity due to absences. . A risk assessment and an amendment to the service delivery structure is in place to mobilise staff where required. 5. There is a lack of governance and reporting of Court of Protection activity relating to a Community setting. Immediate safeguards are in place and work is taking place to develop a standard procedures.

Actions	**Due Date**	**Progression Analysis**
Review of the safeguarding team and structure A review of the safeguarding team structure has started, a report will be submitted in March 2024 This date has been amended to reflect an achievable and realistic date given the interdependencies that are required to deliver it	30/09/2024	Date Revised from March 2024
National development and implementation of Single Unified Safeguarding Review SUSR training has been approved by WG. BCUHB attending February 2024	31/03/2025	Progressing
Implementation and monitoring of the 'Workforce Safeguarding Responsibilities SoP, Approved at SGPG being shared at QDG during February2024.	31/03/2024	Completed
North Wales Sexual Assault Referral Centre (SARC) to meet the National Service ISO Specifications, discussions ongoing. This date has been amended to reflect an achievable and realistic date given the interdependencies that are required to deliver it	30/09/2024	Date Revised from March 2024
Development of a DoLS/CoP DoL Standard Operating Protocol (SoP)	31/07/2024	Date Revised from March 2024
CNO is undertaking a safeguarding audit of provision which will provide a benchmark for consideration This date has been amended to reflect an achievable and realistic date given the interdependencies that are required to deliver it	30/09/2024	Date Revised from March 2024
Whilst awaiting the All Wales Data Module conduct a review of the current data capture processes that inform current service demand and future projections which will identify potential gaps and manual data collection practices The timescale for this will be reviewed next month once the action dependencies (team resource) are understood	31/07/2024	Date Revised from March 2024
Risks associated with the DoLS & MCA May 2024 Audit	31/03/2025	Progressing



	Impact	Likelihood	Score
Inherent Risk Rating	4	5	20
Current Risk Rating	4	3	12
Target Risk Score	4	2	8
Risk Appetite	Quality		3 - Open

Rationale for Corporate Risk

Actions are on track and progressing well, risk mitigation best to the ability of the Health Board and yet to receive further steer from legislation. Due to high risk associated with DoLS and MCA the risk is unlikely to reduce until statutory actions confirmed and taken following the next General Election.

CRR 24-04	**Risk Title:** Failure to Embed Learning		**Date Opened:** 19/10/2023
	Assuring Committee: Quality, Safety and Experience Committee		**Date Last Committee Review:** 06/06/24
Date Last Reviewed: 21/05/2024	**Director Lead:** Executive Director of Nursing and Midwifery	**Link to BAF**: SP18 - Quality, Innovation and Improvement	**Target Risk Date:** 30/09/2024

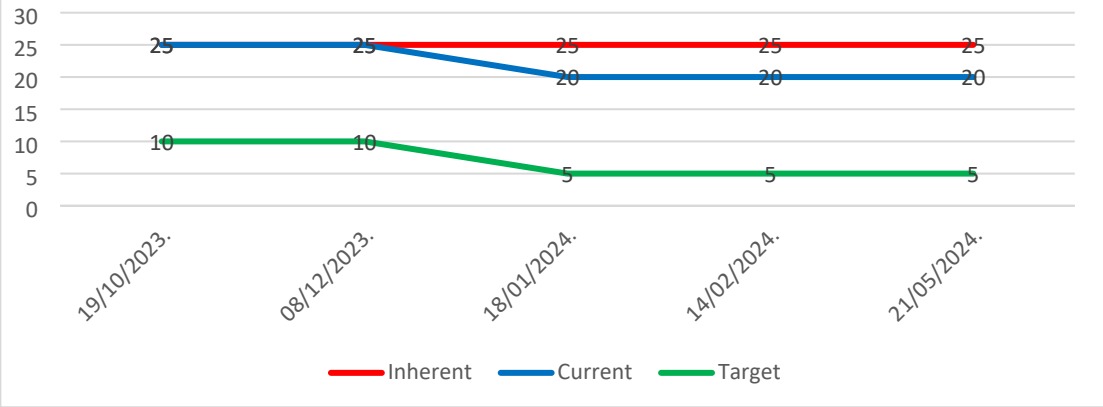
There is a risk that the Health Board could fail to meet requirements for **timely review and learning** from mortality cases, claims, inspections, incidents and complaints. This could be caused by insufficient resources, lack of unified processes, outdated IT systems, duplication of effort, and overreliance on single personnel. The impacts may include missed opportunities for improvement, lack of family/carer engagement, potential patient harm events going undetected, non-compliance with national frameworks or legislation, and reputational damage.

Mitigations/Controls in place	Lines of Assurances	Additional Controls required
1. Putting Things Right and clinical review processes and monitoring 2. Risk management processes 3. Audit programmes & monitoring arrangements 4. Patient and carer feedback and involvement processes 5. Senior sign-off process for National Reportable Incidents (NRIs) and Complaints 6. Clinical policies, procedures, guidelines, pathways, supporting documentation & IT systems 7. Clinical staff recruitment, induction, mandatory and professional training, registration & re-validation 8. Defined nurse staffing levels for all wards & departments as per Nurse Staffing Act 9. Ward accreditation schemes and ward manager/matron checks/audits. 10. Tracking of regulatory action plans 11. Internal Reviews against External National Reports	**1st** – e.g. Operational: 1. Service and IHC Quality Groups (with reporting) 2. Quality Delivery Group, its sub-groups (with reporting) 3. Executive performance reviews with IHCs 4. Clinical audit 5. Regulatory Assurance Group and oversight/assurance reporting 6. Annual Quality Report, Annual Putting Things Right Report and Annual Duty of Candour Report **2nd** – e.g. Risk and Compliance: 1. Executive performance reviews with IHCs 2. Risk Management Group 3. Executive Team Meeting **3rd** – e.g. Independent:	1. Development of a Quality Management System (QMS) setting out an integrated approach to Quality Planning, Control, Assurance and Improvement 2. Clarity on quality leadership, structures and accountabilities 3. Review of the quality governance framework of meetings and reporting 4. Development of a quality learning framework, aligned to the overall learning organisation programme 5. Review of Putting Things Right and clinical review processes and monitoring 6. Resolution of outstanding overdue positions for incidents, complaints, claims, mortality reviews and inquests

12. Getting it Right First Time (GIRFT), localised deep dives, reports and action plans 13. HIW, Ombudsman, Coroner NHS Wales Exec and WG engagement Meetings	1. Internal Audit 2. Clinical audit 3. Regulatory inspections and investigations – HSE, HIW, CIW, PSOW 4. WG performance monitoring and assurance 5. Welsh Government Reviews 6. Royal College Reviews	

Actions	**Due Date**	**Progression Analysis**
The Quality Governance Framework will be reviewed and refreshed and will include greater clarity on the roles, responsibilities and authorities of all groups including the reporting expectations, process and templates. This will include mapping meetings into an overall cycle and introducing standard templates and a single document repository This work is being taken forward with the support of the NHS Wales Executive as part of the Quality Governance Intervention, who are currently observing to inform their recommendations, therefore the work will take slightly longer and a revised date of 30 June 24. A QSE Committee workshop is being held on 29/05/2024.	30/06/2024 due dates to end of July 30/07/24	Date Revised from March 2024
Best practice guidance will be issued to IHCs and Regional Divisions to support effective local quality governance arrangements This work is being taken forward with the support of the NHS Wales Executive	30/06/2024 due dates to end of July 30/07/24	Date Revised from March 2024
A Quality Dashboard will be developed underpinned by a series of specialist dashboards (i.e. falls, complains, etc). These dashboards will create a single version of the truth using agreed metrics directly connected to the quality systems for real time data Work is progressing on the Dashboard and a test version is live however technical issues remain in extracting and presenting data – these are being resolved and the Dashboard will be soft launched on 01 June 2024.	31/05/2024 due dates to end of July 30/07/24	Date Revised from April 2024
A central and digital library of learning will be established which will be launched alongside a revised approach to the collation, analysis and dissemination of learning. The system prototype is in place and will be tested with MHLD during Q1 with a view to refinement based on the feedback and roll-out over the summer.	30/09/2024	Date Revised from April 2024
The approach to quality assurance will be reviewed and refreshed and a new regulatory procedure and quality assurance procedure will be developed This work is being taken forward with the support of the NHS Wales Executive as part of the Quality Governance Intervention, who are currently observing to inform their recommendations, therefore the work will take slightly longer and a revised date of 30 June This action is being discontinued with the work rolled into the QMS (see below).	30/06/2024	Completed (action rolled into QMS action)

The new Quality Strategy will be developed through a co-design process A refreshed approach to planning arising from Special Measures - a separate Quality Strategy will not be produced and quality will be part of the overall organisational strategy underpinned by a QMS, see below. A quality section for the ongoing planning process has been written and submitted – May 2024 – Revised date from 03/24 to 05/24 due to external dependencies. This action is being discontinued with the work rolled into the QMS (see below).	31/05/2024	Completed (action rolled into QMS action)
A Quality Management System will be developed in line with the Duty of Quality, which will describe how Quality Planning, Quality Control, Quality Assurance and Quality Improvement will work together as a collective quality system Update - The initial draft of a QMS is due at Board in May 2024. Therefore, the deadline will be extended. A QMS working group is in place, the first meeting was 13 December 2023. There was a workshop at the Executive Team on 24/01/24, at the Senior Leadership Team on 30/01/24, and at the Board on 29/02/24.The Quality Team visited ELFT (an Outstanding rated English Trust) on 26/02/24.The Quality Team are part of the all-Wales working group. Research has been undertaken into work in Wales and Scotland. Support is being provided by Improvement Cymru and the NHS Wales Executive National Quality Team. We plan two further meetings of the working group, and a wider engagement workshop in April May 2024 – Revised date from 03/24 to 05/24 due to external dependencies	31/05/2024 due dates to end of July 30/07/24	Date Revised from March 2024
The Terms of Reference and Cycle of Business for the Organisational Learning Forum is being refreshed and revised to build on and strengthen the work of the group.	30/06/2024 due dates to end of July 30/07/24	New action
A project has been commissioned to develop a new, integrated approach to Investigating and Learning from Incidents, Complaints and Mortality Reviews – this new policy is due at Board for approval in July 2024	31/07/2024	New action
A Learning from Investigations Project has been commissioned to review all open cases due at inquest and to ensure the investigations and evidence of learning is robust. Phase 1 of this project is due for completion by the end of June 2024. The learning from this work will inform the new Investigating and Learning from Incidents, Complaints and Mortality Reviews Policy and process.	30/06/2024	New action



	Impact	Likelihood	Score
Inherent Risk Rating	5	5	25
Current Risk Rating	5	4	20
Target Risk Score	5	1	5
Risk Appetite	Reputational		4 - Seek

Rationale for Corporate Risk

Significant backlog of incidents waiting investigation and new cases demonstrating learning has not been embedded

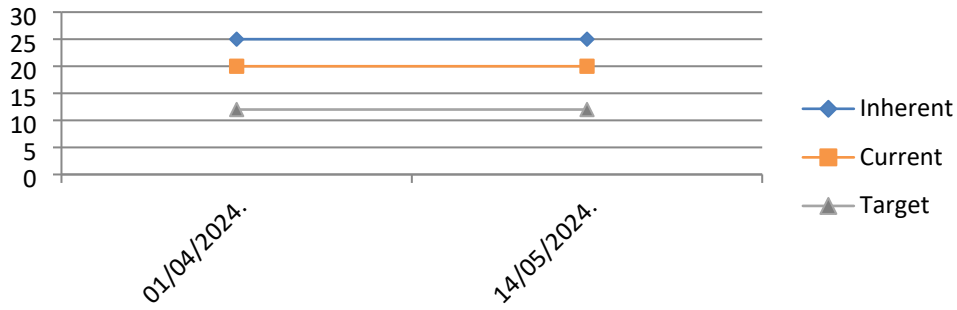
CRR 24-05	**Risk Title:** 2024/25 Financial Plan		**Date Opened:** 01/04/2024
	Assuring Committee: Performance, Finance and Information Governance Committee		**Date Last Committee Review:** 25/06/2024
Date Last Reviewed: 14/05/2024	**Director Lead:** Executive Director of Finance	**Link to BAF**:	**Target Risk Date:** 31/03/2025

Failure to achieve the Annual Plan for 2024/25 (£19.7m deficit), due to non-delivery of planned level of financial improvement
The financial plan for 2024-25 requires the achievement of financial improvement (expenditure savings) totalling £48.0m.
Failure to deliver the target for financial improvement could adversely impact the achievement of the financial plan and increase the deficit.

Mitigations/Controls in place	Lines of Assurances	Additional Controls required
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 2024/25 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. Continuation, for a period of at least six months, of the Enhanced Establishment Control Group (executive approval before advertising) to review all requests for A&C posts and all Band 7+ posts (Non-Patient Facing), moratorium on requests for Permanent recruitment to Band 8D and above (non clinical posts) and minimising interim staff appointments. 4. Internal scrutiny by Central Finance Team, of the Divisional financial assumptions, overspends and forecasts. 5. Financial reporting to Welsh Government on a monthly basis, with the MMR.	**1st** – eg. Operational: 1. Divisional Directors holding Budget Mangers to Account for spending within delegated budgets and delivering the savings targets. 2. CEO led, Divisional Performance Management of Directors at IPEDG and individual performance reviews 3. Regular review of Risks and Opportunities for mitigation 4. Regular Check and Challenge meetings between FD's and CFOs and Divisional Directors on in-month\forecast outturn and savings delivery **2nd** – eg. Risk and Compliance: 1. Standing Orders, Standing Financial Instructions and Scheme of Reservation and Delegation – defining expectations, roles and responsibilities. 2. IPEDG setting goals for Directors, for implementation. 3. Risk management framework in place. 4. Early identification of emerging issues through horizon scanning and trends in run rate and alerting Operational Management to changes to regularity requirements. 5. Monitoring the adequacy and effectiveness of internal control, accuracy and completeness of financial	1. Welsh Government (WG) expectation to achieve financial balance, due to the financial settlement/allocations to Health Boards and to enter into financial stability.

6. Financial Position (including Savings) oversight arrangements in place through the Performance, Finance and Information Governance Committee (PFIG) 7. Regular communication with Welsh Government regarding £82m strategic funding with regards to making this recurrent rather than non-recurrent.	reporting and forecast, compliance with laws and regulations, and timely remediation of deficiencies. **3rd – eg .Independent:** 1. Internal Audit 2. WG in the form of a monitoring return submission – detailing for example, expenditure run rates and reasons for movements, savings profile delivery and risks and mitigating actions. 3. Fortnightly performance meeting with the WG and NHS Executive.	

Actions	**Due Date**	**Progression Analysis**
Value and Sustainability Programme approach to savings – assign Exec Leads and Support Teams to each theme and cost up Opportunity Plans for consideration by the Divisions.	31/06/2024	Progressing
Progress Savings Opportunities by generating Saving Scheme Documents setting out the planned delivery agreed by Executive Lead or Divisions and monitor actual delivery.	31/03/2025	Progressing



	Impact	Likelihood	Score
Inherent Risk Rating	5	5	25
Current Risk Rating	4	5	20
Target Risk Score	4	3	12
Risk Appetite	Financial		2 – Cautious

Rationale for Corporate Risk

to the Board approved the Annual Plan in March 2025, which set out to achieve a control total of £19/7m deficit. The risk will assess each month progress against the delivery of the Plan.

M3 - Year to date, £7.9m above Planned Deficit

CRR 24-06	**Risk Title: Suitability and Safety of Sites**		**Date Opened:** 04/01/2024
	Assuring Committee: Performance, Finance and Information Governance Committee		**Date Last Committee Review:** 25/06/2024
Date Last Reviewed: 13/06/20224	**Director Lead:** Executive Director of Finance	**Link to BAF**: SP14	**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).

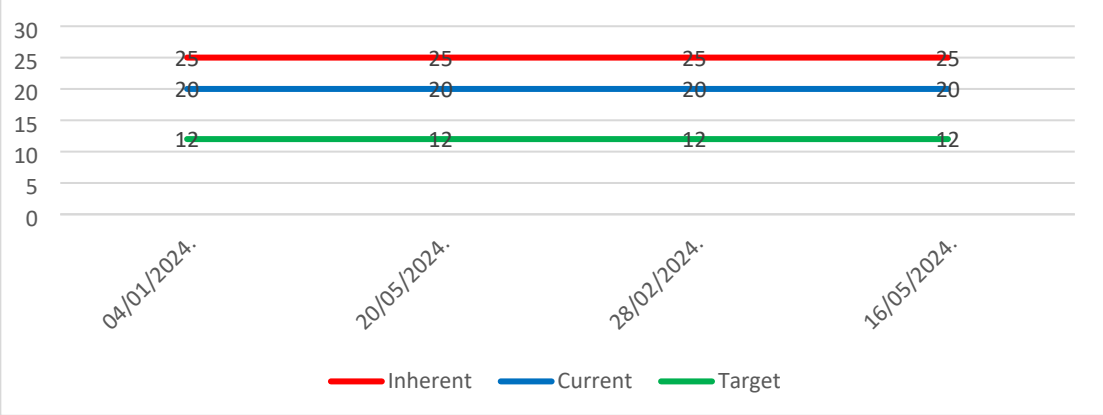
There is a risk that the suitability and safety of the estates and infrastructure across BCU could severely impact on service delivery, staff and patient safety. This could be caused by aging and unsuitable buildings, backlog maintenance issues, non-compliance with regulations, inadequate space capacity, and lack of capital funding. The impacts may include inability to meet service needs, reduced access to diagnostics and treatment, risks of infection, fire, asbestos, legionella and other hazards, increased costs, regulatory enforcement action, and significant reputational damage. This presents risks to the continuity of care, patient outcomes, staff wellbeing, and the Health Board's ability to provide safe, therapeutic environments across the region.

Mitigations/Controls in place	Lines of Assurances	Additional Controls required
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 £12.448m for 24/25 approved by Welsh Government with an allocation of approximately £3.208m 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.	**1st** – eg. Local Assurances: Existing groups in operation within the Health Board where capital prioritise are reported: 1. Capital Planning Management Team 2. Capital Investment Group 3. Risk Management Group 4. Executive Team meeting Existing groups in operation within the Health Board where environmental issues and safety are escalated: 5. Strategic Occupational Health and Safety Group **6.** Strategic Infection Prevention Group 7. Risk Management Group 8. Executive Team meeting	1. 6 facet survey to be undertaken to obtain an updated report of the condition of the Estate. 2. Assurance around the development control plan aligned with both the Estates strategy and the Clinical strategy. 3. Business Case Review Group to be set up to review all business cases to provide scrutiny prior to submission to Executive team. 4. 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. 5. Ensure that the Health Board Capital prioritisation plan is shared with Welsh Government (WG) to identify required investment. The end date is dependant of how much capital investment is provided to

7. Operational Estates Safety Groups in place to provide assurance, the safety groups are as detailed below a) Fire Management b) Asbestos Management c) Water Safety, d) Ventilation Safety e) Electrical Safety 8. Welsh Government Capital Resource Meetings in place to provide route for escalation. 9. Estates and Facilities Performance Management System (EFPMS) reporting template and recording of backlog maintenance	**9.** Internal Audit **2nd** – eg. Board/Committee Assurances: 1. Performance, Finance and Information Governance Committee **3rd** – eg. External Assurances: Internal Audit External Audits undertaken by NHS Wales Shared Services Partnerships, Specialist Estates Services, Authorising Engineers in the following disciplines: a. Fire b. Water Safety c. Ventilation d. Electrical (HV / LV) e. Medical Gases f. Decontamination Inspections by the North Wales Fire and Rescue service within inpatient areas.	the Health Board from WG. The 10 year capital investment requests aligns with the capital prioritisation form that we will submit to Welsh Government. 6. Ensure that the Health Board has an Estates rationalisation programme in place that will support the capital prioritisation programme and reduce backlog maintenance. 7.Updated agreed protocol for use of Annual Discretionary Slippage to be put in place by 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.

Actions	**Due Date**	**Progression Analysis**
Business Case Review Group to be developed by Health Board. Development of Business Case Review Group agreed in principle by the Health Board. To be progressed in conjunction with a multi-disciplinary team representing service and technical support leads and has been trailed on a recent Business Case. The process is being finalised and will be presented to Capital Investment Group for ratification.	30/09/2024	Revised from Feb 24 Progressing
Completion of Welsh Government Prioritisation exercise. Welsh Government Prioritisation exercise completed and approved by the Health Board	31/03/2024	Completed
Undertake action to deliver an Health Board Estates Rationalisation Programme Estates Rationalisation Programme being developed and in draft format. This will be in conjunction with the new Director of Environment, once appointed. A Draft will be submitted to a multi disciplinary group for initial comment, with a final version to be ratified by Capital Investment Group .	30/09/2024	Revised from March 24 Progressing
Agreed protocol for use of Annual Discretionary Slippage to be put in place. Protocol for the use of Annual Discretionary Slippage in place and approval route is through the Capital Investment Group.	31/03/2024	Completed
Review / Standardisation of IHC's / Mental Health Learning Disability Estates and Capital Group 'Terms of Reference' and escalation process	30/09/2024	Progressing

Undertake actions to deliver a 6 facet survey across the Health Board over the next 5 years	31/03/2026	Progressing
Review and update Development Control Plans	30/04/2025	Progressing



	Impact	Likelihood	Score
Inherent Risk Rating	4	5	20
Current Risk Rating	4	5	20
Target Risk Score	2	4	12
Risk Appetite	Quality		3

Rationale for Corporate Risk

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 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.
Our 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.

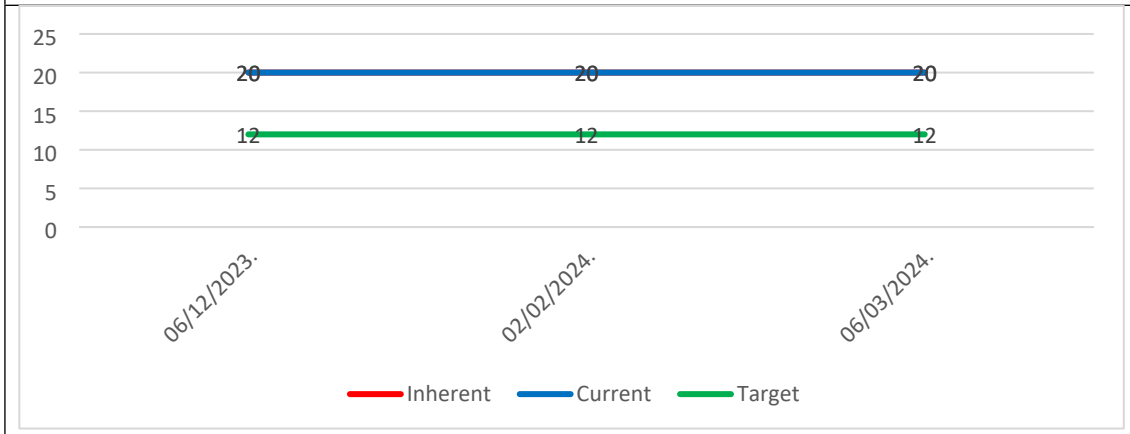
CRR 24-07	**Risk Title:** Availability and Integrity of Patient Information		**Date Opened:** 06/12/2023
	Assuring Committee: Partnerships, People and Population Health Committee		**Date Last Committee Review:** 18/06/2024
Date Last Reviewed: 14/05/2024	**Director Lead:** Chief Digital and Information Officer	**Link to BAF**: SP13	**Target Risk Date:** 31/03/2029

There is a risk that patient harm will be caused due to the lack of a joined up longitudinal Electronic Healthcare Record system that digitalises clinical workflow, alerts, hand overs and scheduling under a single patient identifier, which could lead to deaths and harm.

Mitigations/Controls in place	Lines of Assurances	Additional Controls required
1. Current paper file identified as the Master Copy of the full record. 2. Access to current clinical systems to print clinical information ready to store in the Master File. 3. CITO Contract in place to house scanned document as a repository. 4. Mandate process in place to control the adoption of new functionality within existing systems to capture patient data. 5. Current system training and standard operating procedures around searching for and registering new patients to prevent the creating of duplicate records in place. 6. Standard operating procedures involving searching for and storing patient information to prevent harm in cases where duplicate records exist is in place within Patient Administration System. 7. Lack of quality within the content of current patient records. Meeting organised with Office Medical Director to consider address improvements in the quality of record keeping moving forward.	**1st** – eg. Operational: 1. Information Governance Toolkit embedded with operational group oversight and monitoring. 2. Chairs assurance report from Information Governance Group presented to Performance, Finance and Information Governance Committee which focuses on performance indicators. **2nd** – eg. Risk and Compliance: 1. Risk Management Group 2. Executive Team meeting **3rd** – eg. Independent: 1. Information Commissioners Office Audit. 2. Internal Audit Annual Information Governance Compliance Audit.	1. Establish and implement the governance arrangements for overall management of the Electronic Health Record Programme. Steering Group set up and will be captured as part of the outline business case requirement. 2. Lack of current system capabilities systems to integrate into the fuller Electronic Health Record. Optimisation programme underway with a focus on EPOC, EPRO, WCP and CITO to review current systems interoperability and functionality. 3. Availability of current paper records within digital environment. The Electronic Health Care Record outline business case will analyse resource requirements to consider scanning or dual processing of records. 4. Patient Records Group currently not meeting. A review of the remit and establishment is underway with the Senior Information Risk Owner and Caldicott Guardian. 5. Standard practice registration across the three acute sites. Proposal developed including resource funding required

		based on the East Health Records service coverage. 6. No agreement to fund additional Health Records staff to address backlog of duplicate patient records / identifiers. Standardised procedures in place to prevent re-occurrence. 7. Establishment of a Change Advisory Board led by Clinicians to standardise the collection, storage and access of digital patient information. 8. Although agreement in principle to fund additional patient record staff to undertake the duplicate patient record issue, funding stream still not approved.

Actions	**Due Date**	**Progression Analysis**
Assessment to be undertaken of what is required for the development of an Outline Business Case for an Electronic Health Record (EHR) Business Justification Case to seek funding for compilation of Outline Business Case being completed with submission due in September 2024.	30/12/2024	Progressing
Seeking approval and funding for the Strategic outline case for Electronic Health Record	31/12/2024	Completed
Establish the cost and resource requirements to back scan all live records	31/01/2025	Progressing
Standardise the way in which using existing systems (paper and electronic) as part of the DDaT optimisation workstreams Paper will be presented mid-June to DDaT SLT for discussion and decision on prioritisation.	31/03/2025	Progressing
Undertake a review of all current systems to ensure these can be integrated into an Electronic Health Record report will be available in mid-June for presentation at the DDaT SLT meeting for decision and prioritisation agreement.	30/04/2025	Progressing
Accelerating the business case, approvals, procurement and implementation of an Electronic Patient Record for Mental Health (minimum 2-year project) BCUHB only Business Case due to be finalised 24th May 2024. A multi-disciplinary steering group has been set up, and continuing to work collaboratively on an All Wales basis.	30/04/2025	Progressing
Recruitment of additional health records staff to standardise the registration practice across three acute sites. Funding request submitted for approval to Executive Team.	30/11/2024	New action



N.B. Inherent and Current score lines stacked as both are 20

	Impact	Likelihood	Score
Inherent Risk Rating	4	5	20
Current Risk Rating	4	5	20
Target Risk Score	4	3	12
Risk Appetite	Quality		3 - Open

Rationale for Corporate Risk

Organisational wide risk based on potential patient safety and negative impact if the risk were to materialise. In addition the financial and resource requirement to implement the controls and mitigations required are significant.

CRR 24-08	**Risk Title:** Population Health		**Date Opened:** 01/11/2023
	Assuring Committee: Partnerships, People and Population Health Committee		**Date Last Committee Review:** 18/06/2024
Date Last Reviewed: 11/06/2024	**Director Lead:** Executive Director of Public Health	**Link to BAF**: SP1	**Target Risk Date:** 31/03/2026

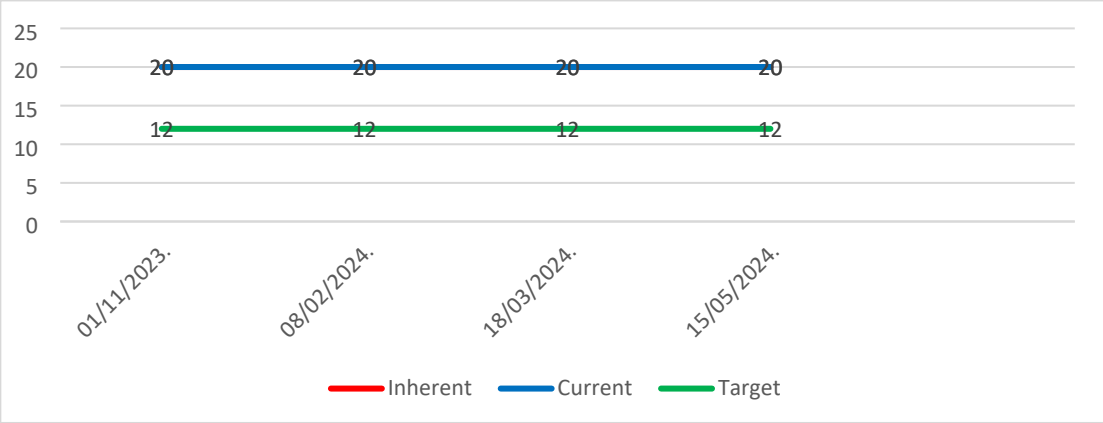
There is a risk that the Health Board fails to adequately support the improvement of population health and reduce health inequalities. This may be caused by a lack of sustainable services, financial and resource constraints within the Health Board, dependency on grant funding to support prevention activity and demand for delivering the urgent and immediate healthcare needs of the population.
Population health improvement and protection may also be impacted by population behaviours and beliefs, modifiable risk factors, wider determinants of health (eg Housing, Education, Employment), the local demographics, the living environment, food production and consumption, local planning, socio-economic factors or the accesibility of health care services.
This may lead to continuation and increases in largely preventable non-communicable diseases including Type 2 Diabetes, Respiratory conditions, Cardiovascular disease, Cancer, Musculoskeletal conditions, mental health and wellbeing and multiple co-morbidities. It may also lead to to increasing rates of infectious disease. Failure to address the risk could potentially lead to avoidable morbidity and mortality within the population of North Wales

Mitigations/Controls in place	Lines of Assurances	Additional Controls required
1. Population Health Executive Delivery Group provides strategic direction. 2. Grant funding secured from Welsh Government supporting prevention and early years activity. Grant funding associated with Prevention, Whole System Approach to Healthy Weight, Whole School approach to Mental Health and Healthy Schools/Healthy Pre-schools awarded via Public Health Wales has been confirmed for 24/25 3. The Executive Director of Public Health provides consistency to the regional strategic approach and prioritisation. 4. Annual development of Public Health work plan to reflect current and emerging need. 5. Consultants in Public Health are linked to delivery of key programmes of work, Public Health Wales and with IHC areas, providing expertise and guidance. 6. Public Health Team provide review and feedback on planning applications. 7. Health Protection Team work in partnership with Local Authorities to provide expertise and management of risks and issues.	**1st** – eg. Operational: 1. Population Health Executive Delivery Group and the Public Health Senior Leadership Team. 2. The Public Health Team provide the Health Board, its partners and the public with evidence informed information and approaches to improve health and wellbeing. 1. The Public Health Team support population needs analysis and provide professional expertise to support the development of Health Board and partner plans. 3. Prevention is embedded in the Living Healthier, Staying Well Strategy and a 'life-course' approach is promoted. **2nd** – eg. Risk and Compliance: 2. Risk Management Group 3. Executive Team. 4. A 'Whole System Approach' is being implemented across a number of key priority areas 5. **3rd** – eg. Independent:	1. Response to the demographic profile and the current and forecast prevalence of chronic conditions and their effect on demand. 2. There is no secured long term funding to support implementation and growth of the whole system approach across North Wales at scale. 3. The availability of data and intelligence to support strategic focus at the local level and subsequent planning is not available. 4. The Deputy Director of Public Health post is currently vacant as the post holder is Acting Executive Director of Public Health.

8. Funding associated with Healthy Weight Healthy Wales which was formerly non-recurrent grants has now been added recurrently to the Health Board core budget. 9. Prevention and health inequalities form key part of the Health Board Integrated plan 24-27. 10. The RIGA process has agreed continuation of funding for 24/25 to support the Well North Wales programme including ICL. 11. Grant funding (Welsh Government, Public Health Wales, Arts Council for Wales) has been secured for 24/25 for a number of small projects	1. Internal Audit 2. Representation by senior Public Health team members at Public Service Boards, Partner Boards, Regional Partnership Board and National forums. 3. A number of national programmes of work are underway including implementing the Weight Management Pathway and Smoke Free Sites regulations. 4. National Performance Framework measures. 5.	

Actions	**Due Date**	**Progression Analysis**
Infant Feeding Strategy 2019 (current refresh underway to 2025) forms part of Public Health team deliverables in conjunction with Womens Directorate	31/12/2024	Progressing
Tobacco Control Legislation (including Smoke Free Sites) / Welsh Government Tobacco Control Plan confirmation that all smoke free site officers are in place.	31/03/2026	Progressing
All Wales Weight Management Pathway 2021 continuation of funding for 24/25 to support weight management services.	31/03/2026	Progressing
Health Care Public Health Programme (also linked to Special Measures Plans and chronic disease pathways) the HCPH Diabetes programme is part of deliverables within the Health Board approved integrated plan.	31/03/2026	Progressing
Together for Mental Health Strategy (local / national) delivery managed via MH&LDS Directorate	31/03/2026	Progressing
Well North Wales targeted partner programmes Extension of Strategic Partner Development Manager post confirmed to 31/3/25. Discussion paper to PPHP in June.	31/03/2026	Progressing
Health Board Annual Plan / 3 year milestones and associated activity The Health Board plan approved for 24-27 reflects prevention priorities and deliverables.	31/03/2026	Progressing
Working in partnership across BCUHB, PHW and LA to reduce the risk associated with infectious diseases Confirmation of the funding to support the Health Protection Team. Development of processes for data sharing across organisations. Training and development for LAs and Partners. Measles response plans.	31/03/2026	Progressing
Immunisation Strategy 2023-2026 under review	31/03/2026	Progressing
Recruitment to the post of Executive Director of Public Health	31/12/2024	New action
Public Health team and DPH to meet with DDaT to discuss data and intel gaps to inform planning to support strategic focus for Public Health	31/07/2024	New action

Delivery of the 1st year deliverables from the Health Board's 3 year plan.	31/03/2025	New action
Deliver 24/25 Welsh Government and Public Health Wales grant funded programmes of work	31/03/2025	New action
Deliver 24/25 BCUHB funded programmes of work – Health Care, Public Health (Diabetes) programme	31/03/2025	New action
Deliver 24/25 BCUHB funded programmes of work – Well North Wales programme (Including inverse care law)	31/03/2025	New action
Develop a case for long term sustainable funding Local / Nationally	31/03/2025	New action
Through provision of recognised evidence contribute to the development and delivery of local partner plans (Regional Partnership Board and Public Service Board)	31/03/2025	New action



N.B. Inherent and Current score lines stacked as both are 20.

	Impact	Likelihood	Score
Inherent Risk Rating	4	5	20
Current Risk Rating	4	5	20
Target Risk Score	4	3	12
Risk Appetite	Quality		3 - Open

Rationale for Corporate Risk

The population health of North Wales is worsening and 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 through loss of involvement. Worsening health outcomes, increasing ill health and widening inequalities directly affects the Health Board ability to deliver excellent healthcare services meaning the Health Board purpose must retain clear focus on improving the health and wellbeing of the population

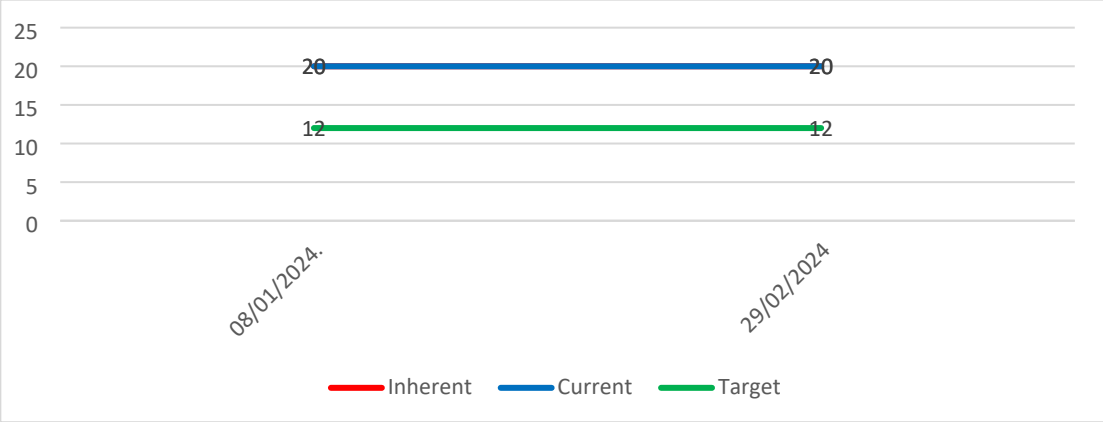
CRR 24-09	**Risk Title: Primary Care**		**Date Opened:** 08/02/2024
	Assuring Committee: Quality, Safety and Experience Committee		**Date Last Committee Review:** 06/06/2024
Date Last Reviewed: 11/06/2024	**Director Lead:** Executive Director Transformation And Strategic Planning	**Link to BAF**: N/A	**Target Risk Date:** 31/03/2025

There is a risk of the Health Board not fully meeting its legal obligation to provide accessible and high-quality primary care. This may be due the sustainability of primary care professions, patient access, timely diagnosis, and appropriate healthcare utilisation. This may result in a demoralised primary care workforce, increased strain on emergency services, prolonged hospital stays, preventable admissions, lapses in care, regulatory non-compliance, and declining population health indicators. Consequently, there is a cascading effect on patient flow, service performance, care quality, collaborative partnerships, cost-effectiveness, and the viability of primary care and community care models. The ultimate consequence is a rise in mortality rates, treatment delays, and extended hospitalisations, exacerbating patients' health conditions.

Mitigations/Controls in place	Lines of Assurances	Additional Controls required
1. Escalation and sustainability report to address risks associated with workforce and workload pressures allows for early identification and management. 2. Risk management training completed Q3 2023 for all primary care leaders for better identification and management. 3. Programme management implemented to monitor and drive strategic priorities. 4. Primary Care Quality and Delivery Group established Q3 23/24 5. Primary Care Board has now been established with the first meeting held May 2024, monthly meetings planned moving forwards. Sub group reporting into the Primary Care Board. 6. Primary Care contractor services audits of sustainability matrix ongoing periodically – Programmes in place to undertake the audits 7. Greater Health Board oversight of Primary Care issues and risks via PPHP Committee with first report to committee during April 2024 with further reporting in June 2024.	**1st** – eg. Local Assurances: 1. Primary Care Quality and Delivery Group 2. Primary Care Panel **3.** **2nd** – eg. Risk/Compliance: 1. Risk Management Group 2. Executive Team Meeting 3. **3rd** – eg. External Assurances: 4. 1. Internal Audit Regulatory inspections and investigations – HSE, HIW, CIW, PSOW 2. WG performance monitoring and assurance 3. Welsh Government Reviews 4. Royal College Reviews	1. Strategy and resources to support introduction of new roles, ways of working and models of service delivery. 2. Equity of resource to support primary care transformation, management and governance.

Actions	Due Date	Progression Analysis
Primary Care Board established Primary Care Board has now been established with the first meeting held May 2024, monthly meetings planned moving forwards. Sub group reporting into the Primary Care Board.	30/05/2024	Completed

Primary Care strategic plan National Primary Care model being reviewed with HB input which will inform the Betsi Strategic plan.	31/03/2025	Progressing
Escalation and sustainability implementation Primary Care contractor services audits of sustainability matrix ongoing periodically – Programmes in place to undertake the audits which were included in the annual delivery plan.	30/06/2024	Completed
Health Board Managed Practices – recommendations for improved governance report Managed practices governance and assurance sub group reporting into Primary Care Board	31/01/2024	Completed
Focused on implementation of recommendations from the National Strategic Programme for Primary Care. July workshop planned to review the recommendations and programme of work for 24/25	31/03/2025	Progressing (revised date from 30/06/2024)
Primary Care academy to utilise SPPC monies to further progress multi-professional working with a review of cluster monies spend to allow introduction of new roles, ways of working and models of service delivery.	31/12/2024	New action



N.B. Inherent and Current score lines stacked as both are 20.

	Impact	Likelihood	Score
Inherent Risk Rating	4	5	20
Current Risk Rating	4	5	20
Target Risk Score	4	3	12
Risk Appetite	Quality		3 - Open

Rationale for Corporate Risk

Optometry reform delivery compromised, continue to have further managed practices and financial implications to the Health Board. Dental access compromised.
Recognition of inherent score currently further controls needed.

CRR 24-10	**Risk Title:** Urgent and Emergency Care		**Date Opened:** 26/02/2024
	Assuring Committee: Performance, Finance and Information Governance Committee		**Date Last Committee Review:** 25/06/2024
Date Last Reviewed: 07/06/2024	**Director Lead:** Executive Director of Operations (Executive Director Therapies & Health Science)	**Link to BAF**: N/A	**Target Risk Date:** 30/03/2025

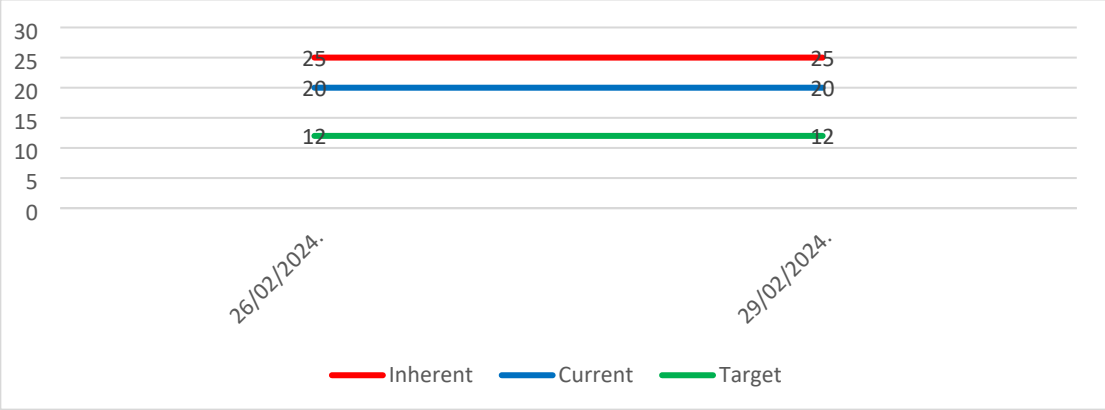
There is a risk of mortality in relation to **critically ill** patients being seen in a **timely** manner through unscheduled **care** routes. This may be caused by delayed dispatching of ambulances, ambulance queues at emergency departments, Out of Hours access and EDs and UTCs being at capacity. This could impact on pressures for other services, reputation and litigation implications.

Mitigations/Controls in place	Lines of Assurances	Additional Controls required
Daily management system in place to manage patient flow including multiple daily local and national calls. Continuous focus on reducing delays for health and social care reasons including complex care management, fast track cases and implementation of a home first ethos. Regular reviews of long stay patients in acute & community hospitals to reduce average length of stay. Training on discharge and complex care management is provided to ward based staff through the Complex Care and Unscheduled Care Team. System lead management 5/7 to have a singular point of escalation with external agencies and internal IHC concerns. Single Integrated Clinical Advice Triage (SICAT). Ambulance escalation process to support peak periods of demand. Hospital full protocols to support rapid de-escalation during peak periods of demand. Care Home risk and escalation plans to support care home capacity with community team's support.	**1st** – eg. Local Assurances: 1. Operational Meetings ensure a Pan North Wales approach for managing daily UEC demand with external stakeholders 2. Clinically optimised reviews across all IHCs take place on a regular basis with access into social care providers for support on getting patients care closer to home. 3. IHC Management team led reviews with clear focus on action to support reducing LoS with a full multi-disciplinary team representation. 4. Nurse led discharges being rolled out across North Wales to support timely discharges and utilisation of STREAM (IT System) to track planning. 5. Senior operational managers managing daily demand across North Wales and being a singular point of escalation when Unplanned and Emergency Care (UEC) demand and capacity increases. 6. Each Acute site has a process of internal escalation when delays occur with ambulance handovers occur with triggers for escalation and actions to be completed. 7. Each IHC has a bed escalation process that supports triggers for escalation and gives triggers to support de-escalation in a timely fashion.	1. Fragility and gaps in social care assessment, delivery and social care market provision (including both domiciliary care and independent care home sector) resulting in substantial delays and patients being stranded in community hospitals and out of county beds. 2. Delays in assessment of complex care cases and inefficient brokering resulting in increased delays and cost. 3. Resources – System lead runs alongside staffs day to day roles and is extremely fragile in the current climate and requires either extending criteria of staff to support or development of a permanent hub similar to that of IA. 4. Funding spot purchasing of beds to assist with stepping up of patient care rather than hospital admissions. 5. Vacant essential roles across BCUHB that will impact on patient care and operational management resulting in inability to drive system change.

Winter Plan developed to manage whole system pressures. Urgent review of escalation options in development between health and social care to increase community care capacity and to reduce delays. Industrial action command and control structure in place to manage service impact and to minimise disruption to services. Winer plan reviewed and signed off by Executives/Board December 2023, with planning under way to commence resilience planning from April 2024 for season 2024/2025, planning is inclusive of local authorities and voluntary sectors to support a North Wales approach 0800-2000hrs funded GP service working alongside WAST/111 to reduce ambulance responses and manage patients through alternative pathways reducing the need for ambulance attendances Monthly updates from WAST to confirm care home at risk for escalation, with regular reviews and training to support managing the patients care closer to home, this is further expanded by Immedicare (Remote advice) being in place across 15 care homes across North Wales. Increasing periods of industrial action occurring, IHCs planning continues along with weekly Silver and Gold reviews to ensure accurate communication with all stakeholders along with assurance for national agencies Review of Complex Care arrangements in place to improve system improvements and to reduce delays, this is now managed via Goal 6 of the six goals programme and also via each IHC's Clinically optimised weekly meetings. Industrial action (IA) management plans in place and require review for sustainability in light of on-going planning for IA throughout 2024 Urgent escalation plan to secure additional system impact to improve community care capacity and flow, amended from lessons learnt	**2nd** – eg. Risks/Compliance: 1. Escalation to Executive Team 2. Risk Management Group **3rd** – eg.External Assurances: 1. Regulatory inspections and investigations – HSE, HIW, CIW, PSOW. 2. WG performance monitoring and assurance 3. Welsh Government Reviews 4. Royal College Reviews 5. National Trauma Peer REVIEW. 6. Internal Audit	6. Trusted assessors development, ongoing work for the last 18months, support required to progress at pace. 7. Review of system lead/on call to support a 24/7 provision with an equal service provision. That amends the narrative from On call to shift focus. 8. Winter resilience, earlier national feedback on any support available over the winter periods, in place of the November/December notification that does not allow maximum utilisation. 9. Continuous flow modelling – National presentation on a model to decompress the Emergency department and create movement to reduce delays.

Actions	**Due Date**	**Progression Analysis**

Health board to identify permanent Executive lead for UEC to allow sustainable programme development over the next 3 years.	01/09/2024	Progressing.
Health board to support development of a pan North Wales UEC (SICAT remodelling) hub prior to Winter 2024 to ensure 24/7 service support, in conjunction with national support and forthcoming escalation triggers	01/09/2024	Progressing.
Transformational development of urgent care system (6 Goals) including ministerial priorities; in light of major change programme completion date has been amended to End of August 2024 to support a singular approach for one system.	31/08/2024	Revised from March Progressing
GIRFT/SEDIT reviews ongoing to support demand management across North Wales, supported by the national programme team, capital funding being sourced from the national programme.	30/09/2024	Progressing.
BCUHB agreement on IHC to trial the Continuous flow model and implement prior to August 2024- WXH IHC have been the sight supported by Executives as initial trial site. Ongoing assurance discussions with East IHC and Swansea Bay continue in light of concerns raised. Final meeting planned for end of June 2024	30/06/2024	Progressing
Confirmation of national requirement for winter resilience plan going forwards or focus on a North Wales resilience plan for 2024-2025	31/08/2024	Progressing
Communication – BCUHB requires a singular approach to communication on UEC planning to prevent conflicting information occurring due to planned care forecasting	30/07/2024	Progressing.
Review of Complex Care arrangements in place to improve system improvements and to reduce delays, this is now managed via Goal 6 of the six goals programme and also via each IHC's Clinically optimised weekly meetings.	30/04/2024	Completed
Industrial action (IA) management plans in place and require review for sustainability in light of on-going planning for IA throughout 2024	30/04/2024	Completed.
Urgent escalation plan in development to secure additional system impact to improve community care capacity and flow to be reviewed and amended from lessons learnt since implementation	31/05/2024	Completed



	Impact	Likelihood	Score
Inherent Risk Rating	5	5	25
Current Risk Rating	4	5	20
Target Risk Score	4	3	12
Risk Appetite	Quality		3 - Open

Rationale for Corporate Risk

Regulations 28, preventing future death reports (2020-2023),

CRR 24-11	**Risk Title:** Planned Care		**Date Opened:** 04/12/2023
	Assuring Committee: Performance, Finance and Information Governance Committee		**Date Last Committee Review:** New
Date Last Reviewed: 12/06/2024	**Director Lead:** Executive Director of Operations (Executive Medical Director)	**Link to BAF**: N/A	**Target Risk Date:** 31/12/2024 (interim review)

There is a risk of further deterioration in patients' health, **harm**, mortality or need for more complex treatment in relation to planned care services with a, resulting in failure to meet national access targets. This could be caused by **long waits and delays** for planned care, insufficient **capacity**, staffing shortages, increasing demand, and backlogs exacerbated by COVID. The impact would be worsening patient outcomes and experiences, increased complaints, financial penalties for target breaches, and reputational damage.

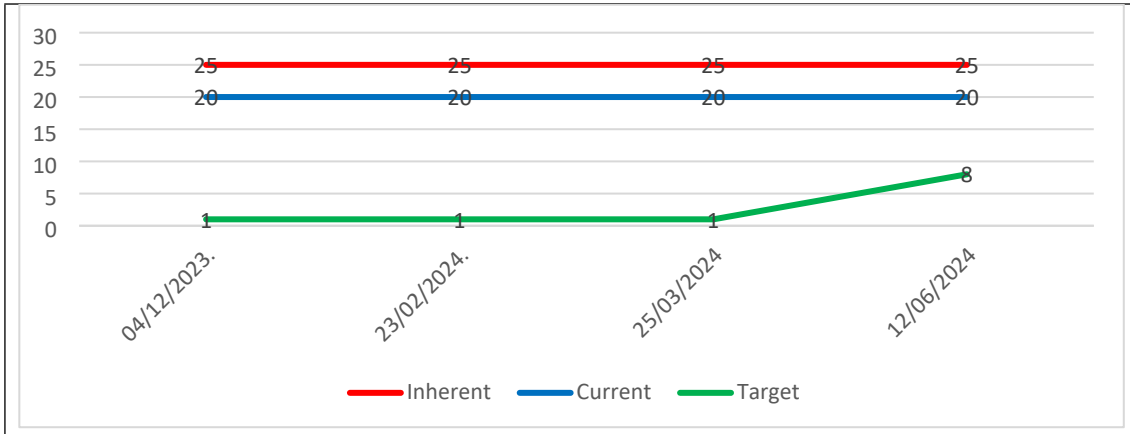
Mitigations/Controls in place	Lines of Assurances	Additional Controls required
1. Routine prioritisation of patients by clinical risk according to national Referral to Treatment Time (RTT) guidance (Cancer > Urgent > Routine) 2. Performance monitored via weekly corporate access meeting and locally via IHC weekly access meetings including long waits and clinical prioritisation. 3. Clinical prioritisation and review of waiting lists ongoing. 4. Validating waiting list cohorts.	**1st** – eg. Local Assurances: 1. Routine operational performance monitoring (weekly corporate access meeting). 2. Application of RTT guidance in maintaining and improving treat in turn rates 3. Escalation to Planned Care Board **2nd** – eg. Risk/Compliance: 1. Risk Management Group 2. Executive Team **3rd** – eg.External Assurances: 1. Internal Audit Regulatory inspections and investigations – HSE, HIW, CIW, PSOW 2. WG performance monitoring and assurance 3. Welsh Government Reviews 4. Royal College Reviews	1. Capacity and demand modelling and trajectory tracking 2. Development of sustainable service models to mitigate existing clinical risks 3. Application of GiRFT and other performance improvement approaches (monitor progress of implementation via planned care board and performance outputs via access). 4. The planned care funds available will mitigate the risks and will be closely monitored through the Planned Care Programme Board 5. Chief Operating Officer vacancy. 6. Refresh and renew INNU policy to ensure referrals are appropriate. 7. Commissioning services where there is need

Actions	Due Date	Progression Analysis
Recruitment to the Llandudno/ Abergele business case (orthopaedic site). Funding not released, action overdue. Partial recruitment complete others ongoing	Original date March	Progressing

	revised 10/06/2024	
Approval of the application of sustainability funds and authority to deploy in line with Plan. Phase 1 completed as planned	Original date March revised 08/05/2024	Complete
Senior Responsible Officer appointed for Planned Care Board	Original date March revised 01/04/2024	Complete
Recruiting to programmes of work in order to support successful delivery	01/06/2024	Progressing
Board Development session for Executives on planned care	Original date Dec revised 06/05/2024	Complete
Chief Operating Officer Recruitment underway	01/07/2024	Progressing
Procurement for insourcing for endoscopy and diagnostics	01/05/2024	Progressing
Endoscopy business case approval	19/05/2024	Progressing

	Impact	Likelihood	Score
Inherent Risk Rating	5	5	25
Current Risk Rating	5	4	20
Target Risk Score	4	2	8
Risk Appetite	Quality		3 - Open

Rationale for Corporate Risk



RTT 52 week waits stage one - NHS Wales Performance Framework 2024-25 Target = 0. Current positions RTT 52 Stage 1 - 17,505 (although surgical West actuals are nearly 500 lower than the trajectory)

RTT 104 week waits all stages - NHS Wales Performance Framework 2024-25 Target 0. Current positions RTT 104 all Stages -11,503 (9,435 over 104w +1,734 over 156w + 334 over 208w) To achieve this within 12 months would mean an additional 2,417 cases per month, at least 1,459 of which would be stage ones.

RTT 52 week waits all stages - NHS Wales Performance Framework 2024-25 Target 0 by 30.06.2025 Follow up backlog 100% overdue - Target reduction compared to same month last year. East has a bigger share of stage ones over 52w by 2k so there is room to make the pan-BCU list more equitable. Continue to prioritise eliminating 156 or 208 weeks as early in the new financial year as possible.

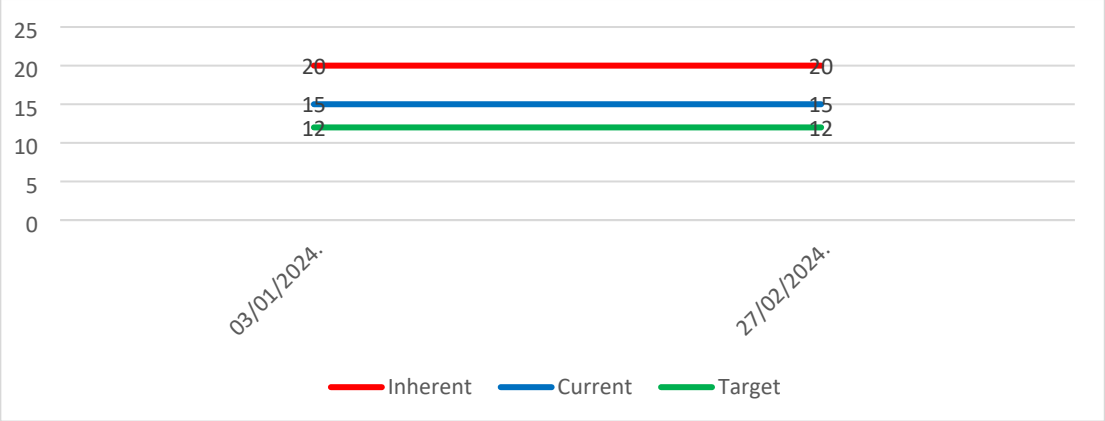
CRR 24-12	**Risk Title:** Clinical Areas of Concern		**Date Opened:** 15/12/2023
	Assuring Committee: Quality, Safety and Experience Committee		**Date Last Committee Review: New**
Date Last Reviewed: 29/05/2024	**Director Lead:** Executive Medical Director/ Executive Director of Operations	**Link to BAF**: N/A	**Target Risk Date:** 01/03/2025

There is a risk of service failure leading to patient harm across a number of fragile clinical specialties. This could be caused by staffing shortages, clinical leadership gaps, lack of productivity, demand backlog, increasing patterns of demand and estates and equipment deficits. The impact may be delayed diagnosis and treatment of significant conditions. This impacts patient safety, healthcare access and public health outcomes.

Mitigations/Controls in place	Lines of Assurances	Additional Controls required
1. Strategic Improvement Groups for the fragile clinical specialities. 2. Progress review groups for ophthalmology, dermatology and urology to develop and review progress of improvement plans. 3. Improvement plans for fragile specialities for specialities with clinical leadership. 4. Prioritising/triaging cases in specialities with backlog.	**1st** – eg. Local Assurances: 1. Special Measures meeting and assurances to committees on 90 day cycle 2. Quality Delivery Group **2nd** – eg. Risk/Compliance: 1. Risk Management Group 2. Executive Team Meeting **3rd** – eg. External Assurances: 1. Internal Audit **2.** National touch point meetings with NHS Executive colleagues	1. Implement plans for integrated electronic patient records 2. Dermatology, ophthalmology, urology continue to have clinical leadership gaps 3. Address lack of consistent medical cover in some specialities. 4. SLA for services provided by non-BCUHB organisations 5. Development of clinical model/pathways for fragile specialities with limited leadership incorporating relevant GIRFT and College recommendations 6. Clinical validation of waiting lists.

Actions	Due Date	Progression Analysis
Engagement with National Procurement Processes (i.e. eye record system) and National Programmes (i.e. Robotics) Ongoing engagement with Welsh Government is taking place and is satisfactory.	01/07/2024	Progressing
Ongoing recruitment for substantive medical leadership roles. Now recruited into an Ophthalmic Clinical lead role (May 2024). Start date to be confirmed. In addition the team has now had authorisation to appoint a Clinical Lead for Dermatology	01/01/2025	Progressing
Recruitment efforts including substantive, locum and agency staff. Work continues on a cycle of recruitment. Locum dermatological cover in Ysbyty Gwynedd from June 2024 has been confirmed in May 2024.	01/01/2025	Progressing
SLAs to be signed off through governance structures Work has now commenced on the process to implement a Dermatology Outsourcing SLA with national lead input. In relation to governance. Updates and any approvals will be sought through the Executive Team. (for SLA approval)	01/08/2024	Progressing

Clinical pathway events Engagement during May 2024 with NHS Wales Executive on the development of the Community Clinical Pathway system. This will be received at Executive Team for consideration.	30/07/2024	Progressing
Non-clinical and clinical validation exercises Andrew Oxberry from BCUHB has commenced work on this and this will be able to reported at the next update to this risk.	30/07/2024	Progressing



	Impact	Likelihood	Score
Inherent Risk Rating	5	4	20
Current Risk Rating	5	3	15
Target Risk Score	4	3	12
Risk Appetite	Quality		3 - Open

Rationale for Corporate Risk

The impact of the inherent risk has not been altered by current actions, although its likelihood has been reduced by the identification of the clinical issues and improved governance around the services.

- Ophthalmology R1 seen within 25% over their clinical due date - NHS Wales Performance Framework 2024-25 Target improve to 95%
- Cancer 62 Days - NHS Wales Performance Framework 2024-25 Target improvement trajectory to 80% by 31.03.2026

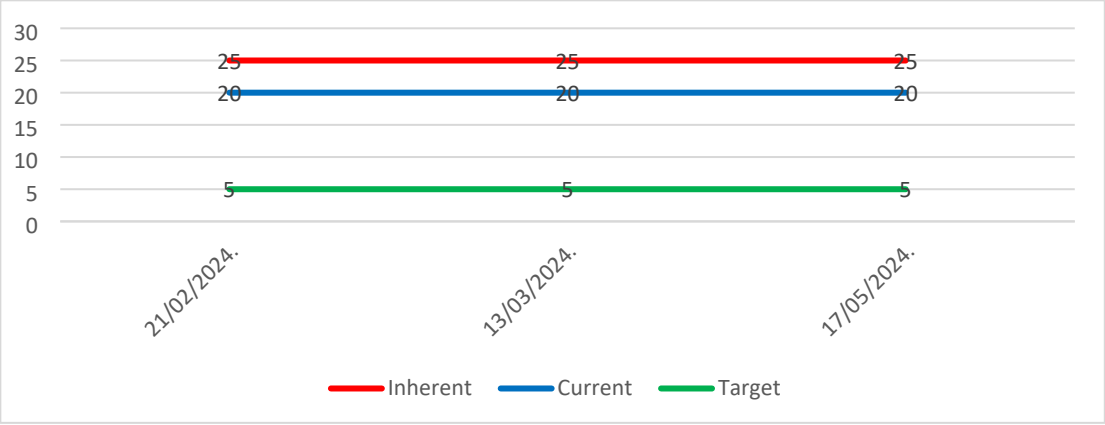
CRR 24-13	**Risk Title:** Timely Diagnostics		**Date Opened:** 21/02/2024
	Assuring Committee: Quality, Safety and Experience Committee		**Date Last Committee Review:** 06/06/2024
Date Last Reviewed: 17/05/2024	**Director Lead:** Executive Director of Therapies & Healthcare Sciences	**Link to BAF**: N/A	**Target Risk Date:** 31/12/2025

There is a risk of delay in diagnostics, service failure, poor performance or disruption to **radiology** and **pathology** services across. This could be caused by shortages of specialist staff, aging or inadequate IT systems and infrastructure, and insufficient governance structures. The impacts may include delays in diagnosis, treatment and discharge, increased outsourcing costs, patient harm events, preventable deaths, regulatory non-compliance, and significant reputational damage. There is also additional risk related to clinicians failing to act on results of diagnostic tests.

Mitigations/Controls in place	Lines of Assurances	Additional Controls required
1. Insourcing of CT, MRI and ultrasound to deliver required capacity 2. Work commenced on new radiology staffing model for the identification of significant restructuring of the service with succession planning, career development, staff wellbeing etc. 3. Significant guidance and steer with National Imaging Programme workforce work. 4. Outsourcing of radiology reporting to maintain Welsh government turnaround times 5. Waiting list & capacity and demand management is in place to monitor radiology required resources.	**1st** – eg. Operational: 1. Local deployment board and wider programme team stood up with collaborative working with Pathology and DDAT. 2. Radiology RISP project board in place **2nd** – eg. Risk and Compliance: 1. Risk Management Group 2. Executive Team **3rd** – eg. Independent: 1. Internal Audit 2. RISP being monitored via National and BCU implementation boards	1. Replacement of Radiology Informatics System (RISP) – implementation underway go live planned for April 2025 2. Replacement of LINC (national pathology IT system) - Contract signed with current supplier plans to implement by September 2025 being progressed nationally 3. Radiology workforce model not suitable for meeting the current demands being placed on the service from both clinical activity and supporting activity required to deliver service e.g. governance, regulatory and accreditation requirements 4. Escalate to BCU Clinical Effectiveness Group – issues around failure to act. Procedure MD (Office of the Medical Director) 23 – 'Mitigation of the risk of failure to act on diagnostic results' needs updating which is being led by the Executive medical director.

		5. PHW Collaborative Executive group. 6. Diagnostic Strategy for BCU needs to be developed

Actions	Due Date	Progression Analysis
Replacement of Radiology Informatics System (RISP) – implementation with anticipated go live date of the 14/04/2024.	14/04/2025	Progressing
Replacement of LINC (national pathology IT system) - Contract signed with current supplier plans to implement by September 2025 being progressed nationally	30/09/2025	Progressing
Procedure MD23 (Mitigation of the risk of failure to act on diagnostic results) to be updated	31/12/2025	Progressing
Radiology workforce revised model to be developed by June 2025	30/06/2025	Progressing
Diagnostic Strategy to be developed by diagnostic group	30/09/2024	Progressing



	Impact	Likelihood	Score
Inherent Risk Rating	5	5	25
Current Risk Rating	5	4	20
Target Risk Score	5	1	5
Risk Appetite	Reputational		4 - Seek

Rationale for Corporate Risk

Increasing demand for both radiology and pathology
Outdated IT infrastructure in both Radiology and Pathology that carry significant clinical and operational risks. – National programmes in place to resolve these issues
Additional work required to mitigate the risks from failure to act and update procedure MD23
Waiting lists longer than the national targets which results in delay in diagnosis which results in harm to patients. In addition, staffing stress related to demand in the service leading to burn out. 31st January 6,801

	diagnostic waits over 8 weeks with Endoscopy (2,163) and Cardiology (1,552) being the largest. Endoscopy capacity at most risk as the insourcing into Wrexham stopped as of 1st April 2024.

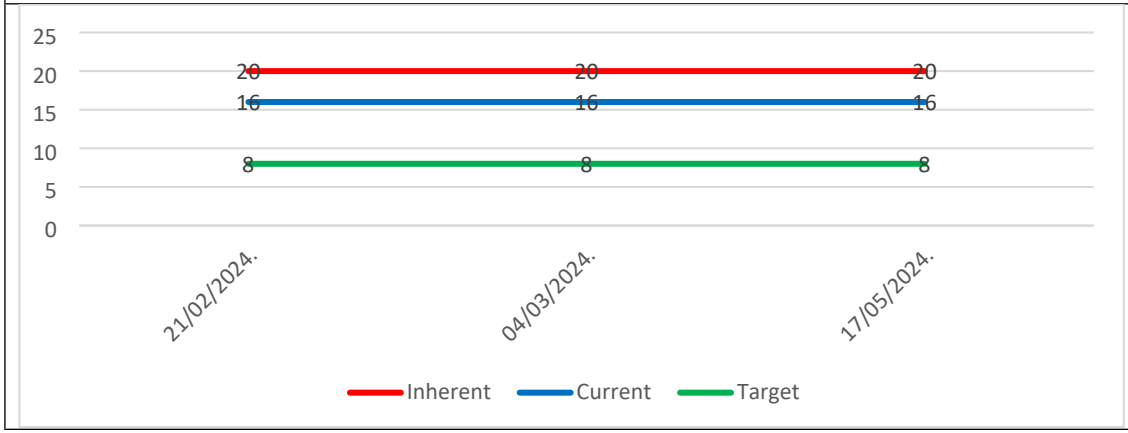
CRR 24-14	**Risk Title:** Harm from the Medical Devices/Equipment		**Date Opened:** 21/02/2024
	Assuring Committee: Quality, Safety and Experience Committee		**Date Last Committee Review:** 06/06/2024
Date Last Reviewed: 17/05/2024	**Director Lead:** Executive Director of Therapies & Healthcare Sciences	**Link to BAF**: N/A	**Target Risk Date:** 31/09/2024

There is a risk of harm and infection from aging, **unsuitable** or unreliable **medical equipment** and devices. This could be caused by equipment breakdowns, **lack of replacement funding**, ineffective cleaning and **decontamination**, insufficient **staff training**, improper use and poor traceability. The impacts may include inability to deliver essential services, delays in diagnostic and treatment leading to incidents and poor patient outcomes, increased costs and reputational damage.

Mitigations/Controls in place	Lines of Assurances	Additional Controls required
1. Medical Devices Oversight Group leads on the capital investment and replacement plan. 2. Annual capital planning process reflects known priorities taking account of key pieces of equipment due for replacement with a risk assessment that support the overall outcome. 3. Scrutiny and assessment of the capital programme at Capital Programme Management Team (CPMT) and Capital Investment Group (CIG). 4. Welsh Government Capital review meeting to escalate and discuss potential risks and requirements for key medical equipment e.g. Linac. 5. An effective medical devices management system is utilised through EBME. 6. EBME uses the management system to monitor the condition and performance of medical devices including device failures	**1st** – eg. Operational: 1. Medical Devices Oversight Group 2. Capital Programme Management Team 3. Capital Investment Group **2nd** – eg. Risk and Compliance: 1. Risk Management Group 2. Executive Team Meeting **3rd** – eg. Independent: 1. Internal Audit 2. National Endoscopy and Diagnostic Programmes	1. Internal risk assessment and priorities are flagged in the context of fully depreciated equipment (£34.659m) to understand priorities and potential risks. 2. External links with National Endoscopy and Diagnostic Programmes are documented and appropriately reported through correct channels to ensure transparency and potential benchmarking. 3. Lack of comprehensive governance structure around ensuring equipment **all** is safe and in line with regulations. 4. Lack of training around equipment and good governance of safety of equipment has been lacking and documented as a risk since 2016. 5. Robust risk assessments of how often certain equipment breaks down, the scale of difficulty sourcing spare parts to

and issues; utilisation, performance, maintenance; repair and calibration history. 7. Audits on majority of affected equipment in line with regulatory compliance completed.		be considered for included in requests for capital replacement. 6. The number of bids not approved now reaching over millions in capital and resources required. Backlog of equipment beyond end of life, some 10 years+

Actions	Due Date	Progression Analysis
CPMT and CIG to review annual planning process to ensure risk scoring to inform prioritisation	31/03/2024	Overdue
Review of internal and external group membership and communication to ensure all opportunities and risks are reported and escalated as appropriate.	31/02/2024	Overdue
Medical physics have been tasked with testing all ultrasound equipment to ensure its safety and will consider compliance	31/09/2024	Progressing
Review medical devices capital replacement to ensure all services have a medical devises replacement programme in place	31/09/2024	Progressing
Medical Devices strategy review	31/9/2024	Progressing
Recruitment to medical devices team	31/09/2024	Progressing



	Impact	Likelihood	Score
Inherent Risk Rating	4	5	20
Current Risk Rating	4	4	16
Target Risk Score	2	4	8
Risk Appetite	Quality		3 - Open

Rationale for Corporate Risk

Significant funding capital required, lack of robust controls and governance to ensure safety of equipment, £33M represents the value of capital medical equipment which is fully depreciated and at end of life.

CRR24-15	**Risk Title:** Health and Safety		**Date Opened:** 01/12/2023
	Assuring Committee: People & Culture Committee		**Date Last Committee Review:** 13/06/2024
Date Last Reviewed: 11/06/2024	**Director Lead:** Deputy Director of People	**Link to BAF**: N/A	**Target Risk Date:** 31/12/2024

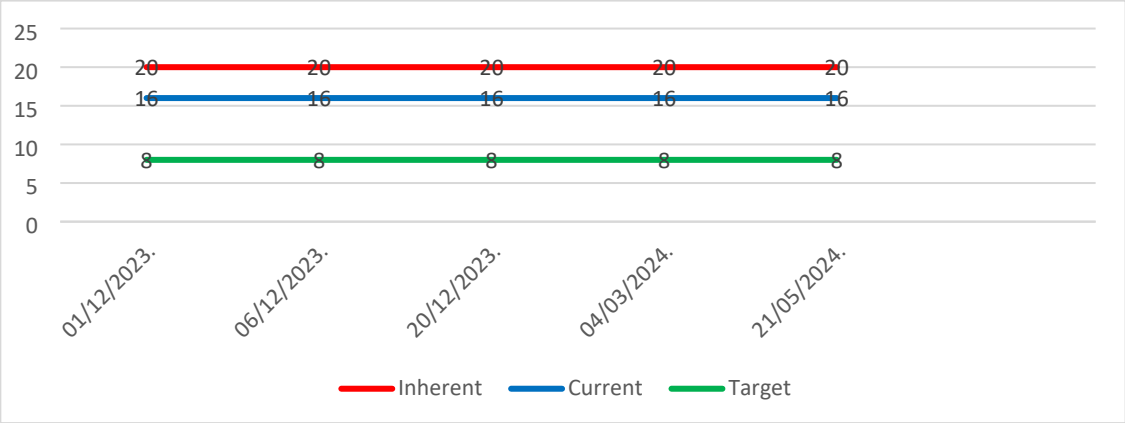
There is a risk of avoidable harm to patients and staff. This is may be caused by a failure of the Health Board to provide safe systems of delivery and work in accordance with the Health and Safety at Work Act 1974 and associated legislation due to the lack of Health and Safety Leadership. The impact is patient and staff harm, financial implications, and reputational impact to the Health Board.

Mitigations/Controls in place	Lines of Assurances	Additional Controls required
1. Health and Safety short courses for managers and staff, and mandatory e-learning are in place, with regular monitoring reported to Strategic H&S group. Further training commenced January 2024 with the NEBOSH General Certificate and NEBOSH Award. 2. Policies and subgroups have been established including asbestos, water safety, fire electrical safety etc. to monitor and report into the Strategic Occupational Health & Safety Group. 3. Competence in training in service areas has been reviewed. Plan in place through business case (subject to approval) to establish robust Safety Competence and leadership training programme. 4. There is a three-year Occupational Health, Safety and Security strategy in place that supports the Strategic Objectives of BCUHB. 5. Gap Analysis has been repeated to establish areas of non-compliance and to inform a new 3 year strategy 6. Falls are closely monitored by H&S advisors to review under RIDDOR reporting requirements 1. The H&S team have additional controls around learning from near misses and mistakes, participating in Falls investigation meetings and learning panels	**1st** – eg. Operational: 3. Strategic Occupational Health & Safety Group 4. Estates overseeing the high level risks as duty holder for asbestos, legionella, contractor management and control, Electricity and Fire and report to the Strategic Occupational Health and Safety Group. **2nd** – eg. Risk and Compliance: 1. Risk Management Group 2. Executive Team **3rd** – eg. Independent: 1. Internal Audit 2. RIDDOR reporting to the Health and Safety Executive in place with robust timeline.	1. HS01 to be updated when the Executive portfolios have been finalised. This will go out of date in December 2023 and a six month extension has been requested. 2. There have been a number of HSE interventions and internal reviews that have highlighted significant gaps in the OHS system. 3. Manual handling training compliance is currently at 68%. The team have moved back to the BCUHB sites as the two year contracts for external training venues have ended. The effects of these moves is not fully known yet. 4. The HSE have identified gaps in safe systems of work and risk assessment in connection with the sudden death of a patient within mental health resulting in. prosecution. 5. A Further intervention has been made by HSE in respect of the deaths of 3 patients following patient falls, a prosecution is expected

2. Professional training and qualifications provided by H&S team to ensure a whole system approach around Health & Safety learning and development 7.		6. Lack of formal arrangements in place to protect premises and people in relation to CCTV, violence and aggression, Security Contract issues (personnel), lone working, lock down systems, access control and training that provides assurance that Security is effectively managed

Actions	**Due Date**	**Progression Analysis**
A clear strategy and framework. The HS01 Policy, and supporting procedures and documents on BetsiNet require a review to ensure staff are provided with up-to-date requirements and guidance relating to Health & Safety.	31/12/2024	Progressing
NEBOSH training courses to go forward for the General Certificate and the Award.	31/12/2024	Progressing
Business case for security provision approval process underway.	31/12/2024	Progressing
H&S not noted as a deliverable on the Annual Plan for priorities and Strategic Objectives are due to be reviewed.	31/12/2024	Progressing
Executive level responsibility for Occupational Health and Safety should be considered, to ensure Health and Safety is a key focus within the Health Board.	31/12/2024	Progressing
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).	31/12/2024	Progressing
The Strategic Health and Safety Operational Group to confirm the reporting required to the group by services and ensure this is communicated to all relevant areas. Instances of non-reporting should be communicated to the services and escalated appropriately, via the Executive or QSE.	31/12/2024	Progressing
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”.	31/12/2024	Progressing
Health Board Policy 5.3.4 is reviewed to ensure that all Corporate Health & Safety recommendations are agreed, assigned to owners, allocated appropriate dates and are subject to follow-up.	31/12/2024	Progressing
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.	31/12/2024	Progressing

Estates to standardise action plans resulting from Health and Safety reviews and ensure regular review and update of actions to monitor progress.	31/12/2024	Progressing
A process to monitor and review department self-assessments should be put in place to ensure departments are adhering to the Health and Safety Policy. This should also include escalation where self-assessments are not completed, reviewing self-assessments for potential risks / issues and identifying areas of similarities / opportunities across departments.	31/12/2024	Progressing
An up-to-date list of Health and Safety leads / champions be developed to ensure there are contacts in place for all departments who are required to undertake self-assessments.	31/12/2024	Progressing
New role of Director of Environment to be recruited to reporting to CEO, which will review Estate business cases. Director of People Services being recruited to.	01/09/2024	Progressing



	Impact	Likelihood	Score
Inherent Risk Rating	4	5	20
Current Risk Rating	4	4	16
Target Risk Score	2	4	8
Risk Appetite	People		4 - Seek

Rationale for Corporate 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 will be implemented in summer 2024, with Health and Safety moving from Workforce Directorate to a new role of Director of Environment, reporting directly to CEO.

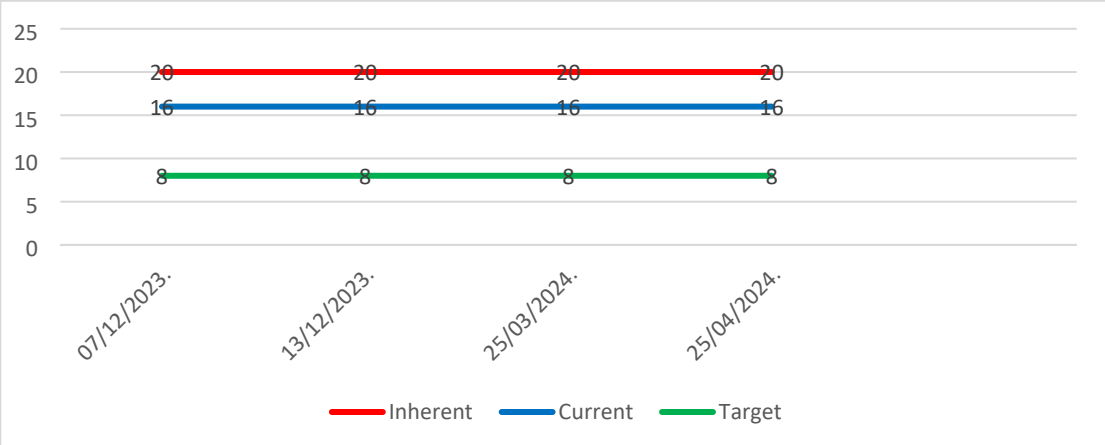
CRR 24-16	**Risk Title:** Leadership/Special Measures		**Date Opened:** 07/12/2023
	Assuring Committee: People & Culture Committee		**Date Last Committee Review:** 13/06/2024
Date Last Reviewed: 12/06/2024	**Director Lead:** Deputy Director of Workforce	**Link to BAF**: SP17	**Target Risk Date:** 30/09/2024

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

Mitigations/Controls in place	Lines of Assurances	Additional Controls required
1. Board Workshop with Professor Michael West on compassionate leadership 2. Suite of leadership conferences, networking and masterclasses on compassionate, inclusive leadership and engagement. 3. Work associated with this risk which links into the Special Measures Framework now monitored via the governance of the Framework and reported to Executive Team and Board. 4. Full Board now in place and all committees now chaired and attended by full complement of Independent Members 5. The new Integrated Leadership Development Framework (ILDF) has been ratified and is live on BetsiNet, this includes the 'Approach to Leadership' which was approved by the OD Steering Group in March 2024 6. The OD Steering Group now in place since February 2024	**1st** – eg. Operational: 1. Organisational Development Steering Group 2. Local Integrated Health Communities & Pan Services People & Culture Committees **2nd** – eg. Risk and Compliance: 1. Risk Management Group 2. Executive Team Meeting **3rd** – eg. Independent: 1.Internal Audit 2.Welsh Government JET meetings	1. Integrated Leadership Development Framework has been signed off by OD Culture group and will be tabled at P&C Steering group mid-June. 2. New compassionate approach to leadership and how to adopt it, aligned with the work on values and behaviours 3. Formal Culture Change Plan and accompanying Comms and Engagement plan 4. A Behaviours Framework, will be derived from the culture change workstream 5. Fully resourced Culture Change programme and realignment of resources within the OD function

Actions	Due Date	Progression Analysis
Integrated Leadership Development Framework socialised across the organisation for feedback. Work has taken place on further co-design and to socialise the draft Integrated Leadership Development Framework (ILDF) across the organisation. This has involved members of the OD team attending meetings already in place to share the proposed framework, inviting staff to feed back on the design and logo as well as the content of the framework. MS Teams virtual sessions (including evening and weekend sessions) have also been hosted inviting staff from across the organisation to attend and share their feedback and comments. Based on the feedback, amendments have been made, a recent copy of the draft ILDF can be found on BetsiNet.	31/01/2024	Complete
Integrated Leadership Development Framework implementation plan presented to Executive Team. The ILDF is currently being updated following feedback from March's OD Steering group where it was presented. The revised ILDF will go to May's OD Steering group for agreement.	29/02/2024	Complete

The ILDF has been tabled and approved by the OD Steering group in May 2024		
Exploration of approach to leadership: Draft proposal of the approach and how to adopt it presented via an appropriate Executive governance process. The Approach to Leadership is integral to the culture development work, the approach was agreed at the ODSG in March	29/02/2024	Complete
REF Gaps in controls; A & B. Draft Integrated Leadership Development Framework in place (forms part of special measures monitoring) With OD resources in place, the ILFD training is expected to be live in September 2024	30/09/2024	Progressing
REF Gaps in controls; C & D. Draft OD plan in development (forms part of special measures monitoring) and has been initially approved by the culture steering group. The next steps is to ratify the plan with the senior team and People & Culture Steering Group	31/08/2024	Progressing
REF Gaps in controls; C& E. Examine the current pervasive culture: Final results from NHS Wales Staff Survey shared with all relevant managers and thematic analysis fed into Culture Change Plan The culture world café in June will deep dive into key themes of the current culture with 800 staff members expected to attend. The results will be analysed and available by end of August 2024	31/08/2024	Progressing



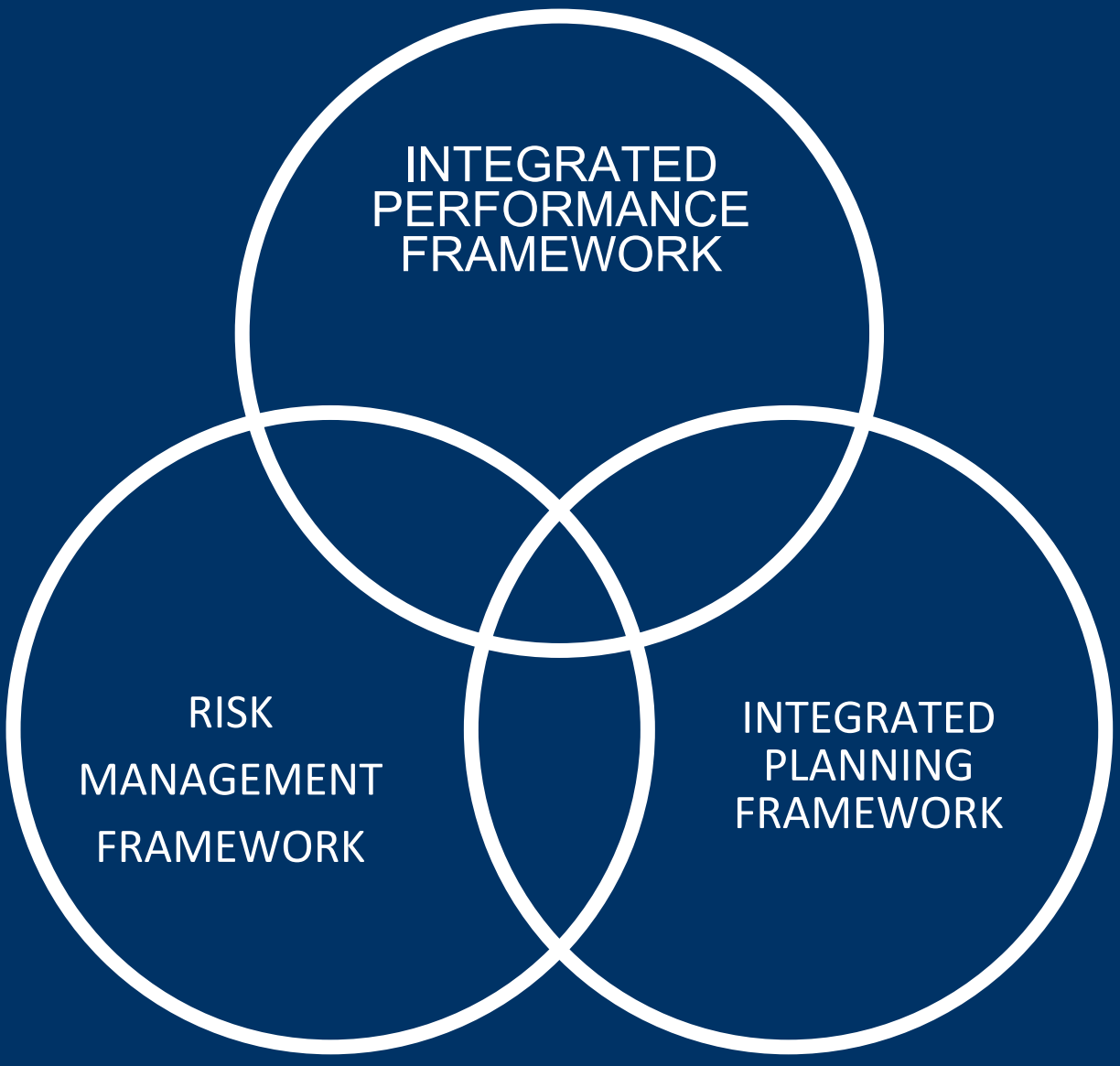
	Impact	Likelihood	Score
Inherent Risk Rating	4	5	20
Current Risk Rating	4	4	16
Target Risk Score	4	2	8
Risk Appetite	Regulatory		3 - Open

Rationale for Corporate Risk

Structures currently being embedded to ensure IHCs, Divisions and Services have clear accountable delivery plans so new ways of leading are embedded locally. Organisational expectations being defined.

RISK MANAGEMENT FRAMEWORK

2023-25



Author & Title	Pam Wenger Director of Corporate Governance Dr Nesta Collingridge Head of Risk Management & Assurance				
Responsible Department / Director:	Risk Management Carol Shillabeer Chief Executive				
Approved by:	Health Board - 28 Sept 2023 Audit Committee (AC) - 15 Sept 2023 ~~Risk Management Group (RMG) - 8 Aug 2023~~				
Date approved:	~~28 Sept 2023~~ July 2024				
Date activated (live):	~~11 Jan 2024~~ July 2024				
Documents to be read alongside this document:	Risk Management Procedures (RM02) Risk Management Training Procedures (RM03) Health and Safety Policy (HS01) Risk Assessment Guidance (HS03) Concerns Policy and Procedure (PTR01 and PTR01A) Information Governance Policy Health and Safety Policy Terms of Reference ~~RMG~~ Risk Scrutiny Group BCUHB Integrated Performance Framework BCUHB Integrated Planning Framework				
Date of next review:	28 Sept 2025				
Date EqIA completed:	Sept 2023 (Original 2016)				
First Operational:	28 Sept 2025				
Previously reviewed:	March 24	July 24			
Changes made yes/no:	Updated glossary.	Y			

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 Executives from the ~~Annual Plan~~ 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 and corporate functions, 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).

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

RISK FRAMEWORK STRATEGY

- 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.

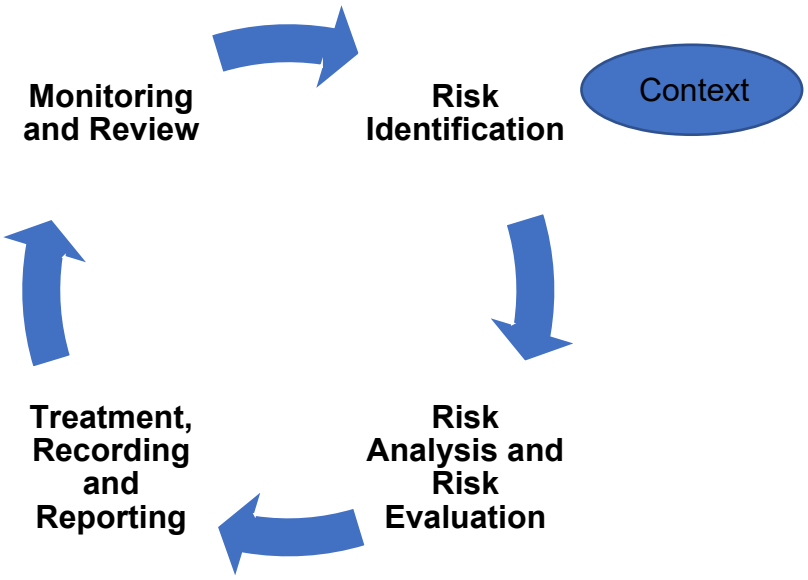
4. RISK MANAGEMENT PROCESS

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 leadership.
- 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 Executives 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 Executives 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 Executives and Corporate Risk Team for review.

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, or for pan BCU risks which have been identified this should also be escalated to the Corporate Risk Team and Executives. 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 Executive Director for awareness and consideration on the CRR, if critical/strategic in nature.

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 an Executive 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

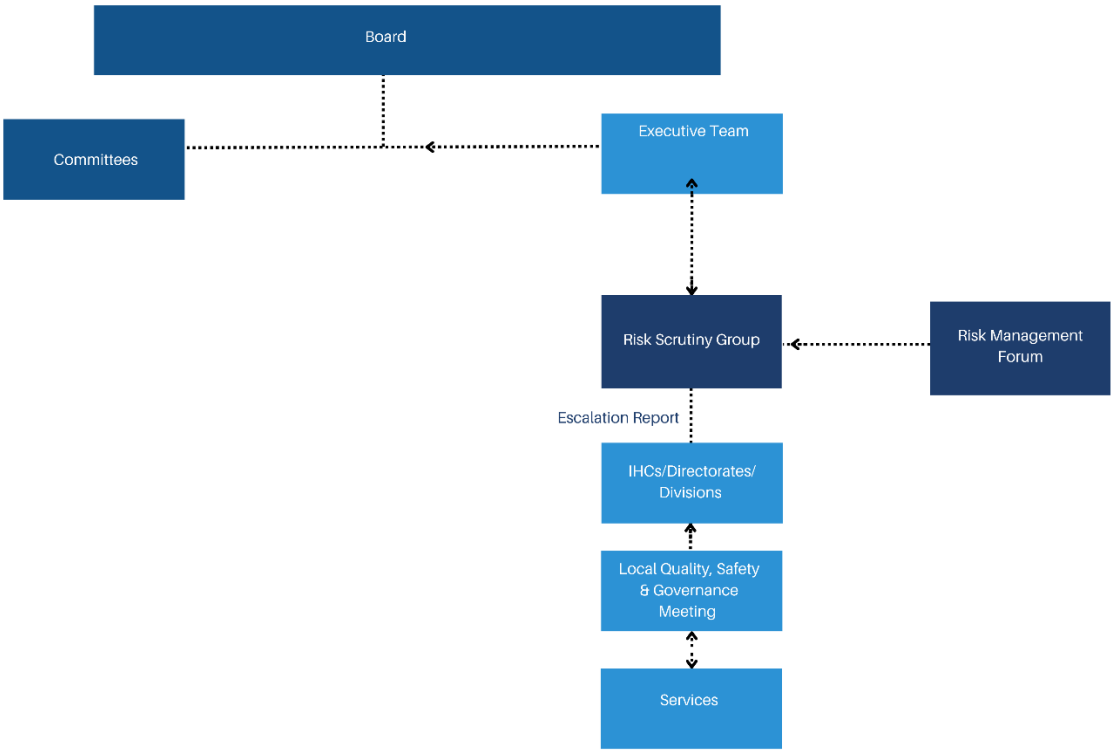
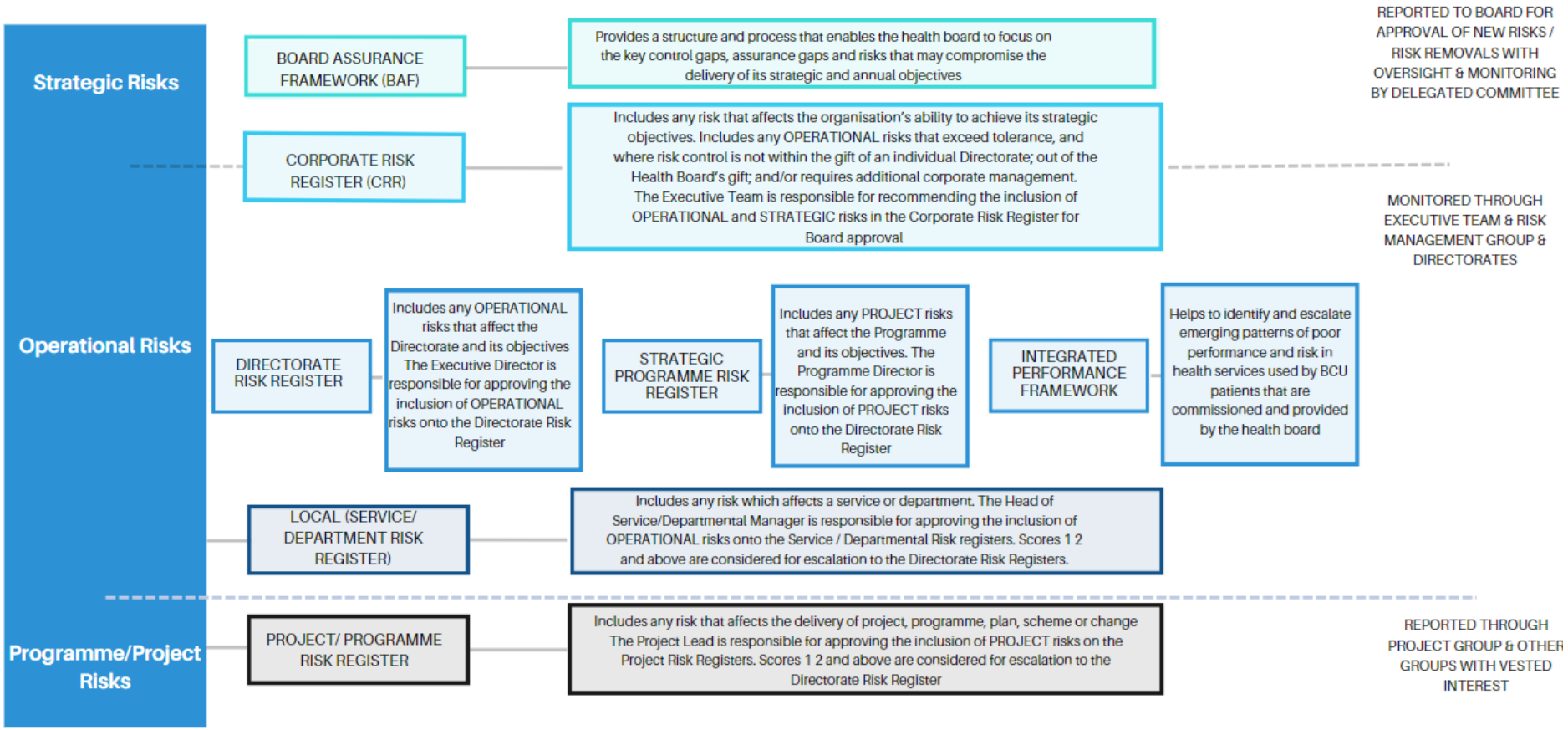


Figure 3 - Risk Management Register



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 and Risk Management Forum 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 team and 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-	Committee Oversight	Board
Board Assurance Framework	Reviewed Bi-Monthly	Risk Scrutiny Group	Executive Team Meeting	Quarterly	Bi-Annually ~~Quarterly~~
Corporate Risk Register				Bi-Monthly	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

~~Three Lines of Defence and Assurance~~

~~The three lines of defence is a model often use in risk management and governance to clarify roles and responsibilities, this has been broken down into two parts, one, operational risks and two, for strategic risks, additionally a section on lines of assurance:~~

~~Operational Risks Responsibilities:~~

~~First line of defence - Operational management: Day-to-day risk management by frontline staff and operational managers. They own and manage risks. Implementing controls, assessing risks, executing risk action plans.~~

~~Second line of defence - Oversight functions: IHCs/Directorates oversee and support first line functions and will include the support of subject matter experts e.g., corporate risk team, compliance, legal, finance etc. IHCs/Directorates will seek assurance over actions and controls to mitigate risks.~~

~~Third line of defence – Executives will hold overall accountability for their portfolios and will seek assurance of overall risk management, identification processes, good mitigation, and action plans. Where costs exceed control of the budget holder and risks are significant, Executives will escalate this to the CRR within the Executive Team Meeting.~~

Strategic (~~CRR &~~ BAF) Risks:

~~First line of defence - Operational management: Executives to own and manage their respective portfolio risks. Ensure the implementation of controls, mitigation and ensuring the execution of action plans, providing updates at the Executive Team Meeting.~~

~~Second line of defence - Oversight functions: Risk Management Group to seek good governance on overall risks management functions. Audit Committee to seek assurances on the progression of corporate and strategic risks.~~

~~Third line of defence – Board to have overall assurances of risk management and robust mitigation efforts.~~

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 Team, 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 (Executive 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 ~~quarterly~~ 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:

• 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.

Risk Scrutiny Group:

The Risk Scrutiny Group reports to the Executive Team 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 Team and Board accordingly;

• Reviewing and monitoring the CRR and BAF;

EXECUTIVE TEAM MEETING

The Executive team are the accountable leads on individual BAF and CRR risks and support the regular review of the register, noting any risks for escalation and de-escalation. Executives will provide updates on action plans associated with mitigating and controlling the risks they are accountable for.

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

The CEO is the Accountable Officer of the Health Board and has overall accountability and responsibility for ensuring it meets its statutory and legal

requirements, and adheres to guidance issued by the Welsh Government in respect of Governance. This responsibility encompasses risk management; health and safety; financial and organisational controls; and, governance. The CEO has overall accountability and responsibility 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.

EXECUTIVE DIRECTORS

Executive 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 will work with the risk management team to ensure the appropriate use of the BAF and CRR.

Executives 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 Directors will do so by ensuring communication is open, and transparent where all staff have the confidence to raise a risk. Executives 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 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 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.

~~BOARD SECRETARY /~~ 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 Management Forum & Risk Scrutiny Group (established by the Executive Team).

HEAD OF RISK MANAGEMENT AND ASSURANCE

The Head of Risk and Assurance 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 and Executive 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 Executives. Senior manager will provide Executives 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 Executive 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 AuditCommittee 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 Directors 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 team 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 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 June 2024 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 accept the possibility of a short-term impact on quality outcomes with potential for longer-term rewards, supporting innovation. Broad learning from events influence improvement. Efforts to promote openness and transparency are on a risk basis by repercussion.

Financial Risk: There was an agreed consensus on an 'open' appetite to be prepared to invest for return but 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.

Compliance/Regulatory: There was an agreed consensus supporting an 'open' risk appetite to accept the possibility of some regulatory challenge as long as we can be reasonably confident we would be able to challenge this successfully.

Innovation Risk: There was an agreed consensus to 'seek' and innovation is to be pursued with the desire to 'break the mold' and challenge current working practices. New technologies viewed as a key enabler of operational delivery. High levels of devolved authority – management by trust rather than tight control.

Reputational Risk: There was an agreed consensus to 'seek' with a willingness to take decisions that may bring scrutiny of BCUHB but where potential benefits outweigh the risks. New ideas seen as potentially enhancing reputation of organisation.

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

Risk Management Procedures

2023-25

RM02
V5.0

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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 Executives from the ~~Annual Plan~~ 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 and corporate functions, 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).

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 PROCEDURES

1. INTRODUCTION

Robust risk management practices are critical in order to identify risks before they could materialise into problems and therefore allow us to deliver on our strategic objectives and build an organisation resilient to risks and uncertainties.

This document provides guidance on the operational application of the Risk Management Framework. It sets out the procedures for the management of risk registers using the online Datix risk module, escalation of risk onto the Corporate Risk Register and Board Assurance Framework

Effective risk management is essential for our Health Board to deliver excellent care and achieve strategic objectives, and thus everyone's responsibility. Risks can be identified by anyone, regardless of role and should be escalated as appropriate. The risk identifier holds the responsibility to ensure the risk is escalated to a senior member of staff for the service, a service risk lead or as appropriate, director of the service.

The Health Board cannot manage risk effectively unless it knows what the risks are, therefore, the online risk management software, Datix, should be utilised to capture risks.

The model utilised by the Health Board is based on the Enterprise Risk Management model, which integrates risk awareness into all aspects of our operations. With the Enterprise model, risk management becomes a shared responsibility across the organisation, empowering **all staff** to flag potential threats or opportunities. This allows for the anticipation of challenges and to respond dynamically to protect our services. By embedding risk management into planning, budgeting, and performance monitoring, we enhance productivity, quality of care, and value for patients and partners. The utilisation of the online Datix system enables real-time risk reporting from the frontline to the Executive level as well as a whole system overview approach. This supports data-driven decision making and targeted mitigation strategies. Standardised risk register procedures are outlined in Appendix 1 as well as a standardised approach to escalating priority risks to the Corporate Risk Register and Board Assurance Framework.

2. SCOPE OF THE RISK MANAGEMENT PROCEDURES

This procedural document applies to 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.

3. RISK MANAGEMENT PROCESS

Risk management is the systematic application of management policies, practices and procedures to identify, analyse, assess, treat and monitor risks 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 risks to an acceptable level, considering the cost of minimising the risk and reducing risk exposure (the level of risk that the organisation is exposed too, either in regard to an individual risk or the cumulative exposure to the risks faced by the organisation).

The Health 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 the following key steps:

Figure 1 - Risk Management Process

Bwrdd Iechyd Prifysgol Betsi Cadwaladr University Health Board

RISK MANAGEMENT PROCESS GUIDE

3.1 CONTEXT

Risks do not exist in isolation; they exist in the context of organisational objectives. Therefore, to identify risks and opportunities that an organisation faces, there must first be an understanding of the organisation's objectives (what are we trying to achieve). That way, the events that may hinder (threats) the achievement of those objectives or enhance them (opportunities) can be identified. Establishing context (objectives) enables the customisation of the risk management process for effective risk assessment and appropriate risk treatment.

3.2 RISK IDENTIFICATION

The Health Board cannot manage risk effectively unless it knows what the risks are. Risk identification is the process of recognition that a threat or opportunity could occur which might help or prevent the Health Board from achieving its objectives.

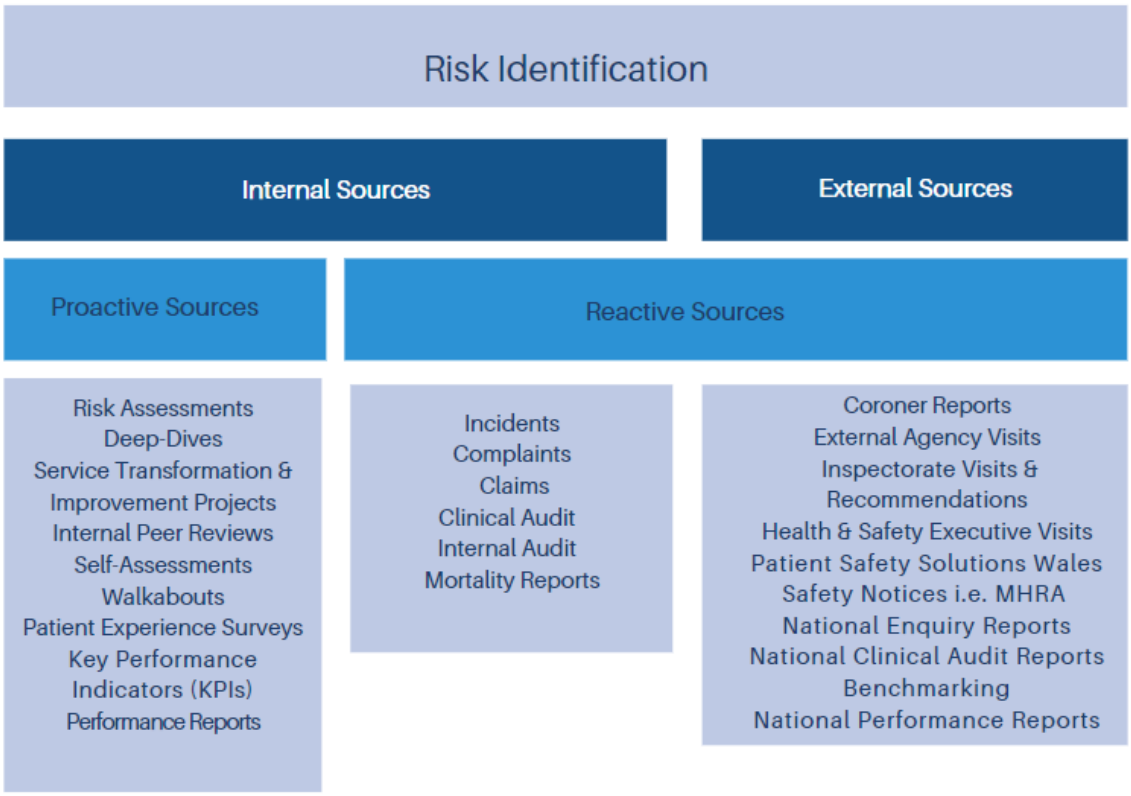
Risks can be identified from a number of sources, proactively and reactively. Proactive meaning to be actively seeking to identify any risks so it can be managed before it materialises into a problem. Reactive identification often being an external source or unexpected event which has presented risks.

For services to have robust risk management practices in place they should have a number of strategies to proactively identify risks on a consistent basis. This allows services to actively seek potential threats or opportunities so they can be managed before they materialise into a problem.

It is important to note that risk identification is the most critical point of the risk management process, if we identify issues (causes) or impacts (consequences) as risks; we are no longer doing risk management, but rather problem solving, crisis management or managing impacts that have not happened yet.

Figure 2 - Risk Identification

Risks can arise from many sources, for example:



Services are encouraged to apply internal proactive methods to strengthen the risk identification and preparation in anticipation of risks, prior to reactive and external sources identifying risks. This allows the Health Board to prepare for any potential threats, giving more time to implement mitigation strategies before problems materialise or are highlighted externally. Being proactive protects the reputation of the Health Board and builds public trust by showing that potential problems are being addressed responsibly.

Where risks are identified outside the service or function, the site leadership team should identify and assign the risk and management responsibility to an appropriate handler.

Where the Board, Independent Members or external partners identify risks, these should be escalated to a member of the Health Board such as an Executive or to the Head of Risk Management to ensure the risk is captured and managed appropriately.

3.3 RISK ANALYSIS AND RISK EVALUATION

Risk analysis is about understanding the nature and characteristics of each identified risk. At this stage, risks are scored utilising a set risk matrix (Appendix 2) to assess the likelihood of occurrence and the impact if materialised. Often described as a risk rating, it is a systematic approach to quantify the significance of the risks numerically.

Risk evaluation is the subsequent step of looking at which risks should be prioritised and comparing them against the Health Board's risk appetite to understand what

needs to be done, or to what extent for that type of risk. Where there are finite resources, we need to ensure that we are dedicating appropriate and proportionate level of management for each risk. This is called risk ranking (what to tackle first). This means we may opt to focus on our most significant risks first, and might decide to embed our low-level risks as part of business as usual, often described as risk tolerance.

3.4 TREATMENT, RECORDING AND REPORTING

Once a risk has been identified there are four response options: Treat, Transfer, Tolerate, and Terminate, as known as the 4Ts. The most common being to 'Treat' the risk, which is to determine and implement the most appropriate options for addressing a risk.

Recording and reporting is part of the process where risks are documented on Datix through the risk module on a risk register pertaining to the service that has identified the risk.

Reporting is an integral part of the Health Board's governance and mandated in the Risk Management Framework in order to facilitate oversight and assurance.

When risks are logged on Datix the corporate risk team are notified whenever risks are submitted onto the risk register module for the purpose of oversight, support and quality assurance.

See Appendix 1 A step by step guide for documenting a risk on Datix.

3.5 MONITORING AND REVIEW

An effective risk management process must include the monitoring, reviewing and updating of risks to ensure the changes and progress of mitigation are captured. Monitoring should always involve reviewing the controls put in place to assess whether they are working effectively. Where identified, that controls have failed or are not robust enough, these should be reconsidered and alternatives control measures sought. Reviewing a risk is a crucial aspect of the risk management process because if controls fail, it alters the significance of the risk.

Risks can morph over a period of time due to the impact of other events or changes to context, uncertainty and complexity. If the original risk changes significantly the risk should be closed and a new risk opened which is more relevant. Risks and risk registers should reflect the current position and be amended as appropriate. This allows services to have a robust and dynamic approach to risk.

When a service reviews its entire risk register it is pertinent to ask if all the risks are still relevant, described accurately, scored accurately, being well controlled and also a general analysis of any gap where risks have not yet been reflected on the register.

The risk management process is iterative, and this review process should be engrained as a standard item of business for all services.

Services should consider how they communicate their findings and share lessons learnt with relevant services pan BCUHB, stakeholders, general staff awareness and assurances to senior managers. This helps to strengthen and inform future practice.

4. ROLES AND RESPONSIBILITIES

High-level roles and responsibilities have been outlined in RM01 (section 7), however, the responsibility of all staff, senior managers, service risk leads and the corporate risk team have been highlighted further below with supplementary operational details.

4.1 ALL STAFF

All staff including, Trade Union colleagues and contractors are required to comply with the Risk Management Framework (RM01) and this document (RM02), raise any potential risks to the attention of their line manager or service risk lead. All staff have a duty 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 in order to protect contractors on site. Contractors should be provided with a risk register, relevant to their activities, to ensure their safety while on site.

All members of staff must ensure they undertake the relevant level of risk management training.

N.B. Not all staff will have access to the risk module within Datix, unlike incident reporting. This is to ensure tighter controls of service risk registers and avoid duplication of risks. Risk register access requests should be directed to the corporate risk team requesting a 'risk register access request form'.

4.2 SENIOR MANAGERS

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

Senior managers are responsible for ensuring risk is discussed at the appropriate meetings for their service. Senior managers will be expected to provide bi-monthly updates to the corporate team for risks, which link to corporate risks. This can be achieved through maintaining Tier 1 risks action plans and 1-1 meetings between the Risk Assurance Manager and Corporate Risk Register or Board Assurance Framework leads.

Senior managers will be responsible for providing Executives and the Risk Scrutiny Group with regular assurances around effective management of risk registers. They

will work with the corporate risk team around overseeing any implementation of feedback on KPI compliance with risk registers.

Senior managers will have both strategic and operational risk management training and will be familiar with utilising Datix to report, manage and oversee risks.

4.3 SERVICE MANAGERS

Service managers such as ward managers, are responsible for ensuring that their service risks are clearly and accurately described, regularly reviewed and updated. This will support ongoing reporting, Health Board oversight, and prompt collaborative action.

Service managers will be responsible for ensuring all staff within the service know who their service risk lead is, in order to escalate newly identified risks for considered reporting on the service risk register. Service managers will be responsible for ensuring activities and action plans within risk registers are regularly maintained.

Service managers are also responsible for supporting the effective allocation of resources in managing, escalating and de-escalating operational and strategic risks within their remit. Service managers will be supported by the risk service lead and corporate risk team to ensure risks are articulated appropriately and described in line with these procedures. They will support continuous learning within the service in relation to risk management and further support organisational wide learning.

Service managers will have operational risk management training and will be familiar with utilising Datix to report, manage and oversee risks.

4.4 SERVICE RISK LEADS

Each service is expected 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. A service risk lead/champion should be someone from within the service whom staff can escalate newly identified risks too. However, a service manager should also be familiar with the risk register and be able to maintain the work of the service risk lead, in the event the risk lead is not available or on duty.

Service risk leads will support the operational management of their respective service risk register and will take responsibility for any feedback around the quality assurance of the risk register. Service risk leads will take delegated responsibility for ensuring activities and action plans within risk registers are regularly maintained.

The service risk lead will take the responsibility to ensure good communication of risks with all staff. This aims to ensure staff are regularly informed of risks relevant to them in order to safely carry out their work, how risks are being controlled and mitigated and any action plans in place.

Service risk leads will have operational risk management training and will be familiar with utilising Datix to report, manage and oversee risks.

4.5 CORPORATE RISK MANAGEMENT TEAM

The corporate risk management team will facilitate and ensure effective risk management practices are in place throughout the organisation.

The corporate risk management team will take a lead on assurances of compliance pan BCUHB with a route to escalation to Executives via the Risk Scrutiny Group.

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. The team will support Executives with the escalation of risks on to the Corporate Risk Register and Board Assurance Framework via the Risk Scrutiny Group.

The corporate risk management team will support with advice on risks that do not have adequate controls or action plans or have not progressed in a timely manner. This is to ensure the robustness and effectiveness of all risk registers BCUHB wide. Where services are not compliant with KPIs set out in this procedure (section 7), the corporate risk team will escalate formally to the Head of Risk Management relevant Executive(s) and Risk Scrutiny Group.

The team will ensure the delivery of training to staff who have responsibilities under this procedure and report on compliance. They will be responsible for the overall management of the risk module in Datix.

5. LEVELS OF RISK

The Risk Management Framework defines three levels of risk and is further highlighted here:

1. Strategic Risks: These are 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: These are risks that arise as a result of the day-to-day running of the Health Board. They may include a broad spectrum of risks comprising of clinical risks, financial risk (i.e., fraud); legal and regulatory risks (i.e., health and safety) and risk of loss or damage to assets or system failures etc.

3. Project Risks: these are risks that may affect 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.

5.1 RISK REGISTERS

A risk register is a repository for risks, prioritised by current score, with associated action plans to reduce current (residual) risk. The purpose of a risk register is to document, review and manage unmitigated risks. Risks that have been mitigated to a reasonably practical level should be managed as part of business-as-usual

management (see risk appetite and tolerance). Board Assurance Frameworks, Corporate Risk Registers and Operational Risk Registers work together in an integrated risk management model. (Figure 3- Risk Management Register)

5.2 BOARD ASSURANCE FRAMEWORK

The Board Assurance Framework focuses on strategic risks that could impact achievement of the Health Board's objectives and priorities as outlined in the strategic and annual plan and will be refreshed with Executives as the plan is updated. Board Assurance Framework risks will reflect both external issues (e.g., political, economic, social, technological, environmental, legal) and internal issues (e.g., culture, resources, capabilities) that could affect the Health Boards ability to achieve its strategic goals.

Ownership of the Board Assurance Framework resides with the Board. The Board will receive the Board Assurance Framework quarterly to scrutinise and challenge if risks are being effectively managed and will aim to seek assurances.

The corporate risk management team will facilitate the maintenance of the Board Assurance Framework with the support of the accountable Executive for the risk. The Board Assurance Framework will be updated bi-monthly by nominated representatives of Executives and overseen by the Risk Assurance Manager. This will be quality assured by the Head of Risk Management and the Executive prior to Committees and Board with the support of the Executive Team and Risk Scrutiny Group.

For each strategic risk, the Board Assurance Framework will outline key controls and actions (Figure 7) being taken to mitigate the risk, as well as risk ratings, targets and relate to the Boards risk appetite statements as well as the Corporate Risk Register. See Appendix 1 10.4 for a guidance on completing a strategic risk.

The Board Assurance Framework is not held within Datix but Board Assurance Framework risks are referenced within the Datix assurance section, to facilitate links with corporate and operational risks within the system.

5.3 CORPORATE RISK REGISTER

A corporate risk register is a repository used to record significant risks that have been escalated and approved by the Executive team. These are significant risk which are cross-functional in scope and could have an impact on strategic objectives and operations of the Health Board. The Corporate Risk Register provides the Executive team with an enterprise view of the most significant operational and strategic risks in one place. The Corporate Risk Register will take a consolidated view of Tier 1 (current score of 15-25 risks) operational risks. As noted above the Corporate Risk Register will align to the Board Assurance Framework but also align to operational risks.

The Corporate Risk Register is a pivotal tool to help proactively strengthen risk oversight and management.

The Corporate Risk Register will be received at the Risk Scrutiny Group, Executive Team and relevant Committee bi-monthly and by the Board quarterly. The Corporate Risk Register enables corporate risk reporting, monitoring and oversight. Trends and risk indicators will be tracked at the corporate level by the corporate risk team. The Corporate Risk Register will be maintained in Datix which will also facilitate the linking to Board Assurance Framework risks as well as operational risks overseen by the Risk and Assurance Manager.

5.4 OPERATIONAL RISK REGISTERS (TIER 1-3)

Each service is mandated to maintain their own risk register within Datix. This will allow the corporate risk team to maintain oversight, ensure a positive risk culture of identification, monitoring of risk KPIs as identified in section 7.

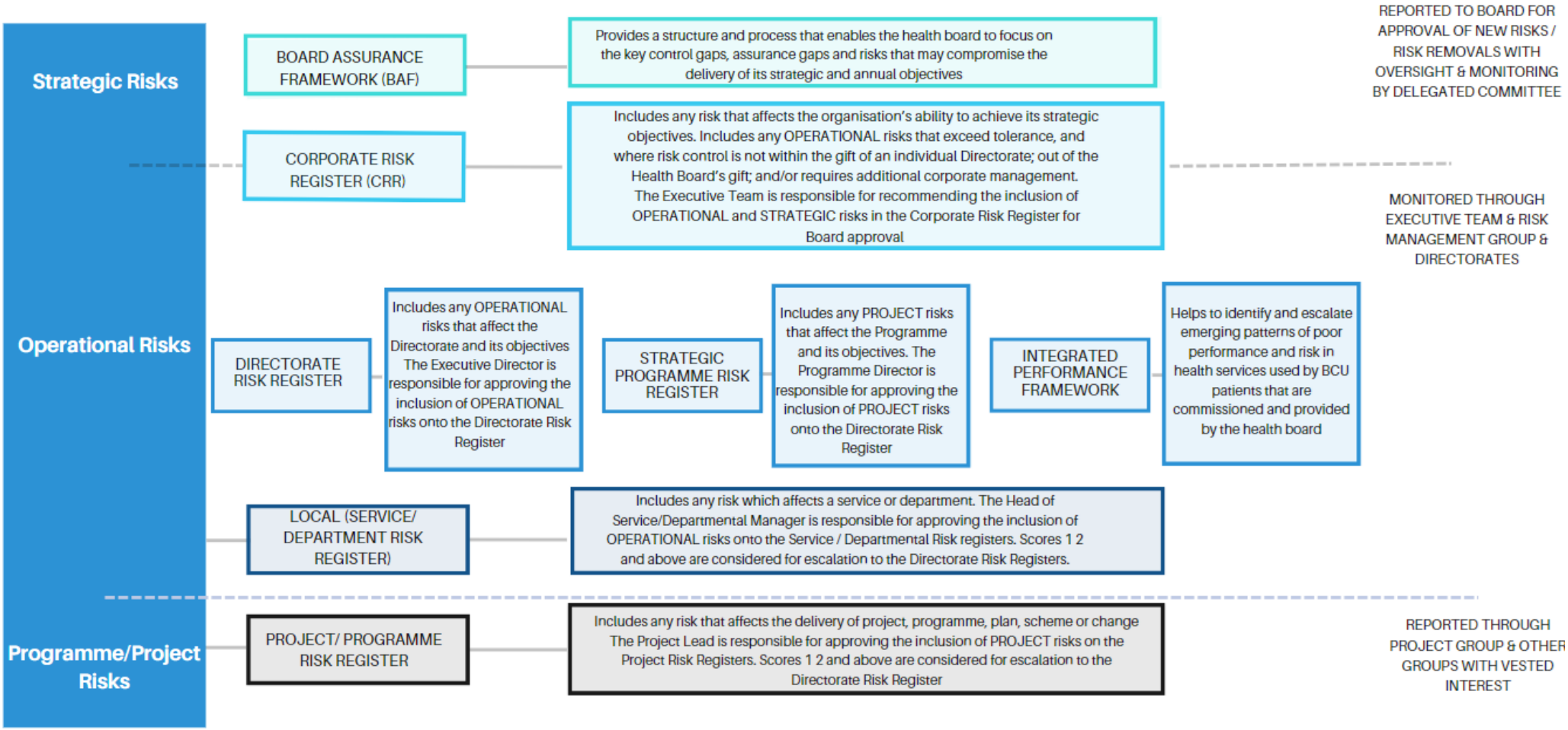
The operational risk register or the services risk register will comprise of the day-to-day operational risks, which could impact on service delivery for example clinical, financial, compliance, IT risks etc.

5.5 PROJECT RISKS

The Health Board recognises that Projects/Programmes maintain workbooks which include identified risks. To alleviate duplication, it is acceptable in this instance for risks to be held outside of the Datix risk register module. However, significant risks that require escalation to Corporate Risk Register or Board Assurance Framework must be recorded onto Datix risk register module for quality assurance, oversight, management and reporting.

Project teams should establish protocols and thresholds for escalating high priority risks from the local project risk register/workbook to the appropriate Executive and corporate risk team for awareness. This may include risks with ratings above a certain threshold or with organisational wide impacts.

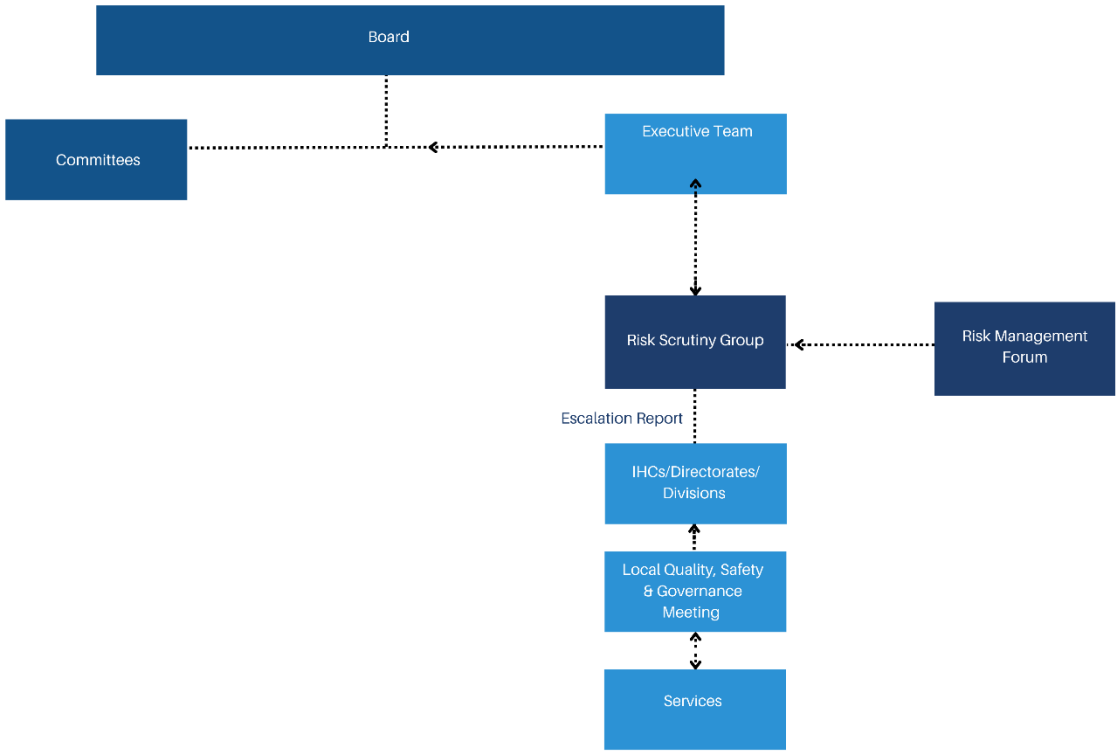
Figure 3 - Risk Management Register



6. ESCALATION/DE-ESCALATION AND MEETINGS

The Health Board operates a three-tier classification system for risks, as well as a separate register for the Corporate Risk Register and Board Assurance Framework.

Figure 4-Escalation/Consolidation/De-escalation and Meetings Structure



6.1 REGISTERS

Board Assurance Framework risks will be identified and managed at Board Level and risks assigned to accountable Committees and Executives. Review of Board Assurance Framework risks are done on a bi-monthly basis with the Risk Assurance Manager and nominated representative of the Executive.

Corporate Risk Register risks that have been escalated, approved and accepted onto the corporate risk register by the Executive Team. Review of Corporate Risk Register risks is done on a bi-monthly basis with the Risk Assurance Manager and nominated representative of the Executive.

Tier 1 (score of 15-25) high to extreme risks will be reviewed by the service on a monthly basis and escalated by services to Directorate/ IHC level. All Tier 1 risks will be considered for consolidation on to the Corporate Risk Register. **Critical or uncontrolled high risks should be escalated individually to the Risk Scrutiny Group via Director and Executive Director. Critical risks will still be required to be managed and updated locally within the ability of the IHC/Directorate.**

Tier 2 (score of 9-12) medium to high risks to be managed locally by services and reviewed by the service on a bi-monthly basis, **escalated by services** to directorate/divisional/IHC level for support and oversight.

Tier 3 (score of <8) low level risks to be **managed locally** by services and mitigated. Risks within/below the Health Board's appetite should be assessed on whether more can be done cost effectively. If no more can be done, the service should consider the management of residual risk as part of business as usual. Tier 3 risks must be reviewed on a quarterly basis.

Any decision to escalate or de-escalate risks should be recorded in the progress notes in Datix and also in governance groups/meetings.

7. MEETINGS & ESCALTION

IHC/ DIRECTORATE/DIVISIONAL MEETINGS

IHC/Directorate/Divisional meetings will take assurance on all Tier 1 risks in particular, advising and supporting on action plans for services, this should be reflected on the meeting agenda. Linked and/or relevant corporate risks should also be reviewed for the progression of action plans and controls to reduce the risk. Handlers for service risks should be identifiable and should be able to update on issues where IHCs/ Directorates/Divisions have the ability to further support the progression of action plans. Where the budget and level of control is beyond the scope of an IHC should be escalated to the Executive and awareness to the supporting corporate regional risk manager. Assurances on managing high risks should be communicated up to the overall responsible Executive for the risk.

7.1 SERVICE MEETINGS & ESCALATION

Services will hold a monthly meeting where risk is on the meeting agenda. The meeting will scrutinise all the risks on the risk register for all Tiers. They should assure themselves that these are regularly reviewed, descriptions comply with this document as outlined below and the risk register remains dynamic, robust and relevant to the service's risks.

Assurances or points of escalation should be up to the IHC, Division or Directorate. For risks being escalated this should be via an escalation report to the Risk Scrutiny Group for consideration on to the corporate risk register. The highlights the need for Executive review of the risk to ensure the Executive can initially advise on actions or further controls.

Risk escalation reports should be sent to the corporate risk team, Risk and Assurance manager for inclusion on the Risk Scrutiny Group Agenda.

See Table below 'Review Cycle of Risk' for the frequency of reviews required by score to support meeting cycles of business.

7.2 RISK SCRUITINY GROUP:

The Risk Scrutiny Group reports to the Executive Team. Ensuring that the Health Board is actively identifying and documenting risks in all directorates of the organisation. It oversees work to mitigate risks, supporting leaders to do so, where necessary by bringing together expertise across the organisation. It takes responsibility for resolving pan BCU risks that are thematic or escalating such concerns for resolution through the Executive and, or within performance reviews. It ensures the risk management framework is being implemented effectively and to advises the Executive/Executive Team where this is not the case. It ensures that risks to delivery of the Health Board strategy are reflected within the risk register or, where relevant, the board assurance framework.

7.3 RISK MANAGEMENT FORUM

The Risk Management Forum will review risk governance arrangements 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 approval of and risk documents such as policies/procedures (further detailed in RM01 section 7). The Risk Management Forum will report into the Risk Scrutiny Group.

7.4 EXECUTIVE TEAM MEETING

The Executive team will take responsibility for the Board Assurance Framework and Corporate Risk Register and support the regular review, noting any risks for consolidation, escalation and de-escalation within the meeting. Executives will provide updates on action plans associated with mitigating and controlling the risks they are individually accountable for within the Executive team meeting.

Committees will take overall accountability and oversight of the section of the Corporate Risk Register and Board Assurance Framework to which they are accountable and will take assurance on actions and targets (further detailed in RM01 section 7).

~~7.4 HIGH RISK INTELLIGENCE MEETING~~

~~The corporate risk team will hold a monthly operational meeting to support services prepare all risks scored 15 or above, analysis on consolidation, horizon scanning lower risks, monitoring trends, any risks raised by; external partners, performance, planning and horizon scanning any other potential threats across the Health Board. This meeting will operationally support the Risk Scrutiny Group and the Executive Team meeting for points of escalation. The Regional Risk Managers will support the consolidated view of risks through prior analysis of operational risks and conduct any~~

~~prior quality assurance for the consideration of the Risk Scrutiny Group and the Executive Team meeting.~~

Table 1 REVIEW CYCLE OF RISKS

Register /Tier	Risk Score	Category of risk	Review	Approval Escalation/ De-escalation	Oversight
Board Assurance Framework	Strategic		Reviewed bi-monthly	Executive Team Meeting	Relevant Committee prior to Board
Corporate Risk Register	Strategic / Extreme Operational Impact / High Pan-BCUHB		Reviewed bi-monthly	Executive Team Meeting	
Operational Risk Registers					
Tier 1	15-25	High to Extreme	Reviewed monthly.	Service Level Escalated to strategic registers via Corporate Risk Team to Risk Scrutiny Group	Appropriate Divisional Governance meeting & IHC oversight
Tier 2	9-12	Moderate	Reviewed bi-monthly		Service Level and can be escalated for information at the appropriate Divisional Governance meeting.
Tier 3	<8	Low	Reviewed Quarterly		Service Level

8. RISK DESCRIPTIONS

There are three main components to include when writing a risk description (event, cause and effect):

There is a risk that …. (event)

This may be caused by …. (issues or problem)

Which could lead to…. (impact or consequence)

Risks will be quality assured to ensure they are described in line with the above and will form a KPI of compliance.

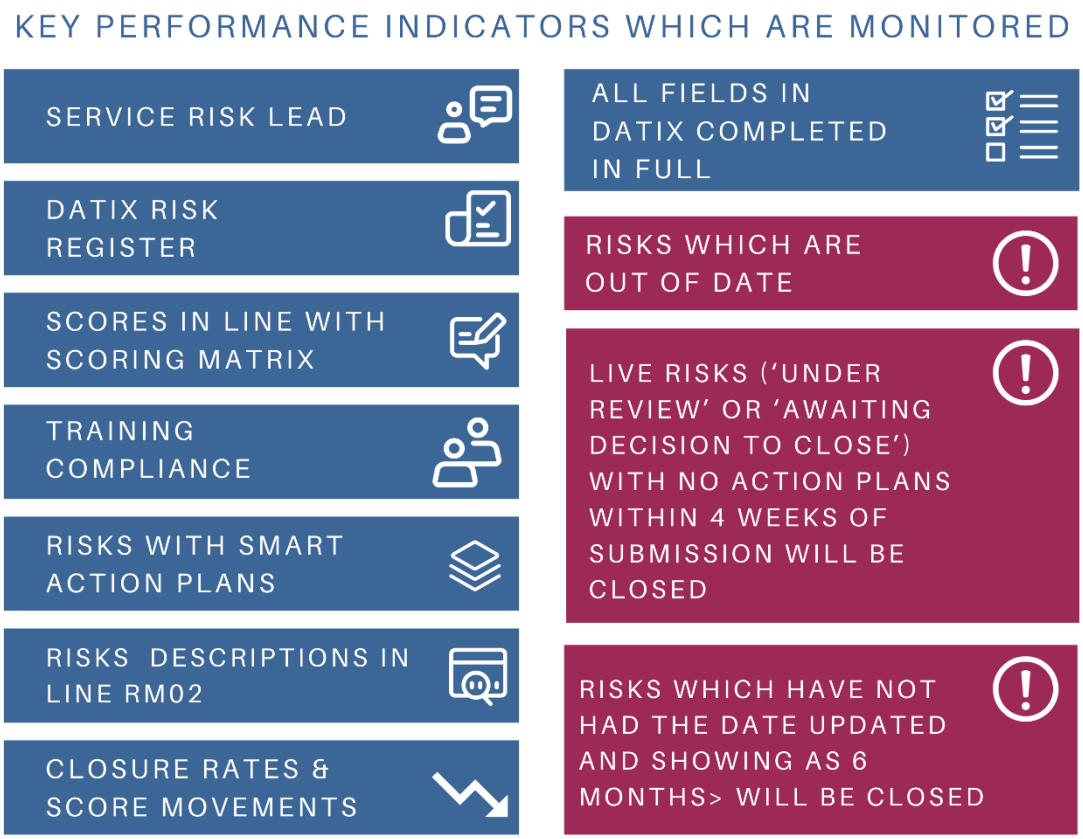
9. MONITORING THE EFFECTIVENESS OF THE RISK MANAGEMENT PROCEDURES

The Health Board will undertake regular risk management self-assessments, annual internal audits, snapshot audits and/or an annual health check of its risk management culture using key performance indicators (KPIs) in measuring the effectiveness of risk management arrangements across its services.

Compliance with this procedure is monitored by Risk Scrutiny Group, Executives, IHCs and also by the corporate risk team. The corporate risk team will report on compliance through quarterly performance reports.

Key Performance Indicators (KPIs)

- % of risks which are out of date;
- % of risks with SMART action plans (Figure 7);
- % of risks with no action plans;
- % of risks with focusing on problems as opposed to a risk (Glossary);
- % of risks with descriptions in line with section 6 of this procedure;
- % of risks aligned to scoring matrix (Appendix 2);
- % of risks with all fields within risk report appropriately completed;
- % of risks not progressed (inactivity in Datix) within 4 months;
- training compliance;
- closure rates;
- service risk lead identified for the service;



9.1 DATIX RISK REGISTER MAINTENANCE

The corporate risk team will oversee Datix risk register module to ensure risk registers are maintained and reviewed. To maintain system data integrity, all non-live risks that remain under the 'Being Developed' status for over 4 months which are incomplete, or with no activity during this time will be rejected by the corporate risk team. Rejected risks will require re-submission therefore, ensure risks are complete and progressed through to live status within 4 months.

Any risks which have not had the date updated and showing as 6 months> will be rejected by the corporate risk team.

Any live risks ('under review' or 'awaiting decision to close') with no action plans within 4 weeks of risk, submission will be rejected by the corporate risk team.

Any rejected risks will require re-submission and the corporate risk team will communicate with the handler and owner named in the risk report before the risk is rejected. Rationale and recommendation for rejected risks will be provided within the risk entry section 'reason for rejection' as well as guidance.

This document should be read in conjunction with the 'Risk Management Framework' (RM01) and 'Risk Training Procedures' (RM03) which are supportive of this procedure and outline all the procedural requirements for managing a risk operationally through to escalation.

10. 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.

11. REFERENCES

- The Orange Book - Management of Risk - Principles and Concepts
- The Good Governance Handbook
- ISO 31000:2018 Risk Management - Guidelines
- Health and Safety at Work etc. Act 1974
- The Management of Health and Safety at Work Regulations
- Health and Safety Executive (HSE)

12. APPENDICES

APPENDIX 1-STEP BY STEP GUIDE FOR LOGGING A RISK ON DATIX

It is important to ensure that any persons responsible for managing risks through the Datix risk register module have received operational risk training on the use of the system. Basic risk training does not cover the use of Datix.

The following step by step guide covers the:

12.1 Logging and submitting of a newly identified risk on to a Datix risk register;
& Management of risks on Datix.
12.2 Register Quality Checks for Handlers and Owners
12.3 Generating Risk Reports
12.4 Guide for Completing Strategic Risk

N.B. If you are uncertain about the process at any point, please contact a member of the **Corporate Risk Team** who will be happy to provide further support and guidance.

12.1.1 STEP 1 - LOG INTO DATIX

Only staff with access to the Datix Risk Register module account can add/submit a risk. To get an account, the datix risk register account form should be completed and returned to corporate risk administrator for processing. Please request a Datix risk register account form from the **Corporate Risk Team**. Please note that risk register access is given to individuals responsible for handling/managing risks, owners and action holders therefore, line management authorisation will be required.

12.1.2 STEP 2 - OPEN RISK REGISTER FORM 1

Click on 'Risk Register', then click 'Add a new risk'. Your name will auto-populate. From thereon, form completion is supported by in-system guidance. Fields marked with an asterisk are mandatory and must be fully completed to enable required data collection and risk record submission. In-system help prompts are available at key points, by clicking on question mark icons.

12.1.3 STEP 3 - ENTER THE RISK LOCATION

Select the location of the risk from the available lists. **N.B.** Whilst some fields in this section are not mandated, it is important to complete this section (risk location) because it is linked to the parameters for the permissions you have requested. If these fields are not completed according to what you requested access to, any risks submitted will fall outside those parameters and you will not be able to view or access your risk once submitted.
If you require changes or amendments to your Datix permissions, please complete the 'Change Account' proforma available by contacting the **Corporate Risk Team**,

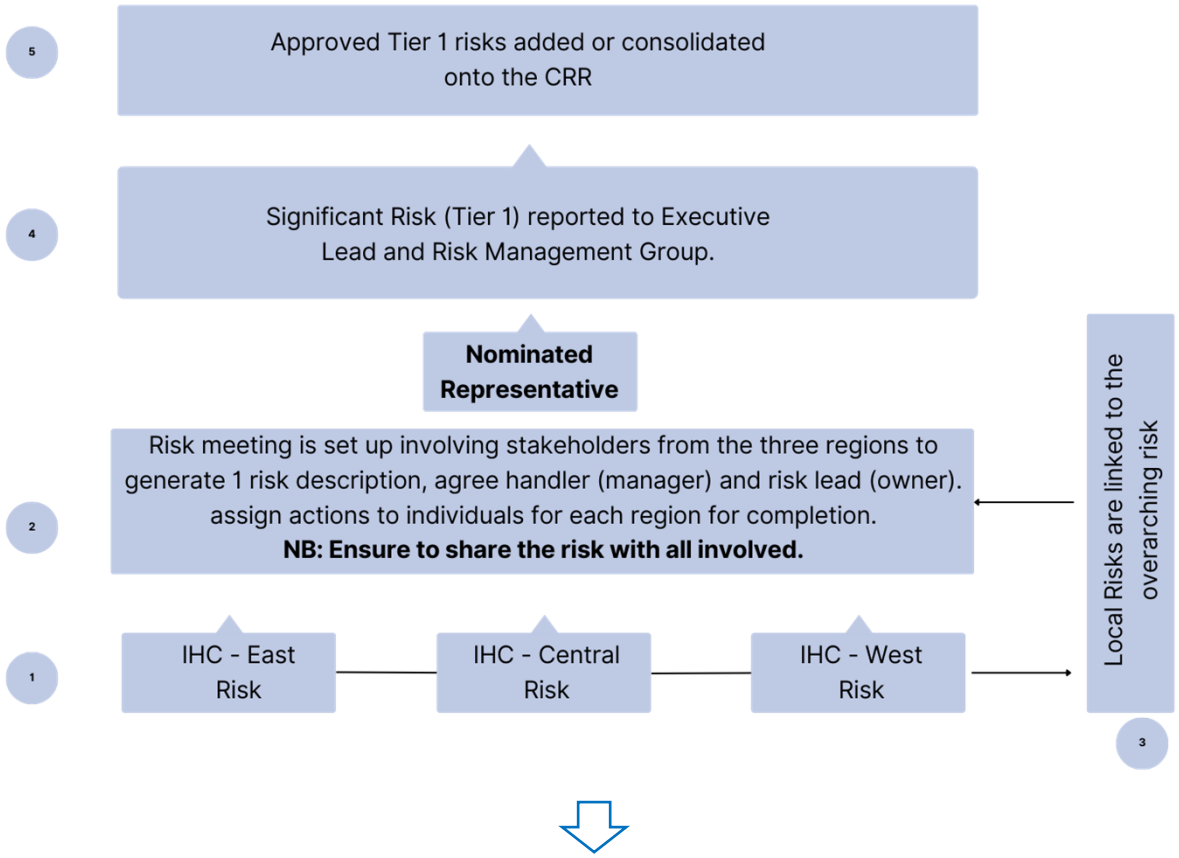
which requires line manager authorisation. **Accurate information in this section also supports the generation of reports – check the details with a member of the Corporate Risk Team, or your line manager for support.**

Pan BCUHB Risks

Pan BCUHB risks are risks that relate to more than one location or service across the Health Board. The process for horizontal collaboration in the management of Pan BCUHB risks is as follows:

1. Risk identified locally. **N.B.** Risks may be recorded and managed both locally and Pan BCUHB in Datix if required, as local teams may have different approaches, whilst wider Pan BCUHB risk mitigating actions are planned for implementation.
2. Risk lead discusses potential for risk to be a Pan BCUHB risk with other leads, agreeing who will 'host' the risk (act as over-arching lead), i.e., East/Central/West Integrated Health Community, Corporate Offices such as Finance, Estates, or Mental Health and Learning Disabilities.
3. Risk presented to relevant governance/risk/senior management meeting, with relevant senior approval as a Pan BCUHB risk documented in meeting minutes. It is the responsibility of the relevant service lead to inform the relevant Director of the risk, and to co-ordinate the required discussions and meetings.
4. Risk then added to the Datix Risk Register as Pan BCUHB, completing fields:
    - Is this a Pan BCUHB risk? (Select drop down list answer 'Yes' or 'No')
    - If Pan BCUHB 'Yes' who is the Host Region? (Select from drop down list – Integrated Health Community East/Central/West, Corporate Offices such as Finance, Estates, or Mental Health and Learning Disabilities).

Figure 5: Pan-BCUHB Risk Management



12.1.4 STEP 4 - ENTER DATE RISK OPENED, RISK, TITLE & RISK DESCRIPTION

Select the date the risk entry is opened from the calendar.
Add the risk title and description with accuracy, precision, and clarity, per the guidance below. **N.B.** Ensure that all text entered into Datix is written so that it is suitable to share formally with the Health Board on report generation, e.g., write words and sentences in full, check grammar, capitalisation and spelling, avoid American English, and always explain acronyms or abbreviations at first use.

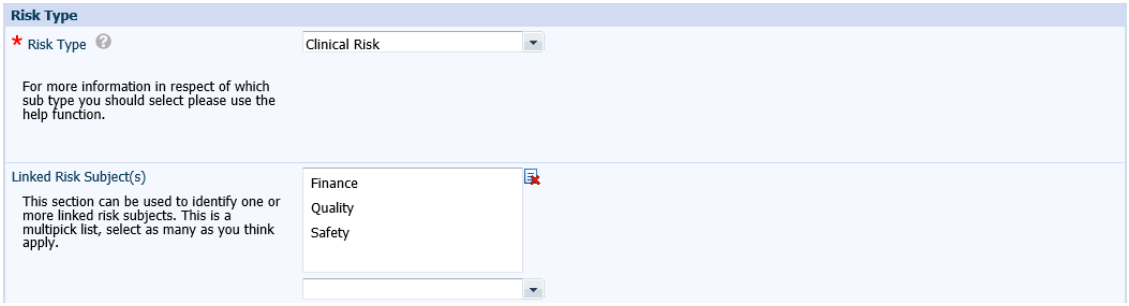
Risk Title
A risk title should give an indication of what the risk is about. For example, if a risk subject pertains to 'nurse staffing shortage, which is, an issue (currently exists/happening). The risk description should focus on implications of this issue on objectives (what you are trying to achieve). For example, 'inability to deliver a service due to nurse staffing shortage'. Alternatively, if staff are using PPE incorrectly which is an issue, a risk title should focus on implications of this which is 'potential outbreak or increase of infection due to incorrect/ inconsistent use of PPE.' Keep titles to less than a sentence for report generating purposes (longer titles do not always show in full).

Risk Description
The Health Board has a standard format for writing risk description. This helps separating risk-cause-effect in a three-part description as outlined in section 6 and below. For consistency, risks descriptions must maintain this standard for all risks.
N.B. Risk descriptions only require information on the three elements (risk-cause-effect) only. Additional information that would form part of an SBAR can be attached in the document section separately on Datix. This is to ensure, clarity, relevance and conciseness.
Handlers and/or owners of risks that do not comply with the Health Board's risk description standard will be contacted and supported to make necessary changes. Where risks are not updated within 4 weeks of contact, they will be rejected from the system.

> **Example BCUHBHB standard for risk description:**
> There is a risk that … This may be caused by … This could lead to ...
> For example,
> There is a risk that covid-19 infection rates may increase.
> This may be caused by inconsistent or incorrect use of personal protective equipment (PPE).
> This could lead to harm to patients and staff, increase in mortality rates, staff shortage due to periods of isolation, longer length of hospital stays for patients. Advance level of clinical intervention required and long-term health effects which may affect quality of life. National targets for infection prevention may be missed.

12.1.5 STEP 5 - ENTER THE RISK TYPE & LINKED RISK SUBJECTS

Within the Risk Type section, select the primary nature of the risk from the list to categorise the risk. Click on the 'help' button, marked with a question mark, for guidance. You can only select one option from the 'risk type' field.
Some risks may have secondary nature and so forth. For example, a clinical risk (primary subject nature) may also indicate financial, contractual, safety and quality sub-subjects or elements. It is possible to select additional 'Linked Risk Subjects' from the list in the subsequent field as required. Multiple options can be selected for this field. This is very useful especially if data is required for all 'financial' or 'health and safety' linked risk report.
Screenshot below:



12.1.6 STEP 6 - INDICATE IF RISK RELATES TO BUSINESS CONTINUITY AND/OR COVID-19

Select 'Yes' or 'No' to indicate whether or not the risk relates to Business Continuity, i.e., the **imminent failure or loss** of one or more of the following: people, premises, utilities, equipment, ICT and essential supplies, which could potentially cause disruption to critical services. Select 'Yes' or 'No' to indicate whether or not the risk relates to covid-19, as this data is still being collected.

12.1.7 STEP 7 - SCORE THE INHERENT RISK

Plot the inherent score also known as initial score on the 5x5 (likelihood x consequence) risk matrix. 'Inherent' is the level of risk before any actions have been taken to change the likelihood or the consequence of the risk. Identifying an inherent risk level makes it possible to assess the importance or robustness of the control measures in place after 'current' (residual) risk level has been scored on the 5x5 matrix.

Risk level scoring should be done as pragmatically and objectively as possible with the use of risk descriptors for each domain of risk for likelihood and consequence. Please see Appendix 2.

Finally, for the first part of the form, ensure that all fields are appropriately and totally completed prior to submission. Following verification that the form is completed, click **'submit'** and second part of the form will open to enable the next steps for risk management. A risk identification number will be automatically generated, for which you will receive an email receipt. Notification for risk submission will also be sent to the corporate risk team and relevant persons i.e., manager if indicated.

12.1.8 STEP 8 - SELECT THE APPROVAL STATUS

There are six statuses available within Datix risk register. This should be changed manually by selecting the drop-down option to indicate the stage at which the risk is currently held. Please ensure you understand the difference between 'non-live' vs 'live' risks as explained below.

N.B. It is important to change the status and save the risk as it progresses through the stages:

1. Risk submitted (Not live): A new risk just added to Datix will automatically fall into this status. **N.B.** Once a risk is submitted, irrespective of its score, an email notification is sent to the line manager of the staff member raising the risk, the staff member, and relevant members of the Corporate Risk Team. The risk is not live at this stage because it is incomplete, section 2 of the form must be completed following risk submission.

2. Being developed (Not live): This status includes risks that:
    - Are incomplete because further information to complete the risk is being sought.
    - Undergoing approval through governance arrangements or meetings.
    - Pending escalation or de-escalation.
    - Failed quality assurance and work is taking place to rectify this within a set timeline.

    Risks in this status are not live until the above is addressed.
    To maintain system data integrity, should you wish to exit the form for whatever reason, change the risk status from 'risk submitted' to 'being developed' and save. This will enable you to complete the form later. However,

    N.B. All fields must be completed within **4 weeks** or the risk will be rejected. All non-live 'being developed' risks must be **progressed onto live status within 4 months** or will be rejected from the register by the corporate risk team.

3. Under review (**Live**): Risks in this status have been fully completed, quality assured and approved by management and through governance meeting proportionate to the level of risk. A live risk is continuously undergoing review i.e., effectiveness of controls and action plans put in place to reduce to the risk. Where controls have failed, alternative response plans should be put in place, and risk monitored and reviewed.

4. Awaiting decision to close (**Live**): Risks in this status may:
    - Have been mitigated to as low as reasonably practicable and cannot be mitigated further cost effectively following consideration of finite resources.
    - Fall within the Health Board's risk appetite for that domain of risk and resources need to be prioritised for significant risks.
    - Have resolved naturally or, through mitigation of another risk's action plan.
    - No longer be relevant – circumstances have changed and the risk altered drastically. New risk assessment and entry may be required.
    - Have materialised and now an issue and should be managed outside the risk management process. This would now be

considered problem solving, crisis management or damage control.

Decision to close risks should be approved by management and/or governance meeting. Risks in this status are live because they continue to be reviewed frequently until they are closed.

5. Risk entry closed (Not live): Risks in this status are closed. Some of the rationale for closure could be any of (not exhaustive list) the points raised above (awaiting decision to close) section. When a closed risk status is selected, a date for closure prompt will show. Please enter closure date and save for the record to be archived.

6. Rejected (Not live): Risks are rejected for various reasons. For example:
    - A risk entry was started and after a short period of time prior completion, the handler/owner decides it's no longer relevant.
    - Risk does not comply with the Health Board risk description format.
    - Entry is an issue, incident, comment, statement, report, progress note, complaint, update from a meeting, feedback following inspection etc.
    - Incomplete risk entry within 4 weeks, and inactive risks held in 'being developed' status for 4 months plus.
    - Failed quality assurance and no action has been taken to address recommendations within set timeline, which may include recommendation to attend or refresh user's risk management training competencies.

    The corporate risk team will contact responsible services or risk handlers/owners regarding a pending decision for a risk due for rejection. Where a risk has been rejected, a 'reason for rejection' will be provided. Feedback should be addressed and communicated to ensure future entries do not fall in a similar category.

N.B. Each time a risk register is presented to management, relevant risk groups or governance meetings, it should include the review and scrutiny KPIs in section 7.

12.1.9 STEP 9 - ENTER THE RISK LEAD (OWNER) & RISK HANDLER (MANAGER)

The Risk Lead (Owner) is the individual assigned or nominated to track and respond to individual risks. This may involve (and not limited to) amendment of risk information including, mitigation controls, action planning, progress chasing, good risk record keeping on Datix risk register, presenting etc.

Risk Handler (Manager) is responsible for overseeing the management of risks within their remit of responsibility. For example, Head of Nursing would be

responsible for overseeing all nursing risks within their remit. Whereas a ward sister would be responsible (delegated or assigned) for an individual risk as a risk lead.

N.B. The risk lead (owner) and the risk handler (manager) should be two separate individuals. This would enable continuity and progression of risk management activities in the event of an absence.

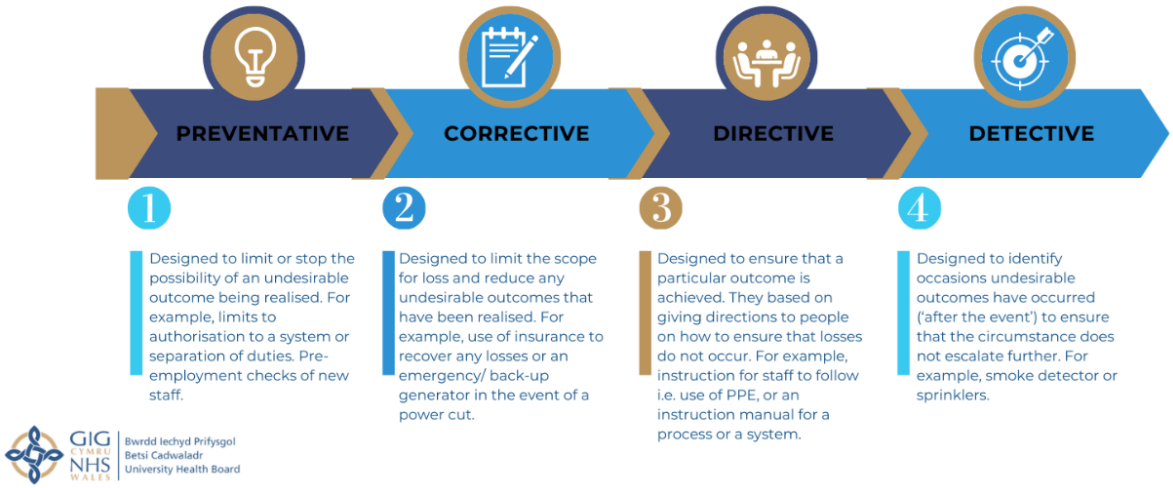
12.1.10 STEP 10 - ENTER THE EXISTING RISK MITIGATION MEASURES/CONTROLS IN PLACE

Existing mitigation measures/controls are the methods or actions that can be implemented that would take effect immediate effect in the reduction of risk. For example, a checklist or procedure for correct method of donning and doffing personal protective equipment would mitigate an infection or biohazard risk.

It is important to note that for project and programme risks, mitigation controls that have been implemented may not take immediate effect in risk reduction compared to operational risks. Some of the implemented controls may require a period of monitoring and data/intelligence gathering to ascertain the effectiveness of implemented controls.

N.B. This section should only contain mitigation controls already implemented to reduce risk.
Use the 5x5 matrix to plot the likelihood and consequence to ascertain residual/current level.

Figure 6-Controls



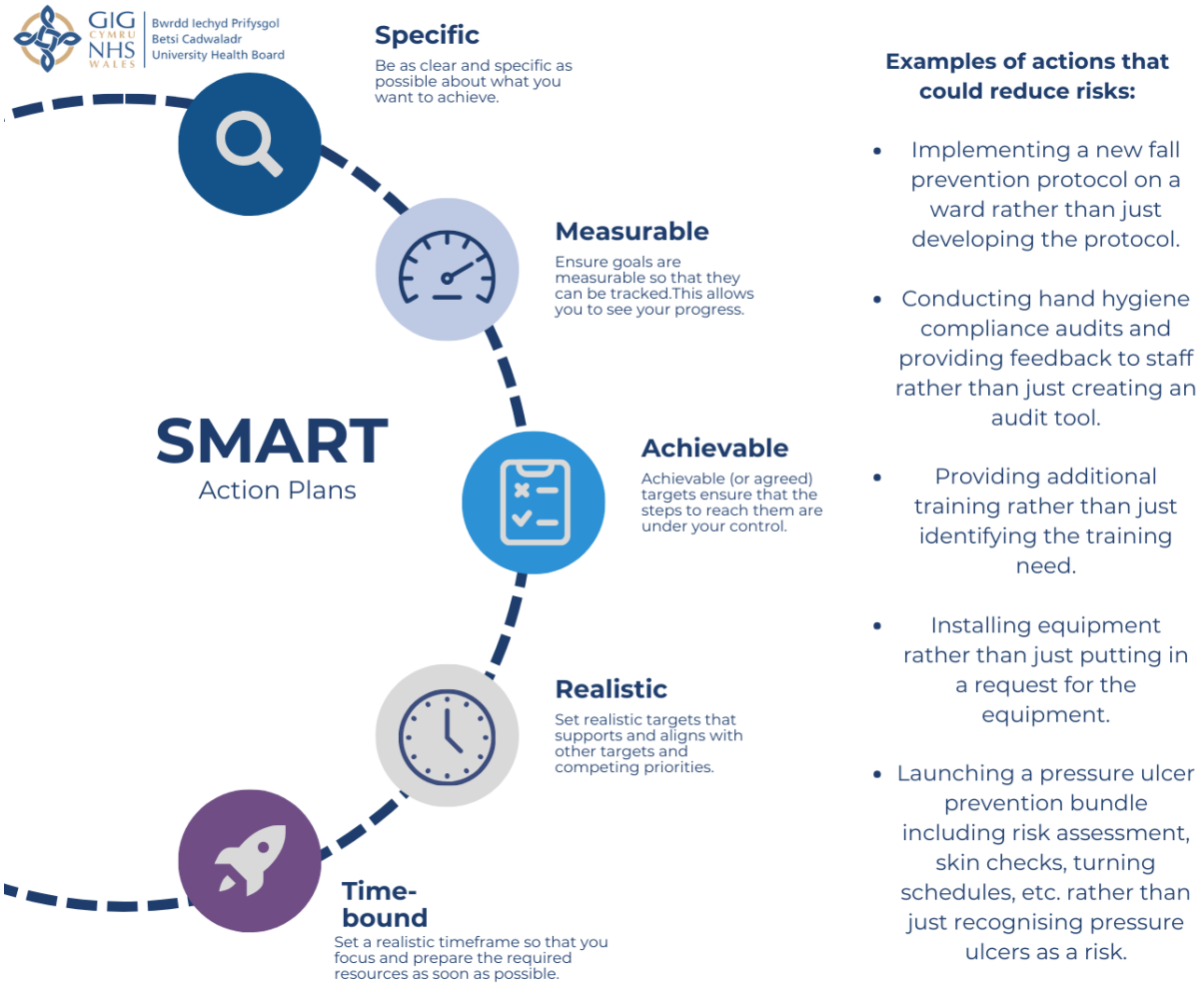
12.1.11 STEP 11 - ENTER THE ACTION PLAN

Following review of the effectiveness of implemented controls to reduce risk from inherent level to current level, an action plan will be required with further actions (things we could do that are not yet implemented) to mitigate the current/residual risk to desired target risk level.

Ensure actions to mitigate current/residual risks are functional (effective in risk reduction). Use Specific, Measurable, Agreed, Realistic and Time-bound (SMART) methodology to support action planning.

Figure 7-SMART Actions

- Go to action plan; select ‘create new action.
- In the ‘Action summary’ – enter title of the action i.e., ‘recruit to vacant post’.
- In ‘State how this action will support risk mitigation and reduce risk grade’ – enter rationale as to how risk would be reduced if the action is implemented.
- Select action start date
- Select action end date (deadline for delivery – set realistic timelines).
- Assign action to appropriate individual responsible for implementation and completion of the action.



When an action is completed, enter the **name** of the person who has completed the action and the **date** to close action and save.

When recording smart actions to mitigate risks, it is important to note examples that are not just functional steps in a larger process. For instance, developing a business case is not a smart action in itself, but rather the proposed solution outlined in the case would be. Similarly, writing an SBAR (situation, background, assessment and recommendations) report does not mitigate risk, but the **recommendations** within it may **lead to actions** that do. Other things that are not considered smart actions include progress notes like escalating an issue to a governance meeting, or procedural steps like forming a working group. The key is that smart actions should have a direct impact on reducing the risk, not just be planning stages or status updates. Additional non-functional examples could include conducting a survey, compiling data, or scheduling a workshop. The outputs and decisions from these may enable smart actions, but in themselves they do not mitigate risk.

12.1.12 STEP 12 - ENTER GAPS IN CONTROLS AND PROGRESS

Gaps in control describe the weaknesses identified having put mitigation controls in place. This helps to understand what will be required, which informs action planning. What do we need to do/ implement in response to risk that we are currently unable to?

12.1.13 STEP 13 - ENTER KEY DATES

The most important aspect of the key performance indicators are the following dates:

- Open Date (when the risk was first recorded/submitted)
- **Date of last review** (when the risk was previously amended)
- **Date of next review** (When the risk, controls, action plan etc. will reviewed again). Please ensure to set the date of next review according to Health Board review requirements.
- **Target risk level due date** (When the risk is expected to be mitigated/resolved to the desired target level). Please ensure that this is realistically set and that it does not conflict with the date of next review.

N.B. The 'target risk level due date' will require approval at a local governance meeting, or Risk Scrutiny Group /Executive level for Corporate Risk Register and Board Assurance Framework risks.

12.1.14 STEP 14 - ENTER SITE RISK REGISTER CODING

This section enables you to identify whether the risk is linked to one or more of the main hospital sites. If you answer 'Yes' to this question, additional sections will open to allow you to select one or more of the main hospital sites.

12.1.15 STEP 15 - ENTER THE CURRENT & TARGET RISK SCORE

The current risk refers to the level of risk with mitigation controls in place (implemented).
The target risk score refers to the level of risk that is desired in order to close a risk. This would typically be applicable where risks have been fully mitigated, or reduced as far as reasonably possible and/or within the Health Board's risk appetite.

Use the 5x5 (likelihood x consequence) matrix to select the current and target risk levels utilising the scoring descriptors in Appendix 2.

N.B. The current risk score should reduce over time as action is taken to address the risk and will be lower than the inherent risk level (which reflects the level of risk without any mitigations controls in place).

12.1.16 STEP 16 - ENTER THE RISK TIER

The current risk score determines which tier the risks should be held. For example,

- Risks with a current score of 15-25 are held at Tier-1
- Risks with a current score of 9-12 are held at Tier-2
- Risks with a current score of 1-8 are held at Tier 3

Please note that as the current score changes, the tier should also be adjusted to ensure alignment. Remember, Tier-1 risks must be reviewed monthly, Tier-2 reviewed bi-monthly and Tier-3 reviewed quarterly. This is to support time management particularly for those services with larger numbers of risks on their register so should be a minimum review period.

Reporting by Risk Tier
The Corporate Risk Register is presented to the Health Board Risk Scrutiny Group every 2 months, Committees and Board quarterly for collaborative development, review, scrutiny, and assurance.

~~Notable Tier 2 and Tier 3 risks, and notable emerging risks in development, are reported to the RMG every 12 months by department (in line with the cycle of business), for collaborative development, review, and assurance, using a summary Risk Register Report.~~

12.1.17 STEP 17 - ASSURANCE SECTION

Identified risks will have links to the BCUHB Plan and objectives as defined by the Board.
Risks submitted onto Datix risk register can also be linked to any one or more of the strategic risks in the 'Assurance' tab as applicable. This enables an aggregated, cross-functional view of risks to determine persisting themes, their impact on the organisation and response planning.

- Select the Executive Director with overarching responsibility for the risk. This would usually be the Executive lead to which the service reports. For example, for finance risks (from finance department) select Executive Director of Finance.
- Select the relevant Committee(s)/Group(s) where risks are reported, scrutinised and management supported.

- Select the relevant ‘priorities’ to which the risk relates.
- List ‘sources of assurance’ and any ‘gaps in assurance’.

Sources of Assurance:
Assurance is a process that provides evidence that the controls in place are effective and working and that the Health Board is doing its very best to ensure appropriately reduce and manage risks to achieve its objectives.

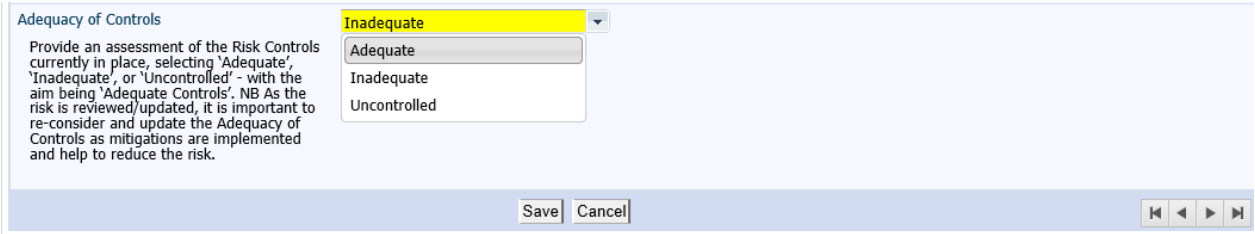
These sources include:

1. First level of assurance comes from services that perform the day-to-day activities and the governance groups where the risks are reviewed, scrutinised and managed. Reviews by operational management.
2. Second level of assurance comes from internally verified data. For example, audits (including internal audit), intelligence gathering i.e., incidents, targets compliance data. Oversight by risk management/compliance functions.
3. Third level of assurance comes from assurance provided from outside the Health Board for example, Welsh Government, Health Inspectorate Wales, Audit Wales, Health and Safety Executive etc.

‘Gaps in Assurance’ provides an explanation about where there is a lack of evidence and/or confidence in our ability to control or manage risks effectively.
N.B This is different for strategic risks and the Board Assurance Framework/Corporate Risk Register (Section 10.4) should be consulted.

12.1.18 STEP 18 - SELECT THE ADEQUACY OF CONTROLS

This is an opportunity for the Risk Lead (Owner) or Risk Handler (Manager) to provide their objective assessment of the effectiveness of mitigation controls that have been implemented to reduce the risk by selecting ‘adequate’, ‘inadequate’ and ‘uncontrolled’.
A risk with a current score the same or very close to the inherent score has minimal or ineffective mitigation in place and is therefore ‘uncontrolled’
A risk with effective mitigation will have a current score significantly lower than the inherent score, but may not be fully mitigated and therefore ‘inadequate’
A risk with significant effective mitigation in place with a current score equal to or very close to the target risk score may be described as ‘adequate’



N.B. As the risk is monitored and reviewed, it is important to re-assess and update the adequacy of controls as new mitigation controls are implemented towards risk reduction.
Click on save to submit the completed risk entry.

12.2 Share this Risk

Sharing a risk allows for multi-service or cross-functional collaboration in risk mitigation or stakeholder input. There are risks within the organisation that may originate from one service but also impacts other services and stakeholders. Sharing a risk allows for services to view, edit or assign actions across risk registers. This is particularly common for Pan-BCUHB risks or risks that involve multiple stakeholders i.e., Finance, Planning, Estates etc.

There are two ways to share a risk, although both can be done at the same time:

1. 'Risk Stakeholders' – able to share a risk with an individual stakeholder (interested/named/nominated) from another service. This gives access to individuals only (not the service). You can select several individuals.
2. The service itself. This allows for the risk to appear in another service's risk register. For example, an Estates risk appearing on Finance risk register through sharing.

Sharing a risk is helpful as part of the communication and consultation section of the risk management process.

12.3 REGISTER QUALITY CHECKS FOR HANDLERS AND OWNERS
Individuals with access and responsible for management of risks within the risk register are expected to maintain the integrity of information and data submitted into the Datix risk register module. The corporate risk management team will perform periodic appraisals of risk registers to ensure that the standards outlined in the Risk Management Framework (RM01) and the procedures (RM02) are maintained.

The following is a list (not exhaustive) of the key areas that should be monitored as part of quality assurance checklist.

1. Risk description follows the format (risk-cause-effect) as outlined in section 6.

2. Grammatical correctness, (e.g., capitals, full stops, commas, spelling), British English rather than American English (e.g., use an ‘S’ not a ‘Z’). Use simple language so that non-subject matter experts or service users are able to make sense of the information.
3. All acronyms described in full before abbreviating.
4. Risks have Risk Lead (Owner) or Risk Handler (Manager)
5. Existing Risk Mitigation Measures/Controls in Place’ are completed
6. Action plan is completed with functional actions (within 4 weeks).
7. Risks are reviewed according to timelines for each tier.
8. Next date of risk review does not go beyond risk target level due date.
9. Target level risk due date is realistic depending on severity of risk and actions undertaken.
10. The ‘Target Risk Score’ falls within the Risk Appetite for the Health Board (see RM01 Appendix 1).
11. Gaps in Controls’, ‘Assurance Sources’, ‘Gaps in Assurance’, and ‘Progress since Last Submission’ updated to reflect progress made, e.g., since last submission to Board/ Committee/Group. N.B. Progress should flow logically (e.g., highlight changes agreed by the Board/Committee previously, areas recently updated, then refer to progress with actions).

12.4 GENERATING RISK REGISTER REPORTS

Two template Risk Register Listing Reports have been created: ‘Basic Risk Register Report with Action Plan’ and ‘Risk Register Template (Summary Report)’. Both reports can be generated from the ‘Design a Report’ section on the left-hand side of the page, following the completion of the relevant search for the risks that are to be included within the report. A 'How to Create Reports' guide is available on the intranet to support you. For further support to create/develop bespoke reports for your department, please contact the Corporate Risk Team.

12.5 GUIDE FOR COMPLETING STRATEGIC RISK

It is important to ensure that any persons responsible for managing strategic risks (Corporate risks or Board Assurance Framework risks) has received strategic risk training on the use of the system. Corporate Risks are maintained in Datix but Board Assurance Framework risks are currently not supported in Datix and a Board Assurance Framework risk report template needs to be completed and maintained. This can be requested from the corporate risk team and/or Head of Risk Management.

For the completion of Board Assurance Framework templates only those risks where the score is 15 or above is submitted as a template for Board awareness, i.e., a high risk of failing to deliver. The risk score should be reviewed regularly as updates are provided to the planning team. Risk scores are collated by the corporate risk team and the score alone, if below 15 is presented to the Board as well as updates from planning on the delivery.

When completing a corporate or Board Assurance Framework risk all of the principles in the step-by-step guide above still apply. However, there are some modified fields for documenting as listed below:

Committee: This will be the Board committee (Quality, Safety and Experience Committee, Performance, Finance, and Information Governance Committee etc.) that has overall responsibility for the risk. This will be completed by the Risk Assurance Manager and approved by the Executive Team.

Date Last Reviewed: This is the date when the Executive last reviewed the risk, not when last updated by the representative risk lead.

Date Last Reviewed at Committee: This is the bi-monthly date when it was last reviewed at the relevant Board committee with overall responsibility for the risk.

Link to Corporate Risk Register and Tier 1: References are used from the Datix IDs for any Tier 1 risks that are linked to the corporate risk.

~~**Lines of defence** for strategic risks is outlined in section 6 (RM01) and meetings should be listed where assurance is sought.~~

> ~~First line of defence - Operational management: Executives to own and manage their respective portfolio risks. Ensure the implementation of controls, mitigation and ensuring the execution of action plans, providing updates at the Executive Team Meeting, local divisional meeting, reporting to Senior Management or any other local operational reporting lines where the risk is reviewed, monitored or discussed.~~
>
> ~~Second line of defence - Oversight functions: Risk Scrutiny Group to seek good governance on overall risks management functions. Executive review and scrutiny as overall accountable lead including providing updates at the Executive Team Meeting and other Executive challenge.~~
>
> ~~Third line of defence –Independent assurance from Internal Audit.~~

Any changes to the document such as description, controls, target date, score etc. must be completed in track changes or highlighter so it can be easily identifiable to the accountable Executive for approval. The Executive will be required to provide this as an update to the Executive team meeting as a change control. This prevents any major changes without the agreement of the Team prior to presentation as a change at Board. These changes will be noted by the Risk Assurance Manager in the progress update section and or coversheet for the Board highlighting the changes.

Register Quality Checks for Handlers and Owners still applies and the document should be concise and to the point minimising operational detail, reflecting a more strategic view on the risk. It should be free from any acronyms as documents are reviewed by members of the Board and Public. Any sensitive information which is not appropriate to be in the public domain should not be detailed here and support can be sought from the Risk Assurance Manager on whether it needs to be a private agenda item.

The risk will be reviewed and quality checked by the Risk Assurance Manager, Head of Risk and Executive prior to submission to Committee and Board, often facilitated through one to ones with the delegated representative of the Executive.

Overall Assessment:

The overall assessment will be completed by the Head of Risk Management detailing movement in scoring, progress update on actions and next steps with actions, detailing any concerns or delays.

APPENDIX 2 - RISK TOLERANCE SCORING MATRIX

Risk Scoring Matrix

	1 Negligible	2 Minor	3 Moderate	4 Major	5 Catastrophic
Safety & Well-being - Patients/ Staff/Public	Minimal injury requiring no/minimal intervention or treatment. No time off work. that requires no treatment or first aid. Minimum psychological impact requiring no support. Low vulnerability to abuse or exploitation - needs no intervention. Category 1 pressure ulcer.	Minor injury or illness, requiring minor intervention. Requires time off work for >3 days Increased hospital stay 1-3 days. Slight physical injury to self/others that may require first aid. Emotional distress requiring minimal intervention. Increased vulnerability to abuse or exploitation, low level intervention. Category 2 pressure ulcer.	Moderate injury/professional intervention. Requires time off work 4-14 days. Increased hospital stay 4-15 days. RIDDOR/Agency reportable incident. Impacts on a small number of patients. Physical injury to self/others requiring medical treatment. Psychological distress requiring formal intervention by MH professionals. Vulnerability to abuse or exploitation requiring increased intervention. Category 3 pressure ulcer.	Major injury leading to long-term disability Might affect more than one person. Requires time off work >14 days. Increased hospital stay >15 days. RIDDOR Reportable. Regulation 4 Specified Injuries to Workers. Patient mismanagement, long-term effects. Death or significant irreversible harm Significant psychological distress needing specialist intervention. Vulnerability to abuse or exploitation requiring high levels of intervention. Category 4 pressure ulcer. Decline in the population health profile.	An event which impacts on a large number of patients/public. Loss of Life / Major incident which is more than likely as a result of negligence or which could lead to prosecution. Or incident leading to possible multiple deaths, multiple permanent injuries or irreversible health effects. Gross deterioration in the population health profile.
Quality/ Complaints/ Assurance/ Patient Outcomes	Peripheral element of treatment or service suboptimal. Informal complaint/inquiry.	Overall treatment/service suboptimal. Formal complaint (Stage 1). Local resolution. Single failure of Internal standards. Minor implications for patient safety. Reduced performance.	Treatment/service has significantly reduced effectiveness. Formal complaint (Stage 2). Escalation. Local resolution (poss. independent review). Repeated failure of internal standards. Major patient safety implications.	Non-compliance with national standards with significant risk to patients/public. Multiple complaints/independent review. Low achievement of performance/delivery requirements. Critical report.	Totally unacceptable level or quality of treatment/service. Gross failure of patient safety. Inquest/ombudsman/inquiry. Gross failure to meet national standards/requirements.
Workforce/ Organisational Development/ Staffing/ Competence	Short-term low staffing level that temporarily reduces service quality (< 1 day).	Low staffing level that reduces the service quality.	Late delivery of key objective/service due to lack of staff. Unsafe staffing level (>1 day)/competence. Low staff morale. Poor staff attendance for mandatory/key professional training.	Uncertain delivery of key objective/ service due to lack/loss of staff. Unsafe staffing level (>5 days)/competence. Very low staff morale. Significant numbers of staff not attending mandatory/key professional training.	Non-delivery of key objective/service due to loss of several key staff. Ongoing unsafe staffing levels or competence/skill mix. No staff attending mandatory/professional training. Inability to deliver services. Uncertain delivery of key objective/service due to lack of staff
Statutory Duty, Regulation, Mandatory Requirements	No or minimal impact or breach of guidance/statutory duty.	Breach of statutory legislation. Reduced performance levels if unresolved.	Single breach in statutory duty. Challenging external recommendations/improvement notice.	Enforcement action. Multiple breaches in statutory duty. Improvement notices.	Multiple breaches in statutory duty. Independent/external enquiry. Public enquiry. Zero performance rating. Prosecution. Severely critical report. Total system change needed.

				Low achievement of performance/ delivery requirements. Critical report.	
Adverse Publicity or Reputation	Rumours. Low level negative social media. Potential for public concern. No impact on reputation	Local media coverage short term reduction in public confidence/trust. Short-term negative social media. Public expectations not met. Slight impact on reputation	Local media coverage - long-term reduction in public confidence & trust. Prolonged negative social media. Reported in local media.	National media coverage <3 days, service well below reasonable public expectation. Prolonged negative social media, reported in national media, long term reduction in public confidence & trust. Increased scrutiny: inspectorates, regulatory bodies and WG. Adverse national press interest. Loss of credibility and confidence in NHS Resolution	National/social media coverage >3 days, service well below reasonable public expectation. Extensive, prolonged social media. MP/MS questions in House/Senedd. Total loss of public confidence/trust. Escalation of scrutiny status by WG.
Business Objectives or Projects	Insignificant cost increase/ schedule slippage. Minimal impact on the quality or timeliness of a project	<5 per cent over project budget. Schedule slippage. Some impact on the quality or timeliness of a project	5–10 per cent over project budget. Schedule slippage. Impact on timeliness of a project, but not quality	Non-compliance with national targets.10-25 per cent over project budget. Schedule slippage. Key objectives not met. Impact on delivery and quality of programme of projects	>25 per cent over project budget. Schedule slippage. Key objectives not met.
Financial Stability & Impact of Litigation	Small loss. Risk of claim remote. Financial implications are negligible	Loss of 0.1–0.25% of budget Claim less than £10,000.	Loss of 0.25–0.5% of budget. Claim(s) between £10,000 and £100,000.	Uncertain delivery of key objective. Loss of 0.5-1.0% of budget. Claim(s) between £100,000 and £1 million. Purchasers failing to pay on time.	Non-delivery of key objective. Loss of >1 per cent of budget. Failure to meet specification. Claim(s) >£1 million. Loss of contract/payment by results.
Service/ Business Interruption	Loss/interruption of >1 hour including IT services Minor disruption. Brief disruption to service delivery	Loss/interruption of >8 hours. Some disruption manageable by altered operational routine. Small to medium group of people affected by data loss, software downtime.	Loss/interruption of >1 day. Disruption to a number of operational areas in a location, possible flow to other locations. Large group of people affected by data loss or system loss or one software affected.	Loss/interruption of >1 week. All operational areas of a location compromised; other locations may be affected. IT services not available for > 1 week, 2> critical software affected. Significant group of people affected by data loss	Permanent loss of service or facility. Total shutdown of operations. Multiple IT services not available across the Health Board. Software critical to patient care or safety which cannot be managed through a manual process.

Environment/Estate/ Infrastructure	Minimal or no impact on environment/service/property.	Some disruption to services. Minor impact on environment/ service/property. Some disruption to service delivery of up to 24 hours	Serious disruption to services due to: fire, flood, loss of power/water, inadequate maintenance or inability to safely access facilities Moderate impact on environment/ service/property. Disruption to service delivery of up to 48 hours	Total loss of ward/department/service/small site due to: fire, contamination (disease/toxin), failure of structure/lack of maintenance, loss of services/power/water Unable to deliver services for more than one month Major impact on environment/ service/property.	Total loss of one or more sites due to: fire, terrorist attack, contamination (disease/toxin), natural disaster, total loss of services/power/water. Catastrophic impact on environment/service/property. Catastrophic impact on environment/service/property. Non-compliance with Statutory Regulations leading to potential loss of life/harm caused which could lead to exposure to prosecution (to include corporate manslaughter).
Health Inequalities/ Equity	Minimal or no impact /data to evidence/demonstrate the impact on patients, staff, public, population health. Minimal or no impact on access to or effectiveness of services to people who share protected characteristics including: Access to services Travel and transport Cultural issues Language requirements Communication and sensory loss	There is minimal or anecdotal evidence to demonstrate harm or reduce health inequalities or lack of clarity on the impact on health equity. Minor impact on access to or effectiveness of services to people who share protected characteristics, recoverable with temporary adjustments. including: Access to services Travel and transport Cultural issues Language requirements Communication and sensory loss	There is clear evidence to demonstrate harm reducing equity gap. Significant impact on access to or effectiveness of services to people who share protected characteristics (e.g., no availability of BSL interpretation in urgent care, loss of hospital transport) which cannot be easily and quickly remedied. Issues may include: Access to services Travel and transport Cultural issues Language requirements Communication and sensory loss	Validated data suggests no improvement in the health of the most disadvantaged, whilst supporting the least disadvantaged. Morbidity rates are increased as a result. Major impact on the availability or effectiveness of services for people who share protected characteristics. People unable to access planned or urgent care. Lack of evidence of compliance with statutory duties in strategic level decisions	Validated data demonstrates a disproportionate widening of health inequalities/significant negative impact on health improvement and/or equity. Mortality rates are increased significantly within patients, staff, public, population as a result. (e.g., cessation of screening services within particular communities, chemical exposure, legionella exposure, access to folic acid, TB outbreaks. Significant financial penalties, litigation and judicial review. Complete removal of services to people who share protected characteristics.

Risk Tolerance Scoring Matrix (Likelihood x Consequence = Risk Score)		Consequence:				
Likelihood:	**Frequency:**	**1 Negligible**	**2 Minor**	**3 Moderate**	**4 Major**	**5 Catastrophic**
1 Rare - Will probably never happen/recur	**Not for years**	**1**	**2**	**3**	**4**	**5**
2 Unlikely - Do not expect it to happen/recur but it is possible	**At least annually**	**2**	**4**	**6**	**8**	**10**
3 Possible - It might happen/recur occasionally	**At least monthly**	**3**	**6**	**9**	**12**	**15**
4 Likely - Will probably happen/recur and are persisting	**At least weekly**	**4**	**8**	**12**	**16**	**20**
5 Almost Certain - Will undoubtedly happen/recur.	**At least daily**	**5**	**10**	**15**	**20**	**25**

Teitl adroddiad: ***Report title:***	Standards of Business Conduct – Internal Audit			
Adrodd i: ***Report to:***	Audit Committee			
Dyddiad y Cyfarfod: ***Date of Meeting:***	Wednesday, 19 June 2024			
Crynodeb Gweithredol: ***Executive Summary:***	Internal Audit have recently completed their audit of the Standards of Business Conduct Declarations of Interest, Gifts and Hospitality and have given a limited assurance rating based on six individual points. A draft of the report is attached at appendix B for review and this report clarifies the plan to address the matter. The Audit Committee are asked to support the recommendations.			
Argymhellion: ***Recommendations:***	The Audit Committee are asked to: • **Note** the Internal Audit and its findings • **Note** the actions proposed to address the issues raised			
Arweinydd Gweithredol: ***Executive Lead:***	Pam Wenger, Director of Corporate Governance			
Awdur yr Adroddiad: ***Report Author:***	Philippa Peake-Jones, Head of Corporate Affairs			
Pwrpas yr adroddiad: ***Purpose of report:***	I'w Nodi *For Noting* ☐	I Benderfynu arno *For Decision* ☒	Am sicrwydd *For Assurance* ☐	
Lefel sicrwydd: ***Assurance level:***	Arwyddocaol *Significant* ☐ Lefel uchel o hyder/tystiolaeth o ran darparu'r mecanweithiau / amcanion presennol *High level of confidence/evidence in delivery of existing mechanisms/objectives*	Derbyniol *Acceptable* ☒ Lefel gyffredinol o hyder/tystiolaeth o ran darparu'r mecanweithiau / amcanion presennol *General confidence / evidence in delivery of existing mechanisms / objectives*	Rhannol *Partial* ☐ Rhywfaint o hyder/tystiolaeth o ran darparu'r mecanweithiau / amcanion presennol *Some confidence / evidence in delivery of existing mechanisms / objectives*	Dim Sicrwydd *No Assurance* ☐ Dim hyder/tystiolaeth o ran y ddarpariaeth *No confidence / evidence in delivery*
Cyfiawnhad dros y gyfradd sicrwydd uchod. Lle bo sicrwydd 'Rhannol' neu 'Dim Sicrwydd' wedi'i nodi uchod, nodwch gamau i gyflawni sicrwydd 'Derbyniol' uchod, a'r terfyn amser ar gyfer cyflawni hyn: ***Justification for the above assurance rating. Where 'Partial' or 'No' assurance has been indicated above, please indicate steps to achieve 'Acceptable' assurance or above, and the timeframe for achieving this:***				
Cyswllt ag Amcan/Amcanion Strategol: ***Link to Strategic Objective(s):***	1 Building and Effective Organisation			
Goblygiadau rheoleiddio a lleol: ***Regulatory and legal implications:***	None			

Yn unol â WP7, a oedd EqlA yn angenrheidiol ac a gafodd ei gynnal? ***In accordance with WP7 has an EqlA been identified as necessary and undertaken?***	N/A
Yn unol â WP68, a oedd SEIA yn angenrheidiol ac a gafodd ei gynnal? ***In accordance with WP68, has an SEIA identified as necessary been undertaken?***	N/A
Manylion am risgiau sy'n gysylltiedig â phwnc a chwmpas y papur hwn, gan gynnwys risgiau newydd (croesgyfeirio at y BAF a'r CRR) ***Details of risks associated with the subject and scope of this paper, including new risks(cross reference to the BAF and CRR)***	N/A
Goblygiadau ariannol o ganlyniad i roi'r *argymhellion ar waith* ***Financial implications as a result of implementing the recommendations***	N/A
Goblygiadau gweithlu o ganlyniad i roi'r argymhellion ar waith ***Workforce implications as a result of implementing the recommendations***	Further resource is required within the Corporate Governance Directorate to support this work. A temporary solution has been identified. This will be reviewed as part of the ongoing work around the structure of the Directorate.
Adborth, ymateb a chrynodeb dilynol ar ôl ymgynghori ***Feedback, response, and follow up summary following consultation***	The Paper has been agreed by the Executive Team for submission to the Audit Committee.
Cysylltiadau â risgiau BAF: (neu gysylltiadau â'r Gofrestr Risg Gorfforaethol) ***Links to BAF risks:*** *(or links to the Corporate Risk Register)*	N/A
Rheswm dros gyflwyno adroddiad i fwrdd cyfrinachol (lle bo'n berthnasol) ***Reason for submission of report to confidential board (where relevant)***	N/A
Next Steps: ***Implementation of recommendations***	
List of Appendices: Appendix A – An update of the current Declarations of Interest, Gifts and Hospitality submissions Appendix B – Standards of Business Conduct – Declarations of Interest, Gifts and Hospitality Draft Internal Audit Report 2024	

STANDARDS OF BUSINESS CONDUCT – INTERNAL AUDIT

1) Introduction

Internal Audit have recently completed their audit of the Standards of Business Conduct Declarations of Interest, Gifts and Hospitality and have given a limited assurance rating based on:

- Policy does not reflect current working practice / systems.
- Inappropriate use of tender waiver to purchase declaration management system.
- Newly activated system features require time to embed, and oversight to ensure they are functioning as intended.
- Reporting to the Audit Committee has not been adequate and does not meet policy requirements.
- Declarations of interest – issues include Board Member's with undeclared interests, low approval rates, staff submitting repeat declarations and duplicate submissions. We were unable to determine the overall level of compliance from the data provided.
- Gifts and hospitality – not all submissions have been declared and approved appropriately. We found examples of events attended prior to declaration / approval. Not all declared hospitality was approved by a Director / Assistant Director. Several declarations (not recent) are marked as pending approval.

A draft of the report is attached at appendix A for review includes our Management Response.

2) Background

In May 2022 the Health Board procured the Civica Declare governance software to manage declarations of interest, gifts and hospitality as the previous system had not been supported due to resource issues in the previous Office of the Board Secretary. The system, now managed by the Corporate Governance Directorate enables staff to make their declarations digitally via the Declare Portal accessible from BetsiNet. Although the system was purchased in May 2022 it did not become live until August 2023 and there was no detailed implementation plan to follow to embed the system into the organisation. Since the beginning of the year work has been ongoing to address issues raised through the Audit Committee and the Directorate but a detailed plan to address what is raised is now being prepared.

The declarations will be reviewed by the Corporate Governance Directorate to ensure that they comply with the Standards of Business Conduct Policy and if there are any exceptions these will be escalated to the Line Manager. It is proposed that the subsequent updates to the Audit Committee will include the compliance with the policy and also the exceptions that had been identified during the reporting period.

As well as the process in relation to declaration of interest, work will need to be taken forward in relation to gifts and hospitality and in future reports, an update on the number of gifts and hospitality declared will be reported. This is an area of work that consistently across NHS organisations requires constant messaging and over the course of the next year, the Corporate Governance Team will monitor the returns and report, through to the Executive Team, Audit Committee and work closely with the Counter Fraud Team.

3) Action

The below addresses how we will respond to the Internal Audit. In addition, there is a requirement under the NHS Counter Fraud Authority, Requirement 12, for Local Counter Fraud to monitor that the organisation has a conflict of interest policy and registers that include reference to gifts and hospitality with reference to fraud, bribery and corruption, and the requirements of the Bribery Act 2010. It is noted that this will be assessed by regular reporting, the inclusion of reference to this in the annual PADR and regular communications through the intranet site and in pay slips.

No	Action	Date	Complete
1	Identify temporary support within the Corporate Governance Directorate to support the Declarations work	1 June 2024	Yes
2	Review and update Policy to ensure that it is in line with the rest of Wales	31 July 2024	No
3	Review Policy to ensure that the pay bands are consistent with the rest of Wales	31 July 2024	No
4	Discuss and agree with the Workforce Directorate ways in which the annual declarations of interest can be embedded into existing mechanisms.	31 July 2024	Yes
5	Communication briefing to all managers on responsibilities in relation to Declarations of Interest	30 Sept 2024	No
6	Review monthly scheduled notifications	31 July 2024	No
7	Review monthly scheduled notifications	31 July 2024	No
8	Review monthly published data to ensure that it is accurate and can be reconciled to source data.	31 July 2024	No
9	Review published guidance documentation is consistent with NHS Wales requirements and relevant to Health Board staff. A meeting with Declare has already been arranged for Friday 14 June 2024	31 July 2024	No
10	Update Cycles of business and submit to the Audit Committee twice a year	18 July 2024	No
11	Monitor and review declarations on a weekly basis	31 July 2024	No
12	Produce a targeted communication campaign and implement	30 July 2024	No

4) Recommendation

The Audit Committee are asked to:

- **Note** the Internal Audit and its findings; and
- **Note** the actions proposed to address the issues raised.

Appendix A

The below table shows the detail for declarations as at 8 July 2024. Decision Makers are those that are on Band 8 and above, as part of the action plan these figures will be monitored on a weekly basis and the associated policy will be updated to ensure that we are capturing the correct decision makers within the organisation. All declarations are now approved by line managers.

Staff Type	Number of Staff	Declarations	Not Declared	Nil Declarations received	Compliance
All	23910	1618	22292	1378	7%
Decision Makers (Band 8 and above)	3024	1337	1687	1152	44%
Non Decision Makers (Band 7 and below)	20886	281	20605	226	1%

The action plan will ensure that our policy is correct and make sure that we have the decision makers banding correct and in line with the rest of Wales.

Standards of Business Conduct - Declarations of Interest, Gifts and Hospitality

Internal Audit Report

June 2024

Betsi Cadwaladr University Health Board

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

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

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Review reference:	BCUHB-2324-21
Report status:	Final
Fieldwork commencement:	7 March 2024
Fieldwork completion:	22 May 2024
Debrief meeting/email:	26 April 2024 / 23 May 2024
Draft report issued:	28 May 2024
Management response received:	19 June 2024
Final report issued:	20 June 2024
Auditors:	Rhys Jones, Principal Auditor Nicola Jones, Deputy Head of Internal Audit CMIIA Dave Harries, Head of Internal Audit CMIIA
Executive sign-off:	Pam Wenger, Director of Corporate Governance
Distribution:	Phil Meakin, Associate Director of Governance Philippa Peake-Jones, Head of Corporate Affairs Jody Evans, Corporate Governance Officer
Committee:	Audit Committee

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

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

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

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

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

Executive Summary

Purpose
The review considered whether there are robust processes and controls in place within the Health Board to support the management of Standards of Business Conduct, specifically staff Declarations of Interest, Gifts and Hospitality.

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

- Policy does not reflect current working practice / systems.
- Inappropriate use of tender waiver to purchase declaration management system.
- Newly activated system features require time to embed, and oversight to ensure they are functioning as intended.
- Reporting to the Audit Committee has not been adequate and does not meet policy requirements.
- Declarations of interest – issues include Board Member' with undeclared interests, low approval rates, staff submitting repeat declarations and duplicate submissions. We were unable to determine the overall level of compliance from the data provided.
- Gifts and hospitality – not all submissions have been declared and approved appropriately. We found examples of events attended prior to declaration / approval. Not all declared hospitality was approved by a Director / Assistant Director. Several declarations (not recent) are marked as pending approval.

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

Report Opinion

		Trend
Limited	More significant matters require management attention. **Moderate impact** on residual risk exposure until resolved.	2021/22

Assurance summary[1]

	Objectives	Assurance
1	The Health Board has a Standards of Business Conduct policy in place to support compliance with Standing Orders, with requirements and responsibilities clearly outlined. There is suitable training and awareness to ensure that new and existing staff understand their responsibilities, expectations, and requirements of the policy.	Reasonable
2	There are effective systems and processes in place to capture Declarations of Interest, Gifts and Hospitality, with appropriate reporting to the Audit Committee.	Limited
3	Compliance with the requirements for submitting Declarations of Interest for all required staff, including Board members, is reviewed regularly, and escalated where appropriate.	Limited
4	Submissions of Gifts and Hospitality are reviewed to ensure they are in line with policy requirements, and suitable action taken where issues are identified.	Limited

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

Key Matters Arising		Objective	Control Design or Operation	Recommendation Priority
1	Health Board policy (OBS02) requires updating to reflect current working practice, requirements, and systems used. There is a lack of clarity regarding mandated declarations of interest by staff that fall outside documented pay band thresholds. Requirements to be communicated to all relevant staff.	1	Design	High
2	Several key features of Declare (including line manager approval and scheduled notifications) were only recently implemented - we cannot be assured that they are all functioning as intended. We were unable to reconcile published performance information to source data and noted that all system embedded guidance documents were NHS England documents.	2	Operation	High
3	During 2023/24 the reporting of declarations of interest, gifts and hospitality to the Audit Committee did not meet policy requirements. Limited performance data was submitted for review and the linked registers (September 2023) were solely for Board Member declarations. The registers were scheduled per 2024/25 cycle of business for submission in the March 2024 Committee, however they were not presented for review.	2	Operation	High
4	All Board Members have submitted declarations of interest, however due diligence work undertaken by the Office of the Board Secretary identified seven Board Members with undisclosed interests. We found variance in the level of detail provided in Board Member declarations and noted that the published public register had not been updated with the undisclosed interests (though this may be a timing issue).	3	Operation	High
5	We reviewed staff declarations of interest data and found that approval rates were low, impacted significantly by nil declarations deemed not applicable for approval – we acknowledge that the approval feature was only recently activated. Other issues impacting data quality include duplicate records and staff submitting multiple (mostly nil) declarations over a short period of time.	3	Operation	High

	We were unable to determine the overall rate of compliance from the data provided.			
6	We reviewed gift, hospitality, and sponsored event declarations and found that not all declarations are submitted and approved in accordance with policy requirements. Issues identified included events having been attended prior to being declared / approved, hospitality declarations not subject to Director / Assistant Director approval (line manager approval provided), non-recent declarations remain pending approval.	4	Operation	High

1. Introduction

1.1 The Health Board is committed to the NHS Codes of Conduct and the principles set out in the NHS Wales Values and Standards of Behaviour Framework, Nolan principles, and Welsh Government's Citizen Centred Governance Principles. To support this, Health Board Standing Orders and Standards of Business Conduct Policy (OBS02) outline the processes, requirements, and expected conduct and behaviour of all employees.

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

- Failure to maintain ethical standards in the conduct of NHS business.
- Ineffective / inappropriate governance and management arrangements.
- Failure to comply with Health Board Standing Orders, policy requirements, and Nolan Principles.
- Failure to safeguard the Health Board where conflicts of interest arise.
- Misuse of public funds.

1.3 This review focusses solely on the governance, processes, and operational management / compliance of Declarations of Interest, Gifts and Hospitality.

1.4 The findings of this report are based upon information provided by the Associate Director of Governance, the Head of Corporate Affairs, Corporate Governance Officer, and information available in the public domain. We would like to express our gratitude to colleagues for their input during the undertaking of the review.

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

We have retained reference to the Office of the Board Secretary (OBS) throughout this review period recognising as it relates to 2023/24.

2. Detailed Audit Findings

Objective 1: The Health Board has a Standards of Business Conduct policy in place to support compliance with Standing Orders, with requirements and responsibilities clearly outlined. There is suitable training and awareness to ensure that new and existing staff understand their responsibilities, expectations, and requirements of the policy.

Policy

2.1 The Health Board has a policy in place outlining the requirements and expected standards of conduct of all Health Board employees. OBS02 Standards of Business Conduct Policy is accessible to staff via BetsiNet, was reviewed and approved by

the Audit Committee in March 2022 and will be due for subsequent review in March 2025. The policy includes practical advice and guidance for users on the responsibilities, requirements, and established processes for managing declarations.

2.2 Health Board expectations regarding Standards of Conduct, including disclosures of interest and gifts and hospitality, are also outlined in the policy WP6 Code of Conduct (Disciplinary Rules and Standards of Behaviour).

2.3 We reviewed the policies and noted the following limitations:

- OBS02 has not been updated to reflect the implementation and requirements of Declare, the current system used to manage declarations. Furthermore, embedded links take staff to the preceding Register of Gifts, Hospitality and Employee Interests which though superseded remains active.
- The monetary value threshold for reporting gifts is not consistent between documents – OBS02 threshold is £25 compared with "approximately" £20 stated in WP6.
- The reporting requirements for the receipt of gifts up to the value of £25 are not clearly stated in OBS02. Par7.22 states that:

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

  However then goes on to state that, *"A Gifts and Hospitality Form should be completed when gifts of up to £25 are accepted."*
- In outlining the requirements for mandatory annual declarations of interest OBS02 refers to employees of any pay band deemed to have "LHB Officer" status. However, there is no formal definition of what roles or responsibilities constitute "LHB Officer" status, and no mechanism to comprehensively identify all employees that meet this criterion.

<u>Training and communication</u>

2.4 OBS02 states that all employees are required to be familiar with the content of the Standards of Conduct policy, and that line managers are responsible for bringing the policy to the attention of their staff. However, there is no measure in place to verify that all staff have read and understood the policy.

2.5 The Health Board does not have formal mandatory Standards of Business Conduct training provision to ensure staff are aware of, and understand, their responsibilities. However, the requirements and responsibilities regarding declarations of interest, gifts, and hospitality are stated in the Board Induction Handbook for Independent and Associate Members.

2.6 For non-Board members - we reviewed the Staff Induction and Training pages on BetsiNet, (including Mandatory training courses, corporate and local induction, and departmental training information), and found no specific reference to Standards of Business Conduct, declarations of interest, or gifts and hospitality. We noted that the Health Board Orientation Staff Handbook encourages new members of staff to familiarise themselves with Health Board Workforce policies, citing the policy on "Code of Conduct and Disciplinary" as an example, and acknowledge that information may be provided to new staff during local induction.

2.7 The Office of the Board Secretary have utilised, and are developing, the following mechanisms to communicate expectations and responsibilities to staff:

- Call to Action notices published in the weekly staff bulletin – notices with links to policy were issued in the September 18th, 2023, and January 8th, 2024, bulletins, though the bandings specified were not consistent with policy requirements.
- A Declaration of Interest, Gifts and Hospitality page has been established on BetsiNet to support staff, providing users with a summary of key requirements and links to relevant supporting documentation and access to the Declare portal.
- Scheduled notices issued directly from Declare (declaration management software) to relevant staff groups – we confirmed that the feature was activated March 2023.
- The Associate Director of Governance advised that work has commenced on incorporating declarations of interest into the Health Board staff Performance Appraisal Development Review (PADR) process – it is not clear how for this work has progressed.
- The Head of Corporate Affairs advised that the Office of the Board Secretary were currently exploring the feasibility of issuing reminder messages within staff payslips.

Conclusion:

2.8 We confirmed that the Health Board has a Standards of Business Conduct policy in place to support compliance with Standing Orders. Expectations and responsibilities are stated however the policy requires updating to reflect current working practice / systems, and further clarity is needed regarding the mandatory annual declarations of interest requirements for staff that fall outside the documented pay band thresholds.

Once updated, management must ensure that relevant staff groups are advised of their responsibilities (e.g. role of line managers and Governance Leads in reviewing, approving, and escalating issues of concern).

2.9 Despite the absence of formal training provision, the Health Board has processes in place to communicate and notify staff of their responsibilities, though we

acknowledge that some are newly implemented, and others are in development. Management need to ensure the notification features within Declare are operating as intended, and that any implemented processes capture all relevant staff, including those that fall outside the mandatory declaration pay band threshold but are in a position of influence.

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

Objective 2: There are effective systems and processes in place to capture Declarations of Interest, Gifts and Hospitality, with appropriate reporting to the Audit Committee.

System

2.10 In May 2022 the Health Board procured the Civica Declare governance software to manage declarations of interest, gifts and hospitality. The system, managed by the Office of the Board Secretary, enables staff to make their declarations digitally via the Declare Portal accessible from BetsiNet. We reviewed the procurement and implementation of the Declare system and noted the following:

Procurement

- A single tender waiver was raised by the previous Interim Board Secretary and approved by the Finance Director – Operational to purchase the Declare system from Civica without open competition. "Genuinely one provider" was noted as the waiver reason and the following justification was provided:

  "to address requirements of internal audit report which specifically referenced this system and which has been received by the Audit Committee".

  Following review, Procurement advised, *"Sole supplier for the specific system needed and noted from the internal audit report".*

  This justification is inaccurate – Internal Audit did not recommend the use of any specific system or supplier to address the issues and limitations found in its February 2022 review of Standards of Business Conduct (BCU-2122-06). The waiver should not have been approved on these grounds.

- The initial agreed cost of the system per the Civica Declare Contract was £33,868+VAT, comprising an implementation fee of £4,000+VAT plus three annual service fees of £9,956+VAT. However, the total actual cost may be higher. To date, the Health Board have paid £25,156.50 (two invoices 27/9/22 – implementation fee plus first annual service fee, 28/3/23 – second annual service fee) - the second annual fee has increased from £9,956+VAT to £11,200.50+VAT, a 12.5% increase.

- We recognise that the contract has provision to increase charges to a maximum of %increase in RPI +2%. However, if the invoice for the final

annual service fee is also £11,200.50+VAT, then this will exceed the Purchase Order provision (£33,868 – per contract) and will be flagged by Procurement. The total cost of system would therefore be £36,357+VAT – an increase of £2,489+VAT.

Implementation

- Though purchased in May 2022 the system did not become live until August 2023. By this time, the Health Board had paid the initial implementation fee and two annual service fees (invoices dated 27/9/22 and 28/3/23).
- It is not clear whether all expected benefits of the system have been fully realised / implemented. We acknowledge that the Office of Board Secretary (OBS) has undergone significant changes in personnel over the last twelve months and that work is currently progressing in embedding and developing the use of the Declare system. Newly implemented features include integration with ESR data, scheduled notifications, and line manager approval.
- From April 2024, the Office of the Board Secretary will receive a monthly report from People and Organisational Development detailing all Health Board staff members in post. We were advised that due to GDPR regulations the Health Board cannot share employee pay banding information with external organisations, including Civica. Consequently, the OBS are required to review the report, manually identify and denote whether an employee / role is deemed a decision maker, then upload the information onto Declare – the data will inform system features including notifications, approvals, and public reporting. The criteria for decision maker is deemed all staff at Band 8a or above. Whilst not a formal Health Board document, we confirmed that the team have developed an ESR Data Transfer SOP to support the process.
- The Declare system includes the facility to automatically issue scheduled notification and reminder emails to targeted staff. Eleven notice types have been set up on the system however management could not confirm that they were all functioning as intended (the recipients for two of the notices were marked as "Test Email"). The feature was activated by Civica on March 14, 2024 following request and approval from the Head of Corporate Affairs.
- The Declare portal provides a public register of Health Board staff declarations. We could not confirm the validity and accuracy of published data as we were unable to reconcile the public register information to source data provided. We also found that the financial year filter is not functioning as intended.
- To support staff, Declare includes links to guidance for each declaration type (i.e. gifts, hospitality, outside employment, shareholdings and other ownership interests etc). Whilst this is good practice, the guidance provided is NHS England documentation, not Health Board or NHS Wales.

- We were advised that Board Members and Executive staff do not submit their declarations via Declare, but rather submit a manual return directly to the Office of the Board Secretary. The reason given is that the manual return captures additional information that is not available in Declare. However, according to the Board Induction Handbook for Independent and Associate Members, this requirement only applies to Independent and Associate Members. Manual returns are retained and declarations are published on the Health Board public website.

Reporting to Audit Committee

2.11 Declarations of interest, gifts and hospitality are subject to review and oversight by the Audit Committee, however the frequency of submission may not meet the reporting requirements stipulated in OBS02. The draft 2024/25 Audit Committee cycle of business includes the following provisions regarding declarations of interests, gifts and hospitality:

- Declarations of interest, gifts and hospitality report – to be presented at the May, September 2024, and January 2025 Audit Committees.
- Annual review of Gifts and Hospitality and Declaration of Interest registers – to be undertaken in the March 2024 Audit Committee. *Note that the registers were not submitted for review at the March 2024 Audit Committee.*

However, OBS02 states that the declaration of interest, gifts and hospitality registers should be submitted for review by the Audit Committee bi-annually.

2.12 We reviewed the Audit Committee papers submitted in 2023/24, and noted the following:

- March 2024 – Brief update of progress from report submitted in January. As noted above, the registers of declarations of interest, gifts and hospitality were not submitted for review at this Committee meeting, contrary to the draft 2024/25 cycle of business. The Director of Corporate Governance advised that the Audit Committee Chair had agreed in the March 2024 agenda planning meeting to defer receipt of the registers until the July 2024 Audit Committee, however we have not corroborated this.
- January 2024 – Declarations of interest, gifts and hospitality implementation plan update (specific report and included as part of the Corporate Governance Report).
- September 2023 - Annual Declarations of Interests / Gifts and Hospitality – update report. This report included a link to the BCU Gifts and Hospitality register (as of 21 July 2023) however details were limited to Board Members only.

Prior to the January 2024 Audit Committee, no performance / compliance data regarding declarations of interest, gifts and hospitality (or other declarations)

were provided to the Audit Committee for scrutiny. Furthermore, linked registers were limited to Board Member' submissions only.

2.13 We were advised that the Health Board is currently taking legal advice regarding an inheritance left to the organisation. OBS02 states that all cases involving bequests, legacies, and wills must be reported to the Audit Committee, however we found no reference to this in the published Audit Committee minutes and papers.

Conclusion:

2.14 In August 2023 the Health Board implemented a new electronic system, Declare, to capture and manage staff declarations of interest, gifts and hospitality. Several key features offered by Declare have only recently been activated therefore we are unable to provide assurance that all features have been fully implemented and are operating as expected – specifically staff notifications, manager approval, and public reporting features. We also noted that system embedded guidance documents were all NHS England documents, therefore may not be relevant to BCU staff.

2.15 During 2023/24 the reporting of declarations of interest, gifts and hospitality to the Audit Committee did not meet policy requirements. We acknowledge that declarations of interest, gifts and hospitality are included in the 2024/25 Audit Committee cycle of business, however the registers (scheduled for the March 2024 Audit Committee) were not submitted to the Committee for review – we were advised by the Director of Corporate Governance that it had been agreed with the Audit Committee Chair at the March 2024 Committee agenda planning meeting to defer this item until the July Committee, however the amendment / deferral was not recorded in relevant minutes.

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

Objective 3: Compliance with the requirements for submitting Declarations of Interest for all required staff, including Board members, is reviewed regularly, and escalated where appropriate.

Board Members

2.16 The Health Board maintain and publish a register of Board Member declarations of interest on the Health Board public website. The register includes declarations made by all current Executive Directors, Associate Members, and Independent Members, as well as those that have been in post and subsequently left during the relevant financial year. The 2023/24 register comprises declarations from thirty (30) individual Board members - twenty-three (23) of which are positive declarations, with seven nil declarations submitted. The following table shows the number of declarations by position as published:

Table 1: Published Board Member Declarations of Interest by position.

Position (as published)	Positive Declaration	Nil Declaration	Total
Acting Board Secretary	1		**1**
Acting Executive Director	1		**1**
Associate Director	1		**1**
Associate Member	3		**3**
Chief Executive Officer	1		**1**
Deputy Director	1	1	**2**
Executive Director	2	3	**5**
Executive Medical Director/Deputy Chief Executive Officer	1		**1**
Independent Member	8	2	**10**
Independent Member Vice Chair as from 03.11.23	1		**1**
Interim Chair	1		**1**
Interim Executive Director	2	1	**3**
Total	**23**	**7**	**30**

Source: BCUHB Register of Board Members Declarations of Interest 2023-24 (published BCU public website).

2.17 The Associate Director of Governance advised that the Office of the Board Secretary actively review all Board Member declarations to ensure submissions are accurate and up to date. Action taken includes due diligence work verifying Companies House data / information to Board Member declared interests, contacting each individual Board Member to confirm interests, and notifying Members of what will be included in the Health Board Annual Accountability Report. We reviewed the evidence provided and noted the following:

- Two Board Members that had been in post during the 2023/24 financial year were not included in the published register of Board Members declarations of interest – both Members left their position at the end of April 2023.
- The due diligence work undertaken by the Office of the Board Secretary identified seven Board Members with undisclosed interests. Six of the seven omissions related to directorship roles within other organisations.
- The published register has not been updated with the identified undisclosed interests – we acknowledge that this may be a timing issue as Board

Members were given a deadline of 2 May 2024 to raise comments or objections to their inclusion within the Annual Accountability Report.

- Transparency issue - not all published declarations relating to external employment provide sufficient detail of role. We noted two instances whereby Board Member' declarations were limited to "employed by…", despite their employment relating to senior / Director level positions within the respective organisations.

Non-Board Member Staff

2.18 The following table provides an overview of submitted declarations of interest. The data has been extracted from a Civica Declare report, provided by the Office of the Board Secretary, showing all declarations made by Health Board staff from initial system activation to 22 April 2024. Note that three Board Members had also made their declaration on Declare – their submissions (all nil declarations) are included in the figures below.

Table 2: Staff declarations of interest reported on Declare (as of 22 April 2024)

	All staff members	Staff designated Decision Maker
Total number of assignments uploaded from ESR report	26,371*	3,559*
Total number of individual staff members that have made declarations	1,958	677
Total number of declarations on report	2,054	727
Total number of duplicate declarations	20	6
Total number declarations (adjusted for duplicates)	2,034	721
Total number declarations approved (adjusted for duplicates)	176 (9%)	76 (11%)
Total number declarations pending approval (adjusted for duplicates)	59	32
Number of declarations NOT approved – approver declined	2	0
Total number nil declarations (adjusted for duplicates)	1,866	642
Approved nil declarations	55 (3%)	23 (4%)
Nil declarations approval pending	14	6
Nil declarations marked approval N/A	1,797	613

Source: Declare report provided by OBS – raw data comprising all declarations recorded on system

We reviewed the data and noted the following issues and limitations:

- The values presented above for the total number of assignments uploaded from ESR report has not been verified – the information was provided verbally by the Office of the Board Secretary. A copy of the source ESR report was requested from Officers but not provided for review. The figures quoted represent assignments not individual staff members, i.e. one staff member may have multiple assignments. The impact of this is that we are unable to accurately determine how many staff members should be submitting mandatory declarations of interest (i.e. staff deemed decision makers), therefore cannot establish the overall rate of compliance.
- We found twenty (20) duplicate entries within the source Declare report.
- We identified a further sixty-one (61) instances where staff had made the same declaration within a short period of time – sixty (60) of these were resubmissions of nil declarations, and all were marked as 2023/24 financial year. The time between submissions ranged from one day to six months.
- Declaration approval rates - only 9% of all declarations, and 11% for declarations made by decision makers, have been approved by line managers – we acknowledge that the approval feature was only activated mid-February 2024. However, removing the nil declarations marked "N/A" (not applicable) for approval, increases the approval rate to 74% and 70% respectively. OBS02 does not explicitly state expectations regarding the approval of nil returns, though we noted that the Head of Corporate Affairs requested the approver feature turned on for all positive and nil declarations in communications with Civica. If all declarations (both positive and nil) are to be approved, the option to select "N/A" should be removed.
- The following tables show declarations by type, approval status, and approved declarations as a percentage of total. The data shows the significant impact that the lack of approval / "approval N/A" status for nil declarations has on the overall approval rate. Table 3 shows declaration data of all BCU staff, whilst Table 4 shows the data for submissions made by decision makers. All data has been adjusted for duplicate entries.

Table 3: Declarations of interest / approvals by type (All submissions) as of 22 April 2024

Declaration Type	Approval N/A	Approval NO	Approval Pending	Approved	Total (% approved)
Loyalty Interests			10	30	**40 (75%)**
Outside Employment			23	60	**83 (72%)**
Shareholdings and other ownership interests			3	4	**7 (57%)**
Nil Declaration	1,797		14	55	**1,866 (3%)**

Sponsored Posts				1	**1 (100%)**
Clinical Private Practice		2	9	26	**37 (70%)**
Total	**1,797**	**2**	**59**	**176**	**2,034 (9%)**

Source: Declare report provided by OBS – raw data comprising all declarations recorded on system

Table 4: Declarations of interest / approvals by type (Decision Maker submissions) as of 22 April 2024

Declaration Type	Approval N/A	Approval NO	Approval Pending	Approved	Total (% approved)
Loyalty Interests			9	14	**23 (61%)**
Outside Employment			12	28	**40 (70%)**
Shareholdings and other ownership interests			3	2	**5 (40%)**
Nil Declaration	613		6	23	**642 (4%)**
Sponsored Posts				1	**1 (100%)**
Clinical Private Practice			2	8	**10 (80%)**
Total	**613**		**32**	**76**	**721 (11%)**

Source: Declare report provided by OBS – raw data comprising all declarations recorded on system

- OBS02 states that, *"Declarations of interest are reviewed by the relevant Directorate Governance Lead… Governance Leads are responsible for escalating any concerns to the relevant line manager"*.

  We contacted the Governance Leads for IHC East, IHC Central, IHC West, and pan-North Wales Womens Services, to establish their role and responsibilities regarding declarations of interest, gifts, and hospitality. The four Governance Leads confirmed that they do not have any operational responsibilities regarding the review, approval, and/or monitoring of staff declarations of interest, gifts and hospitality, or for escalating issues or concerns to line managers.

2.19 We confirmed that the Local Counter Fraud Team review relevant declarations of interest as part of their investigation process – progress updates are reported to the Audit Committee.

Conclusion:

2.20 All Board Members have submitted declarations of interest for the 2023/24 financial year and the Office of the Board Secretary have undertaken due diligence checks to ensure the information submitted is accurate and comprehensive.

Whilst this is good practice, checks should not be limited to year-end only (i.e. to support the Annual Accountability Report) but rather should be incorporated into routine working practice. The due diligence work identified seven Board Members with undeclared interests – at the time of writing the identified interests had not been added to the public register. Board Members should be reminded of their mandated obligation to declare all interests and inform the Office of the Board Secretary of any changes as they arise.

2.21 The data extracted from the Declare system shows that a significant number of staff are now utilising the system to record their declarations. Whilst we were unable to accurately determine the overall rate of submission compliance from the data provided, we did note declarations have not been consistently approved in compliance with requirements. We acknowledge that the line manager approval feature within Declare has only recently been activated – this should ensure approval rates improve going forward however it is not clear whether managers will be required to retrospectively approve previous submissions. Other issues identified, including duplicate entries and repeat submissions within a short time period must be addressed to ensure accurate reporting.

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

Objective 4: Submissions of Gifts and Hospitality are reviewed to ensure they are in line with policy requirements, and suitable action taken where issues are identified.

2.22 The following tables provide an overview of declared gifts and hospitality submitted by Health Board staff between system inception and 22 April 2024. As with declarations of interest above, the data has been extracted from a Civica Declare report of all declarations recorded. Table 5 shows all staff gift and hospitality declaration data, whilst Table 6 shows the data for submissions made by decision makers. Note that we have included declarations categorised as Sponsored Events as the interest descriptions were consistent with hospitality.

Table 5: Gifts, Hospitality, Sponsored Events declarations / approvals by type (All submissions) as of 22 April 2024

Declaration Type	Approval Pending	Approved	Total (% approved)
Gifts	4	21	25(84%)
Sponsored Events	2	9	11(82%)
Hospitality	5	10	15(67%)
Total	**11**	**40**	**51(78%)**

Source: Declare report provided by OBS – raw data comprising all declarations recorded on system

Table 6 Gifts, Hospitality, Sponsored Events declarations / approvals by type (Decision Maker submissions) as of 22 April 2024

Declaration Type	Approval Pending	Approved	Total (% approved)
Gifts	0	3	**3(100%)**
Sponsored Events	1	7	**8(88%)**
Hospitality	1	9	**10(90%)**
Total	**2**	**19**	**21(90%)**

Source: Declare report provided by OBS – raw data comprising all declarations recorded on system

We reviewed the data and noted the following issues and limitations:

- We were unable to verify or review the monetary value of gifts and hospitality declarations as the field was not included in the report provided – though some staff members had included the monetary value within the interest description free-text field. Other relevant Declare data fields omitted from the report were the gift declined / donated to charity checkboxes, the reason for declining gift field, and the date of line manager approval.
- The provider details for eleven (11) of the twenty-five (25) gift declarations were marked as "Overwritten for Data Protection". It is not clear whether this was specified in the initial declarations, or if the field was amended for reporting purposes. However, provider details must be recorded to enable effective monitoring in line with policy requirements.
- Approval rates for gifts, hospitality, and sponsored event declarations are significantly higher than for declarations of interest, though the overall number of individual declarations are also much smaller. The data showed that 78% of all relevant declarations had been approved, increasing to 90% for declarations made by decision makers.
- A named approver (line manager) was recorded for each gift, hospitality, and sponsored event declaration – we confirmed that users cannot submit their declarations on Declare without specifying an approver / line manager. All relevant declarations were either approved or noted as approval pending (none were declined). However, several of those pending approval were not recent submissions - eight (8) of the eleven (11) submissions were declared between 1 September 2023 and 3 January 2024, with the remaining three having been declared on 23 February 2024.

2.23 Despite the high approval rate, the data indicates that declarations of hospitality and sponsored events are not submitted and approved in accordance with policy requirements. OBS02 states that, for acceptable hospitality:

"…These types of hospitality must be approved by a Director/Assistant Director and recorded on the gifts and hospitality register in advance of acceptance".

Not all relevant declarations were subject to Director / Assistant Director approval, and we are unable to confirm that all declarations were approved prior to acceptance and / or the event taking place. We noted the following:

- Key date information provided was limited to Date Declared, Date Arose field, and whether the submission was approved or not. Date of approval and event date were not included in the data set.
- The Date Arose field is not used consistently – some staff members have used the field to record the actual date of the event (confirmed for five declarations that included the event date in the description narrative), whilst we believe others may be using the field to record the date the offer was made (based solely on the narrative date not matching the Date Arose field).
- Of the twenty-six (26) hospitality and sponsored event declarations, only six (6) included the event, conference, committee, seminar etc. date in the Interest Description field. Of these, five matched the Date Arose field. This is significant as the recorded Date Arose precedes the Date Declared for all hospitality and sponsored event declarations. This implies that each of the five declarations noted above were accepted and attended prior to being declared, reviewed, or approved. We have not established whether approval was sought and granted informally / outside of Declare.
- The variance between the recorded Date Arose field and Date Declared ranged from the same day (2 declarations) to 139 days.
- Most of the hospitality and sponsored event declarations related to provision (conference fees, venue costs, travel, and accommodation costs etc) for attendance at relevant conferences, committees, training courses, seminars etc. However, we noted two declarations that did not meet the acceptable criteria per OBS02 – interest descriptions were, "Invitation to Christmas night out" (declared 4 December 2023) and "Lunch at Aintree on Grand National Opening Day" (declared 23 February 2024). Both submissions were noted as pending approval.

2.24 As noted above (Par 2.22) IHC Governance Leads do not routinely review declarations of gifts and hospitality. However, the Associate Director of Governance advised that all gift and hospitality declarations are actively reviewed by the Office of the Board Secretary, and bi-monthly meetings are held with the Local Counter Fraud Team to scrutinise all submissions to ensure appropriateness.

Conclusion:

2.25 The high approval rate demonstrates that gift and hospitality declarations are reviewed by line management, and independent oversight and scrutiny is

provided by the Office of the Board Secretary and Local Counter Fraud Team who periodically review all submissions.

2.26 However, several declarations remain pending approval despite not being recent submissions, including two declarations that meet the criteria of unacceptable hospitality per OBS02 (based on the interest description). We also found that declarations are not submitted in a timely manner – we noted five examples whereby hospitality and sponsored events had been accepted and attended prior to being declared and approved via Declare.

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

Appendix A: Management Action Plan

Matter Arising 1: Policy (Design)		**Impact**
We reviewed existing policy OBS02 Standards of Business Conduct and found the following issues and limitations: • OBS02 does not reflect current working practice / declaration system. The policy references previous declaration system. • Minor continuity errors. • Lack of clarity regarding mandated declarations of interest by staff that fall outside documented pay band thresholds.		Potential risk of: • Ineffective/inappropriate governance and management arrangements. • Staff not aware of, or do not understand, their responsibilities regarding declarations of interest, and gifts and hospitality.
Recommendations		**Priority**
1.1	Management: • Update policy to reflect current working practice and systems. • Ensure that the requirements regarding mandatory annual declarations of interest for staff that fall outside the documented pay band thresholds are clearly stated.	**High**
1.2	Management: • Communicate operational requirements and ensure that relevant staff groups are aware of their responsibilities (e.g. role of line managers and Governance Leads in reviewing, approving, and escalating issues of concern).	**Medium**

Agreed Management Action		Target Date	Responsible Officer
1.1	• Review and update Policy to ensure that it is in line with the rest of Wales • Review Policy to ensure that the pay bands are consistent with the rest of Wales • Discuss and agree with the Workforce Directorate ways in which the annual declarations of interest can be embedded into existing mechanisms.	31 July 2024	Head of Corporate Affairs
1.2	• Communication briefing to all managers on responsibilities in relation to Declarations of Interest	30 September 2024	Head of Corporate Affairs

Matter Arising 2: Declare System (Operation)	**Impact**
In May 2022 the Health Board purchased the Civica Declare system to manage staff declarations. The system was not implemented until August 2023 despite the Health Board incurring implementation fees. We reviewed implementation and noted the following limitations, recognising that some system features were only recently activated: • Scheduled notifications and management approval activated March 2024 - we were unable to confirm that all scheduled notifications were operating as intended – the recipients of two of the eleven scheduled notifications were marked as "test email". • We were unable to reconcile declaration data published on the Declare portal site to source data. We also noted that the financial year filter was not aligning with the BCU financial year (1 April – 31 March). • System embedded guidance documents are all NHS England documentation.	Potential risk of: • Misuse / inefficient use of public funds. • Underutilised system. • System features not functioning as intended, and not picked up by Health Board. • Inaccurate reporting and lack of transparency. • Staff relying on non-NHS Wales / Health Board guidance documents.

Recommendations		Priority
2.1	Management: • Ensure all scheduled notifications are functioning as intended. • Ensure published data is accurate and can be reconciled to source data. • Ensure published guidance documentation is consistent with NHS Wales requirements and relevant to Health Board staff.	**High**

Agreed Management Action		Target Date	Responsible Officer
2.1	• Review monthly scheduled notifications	30 June 2024	Head of Corporate Affairs
	• Review monthly published data to ensure that it is accurate and can be reconciled to source data.	30 June 2024	Head of Corporate Affairs
	• Review published guidance documentation is consistent with NHS Wales requirements and relevant to Health Board staff. A meeting with Declare has already been arranged for Friday 14 June 2024	30 June 2024	Head of Corporate Affairs

Matter Arising 3: Audit Committee Reporting (Operation)	**Impact**
During 2023/24 the reporting of declarations of interest, gifts and hospitality to the Audit Committee did not meet policy requirements. We reviewed Audit Committee minutes and noted the following: • OBS02 states that registers should be submitted and reviewed by the Audit Committee bi-annually – however 2024/25 cycle of business limits this to annual review.	Potential risk of: • Lack of oversight and scrutiny. • Audit Committee unsighted on issues of significance. • Failure to meet policy / cycle of business requirements.

• Declarations of interest and gifts and hospitality registers were scheduled for inclusion in the March 2024 Audit Committee – however, there weas no evidence that the registers were submitted or reviewed at the March 2024 Audit Committee. • Limited performance / compliance data reported to the Audit Committee for scrutiny. • Registers linked in September 2023 Audit Committee (declarations of interest, gifts and hospitality) were limited to Board Member submissions only.			
Recommendations			**Priority**
3.1	Management: • Review reporting arrangements and ensure staff declarations are subject to Audit Committee oversight and scrutiny in line with policy requirements.		**High**
Agreed Management Action		**Target Date**	**Responsible Officer**
3.1	• Update Cycles of business and submit to the Audit Committee twice a year	18 July 2024	Head of Corporate Affairs

Matter Arising 4: Board Members declarations of interest (Operation)	**Impact**
We reviewed Board Member declarations of interest, submitted via manual returns, and found the following issues and limitations: • The due diligence work undertaken by the Office of the Board Secretary identified seven Board Members with undisclosed interests. Six of the seven omissions related to directorship roles within other organisations.	Potential risk of: • Breach of Standing Orders and failure to comply with policy requirements. • Conflicts of interest due to undeclared interests. • Lack of transparency.

• The published public register had not been updated with the undisclosed interests at the time of review. • Not all published declarations relating to external employment provide sufficient detail of role. We noted two instances whereby Board Member' declarations were limited to "employed by…", despite their employment relating to senior / Director level positions within the respective organisations. • Two previous Board Members in post during 2023/24 were not included in the public register – both individuals left their position in April 2023.	• Reputational damage / adverse public opinion.

Recommendations		**Priority**
4.1	The Director of Corporate Governance: • Ensures Board Member declarations are accurate and comprehensive throughout the year – not limit due diligence work to year-end. • Reminds Board Members of the requirement to declare all outside employment as part of their mandatory annual declaration of interest, and to notify the Office of the Board Secretary (Corporate Governance Directorate April 2024 onwards) of any changes as and when they arise. • Ensures the public register of Board Member interests is maintained and kept up to date.	**High**

Agreed Management Action		**Target Date**	**Responsible Officer**
4.1	• Monitor and review declarations on a weekly basis • Produce a targeted communication campaign and implement • Any changes to Board Member interests will be uploaded publicly when received. Accurate as of 1 June 2024	30 June 2024 Ongoing	Head of Corporate Affairs Head of Corporate Affairs

Matter Arising 5: BCU staff declarations of interest (Operation)	**Impact**
We reviewed Health Board staff declarations of interest data (submitted via Declare) and found the following issues and limitations: • Low approval rate (9% for all declarations, and 11% for declarations made by Decision Makers) – we acknowledge that the line manager approval feature was only recently activated. • A significant number (1,797) of nil declarations have been marked as approval not applicable – adversely impacting the overall approval rate. • We found twenty (20) duplicate entries within the source Declare report. • We identified a further sixty-one (61) instances where staff had made the same declaration within a short period of time – sixty (60) of these were resubmissions of nil declarations, all noted as 2023/24. The time between submissions ranged from one day to six months.	Potential risk of: • Failing to adhere with policy requirements. • Conflicts of interest due to undeclared interests. • Lack of accountability. • Inaccurate reporting.

Recommendations		**Priority**
5.1	Management: • Ensure line mangers are aware of their responsibilities regarding approving declarations of interest (and gifts and hospitality). • Ensure staff understand when, and how often, a declaration should be made. • Establish controls and /or oversight arrangements to manage and escalate non-responses (from Decision Makers) and failure to approve (by line managers). • Ensure data extracted from Declare is reviewed and adjusted appropriately prior to reporting (e.g. to Audit Committee).	**High**

Agreed Management Action		Target Date	Responsible Officer
5.1	• Draft a new communication plan and SOP for Declarations to include flow charts so that Managers are clear about their responsibilities. • Work with the Workforce Directorate on options around including Declarations on PADR templates • Regularly review Declarations and identify and escalate non-responses (from Decision Makers) and failure to approve (by line managers)	30 September 2024	Head of Corporate Affairs

Matter Arising 6: Gifts, Hospitality, and Sponsored Events (Operation)	**Impact**
We reviewed gift, hospitality, and sponsored event declarations submitted by staff and found the following issues and limitations: • Not all declarations of hospitality and sponsored events are submitted and approved in accordance with policy requirements. • Only nine (9) of the twenty-six (26) hospitality and sponsored event declarations were subject to Director / Assistant Director approval (a further three (3) were pending approval). • We found five (5) examples of hospitality / sponsored events that had been accepted and attended prior being declared / approved. These findings are limited to declarations whereby staff have included the event date(s) in the interest description field. • All declarations were noted as either approved or pending approval – none were recorded as declined or not approved. We found two submissions that meet the unacceptable hospitality criteria – both were marked pending approval. • None of the declarations marked pending approval were recent submissions – the most recent being declared 23 February 2024. • The date arose field in Declare is not used consistently – some staff have recorded the event date in	Potential risk of: • Failure to comply with policy requirements, financial abuse, fraud. • Conflicts of interest due to undeclared interests.

	the field, whilst others have use it to record the offer date. • The provider details for eleven (11) of the twenty-five (25) gift declarations were marked as "Overwritten for Data Protection". It is not clear whether this was specified in the initial declarations, or if the field was amended for reporting purposes.		
Recommendations			**Priority**
6.1	Management: • Ensure all offers of hospitality and sponsored events are declared, reviewed, and approved prior to attending per policy requirements. All retrospective declarations to be escalated. • All hospitality and sponsored events to be approved by a Director / Assistant Director. • Ensure all declarations pending approval are reviewed and approved / declined. • Ensure provider details are recorded to enable effective monitoring per policy requirements.		**High**
Agreed Management Action		**Target Date**	**Responsible Officer**
6.1	• Reviewed gift, hospitality, and sponsored event declarations and produce a SOP and flow chart to ensure clarity. • Produce a communications plan to raise awareness and compliance	31 October 2024	Head of Corporate Affairs

Appendix B: Assurance opinion and action plan risk rating

Audit Assurance Ratings

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

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

Prioritisation of Recommendations

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

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

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

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

Teitl adroddiad: ***Report title:***	**NHS Wales Shared Services Partnership – Post Payment Verification (PPV) Annual Assurance Report 2023/24**
Adrodd i: ***Report to:***	Audit Committee
Dyddiad y Cyfarfod: ***Date of Meeting:***	Thursday, 18 July 2024
Crynodeb Gweithredol: ***Executive Summary:***	NHS Wales Shared Services Partnership present this Post Payment Verification (PPV Annual Assurance Report for 2023/24 to the Committee which relates to the work undertaken on behalf of the Health Board to verify claims from General Medical Services (GMS), General Ophthalmic Services (GOS) and General Pharmaceutical Services (GPS). The purpose of the PPV process is to provide assurance to Health Boards that the claims for payment made by primary care contractors are appropriate and that the delivery of the service is as defined by NHS service specification and relevant legislation. PPV provides assurance in all contractor disciplines, except for General Dental Services, which is undertaken by the NHS Business Services Authority (England). During 2023-2024, PPV began recovering from the backlog of work, due to a new payment system within Primary Care Services (PCS) and the inability for practices to submit NHS numbers to evidence their claims. This system was developed and enhanced which allowed the PPV Team to return to business as usual in April 2023, and has maintained an excellent level of PPV, which continues to provide Health Boards with reasonable assurance that public monies are being appropriately claimed. The following key points should be noted: **General Medical Services (GMS):** The PPV Team managed to complete all 184 routine visits across Wales with 47 for BCUHB. Regarding the revisits that were due in 2023-2024, and due to the focus on routine visits along with Ad-hoc requests, the Team only managed to carry out a small number across Wales with 4 completed for BCUHB. In 2024/25, the PPV Team will be concentrating on all outstanding revisits, and if a revisit is due at the same time as the routine, then an 'extended visit' which means 10% of the claims for the routine and 100% check on the services that were triggered in the initial routine. **General Ophthalmic Services (GOS):** PPV began remote access options having full support from Optometry Wales and carried out a small percentage of virtual visits via Microsoft TEAMS, which proved successful. Unfortunately, this was more gradual than anticipated due to the lack of electronic patient records. Future visits will now be included in the 2024-2025 visit plan and is still changeable, and although the Team are hoping to increase the number of remote visits, they will also incorporate physical visits to carry through this transition period of electronic patient records, which is being encouraged by Welsh Government. **General Pharmacy Services (GPS):** During 2023/24 the PPV Team introduced a new service check after a successful pilot, which was the Quality and Safety Scheme and completed all visits planned. The Team are also beginning the Collaborative Working Scheme verification this upcoming financial year 2024-2025. The Team can verify both these services remotely and are also investigating other avenues for PPV in GPS and beginning another pilot early this year. **Additional Services:** After technical issues with dispensing Data checks, and further development, the Team can now progress with quarterly provision of these reports Nationally across Wales. Clinical Waste Self Assessments were piloted for GMS and have been live this last year to ensure compliance with legislation. The PPV Team are hoping to conduct a pilot with the Self Assessments for Pharmacies in 2024-2025. The

	Team are also investigating other avenues of savings from the provision of Clinical Waste services and now planning on producing a 'non-collection' 6 monthly report to all Health Boards. There are bi-monthly National GMS, GOS Working Group meetings with Primary Care Managers and PPV to discuss and agree any issues regarding the National application of the programme. PPV are planning to commence a National GPS Working Group to align with the above which has proved successful. PPV training events and roadshows to Practice Managers have been delivered locally and the Team now record these in advance, based on trend data analysis. In addition to facilitating training requirements, particularly for new practice managers, we created a video recorded guide for both GOS and GMS.			
Argymhellion: ***Recommendations:***	The Audit Committee is asked to review, note and seek assurance that the Post Payment Verification cycle is being managed appropriately.			
Arweinydd Gweithredol: ***Executive Lead:***	Russel Caldicott, Interim Executive Director of Finance			
Awdur yr Adroddiad: ***Report Author:***	NHS Wales Shared Services Partnership: Amanda Legge, All Wales, Post Payment Verification Manager Health Board Lead: Andrea J Hughes, Interim Finance Director - Operational			
Pwrpas yr adroddiad: ***Purpose of report:***	I'w Nodi *For Noting* ☒	I Benderfynu arno *For Decision* ☐	Am sicrwydd *For Assurance* ☒	
Lefel sicrwydd: ***Assurance level:***	Arwyddocaol *Significant* ☐	Derbyniol *Acceptable* ☒	Rhannol *Partial* ☐	Dim Sicrwydd *No Assurance* ☐
	Lefel uchel o hyder/tystiolaeth o ran darparu'r mecanweithiau / amcanion presennol *High level of confidence/evidence in delivery of existing mechanisms/objectives*	Lefel gyffredinol o hyder/tystiolaeth o ran darparu'r mecanweithiau / amcanion presennol *General confidence / evidence in delivery of existing mechanisms / objectives*	Rhywfaint o hyder/tystiolaeth o ran darparu'r mecanweithiau / amcanion presennol *Some confidence / evidence in delivery of existing mechanisms / objectives*	Dim hyder/tystiolaeth o ran y ddarpariaeth *No confidence / evidence in delivery*
Cyfiawnhad dros y gyfradd sicrwydd uchod. Lle bo sicrwydd 'Rhannol' neu 'Dim Sicrwydd' wedi'i nodi uchod, nodwch gamau i gyflawni sicrwydd 'Derbyniol' uchod, a'r terfyn amser ar gyfer cyflawni hyn: ***Justification for the above assurance rating. Where 'Partial' or 'No' assurance has been indicated above, please indicate steps to achieve 'Acceptable' assurance or above, and the timeframe for achieving this:***				
Cyswllt ag Amcan/Amcanion Strategol: ***Link to Strategic Objective(s):***	Standing Orders, Standing Financial Instructions and the Scheme of Reservation and Delegation are designed to ensure that expenditure is committed in line with stipulated governance and incurred on the intended purpose.			

Goblygiadau rheoleiddio a lleol: ***Regulatory and legal implications:***	Public procurement law regulates the purchasing by public sector bodies and certain utility sector bodies of contracts for goods, works and services.
Yn unol â WP7, a oedd EqIA yn angenrheidiol ac a gafodd ei gynnal? ***In accordance with WP7 has an EqIA been identified as necessary and undertaken?***	Not applicable
Yn unol â WP68, a oedd SEIA yn angenrheidiol ac a gafodd ei gynnal? ***In accordance with WP68, has an SEIA identified as necessary been undertaken?***	Not applicable
Manylion am risgiau sy'n gysylltiedig â phwnc a chwmpas y papur hwn, gan gynnwys risgiau newydd (croesgyfeirio at y BAF a'r CRR) ***Details of risks associated with the subject and scope of this paper, including new risks(cross reference to the BAF and CRR)***	BAF: 2.3 & CRR 24-05 – Delivery of the Annual Financial Plan.
Goblygiadau ariannol o ganlyniad i roi'r *argymhellion ar waith* ***Financial implications as a result of implementing the recommendations***	Management of financial risk of not achieving value for money.
Goblygiadau gweithlu o ganlyniad i roi'r argymhellion ar waith ***Workforce implications as a result of implementing the recommendations***	None
Adborth, ymateb a chrynodeb dilynol ar ôl ymgynghori ***Feedback, response, and follow up summary following consultation***	Not applicable
Cysylltiadau â risgiau BAF: (neu gysylltiadau â'r Gofrestr Risg Gorfforaethol) ***Links to BAF risks:*** *(or links to the Corporate Risk Register)*	BAF: 2.3 & CRR 24-05 – Delivery of the Annual Financial Plan.
Rheswm dros gyflwyno adroddiad i fwrdd cyfrinachol (lle bo'n berthnasol) ***Reason for submission of report to confidential board (where relevant)***	Not applicable
Camau Nesaf: **Gweithredu argymhellion** ***Next Steps:*** ***Implementation of recommendations*** • The report is for discussion, noting and assurance.	
Rhestr o Atodiadau: ***List of Appendices:*** 1. NHS Wales Shared Services Partnership – Post Payment Verification Annual Assurance Report 2023/24	

Appendix 1: NHS Wales Shared Services Partnership – Post Payment Verification Annual Assurance Report 2023/24

Situation:

NHS Wales Shared Services Partnership present this Post Payment Verification (PPV Annual Assurance Report for 2023/24.

The purpose of the PPV process is to provide assurance to Health Boards that the claims for payment made by primary care contractors are appropriate and that the delivery of the service is as defined by NHS service specification and relevant legislation. PPV provides assurance in all contractor disciplines, General Medical Services (GMS), General Ophthalmic Services (GOS) and General Pharmaceutical Services (GPS), except for General Dental Services, which is undertaken by the NHS Business Services Authority (England).

Background:

During 2023-2024, PPV began recovering from the backlog of work, due to a new payment system within Primary Care Services (PCS) and the inability for practices to submit NHS numbers to evidence their claims. This system was developed and enhanced which allowed the PPV Team to return to business as usual in April 2023, and has maintained an excellent level of PPV, which continues to provide Health Boards with reasonable assurance that public monies are being appropriately claimed.

Actions:

General Medical Services (GMS): Due to the backlog of PPV work across Wales, a visit plan was created for 2023-2024 to try to complete as many visits as possible with the aim of condensing the normal 3-year rolling plan into 2 years. The PPV Team managed to complete all 184 routine visits across Wales with 47 for BCUHB. Regarding the revisits that were due in 2023-2024, and due to the focus on routine visits along with Ad-hoc requests, the Team only managed to carry out a small number across Wales with 4 completed for BCUHB. In 2024/25, the PPV Team will be concentrating on all outstanding revisits, and if a revisit is due at the same time as the routine, then an 'extended visit' which means 10% of the claims for the routine and 100% check on the services that were triggered in the initial routine.

General Ophthalmic Services (GOS): The visit plan for GOS 2023-2024 was not finalised after explaining to Health Boards that these visits were subject to change due to a new way of verifying claims. PPV began remote access options having full support from Optometry Wales and carried out a small percentage of virtual visits via Microsoft TEAMS, which proved successful. Unfortunately, this was more gradual than anticipated due to the lack of electronic patient records. Future visits will now be included in the 2024-2025 visit plan and is still changeable, and although the Team we are hoping to increase the number of remote visits, it will also incorporate physical visits to carry us through this transition period of electronic patient records, which is being encouraged by Welsh Government.

General Pharmacy Services (GPS): During 2023/24 the PPV Team introduced a new service check after a successful pilot, which was the Quality and Safety Scheme and completed all visits planned. The Team are also beginning the Collaborative Working Scheme verification this upcoming financial year 2024-2025. The Team can verify both these services remotely and are also investigating other avenues for PPV in GPS and beginning another pilot early this year.

Additional Services: After technical issues with dispensing Data checks, and further development, the Team can now progress with quarterly provision of these reports Nationally across Wales. From the

pilot carried out and informing practices of the regulations surrounding dispensing eligibility, the data shows the future success of this service.

Clinical Waste Self Assessments were piloted for GMS and have been live this last year to ensure compliance with legislation. The PPV Team are hoping to conduct a pilot with the Self Assessments for Pharmacies in 2024-2025. The Team are also investigating other avenues of savings from the provision of Clinical Waste services and now planning on producing a 'non-collection' 6 monthly report to all Health Boards.

There are bi-monthly National GMS, GOS Working Group meetings with Primary Care Managers and PPV to discuss and agree any issues regarding the National application of the programme. PPV are planning to commence a National GPS Working Group to align with the above which has proved successful. PPV training events and roadshows to Practice Managers have been delivered locally and the Team now record these in advance, based on trend data analysis. In addition to facilitating training requirements, particularly for new practice managers, we created a video recorded guide for both GOS and GMS.

Recommendation:

This report provides the narrative for what PPV, Primary Care, Finance and Counter Fraud consider to be the best approach to support practices in improving. The activity promotes value for money by deterring and preventing fraud and loss. The Committee is asked to note and take assurance from this annual report.

Audit Report - 1st April 2023 to 31st March 2024 = Betsi Cadwaladr University Health Board

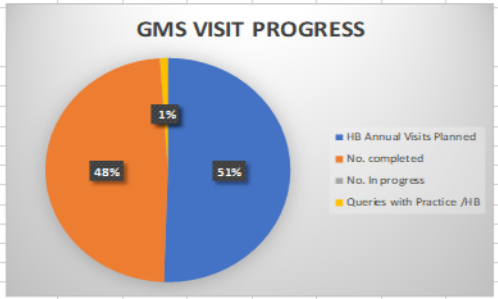
To Note:

Above planned numbers were sent to HB for 23/24 Visit Plan. Numbers may change due to ad hoc visits or closures/mergers
Health Board and Counter Fraud receive copies of each visit report to act upon PPV recommendations
PPV work collaboratively with Health Board managers and Local Counter Fraud to assist with any concerns that may arise
Training/support is provided to practices after visit where necessary

GMS	Visit Type	HB Annual Visits Planned	No. completed	No. In progress	Queries with Practice /HB	No. Recoveries	Value of recoveries	All Wales Completed	All Wales No. in progress	All Wales Planned	All Wales Value of Recoveries
	Routine	49	47	0	1	1250	£25,853.92	167	6	172	£132,837.93
	Revisit	39	4	0	3	1602	£24,039.47	26	3	136	£65,253.30
	Total	88									

Summary of themes/findings/issues

Due to the new payment system, all Revisits across Wales were on hold until Dec 2023



GOS	Visit Type	Annual Visits Planned	No. completed	No. In progress	Queries with Practice /HB	No. Recoveries	Value of recoveries	All Wales Completed	All Wales No. in progress	All Wales Planned	All Wales Value of Recoveries
	Routine	66	3	0	0	25	£1,415.50	44	0	301 Rolling Plan	£5,584.06
	Revisit	4	0	0	0	0	0	0	0	6	£0.00
	Total	70									

Summary of themes/findings/issues

As contractors are transistioning to electronic records, remote access visits were slow in progressing.

GPS	Visit Type	Annual Visits Planned	No. completed	No. In progress	Queries with Practice /HB	No. Recoveries	Value of recoveries	All Wales Completed	All Wales No. in progress	All Wales Planned	All Wales Value of Recoveries
Q&S Scheme	Routine	50	50	0	0	0	£0.00	229	0	229	£0.00
	Total	50									

Summary of themes/findings/issues

Nothing to report at this stage

Teitl adroddiad: ***Report title:***	**Conformance Report: Q1 2024/25**
Adrodd i: ***Report to:***	Audit Committee
Dyddiad y Cyfarfod: ***Date of Meeting:***	Thursday, 18 July 2024
Crynodeb Gweithredol: ***Executive Summary:***	This conformance report provides an update to the Committee on areas that relate to regulatory compliance or assurance and good practice expectations. The areas covered in this report are: • **Purchase orders that are non-compliant with SFI's (April to June 2024)** This data set relates to orders being raised after the invoice has been received. There has been a reduction in non-compliance during the quarter, with 318 in April, 261 in May and 179 in June. The total 758 breaches during quarter 1 (Q1) is a material improvement compared to 1,460 in Q1 2023-24. A significant proportion of the orders are for known expenditure such as out of area treatments, Royal Mail postal collections framework agreement and Medical and Dental Agency; however, the variable nature of the volume means that retrospective orders are produced. Departments in which the breach arose, are reminded of the SFI requirements and are required to take action to ensure future breaches do not re-occur. Reminder bulletins on financial instructions are included in Procurement communications and these reiterate to staff that they must have approval before committing expenditure. NHS Wales Shared Services Partnership (NWSSP) are working with the Health Board to implement a new process involving 'File Notes' to capture and record instances of procurement spend outside of the SFIs/Scheme of Reservation and Delegation (SoRD). This will further improve the information reported to the Audit Committee and will enable improved targeted intervention. NHS Wales Shared Services Partnership are currently reviewing the purchase order (PO) exemption list as part of the updated No Purchase Order No Pay Policy on behalf of NHS Wales with the intention of obtaining final approval during Quarter 2. • **Single Waivers (April to June 2024)** There has been a significant decrease in the number of approved waivers. Single Tenders – 7 approved in Q1, compared to 28 last year. Single Quote – 1 approved in Q1, compared to 23 last year. • **Receivables and conformance with payroll procedures** The Health Board has procedures in place to ensure that balances owed to the Health Board are invoiced promptly. Escalation procedures are in place to ensure that debtors are collected in a timely manner or highlighted for further action. As at 30th June 2024, there were 3,279 outstanding invoices, totalling £13.5m, of which 632 invoices, totalling £7.3m were less than 30 days old.

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

For the period April to June 2024 there were 163 staff overpayments, with a gross value of £0.413m, compared to 168 and £0.427m in the previous year. Failure to complete forms on time remains the main cause of overpayments (139 cases). Staff overpayment breaches are included in service/area monthly management reports and discussed as part of the budget monitoring process in order to improve future compliance.

To mitigate future overpayments the Establishment Control Team has implemented a process that includes reminders, monthly reviews and follow up reports to divisions.

NHS Wales Shared Services Partnership are currently in the process of agreeing an all Wales overpayment procedure that should strengthen the Health Boards current governance and processes on recovering salary overpayments.

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

As at 30th June 2024 the balance outstanding was £1.222m, compared to £1,138m 30th June 2023.

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

The Health Board aims to ensure that all balances are paid within 30 days of receipt of a valid payable invoice. Best Practice (by number) is set at 95%. The year to date achievement for non-NHS invoices by number is 94.6%. Whilst marginally below 95% at Q1, the expectation is that the target will be achieved by year end.

- **Losses and special payments**

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

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

Clinical negligence claims are managed by Legal and Risk Services and there were 308 active claims at the end of June 2024. Of these 120 matters were assessed as either probable or certain of settlement with a cumulative estimated value of £168m (before reimbursement from the Welsh Risk Pool).

- **No Chairs Action in Quarter 1 2024/25**

Argymhellion: ***Recommendations:***	The Audit Committee is asked to: 1. To note and discuss the below elements of performance • Purchase orders that are non-compliant with SFI's • E-Waiver System Developments and Single Waivers • Receivables and conformance with payroll procedures • Payables and conformance with Public Sector Payment Policy (PSPP) 2. Approve the Losses and Special Payments (April to June 2024)			
Arweinydd Gweithredol: ***Executive Lead:***	Russel Caldicott, Interim Executive Director of Finance			
Awdur yr Adroddiad: ***Report Author:***	Denise Roberts, Head of Capital, Business Improvement and Compliance Andrea J Hughes, Interim Finance Director – Operational			
Pwrpas yr adroddiad: ***Purpose of report:***	I'w Nodi *For Noting* ☒	I Benderfynu arno *For Decision* ☒	Am sicrwydd *For Assurance* ☒	
Lefel sicrwydd: ***Assurance level:***	Arwyddocaol *Significant* ☐	Derbyniol *Acceptable* ☒	Rhannol *Partial* ☐	Dim Sicrwydd *No Assurance* ☐
	Lefel uchel o hyder/tystiolaeth o ran darparu'r mecanweithiau / amcanion presennol *High level of confidence/evidence in delivery of existing mechanisms/objectives*	Lefel gyffredinol o hyder/tystiolaeth o ran darparu'r mecanweithiau / amcanion presennol *General confidence / evidence in delivery of existing mechanisms / objectives*	Rhywfaint o hyder/tystiolaeth o ran darparu'r mecanweithiau / amcanion presennol *Some confidence / evidence in delivery of existing mechanisms / objectives*	Dim hyder/tystiolaeth o ran y ddarpariaeth *No confidence / evidence in delivery*
Cyfiawnhad dros y gyfradd sicrwydd uchod. Lle bo sicrwydd 'Rhannol' neu 'Dim Sicrwydd' wedi'i nodi uchod, nodwch gamau i gyflawni sicrwydd 'Derbyniol' uchod, a'r terfyn amser ar gyfer cyflawni hyn: ***Justification for the above assurance rating. Where 'Partial' or 'No' assurance has been indicated above, please indicate steps to achieve 'Acceptable' assurance or above, and the timeframe for achieving this:***				

Cyswllt ag Amcan/Amcanion Strategol: ***Link to Strategic Objective(s):***	Standing Orders, Standing Financial Instructions and the Scheme of Reservation and Delegation are designed to ensure that expenditure is committed in line with stipulated governance and incurred on the intended purpose.
Goblygiadau rheoleiddio a lleol: ***Regulatory and legal implications:***	Areas of identified non-conformance highlight risk of failing to meet regulatory and legal requirements, and expected good practice. Mitigating actions are designed to manage highlighted risks effectively.
Yn unol â WP7, a oedd EqIA yn angenrheidiol ac a gafodd ei gynnal? ***In accordance with WP7 has an EqIA been identified as necessary and undertaken?***	Not applicable
Yn unol â WP68, a oedd SEIA yn angenrheidiol ac a gafodd ei gynnal? ***In accordance with WP68, has an SEIA identified as necessary been undertaken?***	Not applicable

Manylion am risgiau sy'n gysylltiedig â phwnc a chwmpas y papur hwn, gan gynnwys risgiau newydd (croesgyfeirio at y BAF a'r CRR) ***Details of risks associated with the subject and scope of this paper, including new risks(cross reference to the BAF and CRR)***	BAF: 2.3 & CRR 24-05 – Delivery of the Annual Financial Plan.
Goblygiadau ariannol o ganlyniad i roi'r *argymhellion ar waith* ***Financial implications as a result of implementing the recommendations***	Management of financial risk of not achieving value for money.
Goblygiadau gweithlu o ganlyniad i roi'r argymhellion ar waith ***Workforce implications as a result of implementing the recommendations***	None
Adborth, ymateb a chrynodeb dilynol ar ôl ymgynghori ***Feedback, response, and follow up summary following consultation***	Not applicable
Cysylltiadau â risgiau BAF: (neu gysylltiadau â'r Gofrestr Risg Gorfforaethol) ***Links to BAF risks:*** *(or links to the Corporate Risk Register)*	BAF: 2.3 & CRR 24-05 – Delivery of the Annual Financial Plan.
Rheswm dros gyflwyno adroddiad i fwrdd cyfrinachol (lle bo'n berthnasol) ***Reason for submission of report to confidential board (where relevant)***	Not applicable
Camau Nesaf: **Gweithredu argymhellion** ***Next Steps:*** ***Implementation of recommendations*** • ***The report is for noting and, in the case of losses and special payments, approval***	
Rhestr o Atodiadau: ***List of Appendices:*** 1. Single Tender Waivers – April – June 2024	

Section 1 - Conformance with Procurement Procedures

a) SFI requirements

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

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

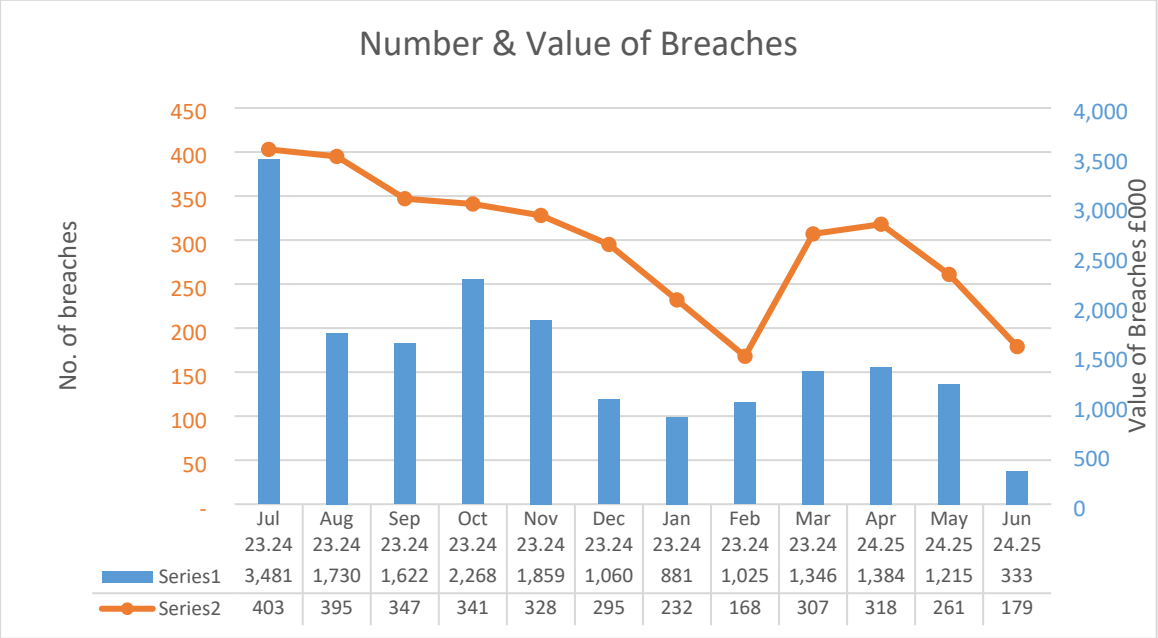
*Exemptions apply (see SFIs)

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

b) Purchase Orders

The use of a formal purchase order system is a key control to ensure expenditure is only committed following proper approval and all committed expenditure is recorded. The trend in the graph below shows that there has been a significant improvement during quarter 1 (Q1), with the number of breaches falling from 318 to 179 between April and June. The current year to date position reported is 758 breaches which hold a value of £2.9m. During the same period last Financial Year, the number of breaches were 1,460 with a value of £6.8m.

The value and number of breaches between July 2023 and June 2024 are detailed below:



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

Division	Month of Breach	Item Description	PO Amount £000's
Mental Health & LDS	May-24	CALL OFF PURCHASE ORDER FOR OOA PLACEMENTS OF MH PATIENTS WITH CYGNET HEALTHCARE LTD	375
WF&OD Executive	Apr-24	SCG GUARDS INVOICE FOR MARCH - INV -90036	94
WF&OD Executive	Apr-24	FEB24 INVOICE FOR SGC GUARDING - INV 89829	85
Mental Health & LDS	Apr-24	CALL OFF PURCHASE ORDER FOR OOA PLACEMENTS FOR MH PATIENTS WITH PRIORY GROUP	84
Chief Digital Information Officer	Apr-24	PHASE 2 -CIRCULAR ECONOMY SBRI CHALLENGE - PROTOTYPING & DEMONSTRATION OF CIRCULAR SOLUTIONS FOR PUBLIC SECTOR WASTE STREAMS	72

NB: Where retrospective 'call off' orders have been placed, the value in the table above only relates to the breach element.

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

Division	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	Apr-24	May-24	Jun-24	YTD
East	125	189	116	126	157	129	111	62	101	119	86	70	275
Centre	98	101	100	82	79	67	49	37	68	83	64	39	186
West	55	71	57	57	44	35	17	30	43	51	51	40	142
Regional Services	28	23	20	27	79	21	29	14	23	27	38	24	89
Mental Health & LDS	34	19	35	11	18	50	23	27	48	27	37	19	83

Divisions have been reminded of the SFI requirements and to take action to ensure future breaches do not re-occur.

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

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

NHS Wales Shared Services Partnership (NWSSP) are working with the Health Board to implement a new process involving 'File Notes' to capture and record instances of procurement spend outside of the SFIs/Scheme of Reservation and Delegation (SoRD). This will further improve the information reported to the Audit Committee and will enable improved targeted intervention.

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

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

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

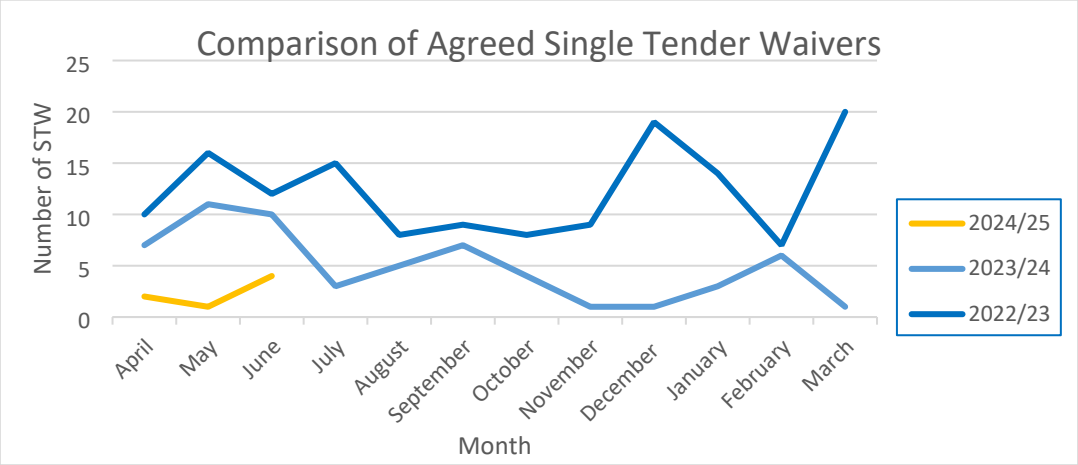
The table below provides a summary of waiver activity for the year and the comparator data of last year.

Single Tender Waivers			

	2023-24 Q1	2023-24 FYE	2024-25 Q1
Waivers Issued	36	100	11
Waivers Approved	28	59	7
Value of Approved Waivers	£2.5m	£4.5m	£0.3m
Waivers approval above EU Threshold	6	8	0
Cancelled Waivers	5	13	2

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

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



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

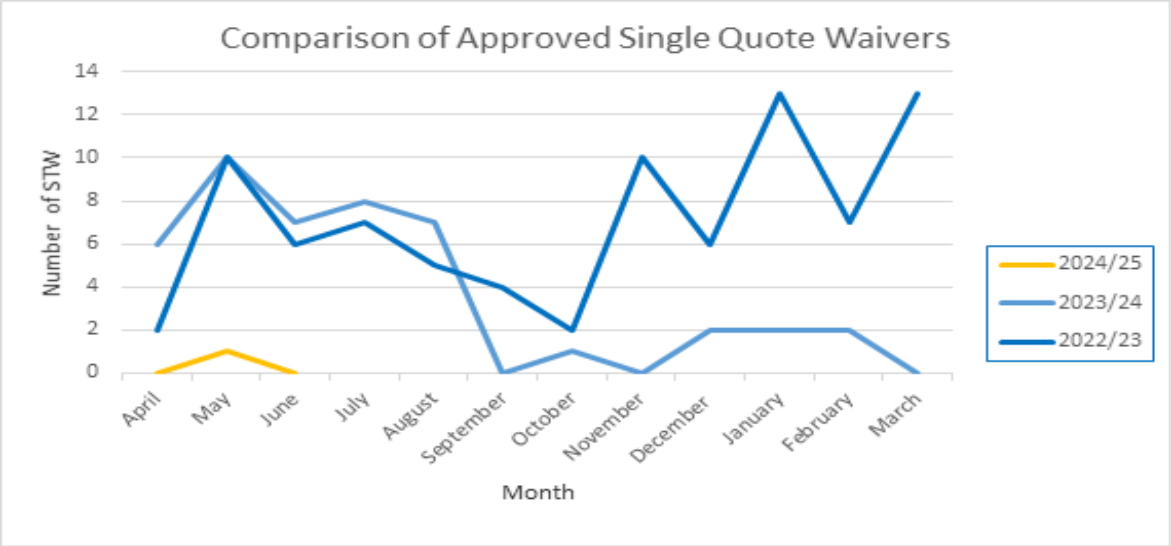
It is normal practice to obtain three quotes. Where this is not possible, then a single quote waiver should be obtained and approved ahead of expenditure being committed.

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

Single Quote Waiver	2023-24 Q1	2023-24 FYE	2024-25 Q1
Waivers Issued	35	94	17
Waivers Approved	23	45	1
Value of Approved Waivers	£0.32m	£0.59m	£0.07m
Cancelled Waivers	2	10	0

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

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


Comparison of Approved Single Quote Waivers
Number of STW
14
12
10
8
6
4
2
0
April
May
June
July
August
September
October
November
December
January
February
March
Month
2024/25
2023/24
2022/23

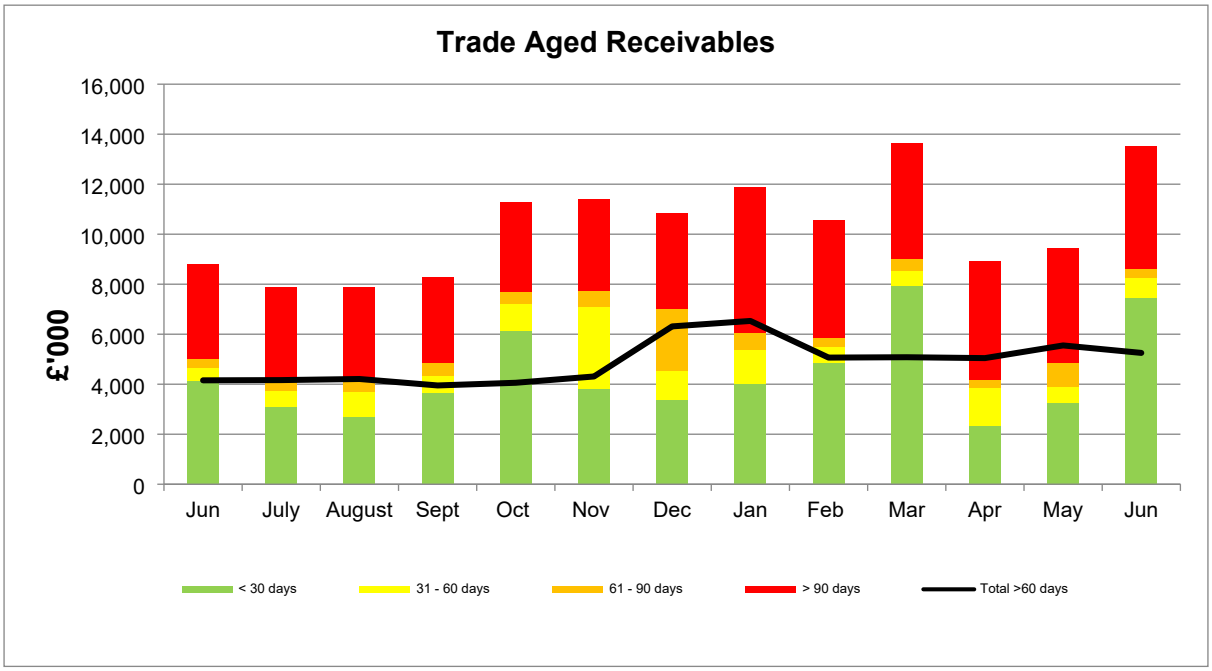
Section 2 – Receivables and Conformance with Payroll Procedures

a) Overview of Balances Owed

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

As at 30th June 2024, there were 3,279 outstanding invoices, totalling £13.5m, of which 632 invoices, totalling £7.3m were less than 30 days old.

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



Provisions for bad and doubtful debts

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

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

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

Customer	£000's	Number of Invoices	Analysis and Further Action	Date Debt Raised
St David's Hospice	457	7	Invoices mainly relate to capital works completed at Ysbyty Penrhos Stanley prior to the Covid-19 pandemic. Whilst the Health Board agreed a re-payment profile with St David's Hospice in October 2022 which would protect the Hospice's cash flow and allow the debt to be repaid in full over 4 years, no payments were received. A revised re-payment profile has now been agreed with the Hospice, and therefore will not form part of future Conformance Reports (unless issues arise with non payment).	Dec 19 – Mar 22
NHS Cheshire and Merseyside ICB	255	5	Invoices all relate to LAC charges, all invoices have been chased with the customer a number of times.	Oct-23
NHS ENGLAND	135	1	Education contract posts (BCUHB) October 2023 to January 2024. The debtor is looking to see if there is a business case as apparently BCUHB did not sign the NHS Education Contract before 01.04.23, they have said that there is a significant back log and will take some time to process the query.	Oct-23
GLYNDWR UNIVERSITY	112	1	Invoice was apparently on hold as no PO, AR have now made contact with department who have confirmed that no PO was necessary. This information was passed to Glyndwr and payment requested again. Last communication 26.06.24.	Nov-23
The Walton Centre	107	5	Charge for radiology testing, a part credit has been raised, awaiting response if invoices can now be paid. Last chased June 24	Apr 22 & Oct 23
St Helens & Knowsley Hospitals NHS Trust (now Mersey and West Lancashire Teaching Hospitals NHS Trust)	97	1	Recharge of specialist registrar rotation. Query regarding funding for placement, customer states they should not have been recharged. Query has been passed to area team to investigate and respond. Now only £97k outstanding out of £176k, £79k has been paid 02.07.24.	Sep 22 - Mar 23
Overseas Patient	59	2	Awaiting confirmation to write the debt off, patient stage 4 cancer and does not have funds to pay this invoice. Family are not able to help cover the costs.	Jul 22 & Sep 22
BCU Non NHS Salary Overpayment	46	1	An investigation is taking place surrounding this overpayment, currently with WOD investigation is expected to be complete end July when a decision on how BCU move forward should be known.	Dec-23
Salary Overpayment	38	2	Overpayments have been referred to Workforce & Organisational Development who are liaising with the debtor.	Feb 22 & Apr 23
Sun Pharma UK Ltd	33	2	Off contract claims. No response from debtor despite numerous reminders, now with CCI.	Aug-23
Salary Overpayment	26	1	Forms have been submitted to payroll 04.07.24 and the debtor has not been overpaid, awaiting for this to be processed by payroll and them to confirm that the invoice can be credited in full.	Nov-21
NHS South West London ICB	22	1	NCA invoice There was some dispute surrounding the amount on the invoice holding up payment, this has since been resolved. The debtor has been chased on a number of occasions but are now not responding. Being escalated to the service.	Jan-23

Overseas Patient	20	1	Overseas visitors charge for inpatient treatment which have been referred to a debt collection agency due to non-payment	Aug-22
Denbighshire County Council	20	1	Recharge for transformation grant £20,000. Council have disputed liability and this is now being dealt with by the Central IHC Finance Team.	Mar-20
Salary Overpayment	20	1	This case is currently with CCI and has been escalated to the High Court Enforcement Officer to recover the monies owed as no payments have been received.	Mar-20
Pfizer Ltd	20	1	Paid in full to CCI, awaiting monies to be transferred to BCUHB.	Mar-21
NHS Greater Manchester ICB	17	1	Invoice for LAC charges, recently made contact with the debtor and the invoice is now with AP	Oct-23
Salary Overpayment	17	1	Overpayment figure has now been agreed by all sides. The employee has requested a repayment plan due to the size of the overpayment a household I&E was received 02.07.24 and BCU are now looking at an affordable repayment offer.	Nov-21
Private Patient	16	1	Charge for inpatient treatment, the invoice has been referred to the patient's insurance company.	Jun-22
NHS Shropshire Telford and Wrekin ICB	16	1	Debtor has said they have queries regarding the invoice, last chased Jul 24 to ask if queries had been sent over to the BCU Income team	Oct-23
Salary Overpayment	14	1	Debtor has not responded despite numerous letters and reminders, no response received, debt now with CCI.	Jan-22
Salary Overpayment	12	1	Debtor has not responded to numerous chasing therefore the debt has been referred to a debt collection agency. The Health Board has now been advised that the debtor has entered into an Individual Voluntary Arrangement (IVA) and full recovery will be unlikely. This is on the July 24 write off schedule.	Sep-21
BCU Non NHS Other	12	1	Invoice relating to dental bursary, non-compliance of terms. We have agreed for the invoice to be repaid by instalments and the debtor has confirmed that the payments, first payment expected July 24.	Nov-23
Salary Overpayment	11	1	The debtor has not responded despite numerous letters and reminders and the debt has been referred to a debt collection agency who are trying to trace the debtor.	Nov-22
Private Patient	10	1	Charge for chemotherapy drugs. The wording was incorrect on the invoice so it has been cancelled in July 24 and re-invoiced with correct wording and re-submitted for payment.	Oct-20
Salary Overpayment	10	1	An initial repayment plan that was agreed by Workforce and Organisation Development has ceased and the debt is therefore being referred back to WOD. The employee has now left BCU, we were awaiting confirmation that the invoice can be referred to a debt collection agency however still no response so 1 reminder letter sent to debtor then CCI mid July if no response.	Mar-23

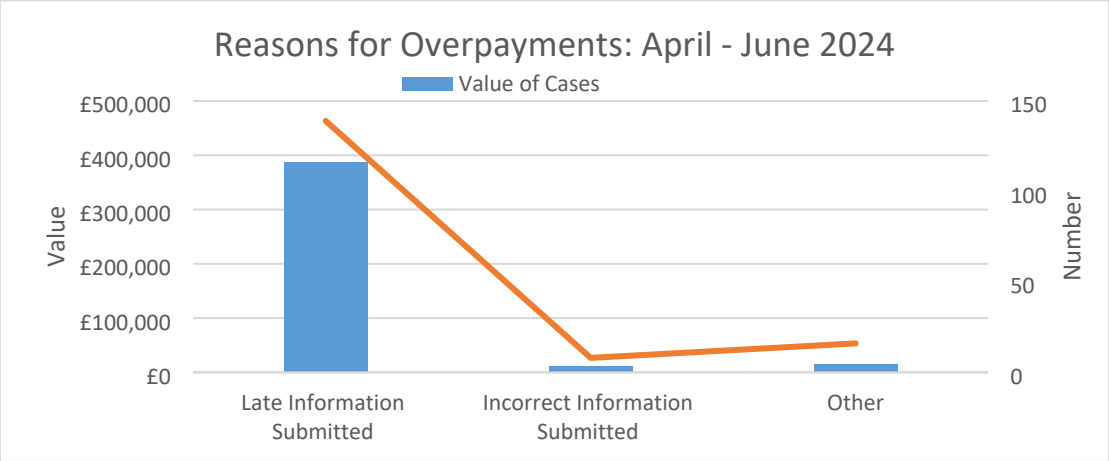
b) Staff Overpayments

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

	2023-24 Q1	2023-24 FYE	2024-25 Q1
Number of Salary Overpayments	168	482	163
Value of Salary Overpayments	£0.427m	£1.216m	£0.413m

For the period April to June 2024 there were 163 staff overpayments, with a gross value of £0.413m, comparable to 168 and £0.427m in the previous Financial Year.

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



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

The specific actions undertaken by the team are:

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

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

It should be noted that overpayments as a result of internal process failures can affect the individuals universal credits, requiring the health board to write of the difference to ensure individuals income are not effected negatively.

Staff Overpayment Repayments

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

As at 30th June 2024 the balance outstanding was £1.222m (31st March 2024 £1.235m). The debt, by collection stage, is detailed below:

	No. of Cases	% of Total Outstanding	Value of Total Outstanding
Agreed Instalment Plans	246	35%	£0.326m
Collection Agents	219	31%	£0.355m
In Dispute or Under Review	166	23%	£0.426m
Reminder Stage	50	7%	£0.069m
Invoice Stage	32	4%	£0.047m

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

The extremely aged debts are there because either:

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

NHS Wales Shared Services Partnership (NWSSP) are currently in the process of agreeing an all Wales overpayment procedure that should strengthen the Health Boards current governance and processes on recovering salary overpayments.

Section 3 - Conformance with Losses and Special Payments Procedures

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

The losses and special payments table below provides an overview of the losses incurred to June 2024. Clinical negligence claims account for the largest element of loss. Amounts in excess of £25,000 can be claimed from the Welsh Risk Pool Service in accordance with the risk pooling arrangements in place for NHS Wales. However, as the Welsh Risk Pool is funded from the NHS Wales healthcare budget these costs are still met by NHS Wales.

In common with the rest of the NHS, the Health Board has experienced an increase in the volume of claim activity within recent years and the table below provides information in relation to clinical negligence claims. Clinical negligence claims are managed by Legal and Risk Services and there were 308 active claims at the end of June 2024. Of these 120 matters were assessed as either probable or certain of settlement with a cumulative estimated value of £168m (before reimbursement from the Welsh Risk Pool). The table below shows the age profile of these claims.

61% of the caseload (188 matters) relate to claims in the early stages and whilst a significant number of these will be successfully defended, there are ongoing financial challenges. However, they are an indicator of future quality and require ongoing monitoring to ensure that any lessons are identified and actioned.

Year claim registered	No of claims
2024/25	13
2023/24	64
2022/23	50
2021/22	48
2020/21	50
2019/20	40
2018/19	20
2017/18	6
2016/17	3
2015/16	3
2014/15	3
2013/14	1
2011/12	3
2010/11	1
2009/10	2
2008/09	1
Total claims	**308**

Losses and Special Payments

	Q2 23/24 £	Q3 23/24 £	Q4 23/24 £	Q1 24/25 £	Latest quarter analysis and further action
Medical Negligence					
Gross cost	3,352,279	6,256,148	9,541,733	4,446,078	Payments were made on 163 cases, of which 28 came under the Redress Scheme.
WRPS Reclaim	(3,008,695)	(5,697,060)	(9,150,159)	(3,989,599)	
Net Cost	343,584	568,088	390,888	456,479	
Personal Injury					
Gross cost	98,142	140,383	77,848	53,115	Payments were made on 40 cases.
WRPS Reclaim	(0)	(31,375)	(16.306)	(406)	
Net cost	98,142	109,008	61,541	52,709	
Loss of cash	0	570	0	165	Payments were made for 2 claims for loss of cash, one from a patient's purse the police and security were informed, the ward will ensure all cash is taken to General Office in future. A further loss resulted when a patient was transferred between hospitals, the money was unaccounted for. Processes for transferring valuables with patients will be reviewed and improved.
Debtors written off	7430	0	15,009	0	There are no debtor write offs in Q1.
Loss or damage to equipment, property and stock	66,263	48,881	104,529	67,606	£39k relates to the loss of Pharmacy stock due to damage, breakages or expiry and obsolete stock written off. There are plans in place to improve this performance through introducing Pharmacy Automated Vending machines and aligning controls across the Health Board. £29k relates to the write off of obsolete stock.
Ex-gratia payments	23,076	17,437	19,259	43,493	Relates to 19 payments for loss/damage of patient's property and 5 ombudsman payments for delayed and unsatisfactory treatment. Payment for £30k was made relating to an employment tribunal.
VERS Payments	0	59,295	8,775	0	All payments are approved by the RATS Committee.
Total	**538,495**	**803,279**	**600,001**	**620,452**	

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

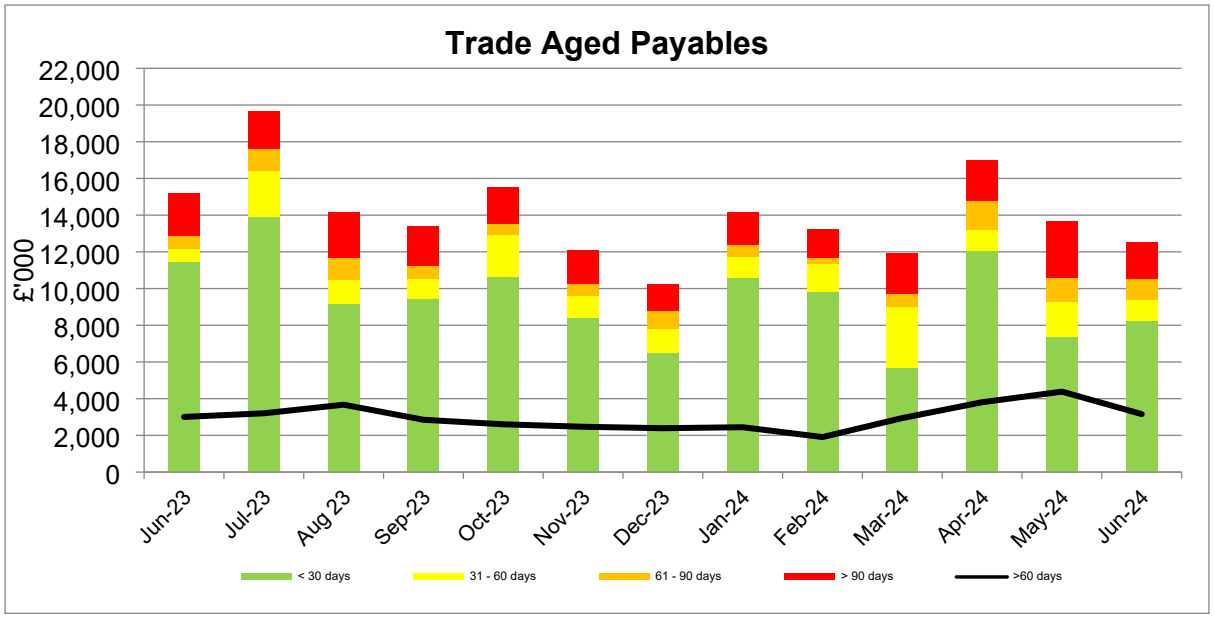
Section 4 - Conformance with Payable Procedures

PSPP Conformance

The Health Board aims to ensure that all balances are paid within a reasonable timeframe (or received for receivables), mainly within 30 days of receipt of a valid payable invoice (or issue of a receivables invoice). Best Practice of 95% (by number) is set for non-NHS invoices at 95%. The year to date achievement for non-NHS invoices by number is 94.6%.

High Value (£10,000 plus) Exceptions

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



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

Payable balances over 6 months old and over £10,000 as at 30th June 2024

Supplier	£000's	No of Invoices	Analysis and further action	Invoice Date
Linea Partners Ltd	245	12	Invoices are in dispute, formal letter to the company being drafted.	Jul - Oct 23
Omnicell Ltd	103	2	Price queries raised with supplier, awaiting response.	Mar 22 & Jun 22
Flintshire County Council	76	4	Receipting issue, requistioner has left BCU referred to Finance to assist.	Sep 23 & Dec 23
Johnson & Johnson Medical Ltd	54	2	Query over duplicate charges, awaiting company to respond.	Dec 22 & Oct 23
Scanassure Medical Ltd	45	2	Receipting issue, contacted requistioner to fully receipt PO and raise additional requisition.	Oct & Nov 23
South London & Maudsley NHS Trust	22	1	Receipting issue, contacted requistioner to fully receipt PO and raise additional requisition.	Oct 23
Vale of Clwyd Mind Association	22	1	Duplicate invoice, supplier contacted and credit requested.	Dec 23
Medtronic Ltd	16	1	PO quoted has been fully billed, requistioner contacted to confirm if goods were received and if they were returned.	Mar 23
Becton Dickson UK Ltd	12	1	Requistioner states goods have not been received, supplier has been contacted to request a proof of delivery. Company are unable to provide PoD due to the length of time. Refer to management for advice.	Sep 22
GN Hearing	11	1	Query raised with supplier as requisitioner has stated some items have been billed under a different invoice. Supplier has been chased.	Nov 22
Healthcare Communications UK Ltd	10	1	Supplier has changed bank details, they have been contacted and asked to confirm the details before they can be changed.	Aug 23

Appendix 1 - Approved Single Tender Waivers >£25K between 1st April – 30th June 2024

Ref No.	Date of Financial Approval	Area	Name of Supplier	Description	Rationale	Value £000s	Supported By Procurement	Procurement Advice	Breached OJEU
2024/2025-1437	02/04/2024	Secondary Care - Managed Clinical Support	Beckman Coulter Life Sciences	Rental and Maintenance for 6 months cover + reagent allowance	Follow on from previous waiver	£45,000.00	Accept	Procurement support the use of a waiver as an appropriate route to market in this instance. A new contract has been awarded to another provider using a competitive tender, however, due to the time required to implement and delays to this implementation period outside of the Health Board's control, this will not start until September 2024. It is not possible to award this extension via a compliant framework and as any new equipment would need to be validated before use an alternative provider is not practical, therefore a waiver is the appropriate route to market.	No
2024/2025-1448	04/06/2024	Estates and Facilities	Static Systems	Waiver is being Sought for 1 year period for the Fire Alarm installed Wrexham Maelor Hospital. The contract supports 24/7 support and statuary testing in accordance with BS5839-1 2002 & A2;2008. The majority of the systems software is supplier specific and fully closed Protocol , therefore cannot be maintained or serviced by a third party contractor. Costs are as follows	Genuinely one provider	£57,628.00	Accept	Procurement support this waiver on the basis of sole supplier. The only supplier Static Systems can provide and maintain the systems programs currently in place. The system is a close protocol system with no other supplier able to maintain. Continuation of previous waiver 2023/2024-1212.	No

2024/2025-1451	09/05/2024	Corporate - WOD	NEBOSH (National Examining board in Occupational Safety & Health)	Accreditation of In house courses and awards of certification together with course materials and support	Genuinely one provider	£25,000.00	Accept	NEBOSH is a professional body which offers qualifications in health, safety, environment and wellbeing management. The following waiver is for the provision of course materials and accreditation awards as part of the Health and Safety at Work Award – NEBOSH and National General Certificate in Occupational Health and Safety – NEBOSH courses. Going to a 3rd party that offer NEBOSH accreditation would not show value for money as they would also be required to obtain the material and accreditation via NEBOSH but also charging the Health Board an uplift fee for that requirement	
2024/2025-1453	30/04/2024	IHC West (Secondary Care - YG)	Echosens	Fibroscan replacement following previous piece of equipment failing and being beyond repair. required to monitor Hepatology patients - do not currently have a machine in West and it would not be suitable due to demand to transfer to other sites.	Genuinely one provider	£85,020.00	Accept	Echosense are the only provider for the Fibroscan, they are the sole supplier of this device. NWSSP explored compliant frameworks options such as HealthTrust Europe and NHS Supply Chain as a possible route to utilise this supplier. Unfortunately no framework options were available for this supplier. Based on the above, Procurement support this single tender waiver request. For future requirements the department will be advised of early involvement with the procurement team to ensure all options are explored.	No
2024/2025-1458	06/06/2024	Secondary Care - Managed Clinical Support	Hologic Ltd	New Fluid Management Systems s/n M4696B24D0/M4681 B24D0 in Ysbyty Gwynedd & Glan	Genuinely one provider	£34,960.00	Accept	Procurement acknowledge and accept that Hologic are the OEM to this product and that no other supplier has the necessary skills, expertise or parts to maintain and repair the equipment-	No

				Clwyd for 4 years folllowing warranty - ending 2029				Assistant Procurement Business Manager	
2024/2025-1459	06/06/2024	Corporate	LoveNation	School Nurse Immunisation App	Genuinely one provider	£30,000.00	Accept	Love Nation are the single source supplier of the School Nursing Immunisation App. The supplier Love Nation has created a bespoke 'App' with Cardiff & Vale to interface with the CYPRiS IT system (provides an e-consent app to all Health Boards within Wales - providing standardisation across NHS Wales). Love Nation are not on a compliant framework. Procurement Business Manager	No
2024/2025-1463	20/06/2024	Secondary Care - Managed Clinical Support	Checkit Europe	Renewal of temperature monitoring alerts, maintenance and calibration to comply with regulatory requirements	Compatibility Issue (eg. warranty cover clause or specific equipment)	£43,514.06	Accept	I support this Waiver request in relation to the Contract Renewal of service, calibration and monitoring support for Checkit temperature monitoring equipment for Pathology Labs. Checkit are the OEM and the only contractor who have the necessary skills, expertise & knowledge to deliver this contract. No other contractor can maintain Checkit's systems. Category Manager, Sourcing Maintenance Team 24th June 2024	No

Appendix 2 - Approved Single Quote Waivers >£25K between 1st April – 30th June 2024

Ref No.	Date of Financial Approval	Area	Name of Supplier	Description	Rationale	Value £000s	Supported By Procurement	Procurement Advice
2024/2025-1457	15/05/2024	Estates and Facilities	Gwynedd Council	This waiver is being sought for the introduction of CCTV on the main road to the front of the YG site. Footage will be interrogated by North Wales Police and Gwynedd Council. BCUHB will assist with hosting the atenna and providing PSBA connection from Gwynedd Council. As part of this scheme there will also be CCTV installed to front of the main hospital providing coverage to the bus stop area to assist with absconding patients.	Other (please specify)	£7,460.00	Accept	The Local Authority & North Wales Police are the commissioner of this requirement to which BCUHB are part funding. It would therefore be impossible to conduct a competitive process for this project, and we thereby support this waiver request.

Teitl adroddiad: ***Report title:***	Internal Audit Progress Report 19 April to 30 June 2024			
Adrodd i: ***Report to:***	Audit Committee			
Dyddiad y Cyfarfod: ***Date of Meeting:***	18 July 2024			
Crynodeb Gweithredol: ***Executive Summary:***	The progress report is produced in accordance with: • the requirements as set out within the Public Sector Internal Audit Standards: Standard 2060 – Reporting to Senior Management. • the Welsh Government NHS Wales Audit Committee Handbook – Section 4.5 Reviewing internal audit assignment reports. The progress report summarises ten assurance reviews finalised since the last Committee meeting in March 2024, with the recorded assurance as follows: • Substantial assurance (green) – none; • Reasonable assurance (yellow) – three; • Limited assurance (amber) – six; • Unsatisfactory (red) – one; and • Advisory/Assurance not applicable (grey) – none. The report also details the reviews with reports issued as draft and work in progress.			
Argymhellion: ***Recommendations:***	The Committee is asked to: • Receive the progress report. • Approve changes to the plan for the Grievance Management and Business Cases: Capital and Revenue reviews.			
Arweinydd Gweithredol: ***Executive Lead:***	Director of Corporate Governance			
Awdur yr Adroddiad: ***Report Author:***	Dave Harries, Head of Internal Audit, CMIIA, QiCA Nicola Jones, Deputy Head of Internal Audit, CMIIA			
Pwrpas yr adroddiad: ***Purpose of report:***	I'w Nodi *For Noting* ☒	I Benderfynu arno *For Decision* ☒	Am sicrwydd *For Assurance* ☒	
Lefel sicrwydd: ***Assurance level:***	Arwyddocaol *Significant* ☐ Lefel uchel o hyder/tystiolaeth o ran darparu'r mecanweithiau / amcanion presennol *High level of confidence/evidence in delivery of existing mechanisms/objectives*	Derbyniol *Acceptable* ☐ Lefel gyffredinol o hyder/tystiolaeth o ran darparu'r mecanweithiau / amcanion presennol *General confidence / evidence in delivery of existing mechanisms / objectives*	Rhannol *Partial* ☐ Rhywfaint o hyder/tystiolaeth o ran darparu'r mecanweithiau / amcanion presennol *Some confidence / evidence in delivery of existing mechanisms / objectives*	Dim Sicrwydd *No Assurance* ☐ Dim hyder/tystiolaeth o ran y ddarpariaeth *No confidence / evidence in delivery*
Cyfiawnhad dros y gyfradd sicrwydd uchod. Lle bo sicrwydd 'Rhannol' neu 'Dim Sicrwydd' wedi'i nodi uchod, nodwch gamau i gyflawni sicrwydd 'Derbyniol' uchod, a'r terfyn amser ar gyfer cyflawni hyn:				

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

Links to BAF risks: *(or links to the Corporate Risk Register)*	
Rheswm dros gyflwyno adroddiad i fwrdd cyfrinachol (lle bo'n berthnasol) ***Reason for submission of report to confidential board (where relevant)***	N/A
Camau Nesaf: **Gweithredu argymhellion** ***Next Steps:*** ***Implementation of recommendations*** The progress report is presented in accordance with the Committee's cycle of business and in line with the requirements of the NHS Wales Audit Committee Handbook.	
Rhestr o Atodiadau: ***List of Appendices:*** • Appendix 1: Progress report • Appendix 2: Risk Management report – **Agenda Item Ref: AC24.96** • Appendix 3: Health & Safety report • Appendix 4: Standards of Business Conduct – Declarations of Interest, Gifts and Hospitality report – **Agenda Item Ref: AC24.98** • Appendix 5: Budgetary Control report • Appendix 6: Effective Governance – Integrated Health Community (IHC) Central report • Appendix 7: Discharge Arrangements report • Appendix 8: Operating Model report	

Betsi Cadwaladr University Local Health Board

Audit Committee
Internal Audit Progress Report

19 April to 30 June 2024

NWSSP Audit and Assurance Services

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

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

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

Disclaimer notice - please note:

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

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

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

Introduction

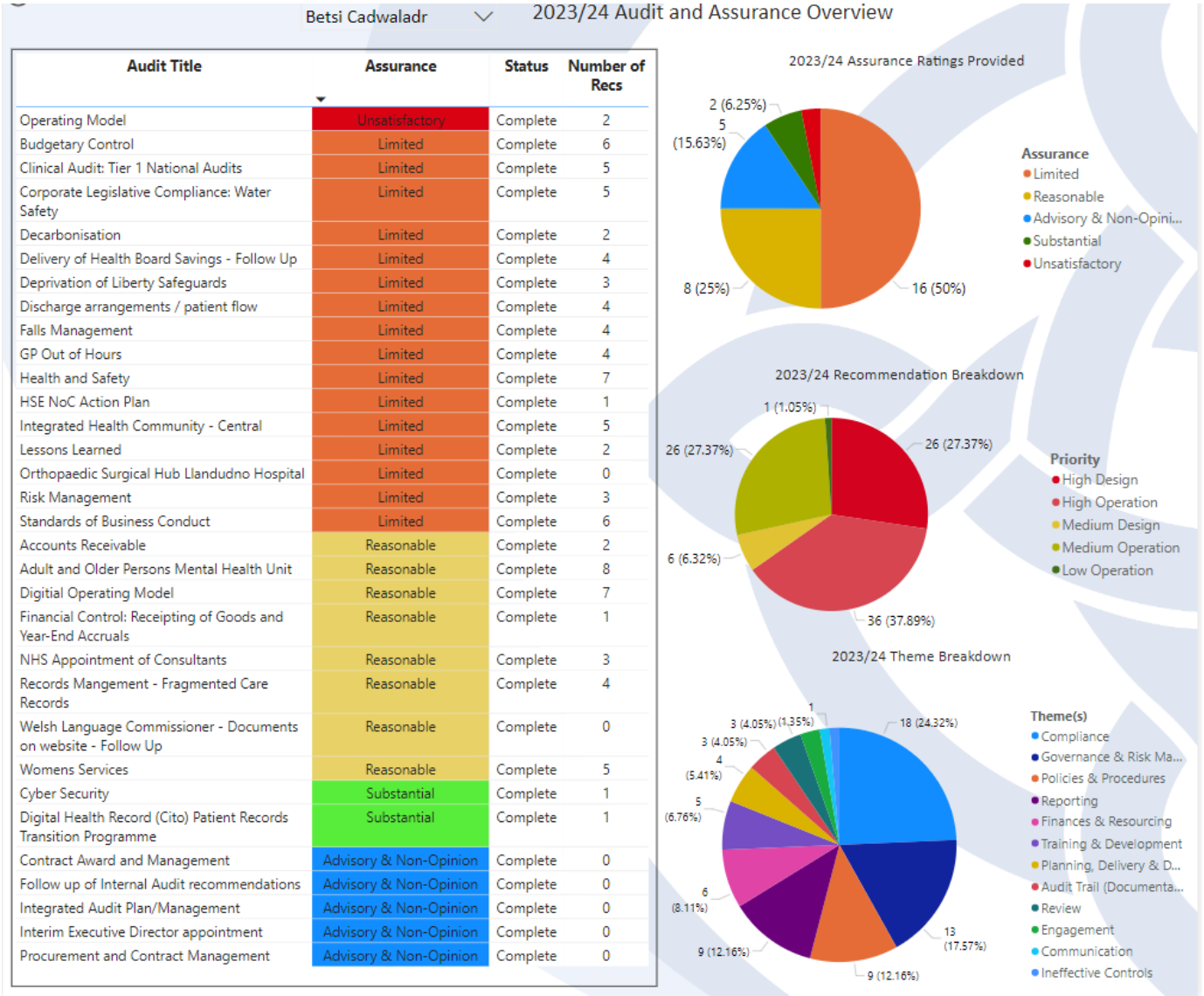
1. This progress report provides an update to the Audit Committee in respect of the assurances, key issues, and progress against the Internal Audit (IA) Plans for 2023/24 and 2024/25.

Reports Issued

2. Since the last progress report, ten reviews have been finalised, and one issued as draft. Executive summaries of the finalised reviews is provided below.

3. In reviewing the 2023/24 draft and final reports issued, image 1 details the high-level information from the reviews. This shows the key themes of recommendations relate to compliance, governance and risk management, policies and procedures, and reporting.

Image 1: Extract from the NHS Wales tracker for Betsi Cadwaladr University Health Board as at 30 June 2024 – 2023/24 overview



Audit Title	Assurance	Status	Number of Recs
Operating Model	Unsatisfactory	Complete	2
Budgetary Control	Limited	Complete	6
Clinical Audit: Tier 1 National Audits	Limited	Complete	5
Corporate Legislative Compliance: Water Safety	Limited	Complete	5
Decarbonisation	Limited	Complete	2
Delivery of Health Board Savings - Follow Up	Limited	Complete	4
Deprivation of Liberty Safeguards	Limited	Complete	3
Discharge arrangements / patient flow	Limited	Complete	4
Falls Management	Limited	Complete	4
GP Out of Hours	Limited	Complete	4
Health and Safety	Limited	Complete	7
HSE NoC Action Plan	Limited	Complete	1
Integrated Health Community - Central	Limited	Complete	5
Lessons Learned	Limited	Complete	2
Orthopaedic Surgical Hub Llandudno Hospital	Limited	Complete	0
Risk Management	Limited	Complete	3
Standards of Business Conduct	Limited	Complete	6
Accounts Receivable	Reasonable	Complete	2
Adult and Older Persons Mental Health Unit	Reasonable	Complete	8
Digitial Operating Model	Reasonable	Complete	7
Financial Control: Receipting of Goods and Year-End Accruals	Reasonable	Complete	1
NHS Appointment of Consultants	Reasonable	Complete	3
Records Mangement - Fragmented Care Records	Reasonable	Complete	4
Welsh Language Commissioner - Documents on website - Follow Up	Reasonable	Complete	0
Womens Services	Reasonable	Complete	5
Cyber Security	Substantial	Complete	1
Digital Health Record (Cito) Patient Records Transition Programme	Substantial	Complete	1
Contract Award and Management	Advisory & Non-Opinion	Complete	0
Follow up of Internal Audit recommendations	Advisory & Non-Opinion	Complete	0
Integrated Audit Plan/Management	Advisory & Non-Opinion	Complete	0
Interim Executive Director appointment	Advisory & Non-Opinion	Complete	0
Procurement and Contract Management	Advisory & Non-Opinion	Complete	0

- Theme definition is included at Table 6.

Executive Summaries

Risk Management	BCU-2324-19	20 June 2024
Report opinion:	Limited	

Purpose: To review the implementation and application of the Health Board's Risk Management process. We also assessed implementation of the management actions agreed as part of the limited assurance review in 2022/23.

Overview

There has been positive progress on risk management over the last year, however it is recognised there are areas still to progress to ensure risk management is fully embedded to a high quality across the Health Board.

The content and quality of the Operational risk registers varies. Risk dates were overdue for almost a quarter (23%) of risks reviewed.

Whilst there has been an improvement in the scrutiny arrangements within the Corporate Risk Team, there is not consistent scrutiny of risks across operational areas.

The Corporate Risk Register has been reviewed and consolidated, however further work is required to ensure information on controls, actions and lines of assurance are captured in sufficient detail to provide assurance to the Health Board.

Whilst the Risk Management Group brings together representatives from across the Health Board, the membership is wide, and the agenda is large, so there is often not sufficient scrutiny of corporate or operational risk registers.

	Objectives	Assurance
1	The Risk Management Framework, and supporting documents, set out the risk management system within the Health Board, outline clear roles and responsibilities, and provide guidance to staff on the requirements for risk management.	Substantial
2	Comprehensive operational risk registers are in place, actively monitored and scrutinised at an appropriate level.	Limited
3	The Corporate Risk Register is reviewed, actively monitored and scrutinised regularly.	Limited
4	There are clear and consistent processes in place for the identification, classification, scoring and escalation / de-escalation of risks throughout the Health Board.	Reasonable
5	The Risk Management Group is operating effectively and in line with the requirements of the Framework and Terms of Reference.	Limited
6	Management actions agreed as part of the 2022/23 Risk Management and Board Assurance Framework review have been progressed / implemented.	Reasonable

	Key Matters Arising	Objective	Control Design or Operation	Recommendation Priority
1	There is still variation in the quality of the information included in operational risk registers, and the review and scrutiny arrangements across the Health Board.	2	Operation	High
2	The risks within the Corporate Risk Register have been consolidated and refined, however there is still further work to ensure all risks, controls, actions and assurances are appropriately documented.	3	Operation	High
3	The Risk Management Group provides a forum for useful discussion on risk, however it is not sufficiently scrutinising the detail of operational and corporate risks, as per its Terms of Reference. The escalation process for corporate risks includes the presentation of the risk at Risk Management Group, however as this meets bi-monthly, alternative arrangements should be considered.	4/5	Operation	High

Health & Safety	BCU-2324-20	22 May 2024
Report opinion:	Limited	

Purpose: To review compliance with HS01 Occupational Health and Safety Policy, assessing the adequacy of management arrangements for Health & Safety to provide assurance to the Health Board.

Overview

The report found there are several areas of concern and non-compliance within this review.

At the time of our review Policy HS01 Occupational Health and Safety was out of date due to accountability arrangements, coupled with a small number of other procedures/ guidance papers.

There is no Executive lead in place for Occupational Health and Safety – this is not compliant with the Health Board's policy but recognise this is being fulfilled by the Chief Executive currently.

There is no regular and consistent monitoring and reporting on Health and Safety matters through the appropriate governance structure. There has been no annual Health & Safety report for 2022-23 presented at Health Board meetings.

There is no consistent approach to reviewing and analysing findings of reviews undertaken by the Health and Safety team. The gap analysis, undertaken to identify areas of risk, is not current and was last updated in January 2022.

There is no consistent organised collation/review of self-assessments undertaken across the Health Board, with some areas not completing or returning any assessments. This is a significant control failure and requires urgent focus, to enable both Operational and Executive management to have complete oversight of risk areas to concentrate its limited resources on.

	Objectives	Assurance
1	There are appropriate health and safety policies and procedures in place.	Limited
2	There is an appropriate governance structure with mechanisms for regular monitoring and escalation of Health and Safety matters.	Limited
3	Health and Safety training is provided as required, with compliance monitored and action taken to address areas of low compliance.	Reasonable
4	The Health and Safety department is undertaking formal Health & Safety reviews for each department, with actions addressed appropriately, The gap analysis previously produced has been subject to review and updated.	Limited
5	Departments are undertaking their twice-yearly Health and Safety self-assessment, with clear actions in place to address areas of non-compliance / risk.	Limited

	Key Matters Arising	Objective	Control Design or Operation	Recommendation Priority
1	The Occupational Health and Safety Policy, and a small number of supporting procedures and documents on BetsiNet are out of date. There is also no Occupational Health and Safety-Board Level Executive Director in post, which is a requirement of the Health and Safety Policy.	1	Operation	High
2	There is a lack of monitoring and reporting of Health and Safety information and issues through the appropriate governance structure. There has been no annual Health & Safety report for 2022-23 presented at the Health Board meetings.	2	Operation	High
3	There is a lack of attendance at Health and Safety training at both Senior and Executive level. Whilst some training has been provided, we are unable to confirm that all those required to undertake training have been identified and offered appropriate training relating to Health and Safety.	3	Operation	Medium

	Key Matters Arising	Objective	Control Design or Operation	Recommendation Priority
4	There is no consistent approach to reviewing and analysing findings of reviews undertaken across the Health Board.	4	Design	High
5	The gap analysis previously produced has not been reviewed since January 2022.	4	Operation	High
6	A review of action plans resulting from Health and Safety reviews has identified that whilst there is some evidence of review, there is no regular review of dates and progress to ensure completion of agreed actions.	4	Operation	Medium
7	There is no consistent collation and review of self-assessments that are undertaken across the organisation.	5	Design	High

Standards of Business Conduct – Declarations of Interest, Gifts and Hospitality	BCU-2324-21	20 June 2024
Report opinion:	Limited	

Purpose: To consider whether there are robust processes and controls in place within the Health Board to support the management of Standards of Business Conduct, specifically staff Declarations of Interest, Gifts and Hospitality.

Overview

The policy does not reflect current working practice / systems.

There was inappropriate use of tender waiver to purchase declaration management system.

The newly activated system features require time to embed, and oversight to ensure they are functioning as intended.

Reporting to the Audit Committee has not been adequate and does not meet policy requirements.

Declarations of interest – issues include Board Member' with undeclared interests, low approval rates, staff submitting repeat declarations and duplicate submissions. We were unable to determine the overall level of compliance from the data provided.

Gifts and hospitality – not all submissions have been declared and approved appropriately. We found examples of events attended prior to declaration / approval. Not all declared hospitality was approved by a Director / Assistant Director. Several declarations (not recent) are marked as pending approval.

	Objectives	Assurance
1	The Health Board has a Standards of Business Conduct policy in place to support compliance with Standing Orders, with requirements and responsibilities clearly outlined. There is suitable training and awareness to ensure that new and existing staff understand their responsibilities, expectations and requirements of the policy.	Reasonable
2	There are effective systems and processes in place to capture the Declarations of Interest, Gifts and Hospitality, with appropriate reporting to the Audit Committee	Limited
3	Compliance with the requirements for submitting Declarations of Interest for all required staff, including Board members, is reviewed regularly, and escalated where appropriate.	Limited
4	Submissions of Gifts and Hospitality are reviewed to ensure they are in line with policy requirements, and suitable action taken where issues are identified	Limited

	Key Matters Arising	Objective	Control Design or Operation	Recommendation Priority
1	Health Board policy (OBS02) requires updating to reflect current working practice, requirements, and systems used. There is a lack of clarity regarding mandated declarations of interest by staff that fall outside documented pay band thresholds. Requirements to be communicated to all relevant staff.	1	Design	High
2	Several key features of Declare (including line manager approval and scheduled notifications) were only recently implemented - we cannot be assured that they are all functioning as intended. We were unable to reconcile published performance information to source data and noted that all system embedded guidance documents were NHS England documents.	2	Operation	High
3	During 2023/24 the reporting of declarations of interest, gifts and hospitality to the Audit Committee did not meet policy requirements. Limited performance data was submitted for review and the linked registers (September 2023) were solely for Board Member declarations. The registers were scheduled per 2024/25 cycle of business	2	Operation	High

	Key Matters Arising	Objective	Control Design or Operation	Recommendation Priority
	for submission in the March 2024 Committee, however they were not presented for review.			
4	All Board Members have submitted declarations of interest, however due diligence work undertaken by the Office of the Board Secretary identified seven Board Members with undisclosed interests. We found variance in the level of detail provided in Board Member declarations and noted that the published public register had not been updated with the undisclosed interests (though this may be a timing issue).	3	Operation	High
5	We reviewed staff declarations of interest data and found that approval rates were low, impacted significantly by nil declarations deemed not applicable for approval – we acknowledge that the approval feature was only recently activated. Other issues impacting data quality include duplicate records and staff submitting multiple (mostly nil) declarations over a short period of time. We were unable to determine the overall rate of compliance from the data provided.	3	Operation	High
6	We reviewed gift, hospitality, and sponsored event declarations and found that not all declarations are submitted and approved in accordance with policy requirements. Issues identified included events having been attended prior to being declared / approved, hospitality declarations not subject to Director / Assistant Director approval (line manager approval provided), non-recent declarations remain pending approval.	4	Operation	High

Budgetary Control	BCU-2324-25	7 June 2024
Report opinion:	Limited	

Purpose: To review whether the Health Board has effective controls in place to manage its financial budgets, including delegation and information available to budget holders.

Overview

There has been positive progress on financial management and control towards the latter half of the financial year. We recognise the significant upheaval and changes in the Finance leadership in year, with a further appointment of a new senior Finance leadership team, both interim and substantive mid-way through the 2023/24 financial year. It is recognised there are areas still to address which are on-going.

The audit found that the Health Board does not have detailed budgetary control procedures in place. We note the provision of a Budget Manager Handbook, however this does not replace the need to have standard operating procedures to ensure consistency in budget setting across the Directorate.

No accountability letters were issued to budget holders and managers at the start of the 2023/24 financial year, as required by the Standing Financial Instruction 5.5 – Budgetary Delegation. This pre-dates the current Finance leadership team.

The Accountability Letter is pivotal in formally delegating budgetary responsibility as well as setting out the achievement of planned levels of service coupled with other key responsibilities. Whilst acknowledging control totals were presented to Officers in November 2023 via the Executive Delivery - Integrated Performance Group, minute evidence is limited in stipulating these totals must be achieved.

A small number in our sample in the E-Financials hierarchy were not in line with the Scheme of Reservation and Delegation approved by the Health Board. We found one limit change was approved by a finance officer but are unsighted whether this was pre-approved by the Board.

There is no documented standard operating procedure for creating and reviewing accrual and journal entries despite this being agreed by management in the 2022/23 review.

The challenge facing both Finance and Procurement colleagues is significant to deliver training to all officers that require it and maintain such. A realistic and risk-based training plan should be developed.

Objectives		Assurance
1	Procedures are available to staff, are up-to-date and reflect current working practices.	Unsatisfactory
2	Accountability Letters have been completed and signed by all Budget Holders for 2023/24 in line with Standing Financial Instructions (SFIs).	Limited
3	Delegated limits recorded in the E-Financials hierarchy are in line with Scheme of Reservation & Delegation.	Reasonable
4	Accrual entries are correct and subject to effective scrutiny.	Reasonable
	Journal entries are subject to appropriate segregation of duties and scrutiny.	Limited
	A Budget Virement Policy exists and is complied with at all times.	Reasonable
	Reporting of the month end financial position is complete and accurate in line with the General Ledger.	Substantial

5	Budget holders have received appropriate training enabling them to manage their delegated budgets.	Reasonable

	Key Matters Arising	Objective	Control Design or Operation	Recommendation Priority
1	The Health Board do not have robust and detailed budgetary control procedures in place.	1	Design	High
2	Accountability Letters have not been issued to budget holders and managers for 2023/24, as required by the Standing Financial Instructions.	2	Operation	High
3	A small number in our sample in the E-Financials hierarchy were not in line with the Scheme of Reservation and Delegation approved by the Health Board.	3	Operation	Medium
4	The agreed recommendation from the 2022/23 audit review has not been implemented regarding the creation of a Standard Operating Procedure for the completion, upload and posting of all journals.	5	Design	High
5	The virement procedure is out of date and requires review.	6	Operation	Medium
6	Budget holders training is main hospital focused and consideration should be given to taking the training out on the road to support broader attendance.	8	Operation	Medium

Fragmented Care Records BCU-2324-28 24 May 2024

Report opinion: Reasonable

Purpose: To review the progress being made to mitigate the risk, and the impact of the residual risk relating to the fragmented care record.

Overview

The issues associated with the fragmented, paper-based health record are understood and articulated at the operational level and included within the corporate risk register.

Tactical actions are underway to resolve the identified issues and are progressing, in particular as part of an improvement project within the Emergency Department (ED).

Strategic actions are underway to achieve a full Electronic Health Record (EHR), however this relies on the national position and requires significant business and culture change.

The matters requiring management attention are:

- Ensuring the risk statement fully reflects the issues;
- Implementing the change function within the ED; and
- Ensuring appropriate reporting from the ED project.

Objectives		Assurance
1	Understanding of Issue	Limited
2	Tactical Actions	Reasonable
3	Strategic Actions to Develop an Electronic Health Record	Substantial

	Key Matters Arising	Objective	Control Design or Operation	Recommendation Priority
1	Risk Statement	1	Operational	High
2	Records Management Training	2	Operational	Medium
3	ED Change function	2	Operational	Medium
4	ED Reporting	2	Operational	Medium

Effective Governance – Integrated Health Community (IHC) Central	BCU-2324-30	24 June 2024
Report opinion:	Limited	

Purpose: To review the effectiveness of the governance arrangements within the service.

Overview

The review has identified that the IHC has developed its governance structure in line with that stipulated by the Health Board on inception of the Operating Model. The matters which require management attention include:

There are identified gaps in Terms of Reference that require addressing immediately.

Whilst there is evidence of regular finance reporting to the Senior Management Team and Performance, Finance and Information Governance Operational Delivery Group, we found no evidence of oversight and ownership for the delivery savings through reducing expenditure. There is evidence the IHC established a Financial Control Group but we cannot find any reporting from the meeting in accordance with the Terms of Reference (ToR).

There is limited evidence that both Tier 2 and Tier 3 audits are being actively monitored, and delivery of the reviews subject to routine update reporting via service leads.

The IHC is reviewing its complaints, concerns, and incidents through the governance structure, however there is poor compliance with the 30-day timeline for complaints handling and a large number of open incidents.

Attendance at the IHC Health & Safety and Risk Management Group is generally poor and the absence of consistent attendance undermines the ability for the IHC Director and Senior Management Team to actively manage risk.

Whilst risk management processes are embedded throughout the service and are in line with the Risk Strategy, we found a large number of risks had not been reviewed per the expected timelines set by the Health Board.

	Objectives	Assurance
1	There is an appropriate governance and reporting structure in place within the service to provide assurance on services and ensure oversight of all areas of responsibility. Reporting includes ward to board assurance, audit results, ward accreditation information and monitoring of actions resulting from external review such as Healthcare Inspectorate Wales and Audit Wales.	Limited
2	There are appropriate financial governance arrangements in place to manage budgets, with regular review of savings and budgets. Where services are not operating within agreed budgetary allocation, appropriate actions and monitoring arrangements are in place.	Limited
3	The service is progressing and monitoring tier 2/3 clinical audits and contributing to tier 1 audits as required, with processes in place to share details of lessons learnt.	Limited
4	Complaints, concerns, incidents, and staff concerns (via Speak Out Safely) are investigated, reviewed, and responded to in a timely manner. Learning from these is captured and reviewed / shared as appropriate.	Limited
5	Risk management processes are embedded throughout the service and are in line with the risk strategy in terms of risk registers and regular review of risks.	Limited

	Key Matters Arising	Objective	Control Design or Operation	Recommendation Priority
1	There are identified gaps in Terms of Reference that require addressing immediately, including identifying Chair and Vice Chair for all meetings, ensuring the Senior Management Team reviews and approves all groups that report into it, and establishing Cycles of Business for all meetings.	1	Operation	High

	Key Matters Arising	Objective	Control Design or Operation	Recommendation Priority
2	There is no apparent evidence of oversight and ownership for delivering savings through reducing expenditure, and the IHC Financial Control Group has not reported in accordance with its ToR.	2	Operation	High
3	There is limited evidence that both Tier 2 and Tier 3 audits are being actively monitored and delivery of the reviews subject to routine update reporting via service leads.	3	Operation	High
4	The IHC is reviewing its complaints, concerns, and incidents, however there is poor compliance with the 30-day timeline for complaints handling and a large number of open incidents.	4	Operation	High
5	Attendance at the IHC Health & Safety and Risk Management Group is generally poor, and many risks have not been reviewed per the expected timelines set by the Health Board.	5	Operation	High

Effective Governance – Women's Directorate	BCU-2324-31	21 May 2024
Report opinion:	Reasonable	

Purpose: To review the effectiveness of the governance arrangements within the service.

Overview

The Directorate has overachieved its savings requirement, the majority of which is recurring. It is currently underspent and forecast to underspend at year end. We wish to highlight and note this as good practice and effective financial control.

The Directorate has established the required governance structure and reporting mechanisms, but some terms of reference and cycles of business need to be reviewed and updated.

The Directorate has been unable to realise a forecast combined recurrent savings total of £1,106,660 as the required contract notifications have not progressed and the block contract arrangements pre-pandemic have not evolved.

The Directorate has limited evidence of clinical audit activity at Tier 2 and Tier 3 levels. There is also a lack of assurance flow from the Clinical Effectiveness Group to the Quality, Safety and Experience Service Delivery Group and the Senior Leadership Team.

The Directorate is reviewing its associated concerns, complaints, etc., through the Incident and Concerns Interface Meeting, but it does not follow the expected governance and assurance structure. There are also delays in closing some complaints.

The Directorate has a Risk Management Group that reviews and discusses risks, but there is a gap in assurance to the Senior Leadership Team and the Quality, Safety and Experience Service Delivery Group.

	Objectives	Assurance
1	There is an appropriate governance and reporting structure in place within the service to provide assurance on services and ensure oversight of all areas of responsibility. Reporting includes ward to board assurance, audit results, ward accreditation information and monitoring of actions resulting from external review such as Healthcare Inspectorate Wales and Audit Wales.	Reasonable
2	There are appropriate financial governance arrangements in place to manage budgets, with regular review of savings and budgets. Where services are not operating within agreed budgetary allocation, appropriate actions and monitoring arrangements are in place.	Substantial
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.	Limited
4	Complaints, concerns, incidents, and staff concerns (via Speak Out Safely) are investigated, reviewed, and responded to in a timely manner. Learning from these is captured and reviewed / shared as appropriate.	Limited
5	Risk management processes are embedded throughout the service and are in line with the risk strategy in terms of risk registers and regular review of risks	Reasonable

	Key Matters Arising	Objective	Control Design or Operation	Recommendation Priority
1	Terms of Reference have not been subject to review in line with that stipulated. Some general housekeeping matters were identified.	1	Operation	Medium
2	The Directorate requires Health Board support to deliver identified recurrent savings through its contract with an English NHS provider.	2	Operation	Medium
3	There is an apparent lack of oversight of Tier 2 and Tier 3 clinical audits.	3	Operation	High

	Key Matters Arising	Objective	Control Design or Operation	Recommendation Priority
4	There are several complaints overdue, and reporting/scrutiny is not in accordance with the published governance structure.	4	Operation	High
5	Whilst there is evidence of the Directorate Risk Management Group in operation, there is limited evidence of provision of assurance to the Senior Leadership Team and Quality, Safety and Experience Service Delivery Group in relation to risk management.	5	Operation	Medium

Discharge Arrangements	BCU-2324-32	10 May 2024
Report opinion:	Limited	

Purpose: To review whether there are robust processes and controls in place within the Health Board to support the implementation of Discharge to Recover then Assess (D2RA) requirements, and management of adverse / unsafe discharges.

Overview

There is no up to date Health Board policy or Standard Operating Procedure to support the management of patient discharges and implementation of D2RA requirements. There is uncertainty regarding the robustness of training provision.

Low compliance against D2RA performance Measures 2 and 3 – not all patients are allocated to a D2RA pathway within 24 hours or discharged within 48 hours of being clinically optimised (for pathways 1, 2 & 3). There are no formal controls or processes to review and address areas of low / non-compliance.

There are no formal escalation arrangements in place to address and support resolution of Pathways of Care Delays. Ward board rounds are not held twice daily.

There is no Health Board policy or Standard Operating Procedure in place to support the management of incidents / adverse discharges.

	Objectives	Assurance
1	There is guidance available on the process for discharging patients, and staff are aware of the requirements to allocate a D2RA pathway within 24 hours of admission.	Limited
2	Data is collated, reviewed, and analysed to support compliance with the key principles of the guidance, and actions taken to address areas of low/non-compliance.	Limited

3	There are processes in place to support timely discharge where a patient has been allocated to a specified D2RA pathway.	Limited
4	There are appropriate routes for partners to raise concerns where there has been an adverse / unsafe discharge, with actions taken and feedback provided to partners. Issues with partners / engagement are escalated appropriately.	Limited

	Key Matters Arising	Objective	Control Design or Operation	Recommendation Priority
1	The Health Board does not have an overarching policy or Standard Operating Procedure in place to support the management of patient discharges and implementation of D2RA requirements. It is not clear whether the completed D2RA training packages / awareness sessions provide staff with the necessary knowledge and skills to effectively embed D2RA within their area of work. We were unable to determine the D2RA training requirements for temporary, bank, and agency staff.	1	Design	High
2	D2RA performance data is captured and reported to the NHS Executive. D2RA performance and patient discharge / flow are reviewed at relevant forums however there are no formal controls or processes in place to address and escalate areas of low / non-compliance.	2	Design	High
3	STREAM usage is significantly reduced over weekends – it is not clear whether this is due to reduced activity and accessibility to services over the weekend, or whether STREAM is updated retrospectively during the week when there are more staff available. D2RA pathway status is not visible on STREAM summary pages.	2	Operation	Medium
4	Pathways of Care Delays are measured and reported however there are no formal escalations mechanisms in place to progress and support resolution. Ward board round arrangements are not meeting Welsh Government Hospital Discharge Guidance requirements.	3	Design	High
5	Adverse / unsafe discharges are reported as patient safety incidents – There is no	4	Design	High

	Key Matters Arising	Objective	Control Design or Operation	Recommendation Priority
	Health Board policy or Standard Operating Procedure to support the management of incidents. Escalation mechanisms for addressing recurring incidents are not formally documented.			
6	The Health Board are not consistently meeting the timescale requirements for completing MIS+ reviews or for concluding investigations and providing feedback (72 hour and 30-day targets as advised).	4	Operation	Medium

Operating Model	BCU-2324-33	9 May 2024
Report opinion:	Unsatisfactory	

Purpose: To review the costs associated with the Operating Model and whether the revised structure has delivered the benefits intended.

Overview

Although the first phase of the operating model has been implemented as planned, there has been minimal advancement in establishing the desired principles of Integrated Health Communities (IHCs).

There are twenty-six services designated as 'Outstanding design' which require urgent focus. We consider the steps taken to date are more an operational structure and not operating model change.

We have been unable to corroborate the original costs of the Operating Model (OM) presented to and approved by the Health Board. We estimate the operating model has cost at least £1,857,819 more than stated, with contingency and transformational funds used to cover increased management costs. This directs funding away from opportunities to transform services for patients. We believe the current costs of the OM are unsustainable and require immediate review. We also noted that the former Area/Hospital structure was not affordable as a balancing figure of £353,049 was used from Transformational Funds.

It is unclear why management approved the IHC model when there was a calculated increase in recurring funding required of £1,387,612, and where the funding for this was. It is our view that this is a breach of Standing Financial Instructions.

There are no evident benefits realisation measures published for the OM project. We cannot provide any assurance that the OM/structure change has delivered any benefits.

Operational functions have implemented the expected structure to mirror the Executive Delivery Groups (EDGs), however we have found anomalies between the expected EDGs and those in operation.

	Objectives	Assurance
1	The implementation of Version 7 of the Operating Model has been completed in line with the plan and timescales approved by the Board.	Limited
2	The total cost of implementing the Operating Model is within the cost/contingency agreed by the Board.	Unsatisfactory
3	The benefits of the Operating Model are being realised, and any limitations / concerns have been actioned.	Unsatisfactory
4	The operational governance and assurance framework has been implemented and is working as intended.	Limited

	Key Matters Arising	Objective	Control Design or Operation	Recommendation Priority
1	There are significant variances in design and practice of the Operating Model in operation to that which was approved by the Health Board. Several services have not progressed and the cost of implementing the model has significantly exceeded the approved cost.	2,3	Design and Operation	High
2	There are variances in the operation of the Operational Governance and Accountability Framework approved by the Health Board.	4	Design and Operation	High

Corporate Legislative Compliance: NHS (Appointment of Consultants) (Wales) (Amendment) Regulations 2005

BCU-2324-34

10 June 2024

Report opinion: Reasonable

Purpose: To review whether the recruitment of consultants is in line with statute and Health Board procedures.

Overview

The Policy Safe Recruitment & Selection Practices is outdated and requires review.

The Standard Operating Procedure (SOP) Medical and Dental Consultant Recruitment Process is incomplete.

Whilst there is some evidence of ongoing supervision, three Locum doctor appointments were not subject to an Advisory Appointments Committee (AAC), despite exceeding the AAC exemption threshold.

AAC panel member feedback identified a few issues relating to the administration of panels, which can affect the robustness of decisions made.

	Objectives	Assurance
1	There is a procedure in place that outlines the process, responsibilities, and timescales for consultant recruitment.	Limited
2	All roles advertised have been through the establishment control process and are approved in line with delegated authority.	Reasonable
3	There is collaboration with the Royal Colleges as required by the Regulations and Health Board procedures.	Substantial
4	There is effective administration of the AAC panels, with panels scheduled regularly, and with appropriate membership.	Limited
5	Appropriate pre-employment checks are completed prior to appointment.	Substantial

	Key Matters Arising	Objective	Control Design or Operation	Recommendation Priority
1	Policies and procedures relating to recruitment of consultants are either out of date or incomplete.	1	Design	High
2	Three locum appointments were not subject to an Advisory Appointments Committee (AAC) panel. As exemptions were not applicable to the roles, this has breached the requirements of regulations.	4	Operation	High
3	Feedback from Advisory Appointments Committee panel members has highlighted several issues that impacts on the effectiveness of the panel.	4	Design	Medium

Work in Progress Summary

4. The following draft reports have been issued:

Table 1: Draft Reports issued.

Review	Status	Date draft report issued	Management response due
Orthopaedic Surgical Hub Llandudno Hospital	Management challenged accuracies within the report. These have been reviewed and responded to and a meeting requested to discuss the report and responses.	20 May 2024	17 June 2024 *A revised date for management response has not yet been agreed, depending on outcome of meeting with management to discuss the report.*

5. The following 2024/25 reviews are currently in progress:

Table 2: Reviews in progress

Review	Draft report due:
Civil Contingencies Act	August 2024
Special Measures	July 2024
Charitable Funds	August 2024
Value Based Healthcare	July 2024
Recruitment of substantive and interim executive and senior posts	July 2024
Fire Safety	July 2024
Grievance Management	July 2024
Intelligence Led Organisation	July 2024

Contingency/Organisational Support/Advice

6. Internal Audit supports the Health Board through providing advice and guidance on areas of control, new systems, and processes. Recent areas include the Annual Governance Statement and advice on the revision of the process for revenue business cases.

7. We meet with Audit Wales, Healthcare Inspectorate Wales, Health & Safety Executive and Public Services Ombudsman for Wales regularly to discuss recent issues and areas of emerging risks to the Health Board.

Delivering the Plan

8. The additional support provided to the Health Board with focused reviews is channelled through contingency

9. As new risks are identified in year, the Director of Corporate Governance and internal audit will consider the planned reviews against the emerging high-level risks.

10. The Audit Committee is requested to agree to the following changes to the audit plan:

Table 3: Changes to audit plans 2023/24 and 2024/25

Audit Title	Reason for requesting deferral / removal from plan
Grievance Management	Request to confirm to defer the review from 2023/24 plan to 2024/25 plan. Due to resources within the Audit team, fieldwork was unable to be fully completed prior to year-end. Testing is underway and we plan to report in July. This was verbally agreed at the March 2024 Audit Committee
Business Cases: Capital and Revenue	Request to split review to consider capital and revenue elements separately. Following planning discussions, it was evident the procedure for revenue business cases is out of date and may not be the 'correct' process that needs following to ensure the annual plan drives the revenue business cases. We were advised that there have been amendments suggested but these have not progressed to Executive Team due to Special Measures etc. With this in mind, we agreed that we would frame the scope to support the Health Board in reviewing the revenue business cases process/expected controls, post establishment of EDGs etc, and believe this review could and should be Advisory in nature. The Health Board has detailed capital procedures in place since 2020 that remain extant and therefore we can measure compliance with these procedures and provide an opinion on the findings. In summary, splitting the review into - Capital Business Cases - there will be a report with an assurance rating. - Revenue Business Cases - audit to support the development in an advisory capacity, there will be no report. This approach is supported by the Director of Corporate Governance and Executive Director Transformation and Strategic Planning.

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

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

Table 4: Performance Indicators

Indicator	Status	Actual	Target	Red	Amber	Green
Report turnaround: time from fieldwork completion to draft reporting [10 days]	Green	100%	80%	v>20%	10%<v <20%	v<10%
Report turnaround: time taken for management response to draft report [20 days per Internal Audit Charter and Service Level Agreement]	Green	77%	80%	v>20%	10%<v <20%	v<10%
Report turnaround: time from management response to issue of final report [10 days]	Green	100%	80%	v>20%	10%<v <20%	v<10%

Table 5: Core Plan 2024-25 (April 2024 to September 2024)

Planned output	Outline timing	Status	Assurance (including draft report assurance opinions)
Corporate Legislative Compliance: Civil Contingencies Act 2004	June / July 2024	Review in progress.	
Special Measures	June / July 2024	Review in progress.	
Follow-Up of Internal Audit recommendations	April to September 2024	Review in progress (ongoing).	
Transformation & Improvement	August / September 2024	Planning meeting held.	
Charitable Funds (Deferred from 2023/24)	June / July 2024	Review in progress.	
Value Based Healthcare	June / July 2024	Review in progress.	
Business Cases: Capital	July / August 2024	Brief issued.	
Quality Governance: Concerns and Complaints	July / September 2024	Planning.	
Corporate Legislative Compliance: Health and Social Care (Quality and Engagement) (Wales) Act 2020 (Duty of Candour and Duty of Quality)	July / September 2024	Planning.	
Intelligence led organisation	July 2024	Review in progress.	

Planned output	Outline timing	Status	Assurance (including draft report assurance opinions)
Network and Disaster Recovery	September 2024	Planning.	
People & OD Strategy: Operational implementation (Deferred from 2022/23 & 2023/24)	June / July 2024	Brief agreed.	
Recruitment of substantive and interim executive and senior posts (Deferred from 2023/24)	June / July 2024	Review in progress.	
Establishment Control and Recruitment	July / August 2024	Brief agreed.	
Integrated Assurance and Approval Plans (IAAP) • Llandudno Hospital Orthopaedic Hub • Ysbyty Glan Clwyd - Adult and Older Persons Mental Health Unit • Ysbyty Maelor Wrecsam - Infrastructure/ Continuity Works	April to September 2024	Planning.	
Corporate Legislative Compliance: Fire Safety	May 2024	Review in progress.	
Contracted Patient Services: Quality and Safety arrangements - Follow up (Deferred from 2023/24)	October 2024 to March 2025	Deferred.	

Audit Assurance Ratings

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

Substantial assurance

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

Low impact on residual risk exposure.

Reasonable assurance

Some matters require management attention in control design or compliance.

Low to moderate impact on residual risk exposure until resolved.

Limited assurance

More significant matters require management attention.

Moderate impact on residual risk exposure until resolved.

	Unsatisfactory	Action is required to address the whole control framework in this area. **High impact** on residual risk exposure until resolved.
	Assurance not applicable	Given to reviews and support provided to management which form part of the internal audit plan, to which the assurance definitions are not appropriate. These reviews are still relevant to the evidence base upon which the overall opinion is formed.

Table 6: Themes and definitions relating to Image 1

Ref.	Theme	Definition
1	Cyber & Data Management	Management of IT systems and data is inadequate, access rights are not monitored or maintained which may compromise cybersecurity.
2	Communication	Information is not communicated clearly internally within teams, or externally with partners, forums, or wider stakeholders.
3	Compliance	Non-compliance with relevant policies, procedures, standards, applicable laws and regulations, and government instructions. No formal compliance monitoring and issue escalation.
4	Policies & Procedures	Inadequate or lack of policies and procedures in place.
5	Audit Trail (Documentation)	There are missing or partially completed documents, or the quality of documents is not sufficient. A lack of document retention, unretrievable documents/data or inappropriate audit trail.
6	Engagement	Lack of engagement with staff, partners, and wider stakeholders. Engagement with external providers is not consistent, resulting in contracts or agreements not being monitored.
7	Governance & Risk Management	Formal governance routes are inadequate, ineffective, or there is a lack understanding of them. This may affect the ability to identify, assess and manage risk.
8	Ineffective Controls	The necessary control(s) to mitigate risk(s) do/does not exist, is ineffective, or there are gaps which result in inefficiencies.
9	Reporting	The adequacy, quality, or accuracy of reporting is insufficient for assurance, or there is a lack of assurance mechanisms and central oversight in place. No formal reporting, escalation, and scrutiny processes are established, all of which may affect the ability to make decisions.
10	Finances & Resourcing	There are inadequate resources to deliver required tasks, a lack of resource management, monitoring, or funding. Financial viability and sustainability need to be properly considered and maintained.

Ref.	Theme	Definition
11	Review	Whilst work is in progress and when it is completed, reviews are not undertaken regularly (or at all) to ensure quality, effectiveness and that the desired outcome is achieved or is on target to be achieved. Best practice is not reviewed or considered, lessons learned are not monitored or documented which may impact development and lead to repeated mistakes.
12	Physical Security	No consideration and actions to protect against current and future threats.
13	Planning, Delivery & Deadline Management	A lack of timescales or deadlines being set, or unmonitored scope creep resulting in missed deadlines, non-delivery of projects and/or tasks, overspends, or negative impacts on the quality of the final output.
14	Training & Development	A lack of training, opportunities to complete training, or training materials within teams; this may lead to gaps in knowledge and over reliance on certain staff members.
15	Contractual	Awaiting definition.
16	Strategy	Awaiting definition.
17	Other	If there is no correlation between a recommendation and one of themes outlined, this option can be selected to help monitor the accuracy of the list provided and to identify potential additional themes.

Health & Safety
Final Internal Audit Report

May 2024

Betsi Cadwaladr University Health Board

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

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

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Review reference:	BCUHB-2324-20
Report status:	Final
Fieldwork commencement:	21 November 2023
Fieldwork completion:	16 January 2024
Debrief meeting:	12 January 2024
Draft report issued:	23 & 31 January 2024
Management response received:	21 May 2024
Final report issued:	22 May 2024
Auditors:	Patrick Williams, Principal Auditor Nicola Jones, Deputy Head of Internal Audit Dave Harries, Head of Internal Audit
Executive sign-off:	Carol Shillabeer, Chief Executive
Distribution:	David Maslen-Jones, Acting Assistant Director of Occupational Health, Safety and Security Jason Brannan, Deputy Director of People & OD Pam Wenger, Director of Corporate Governance Ffion Johnstone, Libby Ryan Davies, Michelle Greene – IHC Directors' Arwel Hughes, Head of Operational Estates David Fletcher, Associate Director Diagnostic Services and Clinical Support Fiona Giraud, Director of Midwifery and Women's services Geraint Roberts, Divisional General Manager Cancer Services Iain Wilkie, Interim Director Mental Health & Learning Disabilities
Committee:	Audit Committee

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

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

Disclaimer notice - please note:
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Executive Summary

Purpose

The overall objective was to review compliance with HS01 Occupational Health and Safety Policy, assessing the adequacy of management arrangements for Health & Safety to provide assurance to the Health Board.

Overview

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

- At the time of our review Policy HS01 Occupational Health and Safety was out of date due to accountability arrangements, coupled with a small number of other procedures/ guidance papers.
- There is no Executive lead in place for Occupational Health and Safety – this is not compliant with the Health Board's policy.
- There is no regular and consistent monitoring and reporting on Health and Safety matters through the appropriate governance structure. There has been no annual Health & Safety report for 2022-23 presented at Health Board meetings.
- There is no consistent approach to reviewing and analysing findings of reviews undertaken by the Health and Safety team. The gap analysis, undertaken to identify areas of risk, is not current and was last updated in January 2022.
- There is no consistent organised collation/review of self-assessments undertaken across the Health Board, with some areas not completing or returning any assessments. This is a significant control failure and requires urgent focus, to enable both Operational and Executive management to have complete

Report Opinion

		Trend
Limited	More significant matters require management attention. **Moderate impact** on residual risk exposure until resolved	2019/20

Assurance summary[1]

Objectives		Assurance
1	There are appropriate health and safety policies and procedures in place.	Limited
2	There is an appropriate governance structure with mechanisms for regular monitoring and escalation of Health and Safety matters.	Limited
3	Health and Safety training is provided as required, with compliance monitored and action taken to address areas of low compliance.	Reasonable
4	The Health and Safety department is undertaking formal Health & Safety reviews for each department, with actions addressed appropriately, The gap analysis previously produced has been subject to review and updated.	Limited
5	Departments are undertaking their twice-yearly Health and Safety self-assessment, with clear actions in place to address areas of non-compliance / risk.	Limited

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

oversight of risk areas to concentrate its limited resources on.

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

Key Matters Arising

		Objective	Control Design or Operation	Recommendation Priority
1	The Occupational Health and Safety Policy, and a small number of supporting procedures and documents on BetsiNet are out of date. There is also no Occupational Health and Safety-Board Level Executive Director in post, which is a requirement of the Health and Safety Policy.	1	Operation	High
2	There is a lack of monitoring and reporting of Health and Safety information and issues through the appropriate governance structure. There has been no annual Health & Safety report for 2022-23 presented at the Health Board meetings.	2	Operation	High
3	There is a lack of attendance at Health and Safety training at both Senior and Executive level. Whilst some training has been provided, we are unable to confirm that all those required to undertake training have been identified and offered appropriate training relating to Health and Safety.	3	Operation	Medium
4	There is no consistent approach to reviewing and analysing findings of reviews undertaken across the Health Board.	4	Design	High
5	The gap analysis previously produced has not been reviewed since January 2022.	4	Operation	High
6	A review of action plans resulting from Health and Safety reviews has identified that whilst there is some evidence of review, there is no regular review of dates and progress to ensure completion of agreed actions.	4	Operation	Medium
7	There is no consistent collation and review of self-assessments that are undertaken across the organisation.	5	Design	High

1. Introduction

1.1 The Health & Safety at Work etc. Act (1974) is the primary legislation covering occupational health and safety in the United Kingdom (UK). It defines the fundamental structure and authority for the encouragement, regulation and enforcement of workplace health, safety and welfare within the UK. The Act defines general duties of employers, employees, contractors, and suppliers of goods and services for use at work.

The HS01 Occupational Health and Safety Policy (HS01) and Strategic approach embraces the concepts of sensible Occupational Health and Safety (OHS) by ensuring control measures are proportionate to risk. The Health Board is committed to take all practicable steps, consistent with the provision of health care services, to safeguard its patients, visitors and staff from injury or ill health whilst on the premises.

The Policy is to provide a healthy and safe working conditions for all its staff and to abide by and satisfy the requirements of the Health and Safety at Work etc. Act 1974 and the Corporate Manslaughter and Corporate Homicide Act 2007.

1.2 The risks associated with the review are:

- Failure to comply with statutory requirements including legal repercussions such as legal fees and fines;
- The Health Board is not aware of any Health & Safety issues;
- Increased health and safety risk for the public and staff; and
- Poor public image for the Health Board.

2. Detailed Audit Findings

Objective 1: There are appropriate Health and Safety (H&S) policies and procedures in place that set a clear direction and clarify responsibilities at all levels of the organisation.

2.1 The BetsiNet Health and Safety homepage "Policies and Written Control Documents" section, includes forty-eight (49) Policies, Procedures, Appendices, Protocols and Other documents.

Outdated Policies and Procedures were presented for approval at the Strategic Occupational Health and Safety Group meeting on 18 December 2023. Following a meeting with the Corporate Health and Safety Department on 12 January 2024, we were informed that all Policies and Procedures, except those listed below, have been ratified and are now being incorporated onto the BetsiNet.

The following are awaiting review;

- HS03 - General Risk Assessment Procedure,
- HS17 - Procedure & Guidance Document for Display Screen Equipment Use – currently awaiting Executive approval due to cost implications of eye testing within the policy,

- Standard Operating Procedure (SOP) for Cleaning & Disinfection of JSP Force 8 Corpro Respirator Half Mask with Filters – Reviewing and updating of SOP sits with infection control,
- SOP for Cleaning & Disinfection of the Optrel Positive E3000X Air Flow Generation Unit & Clearmaxx Helmet - Reviewing and updating of SOP sits with infection control,
- HSEC-01 - Contractors Safety Guidance for All Contractors Working on BCUHB Sites & Premises - Reviewing and updating of SOP sits with Estates,

2.2 The HS01 Occupational Health and Safety Policy was due to be reviewed in December 2023. A request was sent to the Interim Board Secretary on the 20 December 2023 to request a six month extension. We have subsequently been advised that the Policy has not been updated due to accountability arrangements.

HS01 sets out a Safety Management System that is based on the Health & Safety Executive (HSE) HSG65 process of Plan, Do, Check, Act - an over-arching guide on the essential beliefs of good health and safety.

The policy defines roles and responsibilities within the Health Board. This includes the requirement for an appointed Executive lead for Occupational Health and Safety. There has been no designated Executive lead since the departure of the Executive Director of Workforce and Organisational Development in December 2022.

We also note that an interim Assistant Director of Occupational Health, Safety and Security has been in post since July 2023.

Conclusion:

2.3 One key policy and a small number of SOPs/Guidance documents are out-of-date and require review; we recognise that some of the documents are outside the control of the Corporate Health and Safety Department.

2.4 There is currently no appointed Occupational Health and Safety-Board Level Executive Director, which will impact upon the Health Board's strategic focus and drive, coupled with ensuring duties as described within HS01 are fulfilled.

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

Objective 2: There is an appropriate governance structure with mechanisms for regular monitoring of Health and Safety matters with escalation of issues to the Board, appropriate Committee, and the Health and Safety Executive (HSE) where appropriate.

2.5 The governance structure for Health and Safety is outlined in the HS01 policy. To establish whether the Health Board is receiving assurance that Health and Safety is being managed effectively, we reviewed minutes of key meetings detailed in the policy.

2.6 Health Board meetings

The Policy (section 7.2) states *"The Health Board will receive regular reports from*

the Strategic Occupational Health and Safety Group via the Quality Safety and Experience Committee".

The Terms of Reference for the Strategic Occupational Health and Safety Group include that it shall "*Report formally, regularly and on a timely basis to the Health Board on the Group's activities. Including the presentation of an Annual Report".*

A Quality Safety and Experience Committee (QSE) Chairs Assurance report is regularly presented to Health Board meetings. The reports included that the QSE had received and reviewed the chairs reports from the Strategic Occupational Health and Safety Group (SOHSG) up to the 24 November 2022.

We have been unable to observe SOHSG chairs reports feeding into the QSE chairs reports since November 2022. We note there has been discussion within the minutes of 20 January 2023 regarding work with Health and Safety Executive in a report presented to the QSE "Health & Safety report including HSE update".

The delivery of an annual report is the duty of the Occupational Health and Safety-Board Level Executive Director, a position that is currently vacant. There has been no annual Health & safety report for 2022-23 presented at the Health Board meetings.

2.7 Quality Safety and Experience Committee (QSE)

The Policy (section 7.4) states "*The Quality, Safety and Experience Committee shall receive the minutes and any significant issues to be escalated from the Strategic Occupational H&S Group and Quarterly reports on progress of Occupational H&S Plans".*

Chairs assurance reports from the SOHSG, which include issues for escalation, have been reported into the QSE up to 20 January 2023. Since this date there is no evidence of the SOHSG chairs assurance report presented to QSE. We note that QSE did not meet between the months of February and April 2023 inclusive.

The Health and Safety report for quarter 2 (1 July – 30 September 2022) was presented to QSE 20 January 2023. Additionally, within the minutes of 19 May 2023, a Health and Safety report summarising the quarter 4 (1 January 2023 – 31 March 2023) was provided to the QSE meeting, however we have not been able to see the full quarter 4 report being presented.

As well as the quarter 4 report we have not been able to observe quarterly reports 1,2 and 3 for the period of April 2023 to December 2023 inclusive being presented at QSE.

2.8 Risk Management Group (RMG)

The reporting and assurance arrangements in the Strategic Occupational Health and Safety Group Terms of Reference includes the group should "*Provide assurance to the Risk Management Group by raising risks through the governance structure as necessary and providing quarterly and annual reports to the Group".*

Advisory chairs assurance reports can be seen being reported into the RMG up to the 4 October 2022, after which we have not been able to identify any chairs

assurance reports, either quarterly or annual, being presented at the RMG.

2.9 Strategic Occupational Health Safety Group (SOHSG)

A review of the minutes for the 20 April, 4 July, 29 August and 17 October 2023 meetings respectively identify:

- Sub-groups are reporting at the meeting, however, we have been unable to evidence the Operational Occupational Health and Safety Group Health and the Wellbeing Group reporting to the meeting.
- All four meetings reviewed were not quorate as no Executive Director responsible for Health & Safety was present in accordance with the Terms of Reference.
- Issues of escalation to the QSE have been identified within the meeting, however we have been unable to evidence the issues being raised/discussed within QSE, e.g.
  - Clarity on where the meeting sits in the BCUHB meeting structure.
  - Concerns relating to a lack of robust lockdown policy/procedures following the Fire Service / Police tabletop exercise.
  - Issues relating to car parks.
- Integrated Health Community (IHC)/Service reports – reports from the IHCs are being presented regularly however we noted that Mental Health & Learning Disabilities; Women's Services and Cancer are not reporting as expected into the meetings.

Conclusion:

2.10 There is inconsistent reporting from some clinical services to the SOHSG, per the Terms of Reference with two of its meetings not quorate through the absence of the lead Executive Director, as required by the Terms of Reference.

2.11 There has been no regular reporting from the SOHSG to the Health Board via QSE since November 2022. Also, there was no evidence that issues of significance identified within the SOHSG were discussed at QSE.

2.12 There has been no annual report for 2022/23 presented to the Health Board or QSE Committee meetings with quarterly reporting also limited.

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

Objective 3: Health and Safety training is as required, with compliance monitored and action taken to address areas of low compliance.

2.13 Health, Safety and Welfare mandatory training is delivered through Electronic Staff Record (ESR) E-learning and needs to be completed every three years. Figures provided by Workforce & Organisational Development on 9 January 2024 state that as at November 2023, 19,454 staff are compliant (91.39%), with 1,832 staff non-compliant.

2.14 The Policy (Section 5.1.5) states "*H&S department will provide advice and guidance in respect of the training required".*

Evidence has been provided of ad-hoc training being undertaking within all three areas, primary care as well overarching training for all of the Health Board, these courses include:

- Risk Assessment Made Easy.
- RIDDOR Toolbox Talk.
- COSHH Awareness Workshop.
- Risk Assessment Workshop for Managers.
- Ligature Risk Awareness and Risk Reduction (Pilot 1).

Training courses are also published on BetsiNet for West and Central areas, with East noted as 'Coming soon'.

2.15 The Policy (section 5.1.3) states "*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".*

On 16 November 2022, a report was presented to the Health Board Leadership Team (HBLT) with the recommendation that the HBLT and managers of Agenda for Change 8d and above attend an Institution of Occupational Safety and Health (IOSH) leading safely course.

Between December 2022 and January 2023, five courses were organised, with a total of 67 managers completing the course. We were unable to ascertain if the training was attended by all HBLT and managers in grades 8d and higher, as there is no consolidated data that identifies those who require training (band 8d and higher).

2.16 A National Examination Board in Occupational Safety and Health (NEBOSH) Health and Safety Executive (HSE) Certificate in Health and Safety Leadership Excellence, developed jointly by NEBOSH and the HSE, was held on the 12 December 2023, aimed at Directors and Senior Executives. Fourteen staff attended, including 10 associate/assistant directors and 4 Heads of Service; we note that although invites were sent to Executives there was no attendance recorded of Executive-level officers.

2.17 Evidence of a formal quote was provided for the commencement of two courses, the NEBOSH Award and the NEBOSH General Certificate. We were informed that it is hoped that these courses will begin in January and February 2024.

Conclusion:

2.18 The Health Board receives health and safety training at all levels, from ward to Board. This comprises mandated training, ad hoc training, management training, and there are plans for NEBOSH courses starting in 2024 that we recognise as good practice.

Whilst training at Executive level has been offered and provided, we have been unable to confirm full attendance of the Executive Leadership Team.

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

Objective 4: The Health and Safety department is undertaking formal Health & Safety reviews for each department as required by the HS01 Occupational Health and Safety Policy, and any actions from reviews are addressed appropriately. The gap analysis previously produced has been subject to review and updated.

2.19 The HS01 Policy – Section 5 - BCUHB General Arrangements for Occupational Health & Safety, states: *Corporate H&S Advisors will undertake formal H&S Reviews of each Department within their respective area. Frequency of reviews are based on the identified overall level of risk from the previous reviews or incident investigations, risk register entries or Departmental H&S Self-Assessment.*

Within the three areas (East, Central and West), reviews are currently being undertaken based on:

- incidents and themes identified with the DATIX system.
- at the request of the department.
- based on advisors knowledge of their areas and colleagues e.g. security may advise a review following a visit to the department.

We note that Primary care have an 18-month rolling programme.

2.20 We were provided with a current list of H&S reviews completed for 2023. The key performance indicator for current quarterly completion of reviews stands at nine per quarter from H&S Advisors and six from H&S (Fit Testing) Advisors; a total of fifteen per quarter.

The table below states how many reviews have been completed in each area for quarter 1 and 2.

Table 1

Areas	East	Central	West	Primary Care
Quarter 1	9*	18	30	14
Quarter 2	13	15	37	18
Total	24	33	69	32

* Quarter 1 for East was reduced to 9 reviews due to the fit tester in East only commencing in their post during quarter 2.

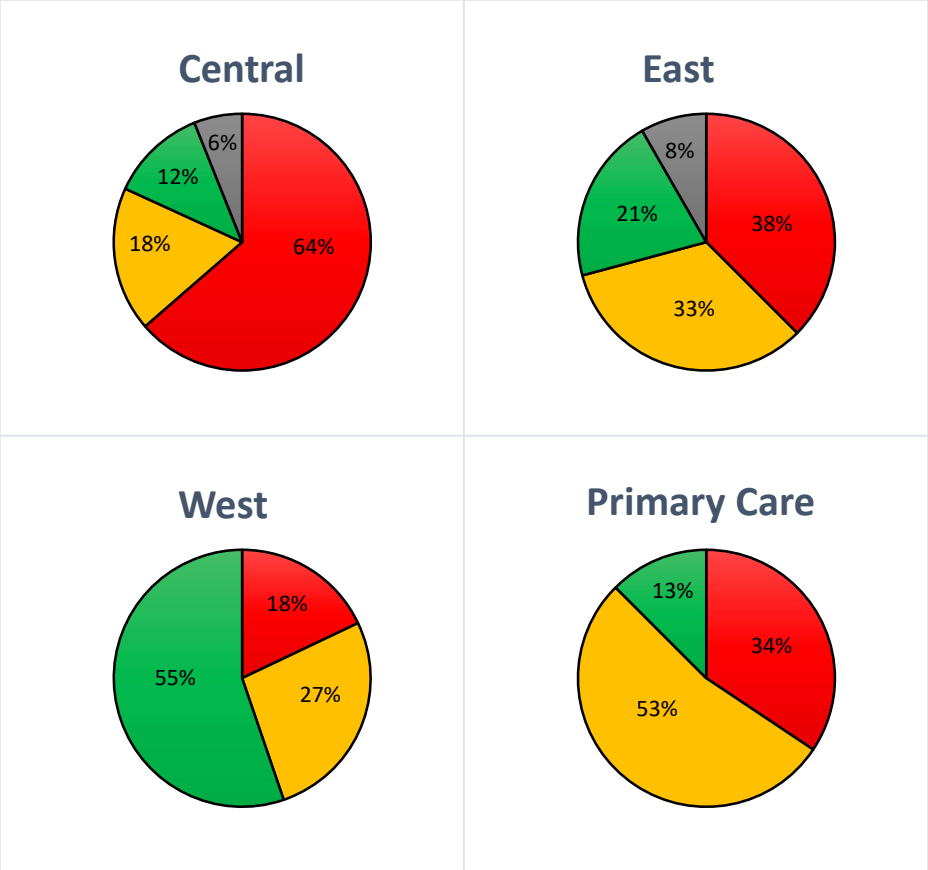
Each review is given a percentage compliance score and a red, amber, green (RAG) rating.

Table for key for percentage compliance score

0% – 75%	Poor compliance and indicative of high risk which requires immediate mitigation or escalation.

75% - 95%	Indicative with significant but lower-level risk requiring planning for mitigation or escalation.
95%- 100%	Compliance is well managed, requiring monitoring of controls and continual improvement.

The graphs below highlights the percentage of reports that received a rating of red, amber and green for quarter 1 & 2 in 2023.



Please note: Grey sections in Central and East indicate that there was no score at the time of preparing this report.

2.21 We are advised that the review process will be standardised further from January 2024 and were provided with a draft Health & Safety advisor and Health & Safety (Fit testing) Advisor KPI document. The total number of reviews going forward will be 25 per region per quarter/100 annual H&S reviews per region.

We reviewed both the SOHSG and the H&S leads meetings to confirm if there was a consistent approach in evaluating the reviews that have been conducted. We were able to observe discussions taking place however the breakdown and summary of findings of reviews was not consistent

2.22 <u>The HS01 Occupational Health and Safety Policy – 6.5 Executive and Senior Management/Directors states they must:</u>

Take appropriate advice and guidance from competent persons for Occupational H&S (Corporate H&S Team) and implement findings of gap analysis, reviews,

audits and incidents, accidents or identified trends.

We have been unable to determine that Executive and Senior Management/ Directors are implementing findings from the reviews undertaken within their areas/services of accountability.

Although senior management/directors are responsible for implementing the findings, as stated in HS01, as good practice we were provided with evidence from the Corporate Health & Safety Department that the Health & Safety team are assisting services/departments on issues discovered as a result of their reviews.

2.23 A gap analysis undertaken in September 2019 identified significant areas of concern in the management of Occupational Health and Safety within the Health Board. The gap analysis we received has not been updated since 1 January 2022. We were informed that due to limited H&S resource, high risk areas within estates have been prioritised whilst other work has concentrated on the implementation of a three-year strategy (2022-25). The strategy was developed to provide a programme of improvement in achieving the Health Board's safety objectives.

2.24 Areas of the gap analysis that have been identified as high risk within the Estates services include Water Safety, Electrical Safety, Asbestos Management, Gas Safety and the Management of Pressure Systems have been reviewed.

We received audits of the high-risk areas, which were undertaken to expand on the gap analysis reviewing specific areas, with action plans prepared. To ensure the action plans were developed and regularly reviewed, we sampled the following high risk areas: asbestos, Hand-Arm Vibration (HAVS), and fire.

- The Asbestos action plan was last updated 17th July 2023, linking in with the audit and the tier 1 corporate risk register CRR20-21 Asbestos Management and Control. 13 goals were identified, 9 are complete, 3 are ongoing and 1 has a completion date set for 1st March 2024.
- The Hand-Arm Vibration (HAVS) action plan was last updated 8th December 2023. We are informed that there is a weekly meeting arranged to update the action plan, however there are no minutes taken at this meeting. The Red, Amber and Green progress rating requires updating to reflect the weekly updates. There are 27 actions with 9 complete, 6 actions in date to be completed and 12 actions outdated.
- The Fire action plan was provided as evidence although there is no date of review on the action plan. However, we were provided with two meetings of the fire safety management group in October 2023 with the Health & Safety gap analysis (Fire Safety) as an agenda item. There are 23 actions, 5 have been completed, 4 target dates have passed, and 14 actions are to be completed in 2024.

2.25 The *Occupational Health & Safety and Security Three Year Strategic Plan 2022-2025* was developed to provide the Health Board with a clear programme of improvement to achieve safety objectives; it is based on the gap analysis undertaken in July 2019.

The strategy has identified three services, Occupational Health & Wellbeing, Security/Violence and Aggression and Health and Safety. Each year a minimum of three areas of compliance within each service has been identified, ensuring that over the 3-year period there are 27 areas of significant risk which have been completed and embedded within the organisation.

Health & Safety areas of compliance year 1

- Manual Handling provision of appropriate policy and training.
- Deliver an effective COSHH management system to key service areas.
- Review the ligature risk assessment process and support the MHLD teams in undertaking these risk assessments.

Health & Safety areas of compliance year 2

- Review work at height systems and documented process.
- Support the development of a contractor management system.
- Review documented process for slips trips and falls for staff and patients.

Action plans have been developed to support the implementation of the years 1 and 2 of the strategy. The action plans are updated on a weekly basis, our findings from the action plans are noted below.

Actions match the issues of compliance within the strategy, the action plan uses a RAG rating and target date for completion to measure progress.

- Year 1 has 27 actions developed from 4 issues of compliance, (reviewing of RIDDOR has been added as well as the 3 identified areas within the strategy).
    - 21 green actions.
    - 6 amber actions. (target dates for completion end of March 2024)
- Year 2 has 18 actions from 3 issues of compliance,
    - 11 green actions within in date.
    - 7 amber actions (target dates for completion end of March 2024).
- All amber actions have the most recent update on progress.
- Action plans are monitored weekly, updates are provided within the action plan on all outstanding actions.

Conclusion:

2.26 Reviews are undertaken by the Health & Safety team, with 158 reviews completed in quarters 1&2, across East, Central, West and Primary Care. Whilst these reviews are discussed in H&S meetings, there is no consistent approach to reviewing and analysing the findings from reviews. The Key Performance Indicator for the number of departmental Health and Safety reviews undertaken by the H&S team is due to be revised for 2024, with the number of reviews increasing to 400 per year (100 per region and 100 for Primary Care).

2.27 The gap analysis that was previously undertaken is now outdated and consideration needs to be given on how this is re-visited, as risks/gaps may have changed.

2.28 A review of action plans because of H&S reviews within estates identifies these need updating to ensure actions are on track for completion, as well as using a standardised template for ease of monitoring and reporting.

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

Objective 5: Departments are undertaking their twice-yearly Health and Safety self-assessment, with clear actions in place to address areas of non-compliance / risk.

2.29 The Policy (section 5.35) states *"All Departments must undertake a H&S Self-Assessment twice per year. The Service Manager is required to identify a designated H&S Champion for their area. The Manager is responsible for providing the H&S Champion with adequate time and resources to undertake the self-assessment review".*

The Health & Safety Champions/Leads oversee the distribution and collection of the self-assessments with their respective areas every April and October. We met with four of the identified Health & Safety Champions/Leads to determine the process undertaken:

- Three of the four areas had not undertaken the self-assessment since April 2022.
- There is some misunderstanding regarding the purpose of the self-assessment; we were advised certain areas/services are using it as a template prior to the Health & Safety team undertaking corporate reviews.
- There are areas/services that are copying and pasting the answers from previous self-assessments, thus undermining the true position of compliance.
- There is limited understanding amongst staff who are completing the self-assessments, as not all staff feel they have the knowledge to complete the self-assessment.

2.30 The Policy (section 5.3.5) states *A copy* (of the self-assessment) *must be forwarded to the H&S Team. Collated data will be reported back on a six monthly basis to the Strategic OHS Group*

The Health and Safety corporate department advise that they receive completed self-assessments through various channels, but there is currently no systematic collation of self-assessments at the corporate level with no monitoring which departments have completed them.

Based on the evidence of minutes provided to us, we have not been able to observe any information / data from the self-assessments being discussed or provided at the Health and Safety Leads meetings or the Strategic Occupational Health Safety Group.

2.31 We were unable to ascertain whether there is a clear list of Health & Safety Champion/Leads, as well as locations where there are no Health & Safety Champion/Leads.

Conclusion:

2.32 The Health and Safety team receive self-assessments from departments, however there is no scrutiny or collation of the information, exposing the Health Board to risk that potential hazards/issues are overlooked and then materialise. Further, opportunities for identifying similar risks and facilitating a root and branch review of the issue to identify controls to minimise/eliminate the risk are missed.

2.33 Self-assessments are an agenda point on the Health & Safety leads meeting, however there is no evidence available to demonstrate regular discussion on compliance with self-assessments.

Discussions with H&S Leads/Champions suggest there is confusion around the process for self-assessments, and the knowledge / expertise required to undertake these.

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

Appendix A: Management Action Plan

Matter Arising 1: Policies & Procedures (Operation)	**Impact**
The HS01 Occupational Health and Safety Policy requires review, as well five other documents on BetsiNet: • HS03 - General Risk Assessment Procedure • HS17 - Procedure & Guidance Document for Display Screen Equipment Use – Currently awaiting Executive approval due to cost implications of eye testing within the policy • Standard Operating Procedure (SOP) for Cleaning & Disinfection of JSP Force 8 Corpro Respirator Half Mask with Filters – Reviewing and updating of SOP sits with infection control • SOP for Cleaning & Disinfection of the Optrel Positive E3000X Air Flow Generation Unit & Clearmaxx Helmet - Reviewing and updating of SOP sits with infection control • HSEC-01 - Contractors Safety Guidance for All Contractors Working on BCUHB Sites & Premises - Reviewing and updating of SOP sits with Estates There is currently no appointment of an Occupational Health and Safety-Board Level Executive Director, which is a requirement of the Policy. This will have an impact on the strategic focus and drive of Health & Safety within the Health Board. It is recognised the Executive portfolios in the Health Board are currently being reviewed.	Potential risk of: • Staff are not provided with up-to-date policies and procedures, increasing the likelihood of non-compliance with requirements. • Health and Safety is not given appropriate focus within the Health Board.

Recommendations		**Priority**
1.1a	The HS01 Policy, and supporting procedures and documents on BetsiNet require a review to ensure staff are provided with up-to-date requirements and guidance relating to Health & Safety.	**Medium**
1.1b	Executive level responsibility for Occupational Health and Safety should be considered, to ensure Health and Safety is a key focus within the Health Board.	**High**

Agreed Management Action	**Target Date**	**Responsible Officer**

1.1a	The Policy is in review and will be completed and submitted for approval to the Health Board.	31/07/2024	**Acting Associate Director of Occupational Health, Safety & Security**
1.2b	The Chief Executive is the responsible Executive Lead until there is a substantive appointment to the Director of Environment post.	Immediately	**Chief Executive**

Matter Arising 2: Monitoring and reporting of Health and Safety (Operation)	**Impact**
There is no regular and consistent monitoring and reporting of Health and Safety information through the Health Board governance structure. Issues identified include: • No regular reporting of the Strategic Occupational Health and Safety Group (SOHSG) into the Quality Safety and Experience Committee (QSE) chairs reports and being presented at the Health Board meetings. • No SOHSG chairs reports feeding into the QSE since the 20th January 2023. • Quarterly reports 3, 4 for 2022/23 and quarters 1 and 2 for 2023/24 have not been presented to the QSE. • No reporting into the Risk Management Group since 4th October 2022 as per policy. • Two of the SOHSG meetings were not quorate due to no Executive being in attendance, as per the requirements of the Terms of Reference. • Issues of significance identified within the SOHSG were not noted as being discussed when escalated to the QSE. • Lack of regular and consistent reporting to the SOHSG by some services (Mental Health & learning Disabilities, Women's and Cancer). • There has been no annual Health & Safety report for 2022-23 presented at the Health Board meetings.	Potential risk of: • Ineffective oversight of Health & Safety matters

Recommendations		Priority
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).	**High**
2.1b	The Strategic Health and Safety Operational Group to confirm the reporting required to the group by services and ensure this is communicated to all relevant areas. Instances of non-reporting should be communicated to the services and escalated appropriately, via the Executive or QSE.	**High**

Agreed Management Action		Target Date	Responsible Officer
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	29/02/2024	**Acting Associate Director of Occupational Health, Safety & Security**
2.1b	To ensure that reports are received by the Chair of SOHSG from all relevant areas, TOR to be recirculated to departmental leads, chair of SOHSG needs to be an Executive Director in order to be quorate so will need to be appointed by Executive team. Will be included in SOHSG reports from 2nd Quarter 2024 through People and Culture Committee, responsibility of responsible Executive Director.	29/02/2024	**Chief Executive** **(Pending appointment of Director of Environment)**

Matter Arising 3: Health & Safety Training (Operation)			**Impact**
There is a lack of senior and executive level attendance at health and safety training. Whilst some training has been provided previously, we are unable to confirm that all persons who require training have been identified and have received appropriate Health and Safety training.			Potential risk of: • Executives and senior staff are not aware of their roles and responsibilities under Health & Safety Legislation.
Recommendations			**Priority**
3.1	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".*		**Medium**
Agreed Management Action		**Target Date**	**Responsible Officer**
3.1	Further training for Executive Team to be arranged, Executive responsibility to ensure attendance.	01/09/2024	**Acting Associate Director of Occupational Health, Safety & Security**

Matter Arising 4: Health & Safety Reviews (Corporate Health & safety) (Design)	**Impact**
The Health and Safety Policy (5.3.4 Corporate-H&S and Self-*Reviews)* states *"….A report will be submitted to the responsible Manager within two weeks following the site visit, which will include:* • *scoring which reflects the level of risk* • *a description of the evidence, and* • *recommendations for actions against identified risks."* Whilst there is evidence that reviews are completed, there is no 'closure' step within the Policy to ensure recommendations have been agreed, responsible officer assigned or proposed implementation date recorded, to enable follow-up.	Potential risk of: • Health & Safety recommendations are not addressed, increasing the risk of prosecution.

Recommendations		**Priority**
4.1	Health Board Policy 5.3.4 is reviewed to ensure that all Corporate Health & Safety recommendations are agreed, assigned to owners, allocated appropriate dates and are subject to follow-up.	**High**

Agreed Management Action		**Target Date**	**Responsible Officer**
4.1	New Process already instigated to ensure that a timetable for H&S visits by the corporate H&S team takes place over the coming year with a minimum number of visits per advisor, but also to ensure the quality of the response. It is the responsibility of Managers within the Health Board to assign and follow up responsibility of IHC/Divisional Director.	01/01/2024	**Acting Associate Director of Occupational Health, Safety & Security** **IHC/Divisional Directors**

Matter Arising 5: Gap analysis (Operation)			**Impact**
A gap analysis undertaken in September 2019 identified significant areas of concern in the management of Occupational Health and Safety within the Health Board. The gap analysis we received has not been updated since 1 January 2022. We were informed that due to limited H&S resource, high risk areas within estates have been prioritised whilst other work has concentrated on the implementation of a three-year strategy (2022-25).			Potential risk of: • Health Board not having an understanding of Health and Safety risks and issues affecting the organisation.
Recommendations			**Priority**
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.		**High**
Agreed Management Action		**Target Date**	**Responsible Officer**
5.1	The Review of the Gap Analysis has commenced, completion is due in April 2024.	30/04/2024	**Acting Associate Director of Occupational Health, Safety & Security**

Matter Arising 6: Action Plans (Operation)	**Impact**
A review of the Estates action plans from Health and Safety reviews identified that whilst there is evidence actions have been reviewed, there is no regular review of implementation dates and progress to ensure agreed action(s) is/are on track, or to address any potential delays. The template used varies, which impacts the ease of use for monitoring and reporting.	Potential risk of: • Estates department will not have a clear understanding of what issues have been resolved and what are still affecting the organisation.

Recommendations		Priority
6.1	Estates to standardise action plans resulting from Health and Safety reviews and ensure regular review and update of actions to monitor progress.	**Medium**

Agreed Management Action		Target Date	Responsible Officer
6.1	Estates are ensuring regular internal reviews of H&S for their areas and working on an action plan to ensure that any actions raised are addressed.	01/04/2024	**Interim Director of Capital & Estates/Head of Operational Estates**

Matter Arising 7: Self Assessments (Design)	**Impact**
In accordance with HS01, Health and Safety self-assessments should be undertaken by departments twice yearly (April & October). There is no consistent monitoring, review and collation of self-assessments being undertaken across the Health Board. There is no up-to-date list of Health & Safety leads/champions within the Health Board to ensure assessments have been completed in all departments as required by policy.	Potential risk of: • Non-compliance with the requirements of the Health and Safety Policy, resulting in increased risk of incidents within areas, services and departments of the Health Board.

Recommendations		Priority
7.1	A process to monitor and review department self-assessments should be put in place to ensure departments are adhering to the Health and Safety Policy. This should also include escalation where self-assessments are not completed, reviewing self-assessments for potential risks / issues and identifying areas of similarities / opportunities across departments.	**High**

7.2	An up-to-date list of Health and Safety leads / champions be developed to ensure there are contacts in place for all departments who are required to undertake self-assessments.	**Medium**

Agreed Management Action		Target Date	Responsible Officer
7.1	A calendar has been completed to schedule actual H&S Visits. There is insufficient resource available for the current H&S Advisors to review all self-assessments of every department within the health board so the responsibility for management at IHC/Divisional Director needs to be delegated to appropriate persons for review of compliance and escalation to management teams, this will then be reported Quarterly as part of the quarterly report to SOHSG.	01/05/2024	**IHC/Divisional Directors** **Acting Associate Director of Occupational Health, Safety & Security**
7.2	To work with comms and managers of areas to ask for H&S leads for each area as part of generic work to be done on ensuring all areas conduct regular self-assessments.	01/05/2024	**IHC/Divisional Directors** **Acting Associate Director of Occupational Health, Safety & Security**

Appendix B: Assurance opinion and action plan risk rating

Audit Assurance Ratings

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

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

Prioritisation of Recommendations

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

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

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

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Budgetary Control
Final Internal Audit Report

June 2024

Betsi Cadwaladr University Health Board

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

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

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

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

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

Executive Summary

Purpose

To review whether the Health Board has effective controls in place to manage its financial budgets, including delegation and information available to budget holders.

Overview

There has been positive progress on financial management and control towards the latter half of the financial year. We recognise the significant upheaval and changes in the Finance leadership in year, with a further appointment of a new senior Finance leadership team, both interim and substantive mid-way through the 2023/24 financial year. It is recognised there are areas still to address which are on-going.

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

- The audit found that the Health Board does not have detailed budgetary control procedures in place. We note the provision of a Budget Manager Handbook, however this does not replace the need to have standard operating procedures to ensure consistency in budget setting across the Directorate.
- No accountability letters were issued to budget holders and managers at the start of the 2023/24 financial year, as required by the Standing Financial Instruction 5.5 – Budgetary Delegation. This pre-dates the current Finance leadership team.

  The Accountability Letter is pivotal in formally delegating budgetary responsibility as well as setting out the achievement of planned levels of service coupled with other key responsibilities. Whilst acknowledging control totals were presented to Officers in November 2023 via the Executive Delivery - Integrated Performance Group,

Report Opinion

	Trend
Limited More significant matters require management attention. **Moderate impact** on residual risk exposure until resolved.	N/A as the scope and objectives are different to 2022/23

Assurance summary[1]

Objectives		Assurance
1	Procedures are available to staff, are up-to-date and reflect current working practices.	Unsatisfactory
2	Accountability Letters have been completed and signed by all Budget Holders for 2023/24 in line with Standing Financial Instructions (SFIs).	Limited
3	Delegated limits recorded in the E-Financials hierarchy are in line with Scheme of Reservation & Delegation.	Reasonable
4	Accrual entries are correct and subject to effective scrutiny.	Reasonable
5	Journal entries are subject to appropriate segregation of duties and scrutiny.	Limited
6	A Budget Virement Policy exists and is complied with at all times.	Reasonable
7	Reporting of the month end financial position is complete and accurate in line with the General Ledger.	Substantial
8	Budget holders have received appropriate training enabling them to manage their delegated budgets.	Reasonable

minute evidence is limited in stipulating these totals must be achieved.

- A small number in our sample in the E-Financials hierarchy were not in line with the Scheme of Reservation and Delegation approved by the Health Board. We found one limit change was approved by a finance officer but are unsighted whether this was pre-approved by the Board.
- There is no documented standard operating procedure for creating and reviewing accrual and journal entries despite this being agreed by management in the 2022/23 review.
- The challenge facing both Finance and Procurement colleagues is significant to deliver training to all officers that require it and maintain such. A realistic and risk-based training plan should be developed.

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

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

Key Matters Arising

		Objective	Control Design or Operation	Recommendation Priority
1	The Health Board do not have robust and detailed budgetary control procedures in place.	1	Design	High
2	Accountability Letters have not been issued to budget holders and managers for 2023/24, as required by the Standing Financial Instructions.	2	Operation	High
3	A small number in our sample in the E-Financials hierarchy were not in line with the Scheme of Reservation and Delegation approved by the Health Board.	3	Operation	Medium
4	The agreed recommendation from the 2022/23 audit review has not been implemented regarding the creation of a Standard Operating Procedure for the completion, upload and posting of all journals.	5	Design	High
5	The virement procedure is out of date and requires review.	6	Operation	Medium

6	Budget holders training is main hospital focused and consideration should be given to taking the training out on the road to support broader attendance.	8	Operation	Medium

1. Introduction

1.1 The Health Board is required, per *Welsh Health Circular (2021) 010 Amendments to Model Standing Orders, Reservation and Delegation of Powers and Model Standing Financial Instructions – NHS Wales* to have approved Standing Financial Instructions (SFI) which govern the regularity of financial transactions.

1.2 *SFI Section 5 – Financial Management and Budgetary Control* includes sub-sections addressing Budget Setting; Budgetary Delegation; Financial Management, Reporting and Budgetary Control; Capital Financial Management, Reporting and Budgetary Control; and Reporting to Welsh Government - Monitoring Returns.

All sub-sections outline expected actions/responsibilities for the Chief Executive, Director of Finance and Budget Holders.

1.3 Whilst the Chief Executive of the Health Board is the Accountable Officer, effective financial control within the Health Board is the responsibility of all officers under the direction of the Director of Finance.

1.4 The potential risk considered at the outset of the review were as follows:

- Breach of Standing Financial Instructions.
- Insufficient control of the Health Board Expenditure.
- Officers approve expenditure outside their delegated authority.

1.5 The review has not considered the budget setting process or obtained feedback from budget holders/managers of the service provided by the Finance Corporate Function.

2. Detailed Audit Findings

The findings in this report are based upon the information provided by officers at the Finance Corporate Function. We would like to express our gratitude to colleagues for their input during the undertaking of the review.

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

There has been a significant amount of work undertaken following the appointment of the new senior Finance leadership team, both interim and substantive mid-way through the 2023/24 financial year. The steps being taken to embed effective budgetary control is ongoing and it is recognised that it will take some time to ensure actions previously agreed by the former finance leadership team are implemented in full.

The findings in this report reflect the controls and actions for the whole financial year and cut across both Finance leadership teams and must be seen in this context.

Objective 1: Procedures are available to staff, are up-to-date and reflect current working practices.

2.1 The Head of Financial Reporting provided copy of the "Budget virement process and procedures", however this is not available on the intranet site.

2.2 Section 5 of the Health Board Standing Financial Instruction (SFIs) "*Financial Management, Reporting and Budgetary Control*", refers to different elements of the budgets setting process, in generic terms:

5.1 Budget Setting

5.2 Budgetary Delegation

5.3 Financial Management, Reporting and Budgetary Control

5.4 Capital Financial Management, Reporting and Budgetary Control

5.5 Reporting to Welsh Government - Monitoring Returns

2.3 The Health Board Finance intranet page includes several links to training materials, among them is a Budget Manager Handbook, updated January 2024. However, this does not take away the need for developing formal Budgetary Control policies or procedures.

Conclusion:

2.4 With the exception of the internal virement procedure for Finance officers, we found no other published policy or procedure(s) ensuring the requirements of the Standing Financial Instructions are met.

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

Objective 2: Accountability Letters have been completed and signed by all Budget Holders and Managers for 2023/24 in line with Standing Financial Instructions.

2.5 Standing Financial Instruction 5.2.1 & 5.2.6 "Budgetary Delegation" of the Health Board SFIs, states the following:

5.2.1 The Chief Executive may delegate, via the Director of Finance, the management of a budget to permit the performance of a defined range of activities, including pooled budget arrangements under Regulations made in accordance with section 33 of the National Health Service (Wales) Act 2006 (c. 42). This delegation must be in writing, in the form of a letter of accountability, and be accompanied by a clear definition of:

a) The amount of the budget;

b) The purpose(s) of each budget heading;

c) Individual or committee responsibilities;

d) Arrangements during periods of absence;

e) Authority to exercise virement;

f) Achievement of planned levels of service; and

g) The provision of regular reports. The budget holder must sign the accountability letter formally delegating the budget.

5.2.6 All budget holders will sign up to their allocated budgets at the commencement of the financial year.

2.6 Through discussion with Officers, we were advised that no Accountability Letters were issued at the start of 2023/24.

2.7 On 14 November 2023 the Chief Finance Manager / Strategy & Planning Accountant requested that each Chief Finance Officer provide the following information:

"The actions the division is going to take to reduce expenditure forecast down to the control total.

Any balance sheet flexibility available that could be released to support the £25.6m of balance sheet and other reductions required to meet the Health Board control total of £20m."

2.8 The Head of Financial Reporting provided agenda and minutes of the Executive Delivery - Integrated Performance Group meeting on 15 November 2023, that recorded the implementation of control totals for the Health Board.

The presentation at the meeting titled *Executive Delivery – Integrated Performance Group: Finance Report*

"Key Actions:

Forecasts revised with CFO's to live within the control targets, performance monitored in EDIPG (Elective Recovery or Emergency Pressures costs contained within issued control totals).

Identification of further balance sheet, income or cost reductions to deliver 10% improvement."

2.9 Section 3 of the minutes "*Updated Finance Position*" record the following:

"Control total moves to a £20m deficit for 2023/24. All areas have been urged to look at their savings plans to ensure are turned to green schemes. The committee was updated on the severity of the situation, with a deadline of month 8 day six for an update before further stronger actions are implemented".

2.10 Due to the timing of this review, we have not verified whether the allocated *Control Totals* have been achieved or not.

2.11 Whilst we recognise the Health Board moved towards issuing a clear total for all Officers accountable for the overall budget in November 2023, the Minutes are scant on whether this was a management instruction mandating Officers agreed to achieve the required total.

2.12 The Interim Executive Director of Finance advised that some actions were put in place that could be considered as mitigation:

"*Meetings were held with the Executive/Healthcare Leadership Teams (HLT)*

and Health Board on living within the budgets (endorsing additional controls) and then the newly formed Integrated Performance - Executive Delivery Group that did endorse expenditure controls".

Conclusion:

2.13 Accountability Letters have not been issued to all Budget Holders and Managers for 2023/24 in line with the Health Board's Governing Standing Financial Instruction 5.2 – Budgetary Delegation. We recognise that steps were taken in November 2023 to set control totals across the Health Board but this does not replace the need for Accountability Letters being issued at the start of the financial year.

There is limited evidence available to us that the control totals were formally signed up to by officers and due to the timing of this review, we are unsighted on whether any were achieved.

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

Objective 3: The delegated limits recorded in the E-Financials hierarchy are in line with current Scheme of Reservation and Delegation (SORD).

2.14 The Operational Systems Service Manager provided a report showing a list of all users against their delegated limits, as at February 2024.

2.15 We compared a sample of 40 delegated officers against the latest version of the SORD updated November 2023. All matched delegated limits as quoted in the SORD except for seven cases where we found variances between the published SORD and E-Financials:

- One had been increased at the request of Finance.
- Three had individual costs centres differing to that in the SORD but the 'Document Total' was at the correct delegated limit. We are advised by Business Systems that the Document Total overrides any cost centre value.
- One had a limit above that stipulated for the post.
- Two had lower limits to that approved in the SORD, as instructed by Finance.

Conclusion:

2.16 The Health Board has updated its Scheme of Reservation and Delegation and assigned generic post profiles to financial limits.

2.17 We found some inconsistencies to the Board approved document and of concern is the ability for Finance officers to make changes to limits without the approval of the Board. Management must ensure a robust procedure exists over changes to delegated limits.

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

Objective 4: Manual and automatic accrual entries are correct and subject to effective scrutiny.

2.18 The Head of Financial Reporting advised that Finance staff are asked to follow the principles in the year end guidance when creating accruals. We received two files including System generated accruals and Manual accruals for review.

2.19 Sample testing of both accruals confirmed they were all supported by evidence and appropriately scrutinised.

2.20 In clarifying the process for authorising accruals, the Head of Financial Reporting advised that *"….each Chief Finance Officer or equivalent is responsible for the journals/ accruals which are entered into the system…...The actual journal is not 'signed' off or authorised….process was stopped at the inception of BCU, is consistent with other organisations across Wales."*

2.21 Whilst noting the process of submitting accruals is an upload into e-Financials, we sought clarity whether there is a standard approach to month end verification. We are advised each Chief Finance Officer have different approaches, however we are not sighted on any post-approval undertaken to verify the accuracy of accruals.

Conclusion:

2.22 We verified a sample of accruals to source evidence and whilst officers are requested to follow year-end process, there is no documented standard operating procedure to embed the expectation coupled with a risk based post-entry review.

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

Objective 5: Journal entries are subject to appropriate segregation of duties and scrutiny.

2.21 We were advised at the outset that journals are not subject to any expected segregation of duties between preparation, upload and approval, but are either scrutinised by the Chief Finance Officers prior to the journal being posted, retrospectively after the journal has been posted, or via the impact of the journal as a result of month end review of respective financial positions.

2.23 We followed-up whether the agreed recommendation from the 2022/23 audit review had been implemented concerning reviewing the process surrounding the completion, upload and posting of all journals and to develop a Standard Operating Procedure, with consideration of retrospective scrutiny via a transaction report for the month, where set criteria is met and reviewed.

The Head of Financial Reporting advised that a generic Standard Operating Procedure has not been developed.

2.24 We reviewed a sample of journals from Month 10-24 (January 2024) and , confirmed that all journals were supported by evidence. We found no evidence of retrospective review to support the appropriateness of the journal.

Conclusion:

2.25 There is a lack of evidence to support whether management review journals to ensure they are accurate and are supported by appropriate evidence. The previously agreed recommendation in this objective has not been addressed at time of this review.

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

Objective 6: A Budget Virement Policy exists and is complied with at all times.

2.26 The Head of Financial Reporting provided a copy of the *"Budget virement process and procedures"* and advised that the procedure reflects the process followed when the e-Virement process went live on 13th July 2020.

We confirmed that this procedure is not available on the intranet.

2.27 In reviewing a sample of virements and audits by Finance, we noted that the Head of Financial Reporting Team undertake a 10% sample of audits on virements to ensure appropriate authorisation and segregation of duties between requisitioner and approver. We received evidence surrounding an instance where the retrospective review had identified issues of compliance with process and notified to the respective Chief Finance Officer.

We were advised this audit forms part of the month-end reporting cycle but are unclear if the breaches identified are reported as part of a monthly summary to Finance management.

2.28 We reviewed a sample of virements and verified against expected controls – testing confirmed all had completed documentation, segregation of duties was in place and all were appropriately authorised.

Conclusion:

2.29 The documented procedure has not been subject to review since 2020 and requires updating to ensure it accurately reflects the current process. It should then be published to ensure guidance is available for all Budget Holders/Managers.

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

Objective 7: The reporting of the month end financial position to the Health Board is complete and accurate in line with the General Ledger. Any manual adjustments made are underpinned by evidence to support the change(s).

2.30 The Head of Financial Reporting advised that every effort is made to ensure the ledger is complete and accurate at the close down period to enable reports to be fully aligned at the ledger.

2.31 We verified the Month 10 (January 2024) General Ledger report to the Finance report for the same period and found no variances.

Conclusion:

2.32 The reporting of the month end financial position to the Health Board was verified to that reported in the General Ledger.

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

Objective 8: Budget holders and managers have received appropriate training enabling them to manage their delegated budgets.

2.33 The Health Board Finance intranet page includes several links to training materials, examples include:

- A Budget Manager Handbook, updated January 2024.
- A short course on an introduction to NHS Wales Finance.
- A short training video for budget managers on the QlikView Budget Holders Document.
- A copy of the All Wales Procure to Pay e-Manual.
- A copy of the Procurement Guide.

2.34 There has been a number of training events held since November 2023 to date that included:

- Corporate Finance Function specific – This included procurement, financial governance, Standing Financial Instructions, SORD, tendering and contracting.
- Budget holders and manager – This incorporated procurement (delivered by NWSSP Procurement Services), Standing Financial Instructions, SORD and the updated Budget Manager Handbook.

2.35 Whilst recognising efforts to ensure budget holders and managers receive appropriate training, we could not establish the expected numbers of who should be in receipt of the training, as the attendance is voluntary. We also found that locations of training are geared towards the main three hospital sites and may not aid the attendance of community-based colleagues needing to travel.

Conclusion:

2.36 Training is available to all budget holders and managers although it is main hospital focused and consideration should be given to taking the training out on the road to support broader attendance and reduce operational pressures in releasing staff to attend.

2.37 Whilst the steps taken are positive, we are unsighted on the task facing both Procurement and Finance colleagues as they strive to embed training in both finance and procurement governance across the Health Board. Realistic milestones and a training plan should be developed.

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

Appendix A: Management Action Plan

Matter Arising 1: Budgetary Control Procedures (Design)			**Impact**
With the exception of the unpublished virement procedure, we found no other policy/procedure underpinning budgetary management that ensure the requirements of the Standing Financial Instructions are understood and complied with.			Potential risk of: • Non-compliance with Standing Financial Instructions
Recommendations			**Priority**
1.1a	The Health Board develops a budgetary control Framework / Policy/ Procedure to support budget holders and managers in discharging their responsibilities.		**High**
Agreed Management Action		**Target Date**	**Responsible Officer**
1.1a	The management response is to articulate there to already be in existence a Budget Manager Handbook, which satisfies this recommendation and is published on the intranet. This includes all relevant guidance for the control environment (the intention being to offer guidance on the control environment, as described in full within the published Standing Orders, Standing Financial Instructions and Scheme of Reservation and Delegation) and is therefore the framework for managers to work within. We are happy to explore with Internal Audit areas that can be strengthened within the guide, the intention being to give managers a single place to seek guidance. A training programme is also in force throughout the Health Board and we will review in conjunction with these sessions the appetite for an alternative means of disseminating this information (expanding as determined necessary) in conjunction with budget managers.	30/09/2024	Finance Director – Commissioning & Strategy

Matter Arising 2: Accountability Letters (Operation)			**Impact**
Accountability Letters have not been completed and signed by any Budget Holder or Managers at the start of 2023/24 financial year in line with Standing Financial Instructions. Whilst "Control Totals" were presented at the Executive Delivery - Integrated Performance Group meeting 15 November 2023, this does not replace the need for Accountability Letters to be issued at the start of each financial year.			Potential risk of: • Breach of Standing Financial Instructions • Poor financial control of Health Board Expenditure • Officers approve expenditure outside their delegated authority
Recommendations			**Priority**
2.1a	The Health Board ensures compliance with Standing Financial Instruction 5.2.1 & 5.2.6.		**High**
Agreed Management Action		**Target Date**	**Responsible Officer**
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 Accountability letters. Accountability Letters are to be issued following conclusion of the setting of financial plans for 2024/25 (savings and financial information already shared	30/09/2024	Finance Director – Commissioning and Strategy

	throughout the Health Board). The letter setting out the clear responsibility for the budget managers to have undertaken mandatory procurement training.		

Matter Arising 3: Delegated Limits changes (Operation)			**Impact**
Whilst we acknowledge that the Health Board SORD was recently updated in November 2023, we found 7/40 in our sample where the limits varied between those approved by the Health Board to those input into e-Financials. We note that in our review, one change which increased the limit above that approved by the Health Board.			Potential risk of: • Officers approve expenditure outside their delegated authority
Recommendations			**Priority**
3.1a	The Executive Director of Finance: • Ensures all delegated limits are applied in accordance with the limits approved by the Health Board and ensures the limits applied have been input correctly. • Develops a standard operating procedure to ensure internal controls are in situ where limits require amendment and appropriate approval is obtained through the established governance process.		**Medium**
Agreed Management Action		**Target Date**	**Responsible Officer**
3.1a	Management believes that all delegated limits have been set in accordance with the SORD, development of which commenced with the Chief Finance Officers undertaking reviews to ensure compliance of the budget holder limits for their areas within the Scheme of Reservation and Delegation (SoRD) Limits. The review of 40 officer's limits identified 7 issues, all of which were below the delegated levels, these are acceptable owing to the SORD articulating a	30/07/24	Finance Director - Operational

	'maximum value' and therefore acceptable if a Director decides to assign a delegated limit to a budget holder that is within a range up to the maximum agreed by the Health Board. Management will develop a standard operating procedure for moving these limits (where below that recorded as a maximum within the SORD) for future reporting, though would also highlight the measure of improvement in this area from historical oversight.		

Matter Arising 4: Journal Entries (Design)			**Impact**
We followed-up whether the agreed recommendation from the 2022/23 audit review had been implemented concerning the process for the completion, upload and posting of all journals and to develop a Standard Operating Procedure, with consideration of retrospective scrutiny via a transaction report for the month, where set criteria is met and reviewed. This has not been actioned.			Potential risk of: • Insufficient control of the Health Board Expenditure
Recommendations			**Priority**
4.1a	The Executive Director of Finance/Nominated deputy reviews the process surrounding the completion, upload and posting of all journals and develops a Standard Operating Procedure. Management could consider retrospective scrutiny via a transaction report for the month, where set criteria is met and reviewed within Finance.		**High**
Agreed Management Action		**Target Date**	**Responsible Officer**
4.1a	Management accepts this recommendation from prior years is yet to be implemented, noting the rating deteriorating from prior year owing to this recommendation remaining outstanding.	30/09/2024	Head of Financial Reporting

	The volume of journals results in a full check being impracticable, though a commitment was made as part of a prior year recommendation and thus a standard operating procedure will be produced and implemented to satisfy this outstanding request.		

Matter Arising 5: Virement Procedure (Operation)			**Impact**
A Virement procedure has been developed and was made available to us but has not been reviewed or updated since July 2020.			Potential risk of: • Non-compliance with Standing Financial Instructions
Recommendations			**Priority**
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.		**Medium**
Agreed Management Action		**Target Date**	**Responsible Officer**
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.	30/09/2024	Head of Financial Reporting

Matter Arising 6: Budget Holder/Manager Training Plan (Operation)			**Impact**
The Finance Corporate Function and NWSSP Procurement Services have re-introduced training across the Health Board which is a positive step in embedding accountability for budgetary control. Training figures provided suggest there remain lots to do and we noted that training is focused on the three main hospital sites which may impact the ability of community-based colleagues to attend. We are also unsighted on the challenge facing Finance and Procurement colleagues and the duration needed to capture all officers that require the training.			Potential risk of: • Budget holders/Managers have not been identified to receive appropriate training to manage their delegated budget and control expenditure
Recommendations			**Priority**
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.		**Medium**
Agreed Management Action		**Target Date**	**Responsible Officer**
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 West (15 July). In addition, there is a	18/07/24	Finance Director - Operational

	on-line event, targeted at Budget Holders (as per the Accountability Letter circulation list) plus an on-line event planned for the 10th July. Updated records of attendance will be shared with Audit Committee via the 2024/25 Quarterly Conformance Reports going forward. Next meeting is July 2024.		

Appendix B: Assurance opinion and action plan risk rating

Audit Assurance Ratings

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

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

Prioritisation of Recommendations

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

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

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

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Effective Governance – Integrated Health Community (IHC) Central

Final Internal Audit Report

June 2024

Betsi Cadwaladr University Health Board

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

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

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Committee:	Audit Committee

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

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

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

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Executive Summary

Purpose

To review the effectiveness of the governance arrangements within IHC Central.

Overview

We have issued *limited assurance* on this area.

The review has identified that the IHC has developed its governance structure in line with that stipulated by the Health Board on inception of the Operating Model. The matters which require management attention include:

- There are identified gaps in Terms of Reference that require addressing immediately.
- Whilst there is evidence of regular finance reporting to the Senior Management Team and Performance, Finance and Information Governance Operational Delivery Group, we found no evidence of oversight and ownership for the delivery savings through reducing expenditure. There is evidence the IHC established a Financial Control Group but we cannot find any reporting from the meeting in accordance with the ToR.
- There is limited evidence that both Tier 2 and Tier 3 audits are being actively monitored, and delivery of the reviews subject to routine update reporting via service leads.
- The IHC is reviewing its complaints, concerns, and incidents through the governance structure, however there is poor compliance with the 30-day timeline for complaints handling and a large number of open incidents.
- Attendance at the IHC Health & Safety and Risk Management Group is generally poor and the absence of consistent attendance undermines the ability for the IHC Director and

Report Opinion

Limited assurance

More significant matters require management attention.

Moderate impact on residual risk exposure until resolved.

Trend: N/A

Assurance summary[1]

	Objectives	Assurance
1	There is an appropriate governance and reporting structure in place within the service to provide assurance on services and ensure oversight of all areas of responsibility. Reporting includes ward to board assurance, audit results, ward accreditation information and monitoring of actions resulting from external review such as Healthcare Inspectorate Wales and Audit Wales.	Limited
2	There are appropriate financial governance arrangements in place to manage budgets, with regular review of savings and budgets. Where services are not operating within agreed budgetary allocation, appropriate actions and monitoring arrangements are in place.	Limited
3	The service is progressing and monitoring tier 2/3 clinical audits and contributing to tier 1 audits as required, with processes in place to share details of lessons learnt.	Limited
4	Complaints, concerns, incidents, and staff concerns (via Speak Out Safely) are investigated, reviewed, and responded to in a timely manner. Learning from these is captured and reviewed / shared as appropriate.	Limited

Senior Management Team to actively manage risk.

- Whilst risk management processes are embedded throughout the service and are in line with the Risk Strategy, we found a large number of risks had not been reviewed per the expected timelines set by the Health Board.

5	Risk management processes are embedded throughout the service and are in line with the risk strategy in terms of risk registers and regular review of risks.	Limited

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

Key Matters Arising

		Objective	Control Design or Operation	Recommendation Priority
1	There are identified gaps in Terms of Reference that require addressing immediately, including identifying Chair and Vice Chair for all meetings, ensuring the Senior Management Team reviews and approves all groups that report into it, and establishing Cycles of Business for all meetings.	1	Operation	High
2	There is no apparent evidence of oversight and ownership for delivering savings through reducing expenditure, and the IHC Financial Control Group has not reported in accordance with its ToR.	2	Operation	High
3	There is limited evidence that both Tier 2 and Tier 3 audits are being actively monitored and delivery of the reviews subject to routine update reporting via service leads.	3	Operation	High
4	The IHC is reviewing its complaints, concerns, and incidents, however there is poor compliance with the 30-day timeline for complaints handling and a large number of open incidents.	4	Operation	High
5	Attendance at the IHC Health & Safety and Risk Management Group is generally poor, and many risks have not been reviewed per the expected timelines set by the Health Board.	5	Operation	High

1. Introduction

1.1 Good corporate governance plays a vital role in underpinning the integrity and efficiency of the Health Board and the wider community in which it operates. Robust properly developed and embedded governance structures are fundamental to ensuring the achievement of the Health Board's strategic objectives and in delivering its statutory, regulatory, and legal requirements.

Each Integrated Health Community (IHC) is required to have effective governance arrangements in place for the services they are accountable for, to provide assurance to the Board and its Committees on the quality and effectiveness of the services provided to its users.

As the Health Board updated its governance structure, effective corporate governance arrangements within the IHC are critical to ensure assurance flows between Ward and Board (and vice versa) are in place. Regular assurance from the management team through to the Executive is expected to ensure the Executive lead is sighted on issues and can provide direction where needed.

1.2 The risks considered in this review were:

- The senior team do not have oversight of all areas of responsibility, or sufficient assurance that controls are operating as intended.
- Financial governance arrangements are not effective in making informed decisions, resulting in overspend.
- Lessons learnt from clinical audits, complaints, concerns, and incidents etc. are not captured or actioned.

1.3 The scope of our review focused solely on the arrangements the IHC has in place to ensure it has effective oversight of matters that could undermine safe delivery of care through ineffective governance arrangements.

1.4 We would like to extend our gratitude to officers in the IHC who supported this review through meeting with us and providing evidence.

2. Detailed Audit Findings

This report is based upon the information provided by officers supporting our review. We have relied solely on the documents, information and explanations provided and, except where otherwise stated, we have not contacted or undertaken work directly to verify the authenticity of the information provided.

Objective 1: There is an appropriate governance and reporting structure in place within the service to provide assurance on services and ensure oversight of all areas of responsibility. Reporting includes ward to board assurance, audit results, ward accreditation information and monitoring of actions resulting from external review such as Healthcare Inspectorate Wales and Audit Wales.

2.1 In line with the expectations set out in the Health Board approved Agenda Item

22.114b '*Operational Governance and Assurance Framework 2022 Draft v 3.1'*, we reviewed whether the IHC had implemented the required governance structure.

2.2 We found the IHC had established the Senior Management Team (SMT) and the four required Operational Delivery Groups (ODG).

2.3 We found the IHC SMT holds separate Operational and Strategic meetings although we observed one Terms of Reference (ToR) geared towards Operational matters.

2.4 Our high-level review of papers and ToR for the six meetings found the following:

- ToR are all in a similar format but were not consistent with the model ToR issued by the Health Board, however we found the IHC ToR easier to follow. We found several were draft, had no date of approval by the SMT recorded and omitted key content such as Chair, Vice Chair and details of all sub-groups that report into each require update/review.
- There were no Cycles of Business evident for any of the meetings for us to verify papers that should have been presented were and subsequently deliver the requirements of each ToR.
- The review of Minutes identified a number of meetings do not appear quorate in instances where the Chair was not present and no Vice Chair is identified in the ToR. Further, we found different styles for Minutes in the IHC with no standard template and some action logs reported delays in progressing specific actions.

  Only the Quality & Safety ODG captured attendance over the duration of the financial year, which we note as good practice; however this could be improved to identify Members separately as we found it difficult to verify post titles back to the ToR in some instances and to confirm that Members attend a minimum of 60% of the meetings, per its ToR.
- We reviewed both Operational SMT and Quality & Safety ODG Minutes to confirm the reporting on Ward Accreditation compliance, External review action plans that directly impact the IHC e.g. Healthcare Inspectorate Wales. We found no papers that explicitly provided assurance on either ward accreditation or action plan(s) are subject to oversight by the SMT.
- We found the IHC Clinical Effectiveness Group reports to the Quality & Safety ODG under agenda item *National Clinical Audit & Outcome Review Programme (NCAORP) Tier 1 and Tier 2* through an Escalation and Highlight report and circulation of Minutes.

  Reviewing the most recent report (23 January 2024) we noted completion of Tier 2 audit of *Consent to Treatment* was poor with Minute 24/004 noting *"The consent tier 2 audit was originally set to close at the end of December, but the link is still open and is waiting to be extended….asked which specialties have completed and which have not…..8 have been submitted from Breast, Ophthalmology have completed all and 3 from Maxi Facial…..These are the*

only ones submitted from Central."

The Escalation and Highlight report identified clinical leadership and as critical issue of significance for escalating, detailing *"There seems to be a disparity about expectations and remunerations from/for leadership roles with some clinical/governance/audit leads expected to do this in their 3rd SPA whilst others getting an extra session. There are some specialties with no lead. Other leads totally disengaged from CEG. We need to consolidate the list of all our leads and ensure these roles are in their job plan. We may also have to cross reference with their appraisals and ensure appropriate accountability."* The impact reported advised *"This is impacting on our ability to take forward CEG related issues with some specialties - such as Tier 1 and 2 audits; NICE compliance; submission of AAA reports to CEG."*

Conclusion:

2.5 The IHC have established the required governance structure in-line with that approved by the Health Board.

2.6 Whilst the Terms of Reference are in a format that is easy to follow, there are identified gaps that require addressing immediately. As a minimum the IHC Director must identify the Chair and Vice Chair for all meetings; ensure the SMT review and approves, annually, all groups that report into it and establish Cycles of Business for all meetings in order that all matters for which the IHC is accountable are subject to oversight and scrutiny and assurance reporting.

2.7 We found no evidence of reports on patient safety and quality through ward accreditation or External review progress on action plans. Whilst we recognise this may be taking place outside of the governance structure, it is important the SMT have oversight of quality and safety of all the services it provides.

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

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.

2.8 To ascertain the most recent financial position as reported to the Health Board on 28 March 2024 under *Item 24/57 Financial Performance report 2023/24 Month 11,* we found the following:

- Overspend of £18,053m with a forecast year-end overspend of £19,190m and is the highest overspend in the Health Board.
- Under-achievement of its savings target of £7,950m by £4,265m (54%) as it has achieved £3,685m.

2.9 On 15 November 2023, the Executive Delivery Integrated Performance Group approved the introduction of control totals across the Health Board which set the expenditure limit for each service. The IHC has a reported control total for 2023/24 of £450,867m; at the time of this review we are unclear whether this

was achieved.

2.10 The IHC has established a Performance, Finance and Information Governance ODG which receives monthly finance reports, with the SMT also receiving a finance update, both from the Chief Finance Officer. Reviewing Minutes of both PFIG and SMT, we found limited actions noted for the IHC to achieve its control total and noted a Minute at PFIG ODG meeting on 25 January 2024 recorded:

"(Officer) highlighted that this is still an unstainable position and the key action required is to significantly develop savings plans and reduce run-rate spend.

Focus on Key Actions:

- *Control Target - Continue to try and meet control target.*
- *Reduction in Spend - Services to look at non-pay as well as pay.*
- *Financial Recovery Plan - Continue to look at areas for the next financial year."*

We could find no specific actions from the meeting for IHC management to take forward achieving a reduction in expenditure.

2.11 In reviewing the finance report, we could find no section on the IHC's delivery of savings.

We were provided with a presentation titled *'Central IHC 2023/24 Month 11 CRES/Control Total'* that included performance against the savings requirement aswell as noting the £5.793m needed in month 12 to meet the IHC's control total. We are advised this report was presented to the Financial Control Group but are unsighted where the issues of significance from the report were escalated as a risk.

2.12 We received evidence of the Financial Control Group meeting, 7 February 2024 which included a finance update (no paper included) as well as a paper on the Financial Recovery Action Tracker which detailed progress against the IHC identified schemes.

2.13 We reviewed the ToR for the *Central Integrated Health Community Financial Control Group* with the following extract concerning its duties:

"…main duties will include, but are not limited to:

- *Oversight and consideration of impact assessments where opportunities for financial savings against CRES targets are identified but will require IHC Senior Management Team sign off.*
- *To receive and consider financial reports on Variable pay: including Agency expenditure in order to identify opportunities to reduce run rates and review Agency Control processes.*
- *Review ECRs and provide challenge and / or approvals.*
- *Receive and consider reports on Oracle requests, identifying opportunities to reduce or avoid expenditure.*
- *To monitor and oversee delivery against CRES targets."*

2.14 Section 7 - Reporting of the ToR records the following:

- *7.1 The Financial Control Group is a sub-group to the SMT Meeting. Reports from the weekly meetings will be included within the IHC Directors Report and tabled at Senior Management Team on a monthly basis.*
- *7.2 The Financial Control Group will provide a report to CHC Performance Finance and Information Governance (PFIG) for information and noting.*

2.15 We reviewed the Operational SMT meetings for the IHC Directors Update Report and found no reference or update from the FCG.

Conclusion:

2.16 Whilst there is evidence of regular finance reporting to the Senior Management Team and Performance, Finance and Information Governance ODG, we can see no evidence of oversight and ownership for delivering savings through reducing expenditure. Minutes are scant on any action being allocated to Officers to drive forward the requirement.

2.17 With the Financial Control Group having been established, we can find no reporting from the meeting in accordance with the ToR. In addition the IHC is forecast to be the highest overspending service in the Health Board and are unclear what steps are being actively taken to address this. The current situation is not sustainable and requires immediate focus.

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

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.

2.18 The IHC Central reviews its clinical audit activity through the Central Clinical Effectiveness Group (CEG) which reports into the Central Quality Operational Delivery Group (QODG).

2.19 We received minutes of the CEG for 17 October, 21 November 2023 and 23 January 2024 as well as the agenda for 19 March 2024. Meetings for December 2023 and February 2024 were stood down.

Quality performance reports from the Clinical Effectiveness Department can be seen being presented at each of the minutes provided to us, the reports include the following:

- Clinical audit reporting - Quarterly reports presented to the Strategic CEG.
- Summary of the of new publications of Tier 1 clinical audits including date of assessment response due and action plans.
- Tier 2 projects - methodology and access to online data.
- Summary of monthly activity for tier 3 audits with further details on the BetsiNet clinical audit intranet page.
- Points for escalation.

2.20 Through our review of papers presented to the CEG, we found limited evidence that Tier 2 audits were being actively reported on for assurance from the operational services e.g. Record Keeping.

Whilst an overarching position of Tier 3 audits is noted in the Clinical Effectiveness Department report, we reviewed the on-line portal and noted without significant activity in Surgery, Anaesthetics and Critical Care, there is limited Tier 3 clinical audit activity evident – Only 30% of audits have been completed for 2023/24 by 30 April 2024. We are unsighted on how lessons learnt are shared throughout the IHC or within the Health Board.

Image 1: Tier 3 audit activity by specialty

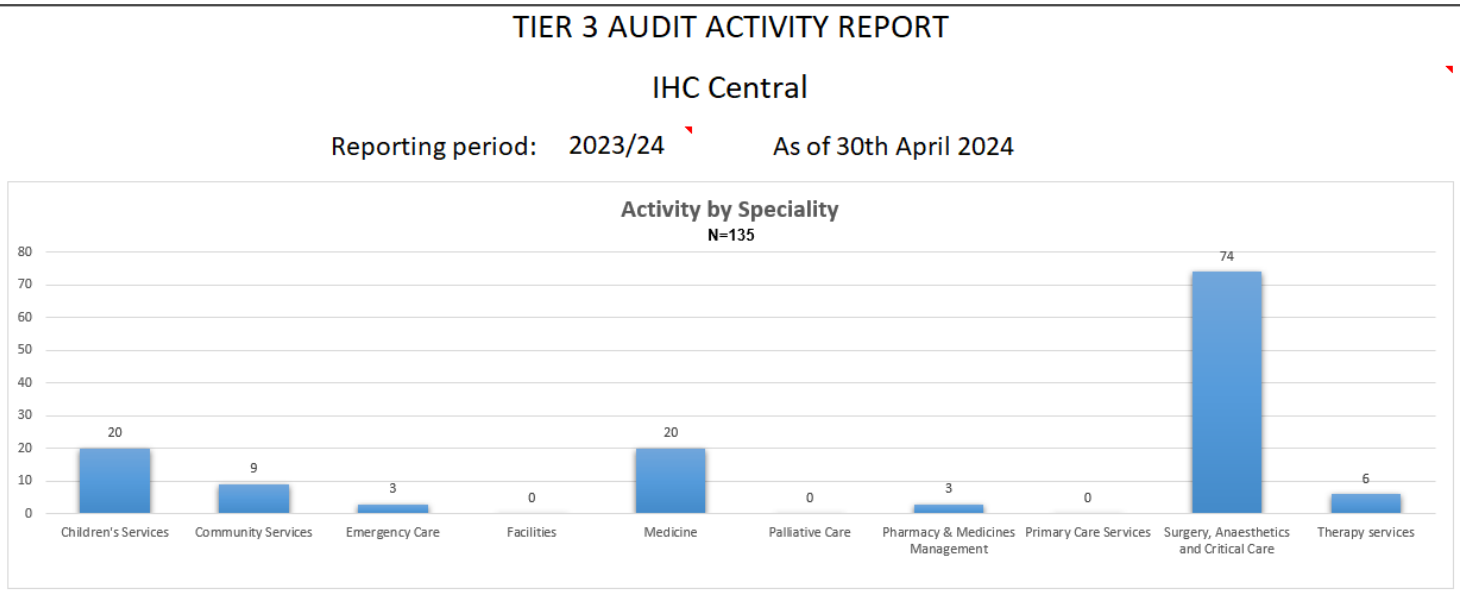
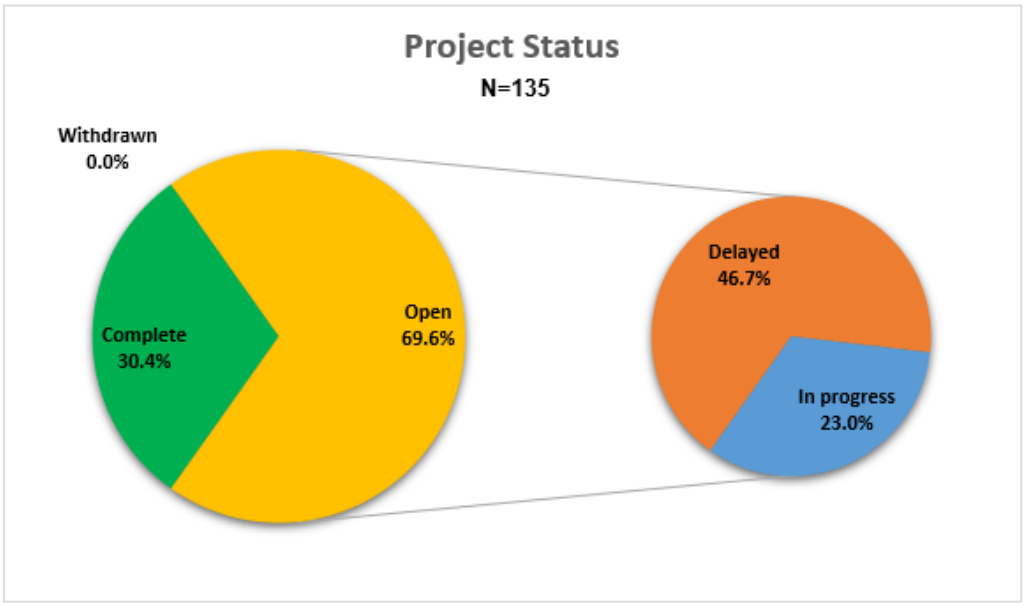


Image 2: Tier 3 audit status



Source: Data obtained from the Health Board Sharepoint site 22 May 2024 - https://nhswales365.sharepoint.com/sites/BCU_Intranet_CLEFF/SitePages/Tier-3-Audits--.aspx

2.21 The Quality Performance Report presented to CEG on 19 March 2024 included a report detailing incomplete participation and outstanding responses to findings for the National Clinical Audits – the report advised that six (6) Tier 1 clinical audits are not progressing.

2.22 We received minutes of the QODG for 23 November, 21 December 2023, 18 January and 22 February 2024.

The 23 November 2023 meeting includes a CEG Chair's report highlighting an issue for escalation of no compliance with a Tier 1 audit.

We have not been unable to observe CEG Chair reports being presented at the QODG since, as CEG meetings for December 2023 and February 2024 were stood down and there have been issues with the alignment of meeting dates for the both CEG and QODG.

Conclusion:

2.23 Quality performance reports from the Clinical Effectiveness Department are being presented at CEG with discussion regarding clinical audit captured in the Minutes. There is limited evidence that both Tier 2 and Tier 3 audits are being actively monitored and delivery of the reviews subject to routine update reporting via service leads.

2.24 CEG reporting is noted on the QODG agenda under *Matters/Reports from each subgroup* however due to meetings dates alignment and recent cancellations of the local CEG, reporting to the Central QDOG is inconsistent.

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

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.

2.25 We received minutes and agendas for the Patient Safety Quality (PSQ) meetings for 23 January, 20 February and 19 March 2024 with the April 2024 meeting stood down due to quoracy.

The Terms of Reference provided is dated November 2020 and does not reflect the current IHC Governance reporting structure.

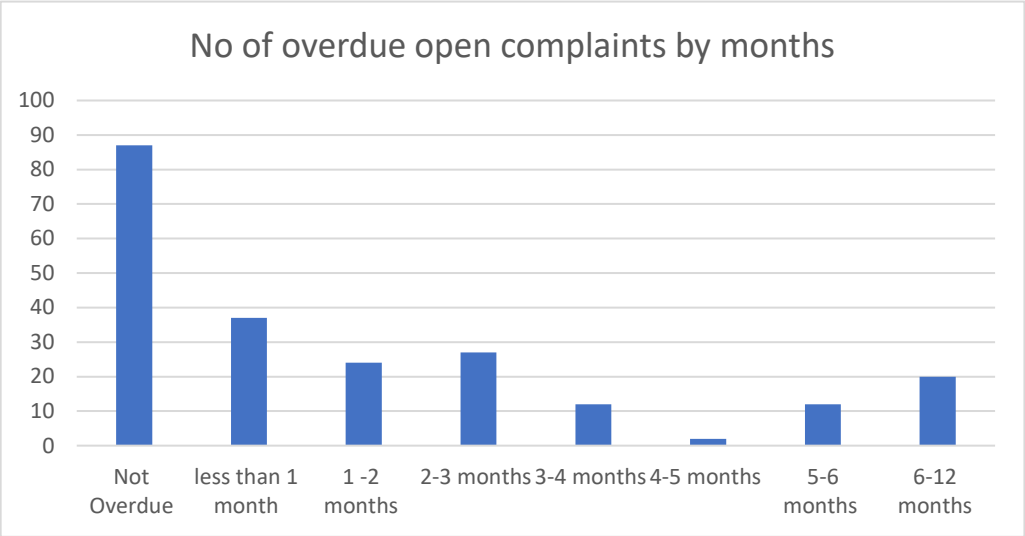
2.26 Through the minutes provided, we can see a Central IHC governance report presented which includes information on the following:

- Complaints
- Incident Management/DATIX
- Falls
- Pressure Ulcers
- Medication Incidents
- Infections
- Patient Safety Notice/Patient Safety Alerts

2.27 The Governance report of 3 April 2024 identified two hundred and twenty-one (221) open complaints across the IHC of which one hundred and thirty-four (134) are overdue in comparison to January 2024 where there were one hundred and sixty (160) open complaints with one hundred and thirteen (113) overdue.

Complaints

Graph 1: Open complaints as of 3 April 2024



Source: Central IHC Patient Safety and Quality Governance Report April 2024

Incidents

As of 5 April 2024, there was a total of two thousand, eight hundred (2,800) Open Incidents within Central IHC. Table 1 records the categories per Datix.

Table 1: Incidents within sections

New Incident	Management review / Make it safe plus	Under Investigation	Awaiting closure	Total
92	2,550	48	110	2,800

Source: Central IHC Patient Safety and Quality Governance Report April 2024

Open incidents are on the increase with the January 2024 Governance report (produced by the Quality Governance Team) reporting two thousand four hundred and ninety-six (2,496) open incidents, an increase of three hundred and four (304) over 4 months.

2.28 The PSQ can be seen reporting issues into the QODG under *Matters/Reports from each of the sub-groups.*

2.29 Through our review, we found no evidence of routine review of any staff complaints being considered in the papers we received but recognise there may not be any active at the time of our review.

Conclusion:

2.30 Overall, we found evidence that the IHC is reviewing its complaints, concerns, and incidents through the reporting into its governance structure.

2.31 The IHC must take steps to must address the reasons for overall poor compliance with the 30-day timeline for complaints handling and address the large number of incidents occurring in the IHC and whether there are commonalities/outliers that require focused support.

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

Objective 5: Risk management processes are embedded throughout the service and are in line with the risk strategy in terms of risk registers and regular review of risks.

2.32 We were provided with the following evidence for Risk Management:

- Minutes for the Central IHC Health & Safety and Risk Management Group for 28 December 2023, 25 January, 29 February and 28 March 2024.
- Agenda papers for 25 January, 29 February and 28 March 2024.
- Draft Terms of Reference (TOR) for Central IHC Health & Safety and Risk Management Group.

2.33 All meetings were quorate, however, attendance was low at all meetings; the draft TOR Membership states eighteen members, however we found attendance to be 50% or less.

2.34 There is a standard agenda item *Progress on all DATIX risk registers*. Risk registers from the services were attached to the agendas however from the minutes provided we were only able to see discussions taking place on individual risks. We were not able to observe discussions taking place on the progress of service risk registers.

We note that the lack of consistent attendance of the services to the meeting may be impacting on the reviewing of the risks as well as progress of the risks.

2.35 We reviewed the risk registers provided at the meeting on 28 March 2024. We identified that as of the 18 March 2024, there were a total of one hundred and sixty-two (162) risks, of which seventy (70) (43%) had not been reviewed in accordance with *RM02 Risk Management Procedures - 6.1 registers*.

The risk registers presented at the meeting are consistent in development and in line with the Health Board's Risk Management Strategy, however whilst the risk registers include the current risk rating there is no target score to be achieved.

2.36 The Central IHC Health & safety and Risk Management Group reports into the (QODG) per its Terms of Reference.

We reviewed the minutes of the QODG for 21 December 2023, 18 January and 22 February 2024 respectively to determine regular reporting and escalation of issues.

2.37 As a standard agenda item *Matters/Reports from each of the subgroups* we were

able to observe minute discussions taking place on risk management matters however we have not been able to evidence a Chair's report presented to QODG that provides consistent reporting on risk management within the IHC.

Central IHC Quality Operational Delivery Group (QODG) – Thursday 18 January 2024

Item 5 - Matters/Reports from each of the subgroups - Risk and Health and Safety

Noted some progress with the risk register but some departments were not maintaining their risks. Corporate Services were now reviewing the risks and advising if they were not updated.

Central IHC Quality Operational Delivery Group (QODG) - Thursday 22 February 2024

Item 3 - Matters/Reports from each of the subgroups - Risk and Health and Safety

Shared the Risk Registers status with the team which showed that there was evidence that the teams were reviewing their risks, with many risks reducing from amber to yellow compared with January figures.

Conclusion:

2.38 Attendance for the Central IHC Health & Safety and Risk Management Group is generally poor in the evidence provided – the absence of consistent attendance across the IHC undermines the ability for the IHC Director and Senior Management Team to actively manage risk.

2.39 Risk management processes are embedded throughout the service and are in line with the risk strategy in terms of risk registers. However we found a large number of risks had not been reviewed in accordance with Risk Management Procedures.

2.40 The QODG discusses Risk Management as part of an agenda item, but we have been unable to observe a report from the Central IHC Health & Safety and Risk Management Group being presented, that would offer consistent reporting on Risk Management issues throughout the IHC.

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

Appendix A: Management Action Plan

Matter Arising 1: Governance arrangements (Operation)			**Impact**
The IHC have established the required governance structure in-line with that approved by the Health Board. Whilst the Terms of Reference (ToR) are in a format that is easy to follow, there are identified gaps that require addressing immediately. We found: • Identification of both the Chair and Vice Chair was not always recorded. • No evidence the SMT has reviewed and approved, annually, all groups ToR that report into it. • Lack of Cycles of Business for all meetings to ensure all matters for which the IHC is accountable are subject to oversight and scrutiny and assurance reporting. • Minutes varied across all meetings with no consistent style adopted and attendance poor for some meetings.			Potential risk of: • The IHC SMT does not have oversight and ownership of issues for all matters it is accountable.
Recommendations			**Priority**
1.1	Working with the Corporate Governance Directorate, review the governance arrangements within the IHC, ensuring all Terms of Reference are reviewed and updated and consider the dates of meetings to always enable quorum.		**High**
Agreed Management Action		**Target Date**	**Responsible Office**
1.1	Central IHC will complete the review of the governance arrangements including frequency of meetings, Terms of Reference (ToR) and Cycle of Business. Suitable Chairs and Vice-Chair will be reviewed within this process.	31 July 2024	IHC Director – Central

Matter Arising 2: Financial control assurance (Operation)			**Impact**
There is evidence of regular finance reporting to the Senior Management Team and Performance, Finance and Information Governance ODG. Through our review we could find no evidence of oversight and ownership for delivering savings through reducing expenditure. Minutes are scant on any action being allocated to Officers to drive forward the requirement. The IHC has established a Financial Control Group with a remit of *"To monitor and oversee delivery against CRES targets"* but we were unable to confirm that it is reporting in line with its ToR to both the SMT or PFIG ODG as we could find no reference to the meeting in the evidence we received.			Potential risk of: • The IHC is unable to achieve financial balance and reduction in its expenditure to meet its allocated savings requirement.
Recommendations			**Priority**
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.		**High**
Agreed Management Action		**Target Date**	**Responsible Office**
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.	31 July 2024	IHC Director of Operations – Central

Matter Arising 3: Clinical Audit (Operation)	**Impact**
Responsibility for Tier 2 and 3 audits sits with the IHC. There is no evident flow of assurance from audit findings through the governance structure despite reports being reported as closed. There appears minimal clinical audit activity in some specialties with Surgery, Anaesthetics and Critical Care being the backstop for the IHC in actively registering Tier 3 audits. We found no evidence on active engagement with Tier 2 audits in the papers we received. The Quality Performance Report (19 March 2024 Clinical Effectiveness Group) notes incomplete participation and outstanding responses to findings for the National Clinical Audits, with six Tier 1 clinical audits not progressing. Alignment of the meeting dates between both the IHC Clinical Effectiveness Group and Quality Operational Delivery Group are affecting the reporting process.	Potential risk of: • Non-compliance with the requirements of the National Clinical Audit and Outcome Review Plan. • Lack of apparent oversight / progress of Tier 2 and 3 audits. • Lessons learned not being shared.

Recommendations		**Priority**
3.1	IHC to ensure that all audits at Tier 1, 2 and 3 are undertaken, and all outstanding responses are received. Findings and lessons learnt must be shared across the IHC and Health Board.	**High**
3.2	IHC Clinical Effectiveness Group (CEG) and Quality Operational Delivery Group (QODG) meetings are aligned appropriately so that CEG meets prior to the QODG to enable the reporting of assurance/matters for escalation in a timely manner.	

Agreed Management Action		**Target Date**	**Responsible Office**
3.1 3.2	The Central IHC Clinical Effectiveness Group (CEG) will be the responsible forum for ensuring that required clinical audit is completed and assurance will be overseen by QODG. The TOR will be reviewed to ensure that this is reflected.	31 July 2024	IHC Director of Nursing – Central

Matter Arising 4: Concerns, Complaints, Incidents (Operation)			**Impact**
Open complaints are on the increase, as of 3 April 2024 there were 221 open complaints open across the IHC, with 134 overdue. As of the 5 April 2024 there were 2,800 open incidents with 2,550 (91%) incidents 'held' in the "Management review / Make it Safe Plus" section.			• Complaints are not managed efficiently. • Potential of repeat incidents recurring.
Recommendations			**Priority**
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.		**High**
Agreed Management Action		**Target Date**	**Responsible Office**
4.1	The IHC have since developed trajectories to address the backlog of Open and overdue complaints, which will support completion of complaints against the reporting timelines. The QODG will receive assurance through the Patient, Safety Group (PSG). All Services will review their respective open incidents and performance will be monitored at PSG and assurance provided to QODG	31 July 2024	IHC Director of Nursing – Central

Matter Arising 5: Risk Management (Operation)			**Impact**
Attendance at the Central IHC Health & Safety and Risk Management Group is generally poor with inconsistent attendance from services. Risk management processes are embedded throughout the service and are in line with the risk strategy in terms of risk registers. However, 70 (43%) of the 162 risks, as of 18th March, had not been reviewed in accordance with RM02 Risk Management Procedures - 6.1 registers.			• Ineffective risk management.
Recommendations			**Priority**
5.1	The IHC Director: • Ensures regular member attendance at the Health & Safety and Risk Management Group in order that they and the Senior Management Team receive assurance concerning the review and progression of all risks. • Ensures that all services regularly review their risks in accordance with RM02 Risk Management Procedures - 6.1 registers.		**High**
Agreed Management Action		**Target Date**	**Responsible Office**
5.1	All services will regularly review their service risks in accordance with RMO2 Risk Management Procedures – 6.1 registers. Assurance will be received at the CIHC Health & Safety Risk Management Group. A review of the terms of reference will be undertaken in July 2024 to support regular member attendance.	31 July 2024	IHC Director – Central

Appendix B: Assurance opinion and action plan risk rating

Audit Assurance Ratings

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

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

Prioritisation of Recommendations

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

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

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

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Discharge Arrangements Internal Audit Report

May 2024

Betsi Cadwaladr University Health Board

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

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

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Auditors:	Rhys Jones, Principal Auditor Nicola Jones, Deputy Head of Internal Audit Dave Harries, Head of Internal Audit
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Committee:	Audit Committee

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

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

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Executive Summary

Purpose

The review has considered whether there are robust processes and controls in place within the Health Board to support the implementation of Discharge to Recover then Assess (D2RA) requirements, and management of adverse / unsafe discharges.

Overview

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

- There is no up to date Health Board policy or Standard Operating Procedure to support the management of patient discharges and implementation of D2RA requirements. There is uncertainty regarding the robustness of training provision.
- Low compliance against D2RA performance Measures 2 and 3 – not all patients are allocated to a D2RA pathway within 24 hours or discharged within 48 hours of being clinically optimised (for pathways 1, 2 & 3). There are no formal controls or processes to review and address areas of low / non-compliance.
- There are no formal escalation arrangements in place to address and support resolution of Pathways of Care Delays. Ward board rounds are not held twice daily.
- There is no Health Board policy or Standard Operating Procedure in place to support the management of incidents / adverse discharges.

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

Report Opinion

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

Assurance summary[1]

Objectives		Assurance
1	There is guidance available on the process for discharging patients, and staff are aware of the requirements to allocate a D2RA pathway within 24 hours of admission.	Limited
2	Data is collated, reviewed, and analysed to support compliance with the key principles of the guidance, and actions taken to address areas of low/non-compliance.	Limited
3	There are processes in place to support timely discharge where a patient has been allocated to a specified D2RA pathway.	Limited
4	There are appropriate routes for partners to raise concerns where there has been an adverse / unsafe discharge, with actions taken and feedback provided to partners. Issues with partners / engagement are escalated appropriately.	Limited

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

	Key Matters Arising	Objective	Control Design or Operation	Recommendation Priority
1	The Health Board does not have an overarching policy or Standard Operating Procedure in place to support the management of patient discharges and implementation of D2RA requirements. It is not clear whether the completed D2RA training packages / awareness sessions provide staff with the necessary knowledge and skills to effectively embed D2RA within their area of work. We were unable to determine the D2RA training requirements for temporary, bank, and agency staff.	1	Design	High
2	D2RA performance data is captured and reported to the NHS Executive. D2RA performance and patient discharge / flow are reviewed at relevant forums however there are no formal controls or processes in place to address and escalate areas of low / non-compliance.	2	Design	High
3	STREAM usage is significantly reduced over weekends – it is not clear whether this is due to reduced activity and accessibility to services over the weekend, or whether STREAM is updated retrospectively during the week when there are more staff available. D2RA pathway status is not visible on STREAM summary pages.	2	Operation	Medium
4	Pathways of Care Delays are measured and reported however there are no formal escalations mechanisms in place to progress and support resolution. Ward board round arrangements are not meeting Welsh Government Hospital Discharge Guidance requirements.	3	Design	High
5	Adverse / unsafe discharges are reported as patient safety incidents – There is no Health Board policy or Standard Operating Procedure to support the management of incidents. Escalation mechanisms for addressing recurring incidents are not formally documented.	4	Design	High
6	The Health Board are not consistently meeting the timescale requirements for completing MIS+ reviews or for concluding investigations and providing feedback (72 hour and 30-day targets as advised).	4	Operation	Medium

1. Introduction

1.1 The national *'Six Goals for Urgent and Emergency Care Programme'* was established by the Welsh Government in 2022, setting out expectations for Health Boards and their partners for the delivery of the right care, in the right place, first time for physical and mental health. It outlines six goals to *help achieve the best possible clinical outcomes, value and experience for patients and staff involved in the delivery of care.* The goals include:

- Goal 5 – Optimal hospital care and discharge practice from the point of admission.
- Goal 6 – Home first approach and reduce the risk of readmission.

Discharge to Recover then Assess (D2RA) is based on the principles of effective and timely discharge home and are aligned to the work of Goal 5. The four pathways apply to all adult inpatients occupying an acute or community hospital bed.

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

- Patients are not discharged on a timely basis, resulting in harm through deconditioning, poor patient experience and lack of bed availability.
- Health Board is unable to demonstrate compliance with the principles of D2RA pathways.
- Concerns raised by partners are not addressed and potentially impact future discharges and relationships with partners.

1.3 The review has focussed on D2RA pathways. **We were advised following closure of the review that the pilot phase for reporting against the national D2RA Measures has been extended to September 2024, and that the Measures have been revised (effective from April 2024). Any reference to performance against national Measures relate to the initial five Measures as these were relevant at the time of review.**

1.4 The findings of this report are based upon information provided by the Acting Assistant Director Care Homes Support and CHC Commissioning, Programme Manager (Operations), Home First Bureau Discharge Matron (West), Operational Improvement Manager (West), Step Down Matron (Centre), Locality Matron (East), Project Support/Senior Admin Coordinator (East Home First Hub), Digital, Data and Technology officers, Lead Patient Experience and Carers Service, Senior Incident and Investigation Manger, and information available in the public domain. We would like to express our gratitude to colleagues for their input during the undertaking of the review.

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

2. Detailed Audit Findings

Objective 1: There is guidance available on the process for discharging patients, and staff are aware of the requirements to allocate a D2RA pathway within 24 hours of admission.

Policy and guidance documentation

2.1 The revised Discharge to Recover then Assess (D2RA) pathways were launched on 15th June 2023 as part of the Welsh Government's Six Goals for Urgent and Emergency Care programme to improve flow and support the delivery of timely and appropriate patient discharge. D2RA forms part of the wider NHS Wales Optimal Hospital Flow Framework which includes SAFER, Red to Green, and Preventing Deconditioning.

2.2 Welsh Government have issued a range of guidance documents and material to support D2RA implementation and patient discharge operational processes including - Optimal Hospital Flow Framework, Six Goals for Urgent and Emergency Care, Hospital Discharge Guidance (December 2023), D2RA Report, The Management of Reluctant Discharge / Transfer of Care to a More Appropriate Care Setting Guidance, launch presentation, information posters, and short videos.

All supporting material apart from Hospital Discharge Guidance (December 2023) and The Management of Reluctant Discharge guidance document are available to staff via established Health Board webpages on BetsiNet.

2.3 The Health Board does not have an up to date formal overarching policy or Standard Operating Procedure in place to support the management of patient discharges or the implementation of D2RA.

A draft revised hospital discharge policy is currently being developed (copy draft submitted for review) – management stated that progress was delayed during 2023 to ensure integration of pending national Welsh Government Hospital Discharge Guidance (this was issued in December 2023).

2.4 West Integrated Health Community (IHC) have developed the following local guidance documents to support operational processes and ensure consistency (copies provided for review):

- Delayed Pathways of Care – Process of Validation and Escalation.
- Interim Choice Protocol.

Both documents are in the final draft stage – management advised that both draft documents will be submitted to the next West Area Leadership Team meeting for approval.

D2RA Training and Communication

2.5 We were advised that the following methods had been used to communicate D2RA requirements and expectations to staff:

- A series of pre-launch presentations were held at each IHC Service Leadership Team meeting – copy presentation submitted for review however

evidence of attendance and/or further distribution not available.

- NHS Executive presentation to all Matrons and ward managers - copy presentation submitted for review however evidence of attendance and/or further distribution not available.
- Separate webinars / presentations to Health Board Consultants and Doctors – not verified.
- Goal 6, D2RA, SAFER, Red 2 Green posters issued to all wards for display - we have not verified is through on-site review.
- Dedicated D2RA webpage on BetsiNet with links to national guidance.

2.6 There are no formal D2RA training requirements for staff involved with patient flow, however in 2023 Welsh Government issued a non-mandatory online NHS Wales Discharge to Recover then Assess e-learning training package. Table 1 shows the number of Health Board staff that have completed and attempted the e-learning by staff group:

Table 1: Health Board NHS Wales Discharge to Recover then Assess e-learning training by staff group

Staff Group	Completed	Incomplete	Not Attempted	Total
Add Prof Scientific and Technic	12	2	-	**14**
Additional Clinical Services	43	17	1	**61**
Administrative and Clerical	5	3	1	**9**
Allied Health Professionals	32	22	8	**62**
Medical and Dental	-	-	1	**1**
Nursing and Midwifery Registered	101	70	11	**182**
Total	**193**	**114**	**22**	**329**

Source: Data provided by Health Board Workforce and Organisational Development

Whilst the above data confirms that one hundred and ninety-three members of staff have successfully completed the learning module, we are unable to verify the total number of staff members that should have completed the e-learning course, or the quality / comprehensiveness of the course content.

2.7 We discussed area specific D2RA training / awareness initiatives with representatives from West, Central, and East IHCs. The following provides a summary of the key points raised however findings are subject to the following limitation - we were unable to complete our review fieldwork for Central and East due to staff availability / non-response, and the responses we did receive are unverified (no supporting evidence was submitted for review):

- West Home First Bureau – currently implementing a Discharge Competencies Workbook for each staff member. The workbook includes provision for D2RA

and What Matters process, with competency sign-off based on assessed knowledge and understanding. The Discharge Matron advised that implementation is supported by whole-day training sessions held monthly to address gaps in knowledge. Matron also advised that pathways narrative is used by staff on daily basis to inform patient discussions.

- Central – The Step-Down Matron stated that all relevant staff have received awareness training and that the Central Discharge Team are currently undertaking a programme of Optimal Patient Flow presentations (covering D2RA, SAFER, Prevent Deconditioning, and Red 2 Green) for all Matrons and ward managers. We were advised the Central held an event for acute and community Health and Social Care staff comprising a one-day practical training session mapping pathways then following-up patient outcomes – the Matron stated that this had been a valuable exercise and that future sessions were planned. We were unable to verify the form, content, or attendance of the training.
- East – advised that the East Home First Project Lead had attended all wards to provide in-person training, and that D2RA posters had been distributed to all wards.

2.8 We are unable to confirm whether agency, bank, or other temporary staff receive D2RA training, or understand the requirements and expectations of D2RA, prior to commencing their employment with the Health Board.

Conclusion:

2.9 The Health Board does not have a current overarching policy or Standard Operating Procedure(s) in place to support the management of patient discharges and implementation of D2RA requirements. Nationally published material is available to staff via dedicated webpages on BetsiNet however has not been updated with the latest Welsh Government Hospital Discharge Guidance (issued December 2023) and Management of Reluctant Discharge guidance document.

Whilst the published documents provide an overview of implementation and expectations, they do not provide users with practical guidance on specific issues such as Health Board escalation arrangements, roles and responsibilities, local oversight and reporting etc.

2.10 The Health Board has actively promoted D2RA to staff, however it is difficult to measure the effectiveness of training in the absence of formal guidance. It is also pertinent that much of the training and awareness sessions have taken place prior to the Welsh Government issuing its Hospital Discharge Guidance (December 2023). The Health Board should also consider whether current D2RA training / awareness arrangements capture agency, bank, or other temporary staff involved with patient care.

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

Objective 2: Data is collated, reviewed, and analysed to support compliance with the key principles of the guidance, and actions taken to address areas of low/non-compliance.

STREAM Patient flow system

2.11 The Health Board utilise the Welsh Patient Administration System (WPAS) and STREAM to inform the management and reporting of patient discharge / flow.

2.12 The STREAM Patient Flow System is a new live interactive electronic board round solution to support optimal patient flow. Information is recorded onto the system via touchscreens installed at each ward (updated during board rounds), or can be entered via PC, or iPad application. The system was developed in-house and implemented initially (pre-covid) in Central only, however was subject to Health Board-wide formal roll-out during 2023 (completed October 2023).

2.13 STREAM is integrated with WPAS and has provision to record key patient information including predicted discharge date, clinically optimised date, D2RA pathway, next destination, required actions, and completed actions. The information should be reviewed and updated during each daily board round. We noted the following limitations regarding D2RA provision within STREAM:

- The provision to record D2RA pathway (comprising a dropdown list noting pathways 0-3) was added to the system part-way through the implementation phase (31st July 2023). We were advised that STREAM had been implemented in many wards prior to this addition therefore many staff had been trained to use the system when there was no requirement to record D2RA pathway.
- At the time of review the online user guide had not been updated to reflect the addition of D2RA pathway provision. We raised this with the System Support Lead and the issue was addressed with the publishing of an amended user guide.
- The system does not prompt users when the D2RA field has not been completed.
- D2RA pathway status is not shown on the STREAM ward Summary sheet. Similarly, D2RA is not a selectable field in the customisable Detailed View – which can be tailored to meet user needs. The impact of this is that users must access each individual patient's STREAM record to view D2RA pathway details.

Dashboards

2.14 The Right Patient Right Place and D2RA dashboards have been established to support the management and reporting of patient discharges, using data fed from STREAM and WPAS. The Right Patient Right Place (RPRP) dashboard provides an overview by ward / area of patient flow status and includes a summary of outstanding actions, D2RA pathways, and patient next destination. The RPRP dashboard includes a link to the D2RA dashboard which summarises D2RA data by reportable Measure. Both dashboards are interactive allowing staff to drill down

into the data to ward and patient level. Dashboards are accessible to staff with relevant IRIS access rights.

Reporting

2.15 The Health Board are required to report monthly D2RA performance against five nationally agreed Measures to the NHS Executive. The Measures are:

- Measure 1 - People allocated to each D2RA pathway once clinically optimised.
- Measure 2 - People allocated to a D2RA pathway within 24 hours of admission.
- Measure 3 - Discharges achieved within 48 hours of being clinically optimised for pathways 1, 2 and 3.
- Measure 4 - People discharged to their usual place of residence.
- Measure 7 - Average Length of stay for each pathway.

2.16 The Measures Report is prepared by Health Board Information Analysts (Digital, Data, and Technology corporate function) using patient data derived from WPAS and STREAM, via the data warehouse, and D2RA dashboard. The team prepare Measures reports for each IHC which are then consolidated to an overall Health Board position. The reports are sent to the Health Board Programme Leads who review the data, distribute to the IHCs along with supporting monthly summary reports, and formally submit the consolidated Measures Report to the NHS Executive.

2.17 Each month the NHS Executive issues the Health Board with a Pathways of Care Delays (PoCD) report, measuring delayed transfer of care activity via a monthly validated census with local authority partners. The report comprises an analysis of delays broken down by reason and local authority and is supported with a formal Regional Action Plan. Pathways of Care Delays are defined as:

"A pathways of care delay is experienced by an inpatient occupying a bed in an NHS hospital, who is ready to move on to the next stage of care but is prevented from doing so by one or more reasons. The revised definition for recording a delay is: "any patient post 48 hours clinically optimised".

The "next stage of care" covers all appropriate destinations out of the NHS hospitals."

2.18 We noted that both the Measures Report and Pathways of Care Delays report are based on census data – i.e. a snapshot of activity on one day of the month (3rd Wednesday of each month). We were advised that work is near completion in developing the function to enable the reporting of rolling aggregate D2RA activity data across the whole month.

2.19 We were advised that performance and activity data is reviewed and scrutinised at the following Health Board forums:

- Urgent & Emergency Care (UEC) & 6 Goal Programme Board – Executive led bi-monthly meeting. Minutes received confirmed review of performance data.

- IHC / Area operational meetings / forums – Urgent and Emergency Care Group meeting (West), daily MFD Meetings (Medically Fit for Discharge meeting), daily Area Safety Huddles, Community Resource Team (CRT) meetings, monthly Pathways of Care Delays validation meetings with Local Authority, weekly Length of Stay meetings, and escalation meetings. West IHC provided examples of action trackers, reports, and agendas to support their responses however we acknowledge that operational meetings are generally not minuted.

Compliance and escalation

2.20 The following tables provide a summary of Health Board D2RA performance against the nationally agreed Measures. Table 2 shows the aggregate Health Board performance over three consecutive months whilst Table 3 shows performance by Area (combined Acute and Community) for the month of December 2023 (November 2023 position shown in parentheses).

Table 2: Health Board Performance against Measures 1-4, October – December 2023

Health Board Combined Position			
Measure	**October 2023 Compliance %**	**November 2023 Compliance %**	**December 2023 Compliance %**
1. People allocated to each D2RA pathway once clinically optimised	96%	90%	93%
2. People allocated to a D2RA pathway within 24 hours of admission	21%	27%	31%
3. Discharges achieved within 48 hours of being clinically optimised for pathways 1, 2 & 3.	32%	39%	15%
4. People discharged to their usual place of residence	64%	77%	73%

Source: Health Board Measures Reports (October, November, December 2023)

Table 3: D2RA Performance by Area December 2023 (November 2023)

Measure	East Compliance %	Central Compliance %	West Compliance %
1. People allocated to each D2RA pathway once clinically optimised	85% (83%)	95% (96%)	100% (98%)
2. People allocated to a D2RA pathway within 24 hours of admission	33% (33%)	30% (23%)	32% (28%)
3. Discharges achieved within 48 hours of being clinically optimised for pathways 1, 2 & 3.	0% (0%)	25% (38%)	15% (67%)
4. People discharged to their usual place of residence	80% (70%)	75% (75%)	65% (93%)

Source: Health Board Measures Report December 2023 (Acute and Community combined)

(x%) = November 2023 reported performance

2.21 The data shows that performance has generally improved over the three-month review period, however compliance against Measures 2 and 3 are significantly lower than the requirements stated in Welsh Government guidance (target is 100% for both). We recognise that the reporting of D2RA data was in its pilot phase (the first reporting period being August 2023), and that STREAM had not been fully rolled-out across all wards during the initial reporting periods.

2.22 In the absence of formal Health Board guidance, we queried whether local controls and escalation arrangements had been established to address areas of non-conformance, specifically where patients had not been allocated a D2RA pathway within 24 hours of being admitted. The following information was provided:

- Central - the Step-down Matron stated that each morning the Central Site Service Manager drills into the Right Patient Right Place dashboard to identify all patients that haven't been allocated a pathway. The information is sent to the Progress Chasers who highlight the issue at relevant daily board rounds. The same process is also undertaken for patients deemed clinically optimised.
- West - the Operational Improvement Manager (West) stated that they do not routinely identify patients that haven't been allocated a D2RA pathway and escalate with the relevant wards / departments, though it is done on occasion. Clinically optimised patients are reviewed daily at operational meetings, however there are no formal escalation arrangements in place to support the management of delayed discharges.
- East – no response received.

2.23 One Matron highlighted a potential issue impacting compliance – they believed that STREAM was not used/updated comprehensively by all wards over weekends. Matron advised that despite lower staff numbers over the weekend all wards are required to hold their board rounds (using STREAM) as usual. However, she stated that the number of patients having not been allocated a D2RA pathway when admitted over the weekend was consistently high. We requested STREAM usage data by day over a three-month period (1st December 2023 – 27th February 2024). Table 4 shows the number STREAM Update Counts by day (Update Count is the number of times a patient record is updated).

Table 4: STREAM Updates by day 1/12/23 – 27/2/24

Day	Count of Update
Monday	20,177
Tuesday	22,768
Wednesday	19,100
Thursday	18,447
Friday	18,801
Saturday	2,718

Sunday	3,610
Total	**105,621**

Source: STREAM usage data provided by Health Board Digital, Data and Technology Information Analyst.

The data confirms that STREAM usage is significantly reduced over the weekend.

Conclusion:

2.24 We confirmed that the Health Board has robust mechanisms in place to capture and collate D2RA performance data to support the patient discharge process and meet national reporting requirements. The data is presented and reviewed at relevant forums however there are no formal controls or processes to address and escalate areas of low / non-compliance.

2.25 STREAM has provision to record patient D2RA pathway however compliance against D2RA Measures 2 and 3 remained low during the review period. It is not clear whether the low compliance is due to D2RA processes not being fully embedded at operational levels, lack of overarching Health Board guidance, staff awareness and understanding of requirements, or whether wards and departments are not utilising STREAM as intended.

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

Objective 3: There are processes in place to support timely discharge where a patient has been allocated to a specified D2RA pathway.

2.26 There is no formal overarching Health Board policy, guidance, or Standard Operating Procedure in place to support operational process and ensure consistency across areas and services. Findings for this objective are predominantly based on information provided by IHC West, though we have included responses from Central and East where provided.

2.27 We were advised that discharge planning begins immediately and starts with "What Matters" conversations with patients. Discharge arrangements are managed at ward / department level with wards responsible for simple discharges (pathways 0 and 1) and Home First Bureau / Discharge Teams supporting complex discharges (pathways 2 and 3). The Home First Bureau comprises a team of Discharge Coordinators, Discharge Facilitators, Trusted Assessors, Progress Chasers, and administrative support, however staff raised concern about the sustainability of the service due to non-recurring funding ending 31st March 2024 (relevant at time of review).

2.28 The following forums and processes are in place to support patient discharge / flow. Note that this is not an exhaustive list:

- Daily ward board rounds – clinically led review of all patients to identify, prioritise, and allocate tasks / actions required to progress patient flow.
- IHC West - Ysbyty Gwynedd Safety Huddle – daily 8:30am Clinically / Medical Director led meeting with representation from all wards / services / matrons etc in attendance – this is a daily safety huddle during which they review the discharge status of all clinically optimised patients on pathway 0. We were

advised that the meeting comprises a review of the Right Patient Right Place dashboard and ward representatives are asked whether all clinically optimised patients on pathway 0 are going home today – if not, why not?

- Patients suitable for early morning discharge or transfer (Pre 11am) are identified at the Safety Huddle. We were advised that whilst discharge lounge provision is available limited patient transport availability can result in patients not being discharged as intended – We have not verified this assertion.
- Central Safety Huddle – daily meeting with area wide attendance as per West. Separate meetings held for Acute and Community – Acute Safety Huddle is chaired by Head of Site whilst the Community Safety Huddle is chaired by the Matron of the day. Meetings comprise updates from each ward / service. Following the Acute Huddle, a Site Safety and Flow meeting is held. This meeting comprises a review of all clinically optimised patients, any issues, blockages, and actions are agreed. Planned actions are recorded on a board and progress is reviewed and updated during the day.
- Clinically Optimised meetings (previously and still referred to as MFD Medically Fit for Discharge meetings) – senior led daily meetings reviewing the status of each patient deemed clinically optimised for discharge or transfer. Meetings are attended by Associate Director or Director (Chair), MFD Administration, Acute Matrons, Ward Managers, Discharge Coordinator, Progress Chasers, Home First Bureau representative, Community Matron, Tuag Adref (West IHC employed Team who support admission prevention and reablement Packages of Care), Physiotherapy and Occupational Therapy representation, and Local Authority attend on a Tuesday. Progress Chasers verify the data held on STREAM / WPAS prior to the meeting – a Live Action Tracker (spreadsheet) is maintained to inform discussions and to record required actions. Following the meeting the Live Action Tracker is shared with the area senior management team. A copy of the West Live Action Tracker was provided for review.
- Central - the remit of the MFD meetings include a review of all clinically optimised patients to ensure that they are allocated the correct pathway, as well as to address any blockages. Central also hold weekly Full Length of Stay meetings to review every patient over seven days whether clinically optimised or not, and any under seven days that are clinically optimised - Ward managers and therapists provide updates for each patient meeting the above criteria.

2.29 Table 5 shows the top delay reasons (10 or more delays / patients) for the Health Board as reported in the NHS Executive Pathways of Care Delays Report. The data is based on January 2024 census data.

Table 5: Health Board Top Delay Reasons (10 or more delays/patients) January 2024

Delay Reason	Delays
Awaiting joint assessment	64

Delay Reason	Delays
Awaiting completion of assessment Nursing/AHP/Medical/Pharmacy	59
Awaiting start of new home care package	33
Awaiting RH availability	28
Awaiting Social worker allocation	22
Awaiting Residential care home manager to visit and assess (Standard 3 residential)	20
Awaiting NH availability	18
Awaiting EMI residential availability	16
Awaiting Nursing care home manager to visit and assess (Standard 3 residential)	15
Awaiting completion of assessment by social care	11
Awaiting reablement care package	11
Awaiting EMI nursing availability	11

Source: Health Board PoCD Summary Report January 2024

2.30 Whilst patient discharge information is reviewed and updated daily, internally and via engagement with partners, the Health Board does not have an overarching formal escalation framework to progress and support resolution of issues delaying discharge / transfer. We recognise that IHC West have developed draft local guidance (please refer to paragraph 2.4).

2.31 The Welsh Government Hospital Discharge Guidance states that ward level board rounds should be held twice daily (early morning and afternoon) in acute and community hospitals.

"A second, brief afternoon board round (huddle) will agree any further patients not required to be in hospital and therefore able to be discharged. The huddle will also agree tasks that need to be completed to enable early next day discharges ("doing tomorrow's work today")."

Management advised that this has not been implemented.

Conclusion:

2.32 The status and progress of patients deemed clinically optimised and ready for discharge / transfer are subject to oversight and scrutiny by senior Health Board Area Management Teams. Reasons for Pathways of Care Delays are measured, reported, and reviewed, however there are no formal overarching escalation mechanisms in place to progress and support resolution.

2.33 Current ward board round arrangements are not meeting the requirements stated in the Welsh Government Hospital Discharge Guidance document - specifically that board rounds should be held twice daily in all acute and community wards. However, we acknowledge that some of the intended remit of the second ward

round may be picked up and actioned in other relevant meetings / forums (e.g. daily MFD Meeting).

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

Objective 4: There are appropriate routes for partners to raise concerns where there has been an adverse / unsafe discharge, with actions taken and feedback provided to partners. Issues with partners / engagement are escalated appropriately.

2.34 Patients, carers, or partners organisations can report concerns relating to unsafe or adverse discharge by contacting the Health Board Concerns Team or PALS via telephone, email, or online, or by raising directly with any member of Health Board staff. There is also a standardised Adverse Discharge Report (form) that partner organisations can complete and submit. The concerns are recorded on Datix, reviewed, then managed as Patient Safety Incidents or as formal complaints.

2.35 PTR01 Complaints Policy and Procedure is in place to support the management of complaints, however there is no overarching Health Board policy or Standard Operating Procedure for managing Incidents (despite PTR01 referencing Health Board Incident Policy and Procedure), or for escalating issues with partners. Guidance is limited to two Adverse Discharge flowcharts developed by the Patient Safety Team (shared and accessible via BetsNet) outlining operational requirements.

2.36 We were advised that reported adverse / unsafe discharges are subject to the same review, investigation, escalation, and timescale requirements as all other incidents, depending on the severity and level of harm. Six examples of Adverse Discharge Investigation Reports were provided for review, with evidence of distribution to Local Authority. Table 6 provides a summary and analysis of key dates as recorded in the Investigation Reports / Adverse Discharge Reports (where available).

Tabe 6: Summary and analysis of key dates as recorded in the Investigation Reports / Adverse Discharge Reports

Incident Sample	Date reported per Adverse Discharge Form / Datix	Management review / MIS+ review started	No. working days from Date Reported to start of MIS+*	Date that Investigation Report was shared with Local Authority	No working days from date reported to date Inv Report shared.*	Local Authority
1	28/2/24	8/3/24	8	14/3/24	11	Denbighshire
2	12/12/23	15/12/23	3	15/2/24	44	Denbighshire
3	19/1/24	7/2/24	13	8/2/24	14	Wrexham
4	23/10/23	4/1/24	50	7/2/24	74	Wrexham
5	19/9/23	18/10/23	21	7/2/24	98	Denbighshire
6	23/8/23	5/1/24	94	7/2/24	117	Conwy

Source: Data taken directly from Investigation Reports and Adverse Discharge Reports submitted for review.

**Online calculator (timeanddate.com) used to calculate number of working days between two dates – result is adjusted for UK public holidays.*

- We were advised that Make it Safe Plus (MIS+) reviews should be undertaken within 72 hours of the incident occurring, and the outcome of investigations communicated within 30 working days (consistent with PTR requirements). The analysis above shows significant delays both in starting MIS+ reviews and in providing feedback to partners - we have not verified whether the Local Authorities were informed of the delays or exemptions were agreed.

2.37 Table 7 provide a summary of reported Adverse Discharges (incidents) for the period 1st October 2023 to 15th March 2024).

Table 7: Health Board Incidents - Adverse Discharges 1/10/23 – 15/3/24

Adverse Discharge	Delay - Unavailable equipment / medical device	Discharge inappropriate	Discharge planning failure - Medication not prepared	Discharge planning failure - No home support	Discharge planning failure - Referred services did not attend	Discharge planning failure - Service referral not made	Pressure ulcer present before admission to this clinical care area/caseload	Total
Oct 23	0	8	0	0	0	0	0	**8**
Nov 23	0	8	0	0	0	0	0	**8**
Dec 23	0	9	1	3	1	2	1	**17**
Jan 24	0	9	0	1	0	0	0	**10**
Feb 24	1	5	0	0	0	0	0	**6**
Mar 24	0	1	0	0	0	0	0	**1**
Total	**1**	**40**	**1**	**4**	**1**	**2**	**1**	**50**

Source: Datix data – Report prepared and provided by Patient Safety Team

Tabe 8: Health Board Adverse Discharges by Area 1/10/23 – 15/3/24

Adverse Discharge	IHC Central	IHC East	IHC West	Mental Health and Learning Disabilities	Total
Oct 23	2	6	0	0	**8**
Nov 23	5	2	1	0	**8**
Dec 23	11	3	2	1	**17**
Jan 24	7	3	0	0	**10**
Feb 24	5	1	0	0	**6**
Mar 24	1	0	0	0	**1**

Total	**31**	**15**	**3**	**1**	**50**

Source: Datix data – Report prepared and provided by Patient Safety Team

Please note the following limitations based on the data and information provided:

- We were unable to confirm that the required timescales for review and feedback were met – date information was limited to Incident Date and Date Opened.
- We could not discern whether the Adverse Discharges were raised internally (i.e. following internal patient transfer), by patients, or by partner organisations. The Senior Incident and Investigation Manger advised that this issue will be addressed from April 2024 – a new field has been added to Datix to enable specific partner organisations to be named where an incident requires external reporting / joint review.

2.38 In late 2023 IHC West established a monthly Adverse Discharge Group to review and scrutinise Adverse Discharge incidents and to provide a forum to share learning. Meeting minutes are not recorded however an action tracker is maintained. Copies of recent agendas, action tracker, and Terms of Reference were provided for review. We were advised that IHC Central were also implementing an Adverse Discharge Group (first meeting to take place imminently). IHC East position is not known.

Conclusion:

2.39 There are appropriate routes for partners to raise concerns regarding adverse / unsafe discharges as part of the Health Board's wider Complaints, Concerns, and Incidents management procedures. However, there is no Standard Operating Procedure in place to support the management of incidents, or to outline the escalation routes where issues persist – this is pertinent as partner organisations may raise multiple concerns regarding adverse / unsafe discharges which require review and resolution beyond the scope of current procedures.

2.40 Feedback from incident reviews are provided to partner organisations, however the Health Board are not consistently meeting the timeframe requirements for completing MIS+ reviews or for concluding investigations and providing feedback (based on 72 hour and 30 day targets as advised). IHC West have established the Adverse Discharge Group to monitor and review relevant incidents – whilst this is good practice, we were unable to confirm whether the Group membership, roles and responsibilities, lines of escalation / reporting etc had been clearly defined as no Terms of Reference was provided for review.

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

Appendix A: Management Action Plan

Matter Arising 1: Policy, guidance, and training (Design)	**Impact**
The Health Board does not have any formal overarching policy or Standard Operating Procedures in place to support the management of patient discharges and implementation of D2RA requirements. Staff have had access to D2RA training (e-learning, presentations etc) however, • It is not clear whether all staff that should have received training, have accessed the training material. • Majority of training was provided prior to Welsh Government issuing its Hospital Discharge Guidance. • We were unable to determine whether D2RA training / awareness arrangements capture agency, bank, or other temporary staff involved with patient care. • STREAM training provided to staff prior to 31/7/23 did not include the provision to record D2RA pathway – published training material was updated during this review.	Potential risk of: • Lack of clarity, consistency, and transparency • Lack of organisational direction resulting in a fragmented approach to the management of patient discharges. • Lack of robust governance arrangements. • Staff not aware of requirements.

Recommendations		**Priority**
1.1	Management: • Establish an overarching policy or Standard Operating Procedure(s) to support the management of patient discharges and implementation of D2RA. Governance, reporting, and escalation requirements to be clearly defined. • Ensure all staff (substantive, temporary, bank, and agency) involved with patient discharges / flow have a sound understanding of D2RA requirements and expectations.	**High**

Agreed Management Action		**Target Date**	**Responsible Officer**
1.1	Draft revised BCUHB Hospital Discharge policy has been developed to replace the Covid discharge requirements and the former NU01 BCUHB Hospital Discharge Policy which is out of date. The revised draft policy will be	Q2	Acting Assistant Director Care Homes and Continuing Health Care Commissioning

	presented through the Health Board's governance process for approval, this will include a consultation period on the BCUHB website and sign off by relevant Health Board committee. Other supporting documentation including Choice & Reluctant Discharge Guidance and Criteria Led discharge is also being reviewed as part of this review of discharge documentation.		Programme Manager for Urgent & Emergency Care
1.2	Training Needs Analysis will be undertaken across each acute and community hospital.	Q2	Central IHC Director
1.3	Establish training plan, informed by TNA (to include staff across acute, community hospitals and from disciplines, doctors, nursing, AHP as well as students and including agency / bank staff).	Q3	Central IHC Director

Matter Arising 2: D2RA performance Measures (Design)			**Impact**
D2RA data captured via STREAM is presented and reviewed at relevant forums however we noted the following limitations: • Low compliance against Measure 2 (31% - D2RA pathway allocated within 24hrs) and Measure 3 (15% - Discharges achieved within 48 hours of being clinically optimised for pathways 1, 2 & 3). • No formal controls or processes to address and escalate areas of low / non-compliance. • Review and challenge of patients not allocated D2RA pathway is not routine practice across all Areas – key forums focus on patients deemed clinically optimised. • D2RA pathway not visible on STREAM summary pages. • STREAM usage significantly reduced over weekends.			Potential risk of: • Adverse impact on patient safety, health, and wellbeing. • Lack of bed availability. • Failure to adhere to Welsh Government requirements
Recommendations			**Priority**
2.1	Management: • Establish formal escalation arrangements to address and support areas of low / non-compliance. • Ensure that all patients without an allocated D2RA pathway are identified and highlighted to the relevant ward managers. Persistent failure to meet mandated requirements to be escalated.		**High**
2.2	Management: • Remind staff to utilise STREAM to support their ward board rounds and to ensure that patient records are kept up to date. • Consider incorporating D2RA pathway field onto STREAM summary pages to provide users with an at a glance overview of ward D2RA pathway status.		**Medium**
Agreed Management Action		**Target Date**	**Responsible Officer**

2.1	Develop Comms and engagement plan, informed by TNA to refocus and raise awareness to increase focus & awareness on D2RA pathways, STREAM, etc.	Q1	Acting Assistant Director Care Homes and Continuing Health Care Commissioning Programme Manager for Urgent & Emergency Care Central IHC Director
2.2	Implement comms and engagement plan.	Q2, Q3, Q4	Central IHC Director
2.3	STREAM development group established and a key priority will be to support increasing the compliance of D2RA reporting.	Q2	Acting Assistant Director Care Homes and Continuing Health Care Commissioning Programme Manager for Urgent & Emergency Care
2.4	Identify areas of good practice and areas of learning / improvement from poor compliance demonstrated through monthly performance reporting.	Q1	Acting Assistant Director Care Homes and Continuing Health Care Commissioning Programme Manager for Urgent & Emergency Care
2.5	Produce monthly reports for Central IHC Director on compliance for review and monitoring at IHC UEC meetings and scrutiny at the 6 Goals programme board (second phase of pilot now commenced for next 6 months April to September to test reporting against revised / additional measures).	Q1	Acting Assistant Director Care Homes and Continuing Health Care Commissioning Programme Manager for Urgent & Emergency Care

Matter Arising 3: Pathways of Care Delays (Design)	**Impact**
Pathways of Care Delays are measured and reported however there are no formal escalations mechanisms in place to progress and support resolution. Current ward board round arrangements are not meeting Welsh Government Hospital Discharge Guidance requirements – board rounds are held once daily in all acute and community wards and not twice daily as stated in the Guidance document.	Potential risk of: • Adverse impact on patient safety, health, and wellbeing. • Extended length of stay. • Lack of bed availability. • Failure to adhere to Welsh Government requirements.

Recommendations		**Priority**
3.1	Management: • Establish formal escalation framework to address and support resolution of Pathways of Care Delays. • Ensure working practice complies with Welsh Government requirements.	**High**

Agreed Management Action		**Target Date**	**Responsible Officer**
3.1	Stock take of which areas are doing Board rounds twice daily with the aim of developing an improvement plan to support improved compliance.	Q1	Central IHC Director
3.2	Agree robust reporting and governance arrangements at RPB level.	Q2	Acting Assistant Director Care Homes and Continuing Health Care Commissioning
3.3	Regional action plan refreshed in April 2024 discussed with each IHC and respective LAs to ensure actions align with top delays / areas of challenge and submitted to NHS Exec (quarterly).	Q2, Q3, Q4	Acting Assistant Director Care Homes and Continuing Health Care Commissioning / Programme

			Manager for Urgent & Emergency Care Central IHC Director
3.4	Health & Social Care Trusted Assessor joint action plan submitted monthly to NHS Exec to monitor progress of additional roles and functions to support assessment delays.	Quarterly	Acting Assistant Director Care Homes and Continuing Health Care Commissioning / Programme Manager for Urgent & Emergency Care Central IHC Director

Matter Arising 4: Adverse discharges / Incidents (Design)	**Impact**
There is no Policy or Standard Operating Procedure in place to support the management of incidents. Escalation mechanisms for addressing recurring incidents are not formally documented. Health Board are not consistently meeting the timeframe requirements for completing MIS+ reviews or for concluding investigations and providing feedback (based on 72hour and 30day targets as advised). An Adverse Discharge Group has been established by IHC West to review adverse discharge incidents and provide a forum to share learning. Implementation is currently limited to IHC West.	Potential risk of: • Adverse impact on patient safety, health, and wellbeing. • Poor relationship with partner organisations. • Lack of clarity, consistency, and transparency. • Lack of robust governance arrangements.

Recommendations		**Priority**
4.1	Management establish formal overarching policy or Standard Operating Procedure to support the operational management of incidents, including providing for adverse discharges. Governance, reporting, and escalation requirements must be clearly defined.	**High**
4.2	Management ensure adverse discharges are reviewed in accordance with stipulated timelines, with action taken (where necessary) and outcomes fed back to partner organisations in a timely manner.	**Medium**

Agreed Management Action		**Target Date**	**Responsible Officer**
4.1	Each IHC to establish an Adverse Discharge Group with clear ToRs.	Q2	Central IHC Director
4.2	Hold Discharge webinars with Care Homes across each IHC to improve communication and build trust between Health and Providers.	Q2	Acting Assistant Director Care Homes and Continuing Health Care Commissioning / Programme

			Manager for Urgent & Emergency Care Central IHC Director

Appendix B: Assurance opinion and action plan risk rating

Audit Assurance Ratings

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

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

Prioritisation of Recommendations

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

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

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

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Operating Model
Final Internal Audit Report

May 2024

Betsi Cadwaladr University Health Board

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

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

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Committee:	Audit Committee

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

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

Disclaimer notice - please note:
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Executive Summary

Purpose

To review the costs associated with the Operating Model and whether the revised structure has delivered the benefits intended.

Overview

We have issued *unsatisfactory assurance* on this area.

- Although the first phase of the operating model has been implemented as planned, there has been minimal advancement in establishing the desired principles of Integrated Health Communities (IHCs).
- There are twenty-six services designated as 'Outstanding design' which require urgent focus. We consider the steps taken to date are more an operational structure and not operating model change.
- We have been unable to corroborate the original costs of the Operating Model (OM) presented to and approved by the Health Board. We estimate the operating model has cost at least £1,857,819 more than stated, with contingency and transformational funds used to cover increased management costs. This directs funding away from opportunities to transform services for patients. We believe the current costs of the OM are unsustainable and require immediate review. We also noted that the former Area/Hospital structure was not affordable as a balancing figure of £353,049 was used from Transformational Funds.
- It is unclear why management approved the IHC model when there was a calculated increase in recurring funding required of £1,387,612, and where the funding for this was. It is our view that this is a breach of Standing Financial Instructions.
- There are no evident benefits realisation measures published for the OM project. We cannot provide any assurance that the OM/structure change has delivered any benefits.

Report Opinion

		Trend
Unsatisfactory assurance	Action is required to address the whole control framework in this area. **High impact** on residual risk exposure until resolved.	N/A

Assurance summary[1]

	Objectives	Assurance
1	The implementation of Version 7 of the Operating Model has been completed in line with the plan and timescales approved by the Board.	Limited
2	The total cost of implementing the Operating Model is within the cost/contingency agreed by the Board.	Unsatisfactory
3	The benefits of the Operating Model are being realised, and any limitations / concerns have been actioned.	Unsatisfactory
4	The operational governance and assurance framework has been implemented and is working as intended.	Limited

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

- Operational functions have implemented the expected structure to mirror the Executive Delivery Groups (EDGs), however we have found anomalies between the expected EDGs and those in operation.

Key Matters Arising		Objective	Control Design or Operation	Recommendation Priority
1	There are significant variances in design and practice of the Operating Model in operation to that which was approved by the Health Board. Several services have not progressed and the cost of implementing the model has significantly exceeded the approved cost.	2,3	Design and Operation	High
2	There are variances in the operation of the Operational Governance and Accountability Framework approved by the Health Board.	4	Design and Operation	High

1. Introduction

1.1 Following views from staff working within the Health Board, and to deliver ambitions set out in the Health Board's long-term strategy Living Healthier, Staying Well, the Health Board was presented with an Operating Model in 2022. This would define leadership and management arrangements and help the Health Board get better organised to serve its communities.

Across several Health Board meetings in 2022, the Board received and considered the Operating Model (OM), with the private Health Board Meeting on 3 February 2022, receiving a paper from the then Chief Executive, Item 22.45 – The Operating Model with the following extracts noted with regards to financing the OM:

> *"Senior Management Configurations*
>
> *Management arrangements will reflect pathways and communities as much as possible bringing management arrangements together in an Integrated Health Community. This will be managed within the existing organisational budget and Integrated Medium Term Plan. Any proposals requiring additional investment will need to demonstrate robust return on investment, and subject to the organisation's business planning process and governance.*
>
> *Financial Implications*
>
> *The direct cost of the revised Operating Model described above is £653,303 including a contingency for additional costs associated with role banding and recruitment given the need to attract high quality applicants in a competitive recruitment market. This contingency has been based upon an assessment of current market rates in for comparable roles and has been informed particularly by the current largescale recruitment to roles in newly forming Integrated Care Boards in NHS England. Funding of £435,000 has been set aside in the plan from the Performance Fund, and, subject to approval through the Remuneration and Terms of Service Committee, recurrent savings released from deletion or realignment of posts as a result of approval of applications for Voluntary Early Release will be offset against these costs before being included in savings delivery."*

1.2 The risks considered in this review were:

- The OM costs are more than that approved by the Board.
- The OM has not improved the Health Board's services to its users.

1.3 The scope of our review was restricted to assessing progress in implementing the OM and did not include a detailed review of all areas/Integrated Health Communities (IHCs).

1.4 We would like to extend our gratitude to all Health Board colleagues who supported this review through meeting with us and providing evidence.

2. Detailed Audit Findings

This report is based upon the information provided by officers supporting our review. We have relied solely on the documents, information and explanations provided and, except where otherwise stated, we have not contacted or undertaken work directly to verify the authenticity of the information provided.

As part of testing for this review, we issued a questionnaire to forty-eight (48) officers at Executive (Tier 1 and 2) and Senior Leader (Tier 3 and 4) level in the Health Board. Nineteen officers (40%) responded to our questionnaire.

Key comments from the questionnaire are provided in the diagram below with detailed analysis and comments from Officers included in Appendix B.

Image 1 – Headline summary of responses

- Dissatisfaction with the operating model: Many respondents felt frustrated and stressed by the current operating model, which they perceived as ineffective, unresponsive, and lacking in autonomy and support.
- Lack of clarity and consistency in the operating model: Some respondents pointed out that the operating model was incomplete, inconsistent, and not aligned with the original vision. They also noted that some roles and functions were unclear or poorly defined.
- Exclusion of mental health and learning disabilities from the IHCs: A major concern raised by some respondents was the decision to exclude mental health and learning disabilities from the IHCs, which they argued was against the evidence base and the best practice of integrated care. They also felt that this decision stigmatized and marginalized these services and their users.

Source: Response to Question 12 summarised using Copilot AI.

Objective 1: The implementation of Version 7 of the Operating Model has been completed in line with the plan and timescales approved by the Board.

2.1 On 26 May 2022, the Health Board meeting considered Agenda Item *22/114 Operating Model Implementation Infrastructure - For Approval* which consisted of cover report and seven appendices. The Board considered Item *22.114a Health Board Operating Model Appendix 1 Document v8* (noted Version 7 on the report) with Minute 22/114.8 recording that the Board resolved to '*Approve the implementation of the revised Operating Model;'*.

2.2 An Operating Model (OM) serves as the strategic framework that defines how the Health Board delivers its vision and mission, thereby meeting its corporate objectives. It outlines how various elements like processes, technology, governance, and people should interconnect and interact to deliver intended outcomes. We found no reference in the OM document to the intended delivery of Health Board Corporate Objectives or its strategy.

2.3 Our review of the Operating Model Version 7 document identified that the key changes concerning the three Integrated Health Communities (IHCs) structures were implemented as expected. However, we note that appointments to some key posts took time, with interim arrangements in place for a minimum of six months pending substantive appointment.

2.4 The *Change Readiness Assessment V1.8* (Appendix 4) presented at the meeting identified seven projects and assessments of readiness; four were rated amber "Plan progressing, risks are being managed".

Image 2: Change Readiness Assessment – Presented to Health Board 26 May 2022

Purpose	The purpose of the Change Readiness Assessment is to understand the state of readiness of the individual components identified as requiring change within the scope of the programme: How we Organise Ourselves (delivering our new Operating Model). To support the Board in their decision to proceed (Go) or delay (No Go) with go live of the new Operating Model design between 01 August 2022 and 01 September 2022.	**Go Live – what do we mean?** *The new Integrated Health Communities, Pan and Support services structure will be in place. Enabled by an operational governance & assurance framework and digital systems which facilitates the execution of the role & responsibility by a post-holder. Whilst not increasing the likelihood of an Unintended incident of Patient Harm or Breach of our Statutory Duty. Acknowledging that transition to the final design will continue post go-live.*

Implementation – summary by Project (Level 0)		Go Live 01.08.2022 - 01.09.2022				
		On Track / Plan progressing Some risks – being managed / Off Track	If NOT ready – increase the likelihood of		Go / No Go	Support description summary – including critical risk(s) for escalation
#	**Project (Grouped Activities)**		Unintended incident of Patient Harm	Breaching our Statutory Duty		
A	Roles & the people				Go	Plans are progressing – risk are being managed.
B	Leadership development & support for emerging teams				Go	Plans are in place and on track.
C	Engagement & communications				Go	Plans are progressing – risk are being managed.
D	Goals, governance, finance, performance				Go	Plans are in place and on track.
E	IHC Operational transition plan				Go	Plans are progressing – risk are being managed.
F	Outstanding design				Go	Plans are progressing – risk are being managed.
G	Enabling services				Go	Plans are in place and on track.
New Operating Model – Go live					**Go**	A designation status of Go can be applied to the commencement of Go-live from the 01.08.2022 - 01.09.2022

Source:https://bcuhb.nhs.wales/about-us/health-board-meetings-and-members/health-board-meetings/health-board-meetings/health-board-26522-v10-public-session/ (Item 22.114d – Bundle Page 227/629)

2.5 We met with several senior officers to gain an understanding of whether key elements of the OM have been implemented, and how they believed the OM had progressed in practice. We noted the following key messages from our meetings:

- There is a greater need for clarity and consistency of the governance and accountability arrangements, coupled with clear expectations on what autonomy is devolved as outlined in the OM documentation.
- Focus on Primary Care and Community Services has been reduced since the IHCs were established as secondary care pressures take the focus of IHC leaders.
- The ambition for pan-North Wales services to become part of and contribute to each health community senior leadership has not been realised as intended.

- Business Partnering/Service support functions require review to determine whether they add value, and where they retain responsibility back to their corporate function.
- Clarity is needed on delegation/decision making of certain roles i.e. Director of Primary Care; Associate Director of Planned Care; and Chief Pharmacist.
- There is uncertainty how the overall Health Board Strategy/Three-year Plan is developed; we are advised that services provide detailed input but this is sometimes overlooked at drafting stage.

2.6 We reviewed the appointment of officers to job matched JESP Pay Bands as defined by Welsh Government. We noted that some officers had been appointed at the top of the band but have been unable to verify whether these were considered and approved by the Remuneration and Terms of Services Committee.

2.7 We received email correspondence titled '*How We Organise Ourselves'* dated 5 September 2022, one month after the Board agreed OM implementation date. The review of this document, coupled with an understanding of the risks and service pressures currently impacting the Health Board has confirmed that several areas are still to progress. We have noted the following:

- We are unsighted as to how some key service areas are to be addressed as we have seen limited/no progress in areas such as Psychology Services, Commissioning Unit or Clinical Effectiveness Function (incl. Quality, Governance, Risk).
- Following the departure of some Officers in 2022, the program has paused with no apparent progress made since. There are twenty-six key services detailed in the *'Outstanding Design'* that require direction considering the current risks facing the Health Board e.g. Dermatology; Diabetes; Childrens Services; Vascular; and Urology.
- There is no apparent oversight function to manage the clinical networks as outlined.
- No oversight of Therapies within Mental Health and Learning Disabilities akin to IHCs.

Conclusion:

2.8 It is evident that the requirements for phase 1 have progressed as expected, however on-going progress to develop the intended principles of IHCs have been hampered through departures and Special Measures.

2.9 Based on the evidence reviewed and through discussions, we can only see that Tier 3 and 4 management structures have changed for the former Area, Hospital and Facilities management arrangements, bringing them into the IHC structure. We are unsure whether this OM is solely an organisational structure change due to limited impact, if any, on it delivering against the corporate objectives.

2.10 We could not confirm that the Remuneration and Terms of Service Committee approved the appointment of Officers to the top of JESP Bands – governance and approval concerning JESP banding must always be adhered to.

2.11 There remain many services recorded as 'Outstanding Design' which require urgent focus, noting some are identified as current risk areas e.g. Diabetes, Dermatology, Childrens Services, Neurosciences Network and Eye care.

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

Objective 2: The total cost of implementing the Operating Model is within the cost/contingency agreed by the Board.

2.12 At the Health Board meeting on 26 May 2022, Agenda Item *22/114 Operating Model Implementation Infrastructure - For Approval* was presented that outlined the following:

> ***'Goblygiadau Ariannol / Financial Implications***
>
> *The direct cost of the revised operating model described above is £653,303 including a contingency for additional costs associated with role banding, recruitment given the need to attract high quality applicants in a competitive recruitment market.*
>
> *Funding of £435,000 has been set aside in the plan from the Performance Fund, and, following of approval through the Remuneration and Terms of Service Committee and Welsh Government, recurrent savings of £683,790 released from deletion or realignment of posts as a result of approval of applications for Voluntary Early Release will be offset against these costs before being included in savings delivery.'*

2.13 The narrative provided to the Board included releasing £683,790 recurrent savings through Voluntary Early Release (VER) contributing to the OM costs. Previous reviews undertaken by Internal Audit identified that all recurring savings from VER, through reviewing business case submissions to both Remuneration and Terms of Service Committee and Welsh Government, recorded the savings as cash releasing and not for reinvesting in the OM. Consequently, the £683,790 cannot be viewed as funding the OM.

2.14 We contacted officers in the Finance Corporate Function to request financial information pre and post OM implementation to identify whether it had cost more than stated to the Board. We also requested the backing information underpinning the calculation of the outlined cost of £653,303. Finance colleagues who assumed responsibility for the OM budget allocation, post approval by the Board, have been unable to identify who or how this figure was calculated.

We did receive all the information requested coupled with a further document titled *Operating Model - management structure 2324 V3* which provided a detailed analysis of budget movements from the old management structure and how funding was to be allocated in the new OM structure.

2.15 Our review of *Operating Model - management structure 2324 V3* provided us with sufficient information to identify the following:

- The previous management structure of the three Area/Hospital model appears unaffordable as management were using non-recurring Transformation Funds

(Balancing figure) of £353,049.

- An increase of six (6) whole time equivalent (wte) across the three IHCs and a re-banding with a direct increase in cost of £1,387,612.
- Management are using funding of £831,815; £300,000 from Transformation Fund and £531,815 from Contingency to meet the revised structure. This exceeds the £653,303 the Board approved by £178,512 (27.3%).
- We noted that through the revised structure, the Health Board is also incurring pay protection of £24,555 (excluding all on-costs) for three posts. The duration of pay protection is unknown.

2.16 Through our review of organisational change in the Health Board, we found four corporate functions that, as a direct response to the OM, needed to change their own structure to support the OM.

2.17 Following our review of information provided by the Finance Corporate Function, we excluded Digital, Data and Technology Divisional OM change as this was undertaken through a separate process and was not part of the main OM.

2.18 Our review of Month 12/22 (March 2022) and Month 12/23 (March 2023) detailing pre and post OM implementation identified the following:

Table 1 – Summary of three corporate functions where Organisational Change has been driven due to the Operating Model

Month	Cost Centre	Funded WTE	Actual WTE	Annual Budget (£)	Annual expenditure (£)	Variance (£)
M12 22	L001 Medical Executive	19.72	23.77	1,426,551	1,324,455	-102,096
M12 23		20.72	18.84	1,654,749	1,197,756	-456,993
M12 22	R001 Nurse Executive	8.00	9.27	1,237,537	1,346,719	109,182
M12 23		7.00	11.77	971,327	1,332,813	361,486
M12 22	T300 HR Management	4.00	5.20	562,509	745,439	182,930
M12 23		4.00	8.27	552,098	1,510,679	958,581

Source: Finance Corporate Function GL reports 11 January 2024

2.19 We found that changes from the organisational change do not appear to have been reflected in recurring funding. Excluding the under-establishment in the Medical Executive, both Nurse Executive and HR Management are significantly

over-established. Identifying the variance between March 2022 and March 2023 we identified that:

- R001 Nurse Executive is 4.77 wte over-established with a net overspend of £252,304 compared to pre-OM change (M12 22).
- T300 HR Management is 4.27 wte over-established with a net overspend of £775,651 compared to pre-OM change (M12 22).

2.20 We contacted the three IHC Medical Directors to confirm whether the organisational changes noted in the Medical Executive (three posts per IHC) had been applied in their structure with the West IHC Medical Director replying to our request.

2.21 Based on our review of all information we have to hand, we have estimated the cost of the OM (structure change at Tier 3 and 4 with Corporate Function changes) as £2,511,122 – Table 2 details the estimated costs by cost centre.

Table 2: Estimated costs of the Operating Model by Cost Centre

Cost Centre	Estimated Cost (£)
IHC Centre*	531,107
IHC East*	374,119
IHC West*	459,714
Director rebanding*	22,672
Pay Protection for 3 Officers (excludes on-costs)	24,555
IHC West Acute Medical Director (Unfunded 5 sessions/0.5wte)	71,000
Organisational Change – Nursing Executive (R001)	252,304
Organisational Change – HR Management (T300)	775,651
Total Estimated cost of the Operating Model	2,511,122

Source: * Evidence obtained from spreadsheet provided by Finance

2.22 We reviewed compliance with Health Board Standing Financial Instructions (SFIs) and noted the Health Board appears to have breached the following:

'5.2. Budgetary Delegation

- *5.2.2 The Chief Executive, Director of Finance and delegated budget holders must not exceed the budgetary total or virement limits set by the Board.*
- *5.3.4 Each Budget Holder is responsible for ensuring that:*
  - *c) No permanent employees are appointed without the approval of the*

Chief Executive other than those provided for within the available resources and workforce establishment as approved by the Board.

14.3 Staff Appointments

- *14.3.1 Staff must only be engaged by authorised managers, in accordance with the Board's Scheme of Delegation. The engagement must be within the approved budget and funded establishment.*
- *14.3.2 No Board member or LHB official may engage, re-engage, or re-grade employees, either on a permanent or temporary nature, or hire agency staff, or agree to changes in any aspect of remuneration outside the limit of their approved budget and funded establishment unless authorised to do so by the Chief Executive.'*

Conclusion:

2.23 We have been unable to corroborate the original OM costs presented to the Health Board and our estimated findings suggest the OM is a significant cost pressure for the Health Board and unsustainable in its current format. Further use of contingency and transformational funds into management costs directs resources away from opportunities to transform healthcare for service users.

2.24 It is unclear how management approved the IHC model where there was a calculated increase in the recurring funding requirement of £1,387,612, but the funding was unclear. It is our view that this is a breach of Standing Financial Instruction 5.2 – Budgetary Delegation due to the increased charge to Contingency and Transformation Fund which was not approved by the Board.

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

Objective 3: The benefits of the Operating Model are being realised, and any limitations / concerns have been actioned.

2.25 Through our review of the OM papers presented to the Health Board on 26 May 2022, we have been unable to identify what the reported benefits of the OM were, consequently we cannot provide any assurance that the OM has delivered what it set out to achieve.

2.26 We reviewed risks associated with the OM and found Risk ID 4371, owned by Workforce and OD, that included the following narrative:

'Risk of confidence in leadership being compromised if benefits realisation of the new operating Model are not demonstrated.'

The risk included several control measures and found '*2. Outcome measures incorporated into IMTP, enabling Strategies and Targeted Intervention maturity matrices.'*

2.27 We also found reference within the Engagement and Communications Handling Plan regarding benefits of the OM: *'We believe that we will see benefits within the next three years, but this is very much about the medium to long-term.'*. There are no benefits recorded for us to verify against.

2.28 Using the *Control Measure* record that *'Outcome measures incorporated into IMTP'* we reviewed the *Integrated Medium Term Plan 2022/25* (IMTP) presented to the Health Board on 30 March 2022 (Agenda Item *22/97 Approval of the Integrated Medium Term Plan including the Financial Plan (IMTP))* and found the following reference including a 2022/23 and full year effect cost of £0.7m:

Image 3: IMTP Extract referring to the Operating Model

a.2022.28	**Operating Model**	●	●	0.7	0.7

Source: Bundle Health Board 30 March 2022 (nhs.wales) Page 28/454 and 107/454 of the Agenda bundle

Key: ● IMTP confirmation of Workforce and Financial Testing respectively

Developments Priorities commenced before 2022 and being consolidated during 2022
SMART detail

Ref No	Title
a.2022.28	**Operating Model**

Short description

Implement revised senior leadership structure to facilitate movement to Integrated Health Community and Pan North Wales operating model.

Longer description

The Operating Model is defined as the 'arrangements for how we organise and manage the business of the Health Board'. Specifically the Operating Model describes the:
- Design principles, outlining the basis for model design, what it will achieve for the people we serve and the people who work with and for the Health Board;
- High level structure of the organisation, including Executive Team portfolios, the arrangements for the most senior tiers of clinical operational management, accountabilities and reporting lines;
- Operational ways of working, which support organisational effectiveness, aligned to the governance and performance accountability frameworks.

Measure 1	Timeline 22/23
Appointment to key leadership roles	A M J J A S O N D J F M
Measure 2	**Timeline 22/23**
Implementation of full operating Model	A M J J A S O N D J F M
Measure 3	**Timeline 22/23**
Post implementation gateways	A M J J A S O N D J F M

2.29 Noting the IMTP was not approved by Welsh Government and was subsequently translated into an annual plan, we sought evidence that the OM was included. We can find no reference to the OM in the annual plan and through discussions with colleagues in Planning, have been unable to locate any project documentation that originally created the project in the IMTP.

2.30 In the absence of specific benefit realisation/measures set by management to demonstrate whether the OM had improved Health Board services, we reviewed high-level performance and quality measures however we are unable to determine if any improvement or deterioration in service is a result of the OM changes.

Conclusion:

2.31 There are no evident benefits realisation measures published for the OM project. We cannot provide any assurance that the OM/structure change has delivered any benefits; this is a significant gap in controls when developing the project.

2.32 The Chief Executive and Board may wish to consider whether the OM in its current guise is fit for purpose to deliver against its new corporate/strategic objectives and the significant transformational agenda required to improve its services,

coupled with addressing the unprecedented financial challenge it faces.

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

Objective 4: The operational governance and assurance framework has been implemented and is working as intended.

2.33 At its meeting on 26 May 2022, the Health Board approved Agenda Item 22.114b '*Operational Governance and Assurance Framework 2022 Draft v 3.1*' that provided the backbone for governance and accountability across the Health Board.

2.34 We compared the framework document to the structures in place across the Health Board, and all operational services including two corporate functions. Our review identified that:

- All IHCs, Women's, and Cancer Services were operating as expected, although we note there was no Public Health Local Delivery Group established for any service. We are advised they had been told not to implement this Group but have not corroborated this assertion.
- Digital, Data and Technology Corporate Function were operating as expected.
- No response was received from Mental Health and Learning Disabilities, North Wales Clinical Services or Finance Corporate Function.
- Health Board Leadership Team (HBLT) is no longer meeting, and we were advised that a new Health Board Senior Leadership Team has been established but have not received any evidence to corroborate this.
- An Operational Leadership Team, chaired by the Executive Director of Operations has been established but this is not reflected in the governance framework – We are unclear whether the Terms of Reference shared with us has been approved.
- We requested details *of 'A senior leader, within each leadership team, will take responsibility for Governance within the team structure and link in with the Associate Director of Governance within the Office of the Deputy Chief Executive'* but at time of this report have received no response to our request.
- We found no evidence that Executive Delivery Group Chairs Assurance reports were presented to the HBLT prior to it being stood down.

2.35 We requested details of all Executive Delivery Groups (EDGs) in operation at the time of this review to compare with those detailed in the governance framework.

2.36 At the outset we were advised the Chief Executive is reviewing Terms of Reference (ToR) for the EDGs. We did not review compliance with the ToR in detail and are unable to confirm that all ToRs provided were approved by the former HBLT (assurance receiving meeting). Table 4 below details our high-level review of the evidence provided:

Table 3 – Review of Executive Delivery Groups per the Governance and Assurance framework

Executive Delivery Group (per Governance Framework)	Internal Audit finding from evidence received
People and Culture	No evidence received that this is meeting.
Quality	No evidence that the ToR has been formally approved as we received an unsigned version dated 8 February 2023 (v0.3) with a scheduled for review after 6 months but no evidence of this.
Population Health	Advised this is called 'Public Health'. The ToR provided is dated 01/23 (v1.1) with a scheduled review after 6 months but there is no evidence of this taking place. We noted an incomplete section at Appendix 1. The ToR states that the Vice Chair is an Executive Director but a review of minutes received show it is the Director Of Partnerships/ Communications and Engagement who is the Vice Chair.
Transformation	Advised this is called 'Transformation and Strategic Planning'. The ToR provided is dated February 2023 (v2) and was approved by the EDG on 14 February 2023, and was scheduled for review after 6 months. However there is no evidence of this. A Chair's assurance report of the EDG was provided.
Performance and Finance	Advised this is called 'Integrated Performance'. We did not receive the updated ToR and were advised that minutes of meetings held in November and December 2023 were not available.

2.37 Our review has identified some differences between the EDGs detailed in the governance framework to those operating. In the evidence provided by the Head of Corporate Office, it also noted the Operational Leadership Team and Capital Investment Group as EDGs, which is not in line with that approved by the Board.

Conclusion:

2.38 Overall, we found that the operational functions have implemented the expected

structure to mirror the EDGs but we have found anomalies between the expected EDGs and those in operation. For the Health Board to deliver on its focus regarding Special Measures governance, it must take the opportunity from this review to re-set its governance and accountability framework to ensure it is fit for purpose.

2.39 There has been no evident review of the EDGs Terms of Reference since inception in early 2023 and concur with the Chief Executive that these require review to ensure they are fit for purpose and set to deliver on the Health Board's imminent publication of its corporate objectives.

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

Appendix A: Management Action Plan

Matter Arising 1: Operating Model (Design and Operation)	**Impact**
Our review of the core Operating Model (OM) identified significant variances in practice to that which was presented and approved by the Health Board in May 2022. Key observations from discussion with staff and a review of documentation and budgets, are: • Both primary care and community services do not have the same exposure since moving into the IHC model, as Secondary Care has taken all the focus. • Twenty-six services designated as 'Outstanding design' have not progressed per evidence presented to the Board since August 2022. These require urgent focus. • The OM structure has exceeded the original cost advised to the Health Board by at least £1,857,819 (estimate); we found that the IHC management structure identified an increase cost of £1,387,612 and six (6) whole time equivalent. • Documentation for the OM does not include any measurable benefits that can demonstrate whether it has delivered what it set out to achieve. • Feedback from Officers through our questionnaire suggest there are many areas that require revisiting.	Potential risk of: • Non-compliance with Standing Financial Instruction 5.2 – Budgetary Delegation. • The Health Board takes a decision using incomplete/ inaccurate information. • The Health Board structure is not fit for purpose to deliver the transformation needed as part of its long-term plan, Strategy and Corporate Objectives.

Recommendations		**Priority**
1.1	The Health Board, through the Chief Executive should undertake a full review of the operating model including: • A review of the Operating Model, as implemented, to ensure it is fit for purpose in delivering the Corporate/Strategic Objectives, long-term strategy/medium term plan of the Health Board. • A review of all twenty-six services identified as 'Outstanding Design – Clinical' with urgency, noting some represent current risk to the Health Board. • Review of the role, remit and accountability of corporate posts where the services they oversee are delivered through Operational Services, for which they have no delegated responsibility or accountability.	**High**

	• A review of funding, to ensure any Operating Model/Structure is affordable and transparency in funding is ensured.		
Agreed Management Action		**Target Date**	**Responsible Office**
	The Chief Executive has undertaken a review of the Executive Portfolios to improve governance and accountability. In April 2024, this process is near conclusion. A number of new roles have been advertised publicly on agreed job descriptions and JESP banding with the Welsh Government. These roles will be interviewed in May 2024	May 2024	Chief Executive
	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.	June 24	Chief Executive
	Areas that have been identified as 'in design' will be considered as part of the wider review noted above, given there may be changes within the structure going forward. Stronger Together was the initial project that supported the change in organisational structures. To ensure we have an integrated approach going forward, a review will take place of the stronger together team and OD team. It is proposed that these teams be merged into one team to provide support to the implementation of any new organisational structure.	June 24	Deputy Director of People Services

Matter Arising 2: Operational Governance and Accountability Framework (Design and Operation)	**Impact**
Our review identified several variances between the framework approved by the Health Board to that in operation. We found that: • Executive Delivery Groups (EDGs) differ to the Governance and Accountability Framework, with Terms of Reference (ToR) that are out of date and not complied with in full e.g. different Vice Chair in Public Health to that stated on the ToR. • The Health Board Leadership Team no longer meets. An Operational Leadership Team has been established, however this has not been updated in the governance and assurance documentation. • No Public Health Local Delivery Group has been established at an operational level and we are unable to corroborate the reasons for this. • We are unable to confirm that *'A senior leader, within each leadership team, will take responsibility for Governance within the team structure…'* as we did not receive a reply to our request for this information.	Potential risk of: • Ineffective governance and accountability arrangements undermine the Health Board to deliver on its Statutory Duties.

Recommendations		**Priority**
2.1	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.	**High**

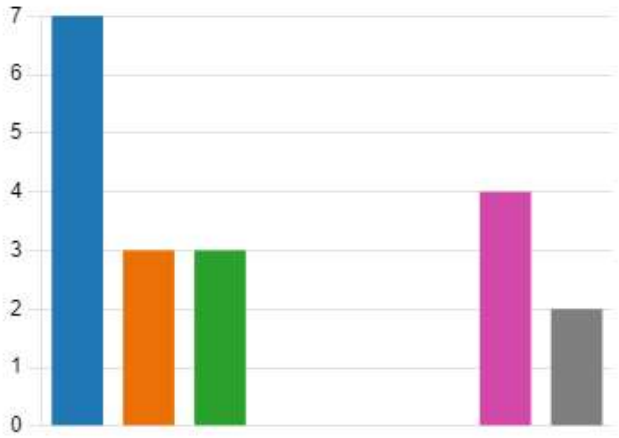
Agreed Management Action	**Target Date**	**Responsible Office**
As part of the organisational structure review, all accountability frameworks will be reviewed	June 24	Chief Executive

Appendix B: Operating Model questionnaire and response

1. Please confirm where you work

More Details

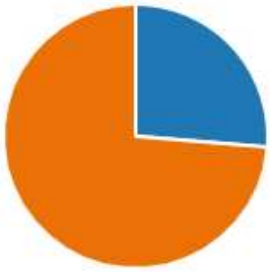
IHC Centre	7
IHC East	3
IHC West	3
Women's	0
Cancer Services	0
North Wales Clinical Services	0
Executive/Director or Corporate ...	4
Mental Health & Learning Disab...	2



2. Do you feel that the Operating Model has been informed by a sufficient amount of feedback and research?

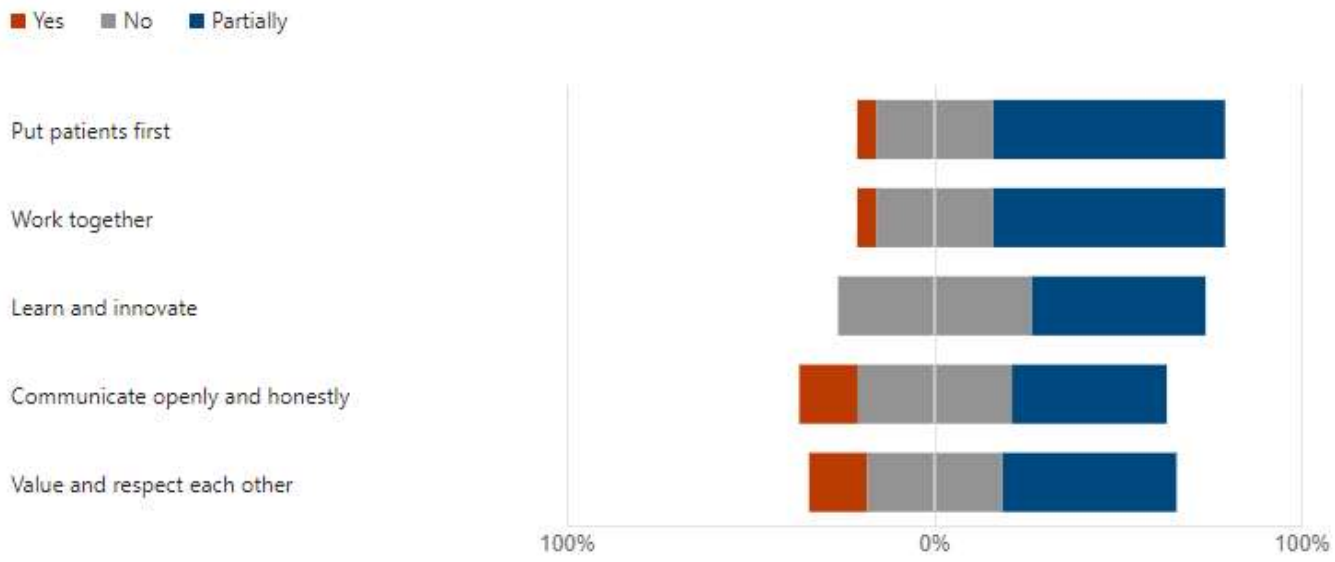
More Details Insights

Yes	5
No	14



3. In your view, has the Operating Model delivered on the five organisational values?

More Details



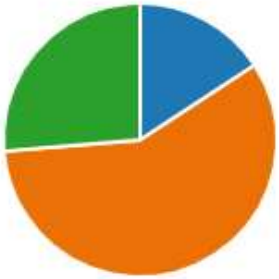
4. In your view, has the proposed structure been implemented as outlined in the Operating Model?

More Details

5. Do you believe that the Operating Model has been designed with career progression in mind and aims to support leadership development and future leaders?

More Details

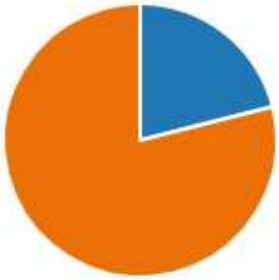
Yes	3
No	11
Partially	5



6. Have you seen/received a copy of the Operating Model Manual?

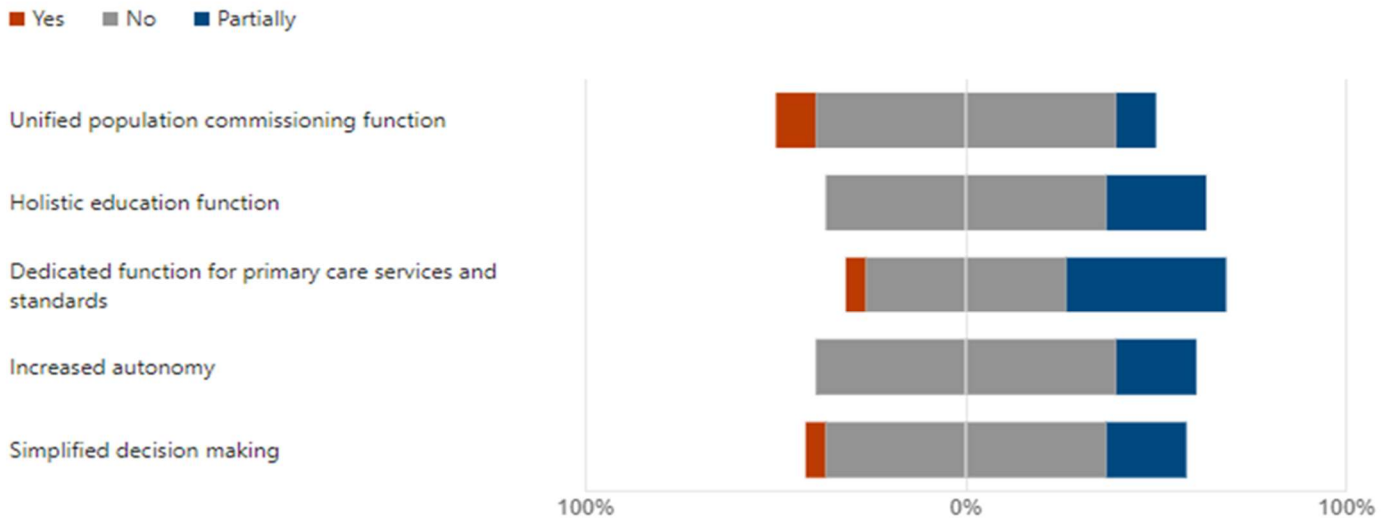
More Details

Yes	4
No	15



7. In your opinion, have the following been achieved?

More Details



8. For those services that are hosted by one Health Community e.g. GP Out of Hours, do you consider the management arrangements to be effective?

More Details

Yes	1
No	5
Partially	5
Don't know / Not applicable	8

9. **Partnership Working:** Have these arrangements improved since the Health Community was established?

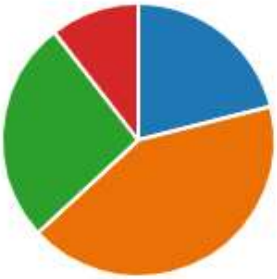
More Details Insights

Yes	2
No	9
Partially	8
Don't know / Not applicable	0

10. Do you believe establishing the Health Communities has impacted your ability to utilise services/spare capacity across the whole Health Board?

More Details

Yes	4
No	8
Partially	5
Don't know / Not applicable	2



11. Do you believe that the services provided on a pan North Wales basis are organised in line with the Health Communities (where possible), and are aligned to Clusters, with effective collaboration?

More Details Insights

Yes	1
No	11
Partially	5
Don't know / Not applicable	2

Additional comments received

- *I do not believe it works from my point of view. Management structure at the top is under so much pressure, it is untenable. Some extra managers have been added but in other areas taken away. I have never been as stressed as I am these days. I work way over my hours with no recompense. I am totally disillusioned by the whole change.*
- *This questionaire [SIC] does not get to the heart of the issue. The operating model work is not complete. The HB prioritised IHC activity and external people supported IHC elements so that they could progress, but HB then simply neglected MHLD. Most pan NW services were to sit with/in IHC model - people have forgotten this and now suggest that womens, childrens, and diagnostics are separate. They are not - they were part of the IHC discussions - with a commissioning or regional element. I don't think the operating model is working well just now (even where it has been worked through) and won't until sufficient WOD support is given to sort the 'unfinished elements' - i.e MHLD and some of the smaller issues that remain. History cannot be changed. I am concerned that IA do not have all the history or understanding in full as some of the questions need different framing. I hope this is anonymous as you promise. I will teams my details through separately and reference the survey.*
- *Implemented without resolving issues around various specialties and hosted services*
- *Since development of the IHCs to include hospital and Community under one function communication has deteriorated lack of clear accountability between corporate and IHC senior functions . No recognition of need for joined up working across the Region for Children's Networks as the organisation very adult focused*
- *Any change in structure takes time to work through in practice and believe that 1 year is not long enough for all the benefits of the structure to be fully embedded. I think the arrangements around special measures has prevented some of the devolved autonomy to be fully realised so assessing if the model if function while in special measures is inappropriate as the assessment will be 'tainted' by the additional scrutiny and direct involvement / observation of WG / NHSE*
- *Autonomy is biggest failure here , never had Autonomy and that weaken the structure made it impossible to make strategic improvement in services*
- *Having the IHCs makes sense - they were just beginning to embed but before they've been able to mature the system*

above them has changed. The IHC autonomy to make decisions has been impacted by the COO role that was never in the model. Making changing too soon without allowing time for change to make an impact results in a constant hamster wheel. we need the confidence to stick to a plan long enough to see if it has worked. So - I think I would have been far more positive if the IHCs had been given enough time to actually try to work as initially intended.

- *many issues with the operating model stem from having responsibility but not the resource or authority or autonomy to act, it also does not support IHCs when pan north Wales divisions are not included and do not collaborate.*
- *The IHC needs more devolvement of some of the corporate functions in order to be able to deliver e.g. quality, transformation, IPC rather than having an embedded model which doesn't feel like it works.*
- *i don't feel the operating model has given the clinically led element time to develop, current COO roles was not in the model consulted on , and several layers of corporate functions eg scheduled care, unplanned care etc seem to have been developed also not in the original operating model framework and often not clinical individuals who are employed on a consultancy basis. [SIC]*
- *The questionnaire conflates the issue within the wider organisation which is that the "Operating Model" as it currently stands is more of an "Operating Structure". An Operating Model is more about the "rules of engagement" that make the structure work in pursuit of our strategic objectives and that is almost completely missing. It's important to recognise this as there is otherwise a risk that we throw the structure out as having not worked, when in reality it might be a perfectly appropriate structure if the model was put into place to work it. The organisation made this mistake before, and we cannot afford neither the distraction nor the time by squandering a structure that might otherwise be made workable.*
- *The model was not mirrored in each IHC. The changes took far too long to implement. Time spent on the model has been wasted but more importantly the resources could have been spent on direct patient care. There were supposed to be no changes below 8b level. Posts have been recruited to across many areas which are not on agreed organisational structures*
- *I am not convinced the divisions work and integrate fully with the IHC's, particularly Mental Health. There seems to be a void of decision making at times and things take forever to be agreed/approved, which slows down opportunities for innovation. Financial decisions are getting in the way of lots of things at the moment and that is understandable given the financial pressures. There are likely to be some challenging decisions that have to be made about service provision and we aren't making those at the moment as it would appear they are too political.*

- *My main concern relates to the exclusion of mental health (and LD) from the local HCs. This decision is absurd, and defies the evidence base. I acknowledge that there are certain specialist areas of mental health provision where pan-NW management may (possibly, perhaps) be appropriate. Forensic services, for example. But the vast majority of mental illness either does not reach health care settings at all, or is dealt with in primary care, or is dealt with in liaison services in the general hospitals, or is dealt with in community mental health teams. MOST work in primary care is either directly related to mental disorder or predicted by it (eg poor outcomes post-MI or post-stroke or post-Diabetes diagnosis). It is therefore vital that MH services are deeply embedded within communities and within primary care and within hospitals, with local arrangements that maximise synergies and minimise inefficiencies. By not doing so, BCU embeds stigma, degrades outcomes from both mental and physical illness (comorbidity is the norm, not the exception), and ignores the evidence that modern, integrated physical and mental health care can improve a wide range of health and social outcomes, especially in deprived and 'hard to reach' communities. BCU can do better.*
- *The Operating model does not provide autonomy to the services on the ground. They feel more removed from the decision making than they previously did. The organisation now defaults to the highest level rather than discuss at the appropriate level. Some roles have lost authority and might as well be band 7s to just do as some else dictates. Little to no discussion around development of services, some of the SLT do not understand the breadth and or depth of the services that they manage and they do not understand the functions of each and as such cannot support decision making and or do not have sufficient insight into the challenges each area faces. What on the face of it seemed like a great idea has fallen flat on its face, i believe that we have lost 2 years of delivery improvement (consultation and then implementation) and we are now waiting for the next change.*

Appendix C: Assurance opinion and action plan risk rating

Audit Assurance Ratings

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

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

Prioritisation of Recommendations

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

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

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

NHS Wales Shared Services Partnership
4-5 Charnwood Court
Heol Billingsley
Parc Nantgarw
Cardiff
CF15 7QZ
Website: Audit & Assurance Services - NHS Wales Shared Services Partnership

Teitl adroddiad: ***Report title:***	Update report on Internal and External Audit Recommendations		
Adrodd i: ***Report to:***	Audit Committee		
Dyddiad y Cyfarfod: ***Date of Meeting:***	18th July 2024		
Crynodeb Gweithredol: ***Executive Summary:***	The purpose of this report is to provide the Audit Committee with: • an update on the changes to the proposed process around the introduction of new Internal Audit Reports to the Health Board since last presented to the Audit Committee • an update on the changes to the proposed process around the closure of audit recommendation since last presented to the Audit Committee • details of all 'no' or 'limited' assurance recommendations • an update of the current position with regards to all open recommendations, those having received Executive and Executive Team approval and are now awaiting Internal Audit approval, prior to their submission to the Audit Committee for final closure approval • update on review of Audit Reports included on Audit Tracker • an update on next steps.		
Argymhellion: ***Recommendations:***	The Committee is asked to: • **APPROVE** the changes to the proposed new processes around the introduction of new External and Internal Audit Reports to the Health Board • **APPROVE** the changes to the proposed new audit recommendation closure approval process • **NOTE** the current position with regards to no' and 'limited' assurance recommendations, and all open recommendations • **NOTE** the Audit recommendations proposed for closure • **NOTE** the update on next steps.		
Arweinydd Gweithredol: ***Executive Lead:***	Pam Wenger, Director of Corporate Governance		
Awdur yr Adroddiad: ***Report Author:***	Glesni Driver, Head of Covid-19 Inquiry and Thirlwall Inquiry		
Pwrpas yr adroddiad: ***Purpose of report:***	I'w Nodi *For Noting* ☐	I Benderfynu arno *For Decision* ☒	Am sicrwydd *For Assurance* ☒

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

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

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

Even though a considerable amount of work has taken place since the last Audit Committee on 7th May 2024 to ensure that all open recommendations are updated with realistic implementation dates, a number of overdue recommendations remain open, with many of these being from 'limited' assurance reports, and of 'high' priority. However, since the last Audit Committee, a new proposed approval process for closed recommendations was put in place, which means that all recommendations proposed for closure are to be agreed by each individual Executive, and thereafter the Executive Management Team prior to submission, with evidence to support closure, to Internal Audit. Due to this, there will no longer be recommendations for closure submitted directly from the Corporate Governane Directorate, but rather from Internal Audit following their review. As usual guidance and support is provided by the Corporate Governance Directorate to all recommendation action owners and Executive Leads.

Cyswllt ag Amcan/Amcanion Strategol: ***Link to Strategic Objective(s):***	Not applicable, other than those relating to individual audit reviews/recommendations.
Goblygiadau rheoleiddio a lleol: ***Regulatory and legal implications:***	Compliance with Internal and External Audit requirements.
Yn unol â WP7, a oedd EqlA yn angenrheidiol ac a gafodd ei gynnal? ***In accordance with WP7 has an EqlA been identified as necessary and undertaken?***	The Equality duty is not applicable. This report is purely administrative in nature and submitted for information only. The associated public sector duties are not engaged, and there are no associated impacts on any of the protected groups
Yn unol â WP68, a oedd SEIA yn angenrheidiol ac a gafodd ei gynnal? ***In accordance with WP68, has an SEIA identified as necessary been undertaken?***	The Socio-Economic duty is not applicable. This report is purely administrative in nature and submitted for information only. The associated public sector duties are not engaged, and the report does not relate to a decision, strategic or otherwise.
Manylion am risgiau sy'n gysylltiedig â phwnc a chwmpas y papur hwn, gan gynnwys risgiau newydd (croesgyfeirio at y BAF a'r CRR) ***Details of risks associated with the subject and scope of this paper, including new risks(cross reference to the BAF and CRR)***	Not applicable, other than those relating to individual audit reviews/recommendations.
Goblygiadau ariannol o ganlyniad i roi'r *argymhellion ar waith* ***Financial implications as a result of implementing the recommendations***	Not applicable, other than those relating to individual audit reviews/recommendations.

Goblygiadau gweithlu o ganlyniad i roi'r argymhellion ar waith ***Workforce implications as a result of implementing the recommendations***	Not applicable, other than those relating to individual audit reviews/recommendations.
Adborth, ymateb a chrynodeb dilynol ar ôl ymgynghori ***Feedback, response, and follow up summary following consultation***	The Chair of Audit Committee met with the Interim Executive Director of Operations prior to her departure to gain further assurance on those recommendations where no update has been received.
Cysylltiadau â risgiau BAF: (neu gysylltiadau â'r Gofrestr Risg Gorfforaethol) ***Links to BAF risks:*** *(or links to the Corporate Risk Register)*	Not applicable, other than those relating to individual audit reviews/recommendations.
Rheswm dros gyflwyno adroddiad i fwrdd cyfrinachol (lle bo'n berthnasol) ***Reason for submission of report to confidential board (where relevant)***	N/A
Camau Nesaf: **Gweithredu argymhellion** ***Next Steps:*** ***Implementation of recommendations*** The Tracker is normally presented to each quarterly meeting of the Audit Committee, but is presented at every bi-monthly meeting at present due to partial assurance. The Corporate Governance Directorate continues to provide support and advice for recommendation owners and final approvers/Executive leads.	
Rhestr o Atodiadau: ***List of Appendices:*** Appendix 1 – Summary of Audit Recommendations Proposed for Closure	

INTERNAL AND EXTERNAL AUDIT RECOMMENDATIONS

1 INTRODUCTION AND BACKGROUND

This report provides an update on the changes to the proposed processes around the introduction of new Internal Audit Reports to the Health Board, and the closure of audit recommendations.

Also provided in this report is an update relating to 'no' or 'limited' assurance recommendations by Executive Directors, and the current state of all Internal and External Audit Recommendations that remain open since the last Audit Committee meeting on 7th May 2024.

There is also detail within the report around the audit recommendations that were submitted to Internal Audit for review prior to submission to the Audit Committee.

The report also provides an update on progress made to date to ensure that all Internal and External Audit recommendations are listed on the audit tracker, following a review in response to Recommendation 4 of the 2023 Structured Assessment, including an update on the next steps.

2 AUDIT REPORT AND RECOMMENDATION APPROVAL PROCESSES

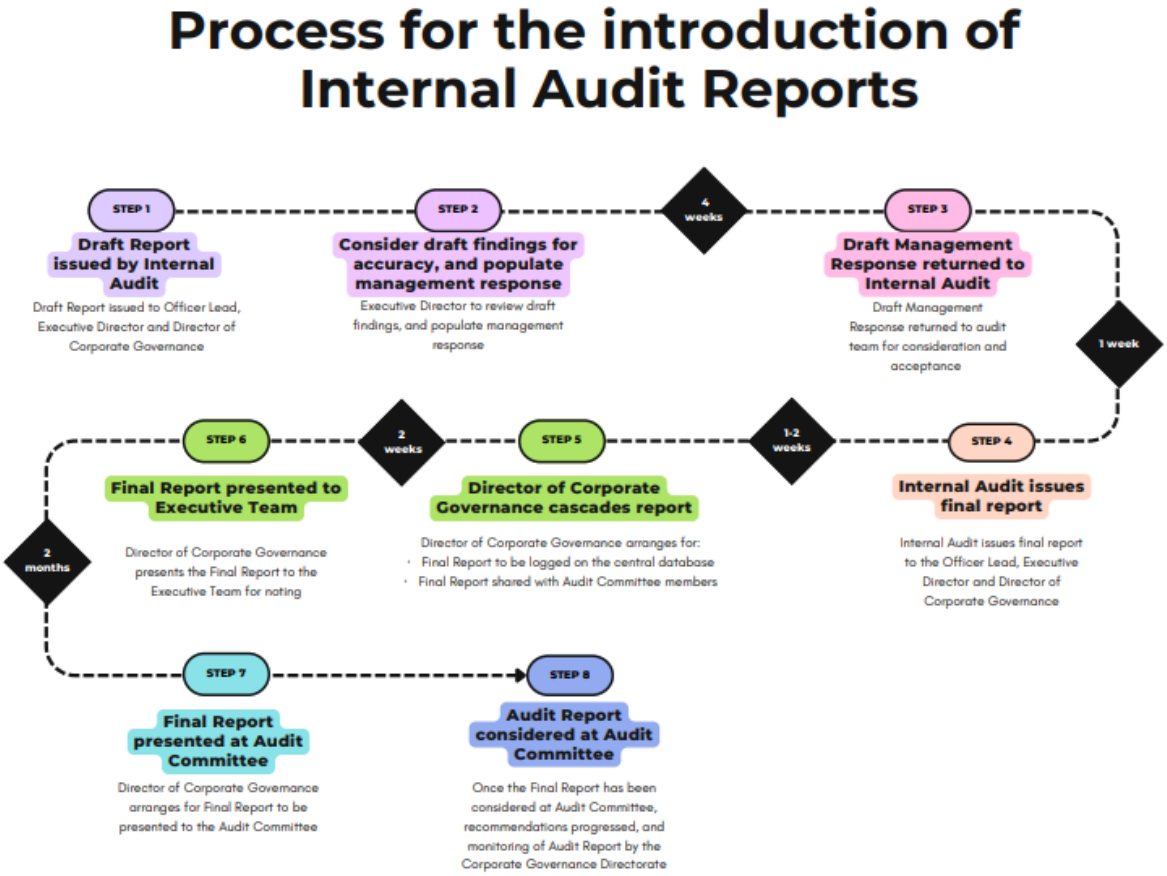
A copy of a proposed process map for both the introduction of external and internal audit reports to the Health Board, as well as the one around the approval of closed Internal and External Audit Recommendations was shared for further comment with the Executives Management Team and Internal Audit again in May. The feedback and comments have now been incorporated into the revised processes, and a summary of these are included below.

2.1 Introduction of Internal Audit Reports to the Health Board

From Internal Audit's perspective, other Health Boards have 15 working days to provide management responses to draft audit reports, however the Health Board has maintained at 20 days for a few years - 5 days for factual accuracy, and 15 days for the completed response, and this has been amended to 20 days within the process.

Also, the Executive Team has agreed that, as we normalise the governance arrangements around audits, that the Executive Lead will respond to the draft audit report for factual accuracy and provide the management response, with all final reports then being brought to Executive Team for noting.

The revised proposed process for the introduction of Internal Audit reports is as follows:

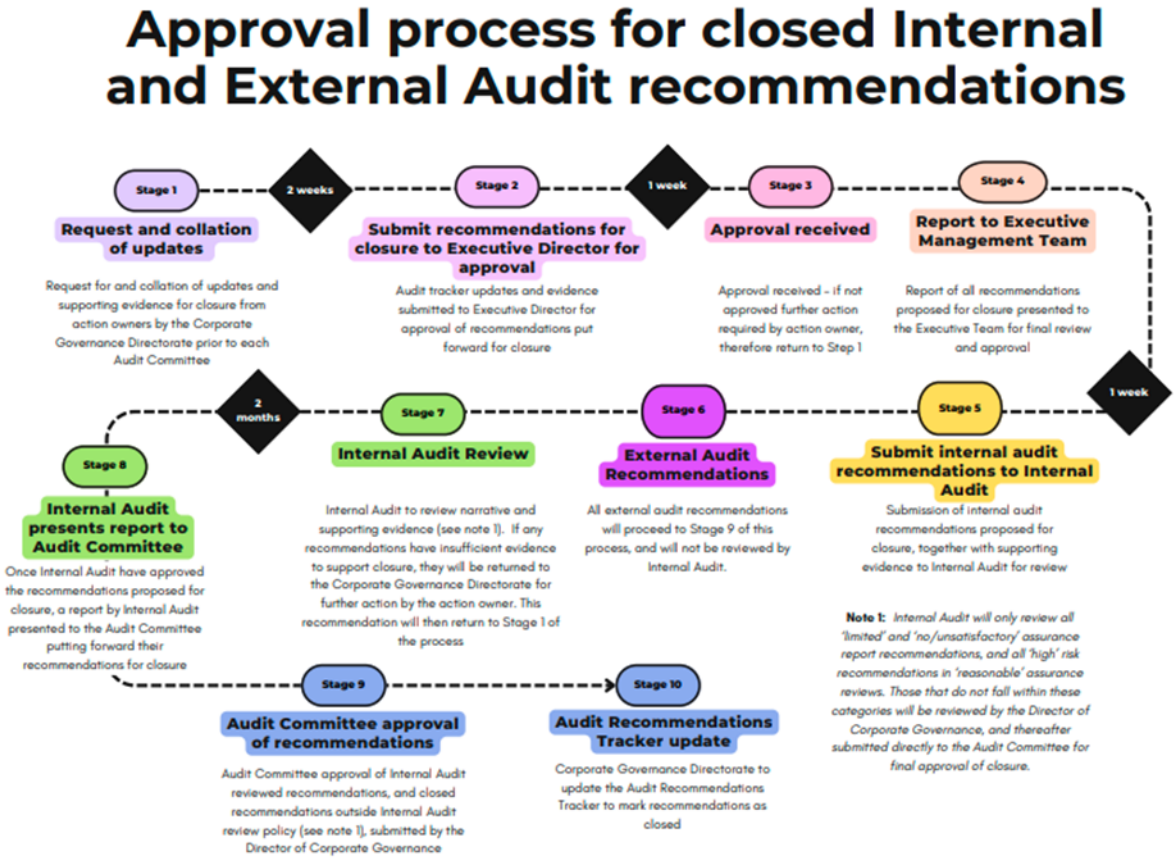


2.2 Introduction of External Audit Reports to the Health Board

Further consultation is required with External Audit in relation to the process around the introduction of their audit reports, and an update will be provided at a future Audit Committee meeting. At present, new Audit Wales reports are being sourced from the Audit Wales website, and recommendations included on the audit tracker.

2.3 Approval of closed Internal and External Audit Recommendations

There were no comments on the approval process around the closure of recommendations, therefore the process is as follows:



3 CURRENT POSITION

A request for updates on open audit recommendations as at the end of May 2024 was made to recommendation owners by the Corporate Governance Directorate on 7th May 2024, with a response deadline of 5th June 2024. Following these updates, a summary of the current position is as follows:

- 22 recommendations were approved by the respective Executive for submission to the Executive Management Team for review on 19th June 2024
- these 22 recommendations were submitted to the Executive Management Team meeting on 19th June 2024 for review.

Due to the absence of the Acting Executive Director Therapies and Health Sciences, no updates were received relating to the 'On-Call arrangements', an Audit Report which was transferred to the Executive following the departure of the Interim Executive Director of Operations.

3.1 **Recommendations submitted for closure approval to Executive Management Team**

Executive Lead	Approved for closure	Awaiting approval by Executive
Acting Executive Director Therapies and Health Science	-	3
Executive Director of Nursing and Midwifery	3	-
Executive Director of Transformation and Strategic Planning	10	-
Deputy Director of People	2	-
Executive Medical Director	-	13
Interim Executive Director of Finance	7	-
Total	22	16

From the 22 recommendations approved for closure, one relates to an Audit Wales report. As per the Audit Charter, the remaining 21 will be subject to Internal Audit follow up as they all fall into the High/Medium/Low priority from Limited assurance reports, and the narrative and supporting evidence has been submitted to Internal Audit for review on 21st June 2024.

3.2 **'No' Assurance and 'Limited' Assurance Recommendations**

3.2.1 **'No' assurance recommendations**

Below is a summary of the 'no' assurance recommendation, and its status:

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

An update from the Executive Team meeting on 19th June 2024 is that, in the absence of the Director of Commissioning and Performance, there will be an oversight of a number of Executive Directors relating to this audit report. Work on progressing the commission arrangements for contracts is underway and an update will be provided to the Performance, Finance and Information Governance Committee in August 2024.

3.2.2 Limited assurance recommendations

Below is a summary, by Executive, of all 'limited' assurance recommendations, and their status:

Executive Lead	'Limited' Assurance recs - open	'Limited' Assurance recs - started	'Limited' Assurance recs - pending	'Limited' Assurance recs - for closure	Total open 'Limited' Assurance recs overdue original implementation date
Acting Executive Director Therapies and Health Sciences	8	8	0	-	8
Executive Director of Nursing and Midwifery	21	8	13	3	21
Executive Director of Transformation and Strategic Planning	-	-	-	10	-
Deputy Director of People	3	3	0	1	3
Interim Executive Director of Finance	6	6	0	7	6
Total	**38**	**25**	**13**	**21**	**38**

3.3 Recommendations awaiting Executive closure approval

Due to the absence of two Executive Directors during the recommendation update and approval period, a total of 16 recommendations have been put forward for closure by the action owner, but not received Executive approval. Once approved by the Executive, these will be submitted to a future Executive Management Team for approval.

3.4 Internal Audit approval

On 17th June 2024, Internal Audit provided feedback on the recommendations and supporting evidence submitted to them over the last few months. Below is a summary of the responses received:

Closed	Outstanding	Partially closed
55	10	13

For the outstanding partially and closed recommendations, the Corporate Governance Directorate are working with the action owners and Executives to source the evidence required, and once available, will submit this to Internal Audit for further review. Once these are been reviewed, Internal Audit will submit to the Audit Committee for final review and closure.

3.5 New recommendations added to tracker

Since the last update to the Audit Committee, a total of 70 new recommendations have been added to the tracker, 54 from internal reports, and 16 from external audit reports, and updates on progress on these will be provided at future meetings. This information is correct as at 27th June 2024.

4 REVIEW OF AUDIT TRACKER ACCURACY

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

Part of the reason for this issue is as a result of the Health Board ceasing the use of the TeamMate system in 2023. This system was used by both Internal Audit and the Health Board, with action owners able to upload their updates and evidence directly onto that system.

However, as there were missing recommendations preceding 2023, this is likely due to the lack of process in place to capture new audit report being published, which has resulted in the accumulation of the problem over a long period of time.

4.1 Progress to date

4.1.1 Audit Wales reports

As at 27th June 2024, all Audit Wales reports are captured following a review of the Audit Wales website for new, published reports on a weekly basis.

4.1.2 Internal Audit reports

Again, as at 27th June 2024, 867 recommendations from 2015 to date have been added to the tracker. 287 of these are from Audit Report from 2022 onwards - 79 of these are Audit Wales recommendations, and the remainder Internal Audit.

4.1.3 TeamMate information

Also, a copy of the information that was captured on TeamMate prior to the Health Board ceasing its use was provided by the Internal Audit. All the recommendations included on TeamMate have now been reconciled with those on the audit tracker, with information going back to 2015. The recommendations from 2015 to 2021 were replicated from the TeamMate system onto the tracker, and are now likely to be historical and outdated reports. A meeting with Internal Audit and the Director of Corporate Governance is to take place to discuss this further.

4.2 Issues identified

This review has identified a number of issues, including:

- instances where recommendations from whole Audit Reports were not included on the tracker
- some but not all recommendations from audit reports were included on the tracker
- not all Audit reports were centrally stored by the Health Board, and therefore the information contained within these reports were not included on the tracker.

Copies of the missing 40 audit reports have now been provided by Internal Audit, and Audit Wales reports sourced, and all the recommendations from these reports are now included on the audit tracker.

4.3 Outstanding work

From the information contained on TeamMate, it is possible to ascertain that a number of these recommendations have progressed to different stages of the approval process in place at that time, however that approval process did not reflect the approval process currently in place. Also, evidence to support closure of those historical recommendations is not now available, and therefore it is hoped that a number of these recommendations can be retrospectively closed from discussions with Internal Audit, with an update on discussions at a future Audit Committee.

Also, as many of these audit reports and recommendations are now historic, and many have been superseded, there is work to be undertaken to identify what audit reports remain relevant, and to seek approval for the closure of those no longer pertinent.

Of the ones that are to remain open, work will be undertaken by the Corporate Governance Directorate, in conjunction with the Executives to identify new action owners as a number of these have since left the Health Board. Once identified, it will then take time for these individuals to familiarise themselves with the requirements of the Audit Report, and provide updates on progress to date.

5 AUDIT TRACKER SYSTEM

The Corporate Governance Directorate continues to review options around the audit tracker, and has been involved in a number of demonstrations of different systems over the last few weeks. However, the Directorate has concentrated its efforts since the last Audit Committee on undertaking the work to ensure that the audit tracker is complete before progressing with identifying an alternative system. An update on progress will be provided at a future Audit Committee.

6 IN SUMMARY

- All recommendations and evidence submitted to Internal Audit for review has been returned, and of these:
    - 55 were approved for submission to Audit Committee for review and final closure approval
    - 10 were outstanding, and further evidence required to support closure – Health Board progressing this at present
    - 13 partially closed, and further evidence to support closure required – Health Board progressing this at present.

Of the 22 recommendations put forward for closure review by the Executive Management Team meeting on 19th June 2024, all were approved for closure, and will progress to the next approval stage as follows:

- 21 recommendations and supporting evidence will be submitted to Internal Audit for review
- 1 recommendation is an Audit Wales review, and will be reviewed once a process for approval has been agreed.

A total of 123 recommendations remain open – 111 of these are Internal Audit recommendations, with 12 External Audit recommendations. This does not include those retrospectively added to the tracker, as detailed in Section 4.

7 REPORT RECOMMENDATIONS

7.1 Approval of audit processes

For the Audit Committee to review and approve the changes made to the proposed processes around the introduction of new audit reports to the Health Board, and the approval process around the closure of recommendations.

8 NEXT STEPS

Once Audit Committee has provided its final approval of the processes, these will be implemented going forward.

Updates relating to recommendations reviewed and approved for closure by the Executive Management Team will be shared, together with supporting evidence with Internal Audit for their review.

Appendix 1 – Summary of Audit Recommendations Proposed for Closure

SUMMARY OF AUDIT RECOMMENDATIONS PROPOSED FOR CLOSURE
FOR FORMAL EXECUTIVE TEAM APPROVAL ON 19/06/2024

			Summary of recommendation with rationale for closure
EXECUTIVE DIRECTOR OF NURSING AND MIDWIFERY			
1	259	*Data analysis – Triangulation of data*	The Quality Dashboard is now live. Work will now be focused on ensuring data quality from the various systems into the Dashboard.
2	300	*Falls Management*	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.
3	307		The Ward Accreditation team are using proposed new metrics (includes questions the quality of the risk assessment and care planning/interventions for falls and patient handling) as part of the supportive visits. Sample size of 3 patient nursing documents are reviewed as part of the visit for compliance with timing of risk assessement, quality and interventions documented and implemented. The metrics will be business as usual as part of the Accreditation programme. This is BAU as also part of the weekly IHC meetings re the quality of risk assessments and care plans. Metrics used as the baseline for the Accreditation team Supportive visits taking place across the Health Board.
EXECUTIVE DIRECTOR OF TRANSFORMATION AND STRATEGIC PLANNING			
1	215	*Unscheduled Care: Urgent Primary Care Centres – Business Case outcomes achieved*	Data is being collected locally, and is being used ('Urgent Primary Care Centre (UPCC) Dataset'). Forward planning is taking place, and this is being actioned by Planning. As an update on the USC: Urgent Primary Care Centres, this will no longer sit with Primary Care, but incorporated into the 6 Goals Programme. The national position (6 Goals) has a change in steer regarding UPCCs and need to transition across to Urgent care Centres. This will come across to the programme for the team to start work on over the coming months. Current funding comes from either the 6 Goals Programme or Performance, the latter currently going through RIGA 2 process. This work continues as part of 6 Goals Programme to consider all the evidence and create a model for North Wales.
2	216		An action plan is in place and is reviewed via the primary care leadership team which meets every month. This work continues as part of 6 Goals Programme to consider all the evidence and create a model for North Wales.
3	217		Data is being collected locally, and is being used ('Urgent Primary Care Centre (UPCC) Dataset'). Forward planning is taking place, and this is being actioned by Planning. As an update on the USC: Urgent Primary Care Centres, this will no longer sit with Primary Care, but incorporated into the 6 Goals Programme. The national position (6 Goals) has a change in steer regarding UPCCs and need to transition across to Urgent care Centres. This will come across to the programme for the team to start work on over the coming months. Current funding comes from either the 6 Goals Programme or Performance, the latter currently going through RIGA 2 process. This work continues as part of 6 Goals Programme to consider all the evidence and create a model for North Wales.
4	218		Datasets are being used to support activity described in action 217. This work continues as part of 6 Goals Programme to consider all the evidence and create a model for North Wales.
5	284	*GP Out of Hours*	The terms of reference has been finalised and regular meetings are in place. These meetings will be minuted and all actions added to the action plan for the group.
6	285		The terms of reference has been finalised and regular meetings are in place. These meetings will be minuted and all actions added to the action plan for the group.
7	286		This is part of business as usual, with updates submitted to the Primary Care Senior Leadership Team. This meeting reports into the IHC SLT.
8	287		Completion dates and improvement actions are now monitored via the action plan for the group. Responsible officers have been identified for each action.
9	288		This was a national discrepancy rather than with Health Board data discrepancy, which has been scrutinised by the Performance Team.
10	289		The IHC Quality Safety and Sustainability meeting ToR are in place and links into the IHC SLT where accountability sits.

DEPUTY DIRECTOR OF PEOPLE			
1	245	*Structured Assessment 2019*	As of the 31st March 2024, there were no senior agency interims in the Health Board, and only a small amount of temporary senior staff (single figures) working through our bank.
2	247	*Recruitment of Substantive and Interim Executive and Senior Posts (ESP)*	The People & Culture Committee approved the WP1 Safe Recruitment & Selection policy in April 2024 with the corresponding procedure relating to VSM recruitment. All executives are also trained in procurement as per WG requirements, and records held centrally.

INTERIM EXECUTIVE DIRECTOR OF FINANCE			
1	196	*Charitable Funds*	The Charity Procedures have been revised and approved by the charitable Funds Committee on 15/04/2024.
2	267	*Performance Management – Quality and Performance Reporting and Accountability Arrangements*	Data Quality & Governance Forum now in place.
3	319	*Decarbonisation*	The Decarbonisation Action Plan is now in place
4	335	*Water Safety*	The SOP was presented at SIPG on 25th April 2024.
5	336		The SOP was presented at SIPG on 25th April 2024.
6	341		New template for Risk Assessment for Augmented Care Areas presented at the Water Safety Group Meeting on 21st May 2024. Risk Assessment now being delivered across the all Augmented care area and outcome will be presented at the Water Safety Group meeting on 23rd July 2024.
7	347	*Follow-up: Delivery of Health Board savings*	The IP EDG receive detailed savings information reports and provide oversight of Value & Sustainability

Archwilio Cymru
Audit Wales

Audit Committee Update – Betsi Cadwaladr University Health Board

Date issued: July 2024

Document reference: 4342A2024

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 7 May 2024.

2 We also provide additional information on:

- Other relevant examinations and studies published by the Audit General.
- Relevant corporate documents published by Audit Wales (e.g. fee schemes, annual plans, annual reports), as well as details of any consultations underway.

3 Details of future and past Good Practice Exchange (GPX) events are available on our website.

Accounts audit update

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

Exhibit 1 – Accounts audit work

Area of work	Executive Lead	Focus of the work	Current status	Planned date for consideration
Audit of the Health Board's Accounts	Russell Caldicott, Interim Executive Director of Finance	Audit of Financial Statements Report including the Opinion on the Financial Statements.	To be confirmed.	To be confirmed.

Performance audit update

5 Exhibit 2 summarises the status of our current and planned performance audit work.

Exhibit 2 – Performance audit work

Area of work	Executive Lead	Focus of the work	Current status	Planned date for consideration
All Wales thematic work on Urgent and Emergency Care	Director of Therapies.	This work examines different aspects of the urgent and emergency care system in three parts: • Part One: Flow out of hospital (not applicable to the Trust). • Part Two: accessing urgent and emergency care. • Part Three: national arrangements and leadership structures.	Part One: Completed. Part Two: Report drafting. Part Three: Planning.	July 2024. November 2024. To be confirmed.
Structured Assessment – deep dive into financial efficiencies	Executive Director of Finance and Corporate Resources	Given the significantly challenging financial position across NHS Wales, this review is examining the approaches NHS bodies are taking in respect of achieving cost improvements, efficiencies, and financial sustainability.	Report drafting.	November 2024.

Area of work	Executive Lead	Focus of the work	Current status	Planned date for consideration
Planned Care	Executive Medical Director	This work will be completed across all health boards and follows on from our national overview report on the planned care backlog in May 2022. Although we are still in the scoping phase, we intend to consider waiting list performance and arrangements to improve elective waits.	Set up delayed.	November 2024.
Structured Assessment - core	Director of Corporate Governance / Board Secretary	This work will review the following core areas: • Board and committee effectiveness, cohesion, and transparency. • Corporate systems of assurance. • Corporate planning arrangements. • Corporate financial planning arrangements. This work will also seek to provide an update on the Trust's progress in addressing audit recommendations made in previous structured assessment reports.	Planning.	January 2025.

Area of work	Executive Lead	Focus of the work	Current status	Planned date for consideration
Structured Assessment - deep dive review of investment in digital systems to support service resilience and transformation	Director of Digital Services	This audit will examine digital arrangements, with a particular focus on how NHS bodies are investing in digital technologies, solutions, and capabilities to support the workforce, transform patient care, meet demand, and improve productivity and efficiency.	Scoping.	To be confirmed.
Use of the strategic financial assistance provided by the Welsh Government for the 3.5-year period October 2020 to March 2024.	Executive Director of Finance and Corporate Resources	This audit will encompass a high-level examination of the Health Board's use of the additional £297m financial assistance provided by the Welsh Government as part of the targeted intervention package announced in October 2020.	Scoping.	To be confirmed.

Area of work	Executive Lead	Focus of the work	Current status	Planned date for consideration
Follow on review of quality governance arrangements	Executive Director of Nursing	This audit will examine progress in addressing issues identified in previous audit work. The scope of the work will be determined during the audit planning process.	Not yet started	To be confirmed.

Other relevant publications

6 Exhibit 3 provides information on other relevant examinations and studies published by the Auditor General in the last six months. The links to the reports on our website are provided.

Exhibit 3 – Relevant examinations and studies published by the Auditor General

Title	Publication Date
Community Pharmacy Data Matching Pilot	May 2024.
From firefighting to future-proofing – the challenge for Welsh public services	February 2024.
Board effectiveness follow-up – Betsi Cadwaladr University Health Board	February 2024.

Additional information

7 Audit Wales has not published any corporate documents since the last committee update.

8 There are no relevant Audit Wales consultations currently underway.

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Rydym yn croesawu gohebiaeth a galwadau ffôn yn Gymraeg a Saesneg.

Discharge Planning Progress Update – Betsi Cadwaladr University Health Board

Date issued: February 2024

Document reference: 4081A2024

Purpose of this document

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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 In 2017, the Auditor General reviewed discharge planning across all Health Boards in Wales. That work focussed on strategic planning, arrangements for monitoring and reporting on discharge planning, and action being taken to manage discharge planning and secure improvements. Our 2017 report on discharge planning for Betsi Cadwaladr University Health Board (the Health Board) found that '**the Health Board can demonstrate its intention to improve patient flow and discharge planning, but staff confidence and training remains challenging and performance remains poor'**. We made several recommendations to the Health Board as part of that report.

2 The Auditor General had originally included work in his 2021 local audit plans to examine whole system issues affecting urgent and emergency care services, including the discharge of patients from hospital. The COVID-19 pandemic resulted in this work being postponed and brought back on stream in 2023. Our work has sought to examine whether health boards and local authorities have effective arrangements in place to ensure the timely discharge of patients out of hospital. The findings from that work are set out in a separate report to the Health Board and its local authority partners in the North Wales region. The regional report will be made available on our website once considered by the appropriate Health Board and local authority committees.

3 As part of our regional review, we have sought to assess the progress made by the Health Board in addressing the recommendations set out in our 2017 discharge planning report. This report sets out the findings with respect to progress against those recommendations. The approach we adopted to deliver our work is set out in **Appendix 1**.

4 We have undertaken the follow up work and our wider regional review to help discharge the Auditor General's statutory requirement to be satisfied that NHS bodies and local authorities have proper arrangements to secure economy, efficiency, and effectiveness in their use of resources, as required by the Public Audit Wales Act 2004. In addition, to support our previous work on discharge planning, we produced 'What's the hold up? Discharging patients in Wales' which sets out important issues that board members should be sighted of when seeking assurance that patients are discharged from hospital in safe and timely ways. Many of the issues identified are still relevant and should be considered alongside the findings of this report.

Key findings

5 The most recent data from October 2023 showed that across the Health Board's main hospital sites, there were 339 patients whose discharge had been delayed beyond 48 hours. Approximately 18% of these delays related to discharge planning issues within the Health Board, including the completion of clinical assessments.

6 In overall terms, the Health Board has made limited progress in addressing the recommendations we made in 2017 to help improve discharge planning. Our 2017 report made five recommendations that set out 12 specific actions for the Health Board. Noting that the Health Board had accepted these recommendations, our follow up work found that:

- no progress has been made against four of the actions;
- work is still on-going against four of the actions; and
- four of the actions have been superseded by other developments.

7 We note that the introduction of Discharge to Recover then Assess (D2RA) has altered the Health Board's approach to discharge planning and that the Health Board is now adopting the nationally mandated D2RA pathways, but it is of concern that:

- Capacity issues are making it difficult to secure consistent application of the new pathways across the Health Board;
- Little progress has been made in providing training on discharge planning and pathways to relevant staff;
- There is limited evidence the Health Board has introduced an audit cycle of compliance with its discharge approach;
- The "golden hour programme" to encourage discharges before 11am is no longer in place and time of discharge is no longer formally reported;
- There remains a lack of understanding of services available in the community to support timely discharge; and
- Action has not been taken to strengthen performance reporting of patient flow and discharge planning to the board and its committees, despite the significant and growing pressures caused by delayed discharges.

8 The following sections of this report set out our follow up findings in more detail and **Appendix 2** summarises our assessment of progress against each of the actions identified in our 2017 report.

Recommendations

9 Our follow up work and wider regional report on patient flow have identified some fresh recommendations on discharge planning for the Health Board, and where relevant, its local authority partners. These have replaced the outstanding recommendations from our 2017 work that are shown in **Appendix 2**.

10 Recommendations arising specifically from this follow up work are set out in **Exhibit 1**. The Health Board's response to these updated recommendations is captured in **Appendix 3**. Recommendations arising through our wider regional report on patient flow which are relevant to, and have replaced, the recommendations from our 2017 work are set out in **Exhibit 2**. The Health Board should respond to these recommendations as part the finalisation of the regional report.

Exhibit 1: new recommendations arising from this follow up work

Recommendations
R1 The Health Board, to support its focus on increasing morning discharges, should: 1.1. ensure learning is captured from previous initiatives, such as the 'golden hour programme' and mitigate the creation of perverse incentives. 1.2. introduce routine reporting of the time of discharge to ensure that morning discharges are maximised where appropriate.
R2 The Health Board should ensure that all relevant staff are aware of the role of the Home First Team (Hub) and that the team operate consistently across the three acute hospital sites.
R3 The Health Board should strengthen its performance reporting by including the following measures within its routine performance report to Board and/or committees: • number and % of patients who have an estimated discharge date; • readmissions within 28 days of discharge from hospital; • % of discharges before midday; • % of unplanned discharges at night; and • % of discharges within 24 hours and 72 hours of being declared 'medically fit'.

Exhibit source: Audit Wales

Exhibit 2: recommendations included in the regional report on discharge planning replacing previous 2017 recommendations

Regional recommendations
R1 The Health Board and local authorities should develop jointly agreed guidance to provide clarity to all staff on how the discharge planning process should work across the region. This should be based on the national guidance issued in December 2023 and should set out clearly defined roles and responsibilities, and expectations, including when referrals for ongoing care should be made.
R2 The Health Board and local authorities should ensure processes are in place to communicate discharge planning guidance to all relevant health and social

Regional recommendations	
	services staff, including those working on a temporary basis, supported by an ongoing programme of refresher training and induction training for new staff.
R3	The Health Board should embed a regular cycle of audit to assess the effectiveness and consistency of the application of discharge policies and guidance, including the application of D2RA.
R5	The Health Board, working with local authorities, should ensure that all relevant staff have access to up-to-date information on services available in the community that support hospital discharge.

Detailed report

Implementation of previous audit recommendations

11 We considered the Health Board's progress in implementing our 2017 audit recommendations. These focus on:

- training on discharge planning (Recommendations 1a, b and c);
- discharge policy compliance (Recommendation 2);
- consistency and clarity of discharge pathways (Recommendations 3a and b);
- timely discharge (Recommendations 4a and b);
- single point of access (Recommendations 5a, b and c); and
- discharge reporting (Recommendation 6).

12 Overall, we found that **the Health Board has made limited progress in addressing our previous recommendations. While the introduction of Discharge to Recover then Assess altered the Health Board's approach to discharge planning, challenges remain relating to training, compliance with guidance, embedding initiatives and reporting discharge planning performance at Board and committee level.**

Training on discharge planning

13 We considered whether the Health Board has:

- broadened the availability of discharge planning as part of induction training to include new medical staff (2017 Recommendation 1a);
- provided refresher training on the discharge policy and protocol for all relevant staff (2017 Recommendation 1b); and
- provided training on the Health Board's simple and complex discharge pathways (2017 Recommendation 1c).

14 We found **no evidence that the Health Board was providing training on discharge planning or pathways to new or existing relevant staff at the time of fieldwork, though some training activity has since started.**

15 The Health Board did not offer routine and accessible training on discharge planning at the time of our work. Health Board staff we spoke to noted that they had not received training on discharge planning either as part of their induction or as part of ongoing learning and development. This is likely exacerbating the variations in discharge practices we found between the Health Board's hospital sites, as well as variations in arrangements of how sites interact with different local authorities. Variations included levels of risk tolerance; the roles of different staff including progress chasers; and how and when to refer patients between different specialties and organisations. High agency and bank staff usage in the Health Board adds to the challenge of maintaining a consistent and clear approach.

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16 The Health Board did not have an up-to-date discharge policy at the time of our fieldwork; however, it is acknowledged that the Health Board has been awaiting updated national guidance before developing its own guidance. National guidance on discharge planning was issued in December 2023. Since our fieldwork we are aware the Health Board has developed training on Criteria Led Discharge with various levels of staff having completed the training at each hospital site. While this is positive, the Health Board will need to build on this work to ensure there is consistent access to training on discharge planning. Training should also be developed jointly with key partners, including local authority social services, to ensure a clear and consistent understanding of the discharge planning processes across partner organisations.

17 We therefore consider there is **ongoing action to address recommendations 1a and 1b (replaced with 2024 Recommendation 1 and 2)**.

18 Since 2020 the Health Board has been implementing the nationally mandated NHS Wales Discharge to Recover then Assess (D2RA) pathways[1] which replaced its previous simple and complex discharge pathways with four pathways:

- Pathway 0 – no additional support required for discharge
- Pathway 1 – Supported, Home First
- Pathway 2 – Short-Term Supported Facility
- Pathway 3 – Complex Support

19 We therefore consider **recommendation 1c to be superseded.**

Discharge policy compliance

20 We considered whether the Health Board has:

- introduced a regular cycle of audit to ensure compliance with its discharge policy and protocol (2017 Recommendation 2).

21 We found **limited evidence the Health Board had introduced an audit cycle of compliance with its discharge approach.**

22 The Health Board stated that, rather than regular audits, it applied methods such as escalation identification and regular meetings to monitor compliance with its discharge approach. However, the efficacy of these monitoring and escalation arrangements is questionable given our wider regional review of patient flow review highlighted:

- weaknesses in discharge documentation;
- examples of staff adding patients to multiple waiting lists to try and expedite their discharge, such as for reablement, home care packages and residential

[1] Discharge to Recover then Assess (D2RA) is designed to support people to recover at home before being assessed for any ongoing need, thereby reducing length of stay in hospital.

care, to facilitate a timelier discharge regardless of patients' specific needs; and

- information relating to discharge planning in patient case notes was of variable quality and completeness with gaps in several important areas including What Matters to Me[2] conversation forms.

23 Acknowledging that the Health Board was waiting for national guidance to update its discharge policy, it is important that it knows whether its discharge arrangements are working as intended. We therefore consider that there is **ongoing action on recommendation 2 (replaced with 2024 Recommendation 3)**.

Consistency and clarity of discharge pathways

24 We considered whether the Health Board has:

- ensured consistent application of its discharge pathways across its three hospital sites (2017 Recommendation 3a); and
- further developed its simple and complex discharge pathways (2017 Recommendation 3b) by including:
  - agreed standards for response times;
  - quality and safety information;
  - processes for sharing information; and
  - signposting for patients with end-of-life care needs.

25 We found **the Health Board is now adopting the nationally mandated Discharge to Recover then Assess pathways, although there remain difficulties in consistent application due to capacity issues.**

26 During our review of discharge planning in 2017 the Health Board had two pathways in place: simple discharge and complex discharge. Since that time, the Health Board has been implementing the D2RA pathways as mentioned in paragraph 19. Each admitted patient is placed on one of the four D2RA pathways and, depending on the acute hospital site, there will be teams in place to facilitate more complex discharges (i.e. discharges that are not Pathway 0), such as the Home First Hub. We therefore consider **recommendation 3a and recommendation 3b to be superseded.**

27 However, whilst the Health Board has been implementing D2RA pathways, we observed that there were difficulties in ensuring their consistent delivery due to the lack of capacity. For example, the ability of the Health Board to apply pathway 2, which states the patient would be transferred to a non-acute bed until able to return home, was limited by the lack of availability of step-down beds. Ensuring a regular

[2] What Matters to me refers to conversations' hospital staff are expected to undertake with patients. The conversations are structured around what the patient can do for themselves and what they will require ongoing support with.

cycle of audit is in place to monitor compliance with discharge policies and guidance, would help the Health Board gain a comprehensive understanding on the challenges preventing it from implementing the pathways consistently (see **Recommendation 3**).

Timely discharge

28 We considered whether the Health Board has:

- taken steps to report more in-depth data on patients discharged between 12am and 7am, and those discharged between 7am and 11am (2017 Recommendation 4a); and
- introduced additional measures that will allow it to understand whether patient discharges under the 'golden hour programme' are appropriate, or whether patients are being delayed overnight unnecessarily to comply with the 11am target (2017 Recommendation 4b).

29 We found that **the Health Board no longer uses the 'golden hour programme' to encourage discharges before 11am, nor does it report the time of discharge although it states it is working to encourage morning discharges.**

30 During our fieldwork we found no evidence of in-depth reporting of the number of patients discharged between different time intervals. We also found that the 'golden hour programme'[3] that was in place during our original review was no longer being used. Observations of ward rounds showed that staff were generally focussed on discharging the patient in a timely way but without reference to any specific time-based target. The Health Board stated it was in discussions to explore and expedite actions to increase morning discharges at the time of our review. Driving a focus on discharging patients as early in the day as appropriately possible can be an effective tool in mitigating risks from increasing admissions throughout the day, but it can also lead to adverse incentives to hold on to patients overnight to comply with targets. We therefore consider that **no action has been taken on recommendation 4a (replaced with 2024 Recommendation 4),** and that **recommendation 4b has been superseded**.

Single point of access

31 We considered whether the Health Board has:

- worked with its local authority partners to ensure consistency and quality of information held on each single point of access (2017 Recommendation 5a).

[3] The golden hour programme was an initiative which encouraged staff to discharge patients before 11am to ensure there would be available beds for new patients later in the day.

- ensured that staff across each of its hospital sites received adequate training on the range of services available through the three single point of access models (2017 Recommendation 5b); and
- ensured that information on the new single point of access models is easily accessible to staff (2017 Recommendation 5c).

32 We found that **there remains a lack of understanding of services available in the community**.

33 The Health Board told us that it operates services to facilitate discharge into the community, including a Bed Bureau and Home First Teams. However, our regional fieldwork once again found that the understanding of the landscape of services outside of hospital was patchy, meaning opportunities to discharge earlier with support from services beyond social care were missed. Ward staff, including progress chasers, felt they knew little about the community services available, particularly within different local authorities, and that they found it hard to keep up to date with regular changes in provision and availability of services. We found that access to information on community and voluntary services was often variable and there was an absence of training to provide information to relevant staff. In addition, our case note review found very few records of single point of access referrals taking place in cases where they would be expected. The Home First Teams are not yet fully embedded and consistently used. We therefore consider that **no action has been taken on recommendation 5a and 5b (replaced with Recommendation 5)** and that there is **ongoing action to address recommendation 5c (replaced with Recommendation 6).**

Discharge reporting

34 We considered whether the Health Board has:

- strengthened its performance reporting (2017 Recommendation 6) by including the following measures within its routine performance report:
  - number and % of patients who have an estimated discharge date;
  - readmissions within 28 days of discharge from hospital;
  - % of discharges before midday;
  - % of unplanned discharges at night; and
  - % of discharges within 24 hours and 72 hours of being declared ‘medically fit’.

35 We found that al**though there is monitoring at an operational level, performance reporting to the board and its committees on discharge planning and patient flow out of hospital had not been strengthened, despite the significant and ongoing pressure on the Health Board caused by poor patient flow.**

36 The Health Board monitors various urgent and emergency care and patient flow indicators through its Integrated Performance Report to the Board and the

Performance, Finance, and Information Governance Committee. These indicators include ambulance response times and the time spent in emergency units until admission, transfer, or discharge. Discharge planning data, specifically delayed discharges, has been nationally tracked since April 2023 but is not contained within performance reports. The Health Board does monitor discharge planning data internally, including length of stay and readmission data, but does not report this to the Performance, Finance, and Information Governance Committee or the Board. Given the significant and ongoing pressure caused by poor patient flow, it is important that the Board receives stronger reporting about performance and mitigating actions to improve patient flow. We therefore consider that **no action has been taken on recommendation 6 (replaced with 2024 Recommendation 7)**.

Appendix 1

Audit methods

Exhibit 3 sets out the methods we used to deliver this work. The methods formed part of the audit methods used to deliver our wider regional review.

Exhibit 3: audit methods

Element of audit methods	Description
Documents	We reviewed a range of documents, including: • Board and committee papers • Operational and strategic plans relating to urgent and emergency care • Standard Operating Procedure for discharge planning
Interviews	We interviewed the following: • Hospital Directors, East and Central • Interim, Director of Regional Delivery • Programme Director for Unscheduled Care • Clinical Lead for Unscheduled Care • Deputy Executive Medical Director • Business Planning and Improvement Manager • Health Board lead for Ysbyty Glan Clwyd improvement work.
Observations	We observed the Health Board Performance, Finance, and Information Governance Committee. We also observed the following individual(s): • Head of Nursing and Site Manager, Ysbyty Gwynedd • Progress Chaser and Home Hub Officer, Ysbyty Maelor • Site Manager and Home First Officer, Ysbyty Glan Clwyd
Data analysis	We analysed the monthly delayed discharges dataset submitted to the NHS Executive. We also analysed data provided by the Health Board relating to all emergency medicine patients discharged in October 2022 with a length of stay greater than 21 days (excluding those who died).

Element of audit methods	Description
Case note review	We reviewed a sample of 32 case notes relating to emergency medicine patients discharged in October 2022 with a length of stay greater than 21 days (excluding those who died).
Self-assessment	We asked the Health Board to complete and submit a self-assessment, setting out its view of progress against our 2017 recommendations.

Appendix 2

A summary of progress against our 2017 recommendations

Exhibit 4 sets out the recommendations we made in 2017 and our summary of progress

Recommendations	Progress
Training on discharge planning R1 We found that despite plans to organise multi-agency and multi-disciplinary training on discharge planning policy and protocol, training is not consistently available. The Health Board should: a) broaden the availability of discharge planning as part of induction training to include new medical staff; b) provide refresher training on the discharge policy and protocol for all relevant staff; and c) provide training on the Health Board's simple and complex discharge pathways.	**Ongoing** – see paragraphs 15 -16 (replaced with Regional Recommendation 1) **Ongoing** – see paragraphs 15-16 (replaced with Regional Recommendations 1 and 2) **Superseded** – see paragraph 18
Discharge policy compliance R2 Although the discharge policy and protocol include the use of clinical audit to monitor compliance, we found that there has been no recent audit undertaken. The Health Board should introduce a regular cycle of audit to ensure compliance with its discharge policy and protocol.	**Ongoing** – see paragraphs 22-23 (Replaced with Regional Recommendation 3)

Recommendations	Progress
Discharge pathways R3 The Health Board uses two generic discharge pathways: simple and complex, however there is inconsistency in application across the three hospital sites and some aspects of good practice are not included. To improve its use of pathways, the Health Board should: a) ensure consistent application of its discharge pathways across its three hospital sites; and b) further develop its simple and complex discharge pathways by including: – agreed standards for response times; – quality and safety information; – processes for sharing information; and – signposting for patients with end-of-life care needs.	**Superseded** – see paragraphs 26 **Superseded –** see paragraphs 26
Timely discharge R4 We found that staff are encouraged to discharge patients by 11am (referred to as the 'golden hour programme'), but this may result in patients who are potentially safe to be discharged the previous afternoon or evening having their discharge delayed to the following day to meet the 11am target. Information reported to the Finance and Performance Committee on discharges by time of day did not differentiate between appropriate and inappropriate discharges as all discharges between midnight, and 11am are included in a single category. While we found no current evidence that perverse behaviour is occurring, the Health Board should take steps to mitigate this risk, by: a) reporting more in-depth data on patients discharged between 12am and 7am, and those that discharged between 7am and 11am; and b) introducing additional measures that will allow it to understand whether patient discharges under the 'golden hour programme' are appropriate, or whether patients are being delayed overnight unnecessarily to comply with this target.	**No action** – see paragraph 29 (Replaced with 2024 Recommendation 1) **Superseded** – see paragraph 30

Recommendations	Progress
Single point of access (SPoA) R5 When reviewing staff's awareness of community services to support discharge, we found inconsistency. The Health Board must ensure that each of the local SPoA models established during 2016- 17 are implemented effectively. The Health Board should: a) work with its local authority partners to ensure the consistency and quality of information held on each SPoA; b) ensure that staff across each of its hospital sites receive adequate training on the range of services available through the three SPoA models; and c) ensure information on the new SPoA models is easily accessible to staff	**No action** – see paragraph 33 (replaced with Regional Recommendation 5) **No action** – see paragraph 33 (replaced with Regional Recommendation 5) **Ongoing** – see paragraph 33 (replaced with 2024 Recommendation 2)
Discharge reporting R6 We found that the Board, Executive Team and the Finance and Performance Committee receives regular information relating to delayed transfers of care but receives limited information specific to discharge planning that would support a better understanding of the reasons behind the Health Board's performance. The Health Board should strengthen its performance reporting by including the following measures within its routine performance report: • number and % of patients who have an estimated discharge date; • readmissions within 28 days of discharge from hospital; • % of discharges before midday; • % of unplanned discharges at night; and • % of discharges within 24 hours and 72 hours of being declared 'medically fit'.	**No action** – see paragraph 36 (replaced with 2024 Recommendation 3)

Exhibit source: Audit Wales

Appendix 3

Organisational response to audit recommendations

Exhibit 5 sets out the Health Board's response to our audit recommendations.

Exhibit 5: organisational response

Recommendation	Organisational response Please set out here relevant commentary on the planned actions in response to the recommendations	Completion date Please set out by when the planned actions will be complete	Responsible officer (title)
R1 The Health Board, to support its focus on increasing morning discharges, should: 1.1. ensure learning is captured from previous initiatives, such as the 'golden hour programme' and mitigate the creation of perverse incentives. 1.2. introduce reporting of the time of discharge to ensure that morning discharges are maximised where appropriate.	Identify areas of good practice and areas of learning / improvement from poor compliance demonstrated through monthly performance reporting Produce monthly reports for IHCs on time of discharge for review and monitoring at IHC UEC meetings and scrutiny at the 6 Goals programme board	**Q1** **Q1**	Goal 6 Lead - Acting Assistant Director Care Homes and Continuing Health Care Commissioning Programme Manager for Urgent & Emergency Care

Recommendation	Organisational response Please set out here relevant commentary on the planned actions in response to the recommendations	Completion date Please set out by when the planned actions will be complete	Responsible officer (title)
			IHCs
R2 The Health Board should ensure that all relevant staff are aware of the role of the Home First Team (Hub) and that the team operate consistently across the three acute hospital sites.	Feedback on process mapping of Home First Bureau processes Develop Comms and engagement plan, refocus and raise awareness to increase focus & awareness on D2RA pathways, STREAM, including raising awareness of the Home First Teams	**Q1** **Q2**	Goal 6 Lead - Acting Assistant Director Care Homes and Continuing Health Care Commissioning Programme Manager for Urgent & Emergency Care IHCs
R3 The Health Board should strengthen its performance reporting by including the following measures within its routine performance report to Board and/or committees:		**Q1**	Goal 6 Lead - Acting Assistant Director Care Homes and Continuing Health Care Commissioning Programme Manager for

Appendix 3

Recommendation	Organisational response Please set out here relevant commentary on the planned actions in response to the recommendations	Completion date Please set out by when the planned actions will be complete	Responsible officer (title)
• number and % of patients who have an estimated discharge date;	Identify baseline position and agree trajectory for improvement	**Q3**	Urgent & Emergency Care IHCs
• readmissions within 28 days of discharge from hospital;	This is one of the revised D2RA Measures which are in pilot phase until September 2024	**Q1**	
• % of discharges before midday;	Identify baseline position and agree trajectory for improvement. Priority area will be discharges to Care Homes. Review the time of discharge number / % of patients discharged before midday by D2RA Pathway	**Q3**	
• % of unplanned discharges at night; and	Identify baseline position and agree trajectory for improvement	**Q1**	
• % of discharges within 24 hours and 72 hours of being declared 'medically fit'.	STREAM development group established and a key priority will be to support increasing the compliance of recording when patient is Clinically optimised in line with D2RA reporting	**Q3**	

Recommendation	Organisational response Please set out here relevant commentary on the planned actions in response to the recommendations	Completion date Please set out by when the planned actions will be complete	Responsible officer (title)
	Monthly reporting will be re-established in May and will be reported as part of the D2RA Measures (Pilot phase until September)		

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Archwilio Cymru
Audit Wales

Urgent and Emergency Care: Flow out of Hospital – North Wales Region

Date issued: February 2024

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Summary report

About this report

1 Once a patient is considered medically or clinically well enough to leave hospital (also referred to as medically fit or clinically optimised) the timely discharge of that patient to the right setting for their ongoing needs is vital. Timely, effective, and efficient moving of patients out of an acute hospital setting holds important benefits for patient care and experience as well as for the use of NHS resources.

2 When the discharge process takes longer than it should there can be significant implications for the patient in terms of their recovery, rehabilitation, and independence. Delayed discharges will also have implications for other patients coming into the urgent and emergency care system[1] who need a hospital bed. Poor patient "flow" creates bottlenecks in the system that contribute to well documented problems such as over-crowded emergency departments and an inability to secure timely handover of patients from ambulance crews.

3 The Auditor General had originally included work in his 2021 local audit plans to examine whole system issues affecting urgent and emergency care services, including the discharge of patients from hospital. The COVID-19 pandemic resulted in this work being postponed and brought back on stream in 2023. Our work has sought to examine whether health boards and local authorities have effective arrangements in place to ensure the timely discharge of patients out of hospital. The approach we adopted to deliver our work is set out in **Appendix 1.**

4 This work is part of a broader programme of work the Auditor General is currently undertaking in respect of urgent and emergency care services in Wales. We are also examining the arrangements in place to help manage urgent and emergency care demand, and to direct patients to the care setting that is most appropriate to their needs. The findings from that work will be reported separately in 2024.

5 The Auditor General's work on urgent and emergency care is designed to help discharge his statutory duties. Specifically, this work is designed to satisfy the Auditor General that NHS bodies and local authorities have proper arrangements in place to secure the efficient, effective, and economical use of resources, as required by sections 17 and 61 of the Public Audit Wales Act 2004.

6 This report sets out the findings from the Auditor General's review of the arrangements to support effective flow out of hospital in the North Wales region (the region). The region encompasses:

- Betsi Cadwaladr University Health Board (the Health Board);
- Conwy County Borough Council;

[1] Urgent and emergency care describes any unplanned, urgent, and emergency care provided by health and social care services. The unscheduled care system is complex with numerous organisations involved in providing services and it deals with acutely unwell, vulnerable, and distressed people in need of urgent assistance.

- Denbighshire County Council;
- Flintshire County Council;
- Cyngor Gwynedd;
- Isle of Anglesey Council; and
- Wrexham County Borough Council.

7 In undertaking this work, we have also considered progress made by the Health Board against previous recommendations made in our 2017 report on discharge planning. Our findings from this work are set out in a separate report to the Health Board.

Key messages

8 Overall, we found that **while partners understand and show a commitment to improving patient flow out of hospital, performance remains extremely challenging with adverse effects for patient experience and care. Partners must continue to work individually and collaboratively to set and implement clear guidance, mitigate the challenges posed by reduced capacity and increased complexity of care, and ensure the impact of activities is continually monitored, challenged, and maximised.**

9 The extent of discharge delays in North Wales has grown significantly in recent years and between April 2023 and February 2024, each month there were on average 334 medically fit patients whose discharge was delayed, with completion of assessments the main cause for delay. For the year to date, up to and including February 2024, the total number of bed days that had been lost to delayed discharges was 71,871 with a full-year cost equivalent of £39.202 million. The consequent impact on patient flow within hospitals and the urgent and emergency care system is significant, with waiting times in emergency departments and ambulance handovers falling well short of national targets. In February 2024, there were over 8,000 lost ambulance hours because of handover delays, and the average wait within the Health Board's emergency departments was around 8.5 hours. Difficulties with discharge are also impacting on the ability of partner organisations to meet some patients needs effectively, especially in the west of the region where a significant proportion of patients are placed in temporary accommodation post hospital discharge.

10 Several factors are contributing to delayed discharges. Many patients, especially elderly people with mental health problems, have complex needs that are not easily met by the services that are available. There are also workforce challenges within the social care sector, particularly in the areas of Conwy, Denbighshire, and Gwynedd. Our work identified numerous weaknesses in the practice and documentation of discharge planning and a need to implement the Discharge to Recover and Assess (D2RA) model as intended. Work is also needed to address an absence of jointly agreed training and guidance on discharge planning for

health and social care staff, and to overcome difficulties in communicating and sharing information across organisational boundaries.

11 Improving patient flow is a key feature of plans across the partners which align to the Welsh Government's six goals for urgent and emergency care[2]. Partners are working together, both strategically and operationally, to improve patient flow, however, pressures on the system are creating an unhelpful blame culture. Financial resources are being applied to improve discharge planning, although financial constraints in partner bodies is leading to the continual roll forward of schemes and ultimately leaves little space for new ideas. Whilst there is regular monitoring of the position within individual organisations, partners lack arrangements to oversee patient flow across the whole health and care system. This limits opportunities to examine whole system solutions, embed learning and to focus on the impact of activity within performance and progress reports.

12 Partners also need to maximise the use of the Regional Integration Fund (RIF), improve oversight and impact of the initiatives that are being undertaken to support timely and effective discharge, and ensure learning from events is embedded into routine practice.

13 Taken together, the above demonstrates that despite hard work and good intentions on the part of organisations within the region, there is still much to do to improve discharge planning and processes. Continued action is needed across a range of areas to secure the improvements which are necessary for patients, their families, and the wider urgent and emergency care system.

Recommendations

14 Recommendations arising from this audit are detailed in **Exhibit 1**. The combined organisational response by the statutory bodies included in this review to these recommendations will be summarised in **Appendix 4** once considered by the relevant committees.

Exhibit 1: recommendations

Recommendations
Improving training and guidance
R1 The Health Board, working with local authorities, should develop jointly agreed guidance to provide clarity to all staff on how the discharge planning

[2] Further information on the Welsh Government six goals for urgent and emergency care can be found via https://www.gov.wales/written-statement-six-goals-urgent-and-emergency-care-programme-update

Recommendations

process should work across the region. This should be based on the national guidance issued in December 2023 and should set out clearly defined roles and responsibilities, and expectations, including when referrals for ongoing care should be made.

R2 The Health Board and local authorities should ensure processes are in place to communicate discharge planning guidance to all relevant health and social services staff, including those working on a temporary basis, supported by an ongoing programme of refresher training and induction training for new staff.

Improving compliance with policies and guidance

R3 The Health Board should embed a regular cycle of audit to assess the effectiveness and consistency of the application of discharge policies and guidance, including the application of D2RA.

R4 The Health Board should establish controls to prevent staff adding patients to multiple waiting lists, such as for reablement, home care packages and residential care to facilitate a speedy discharge, regardless of need. This will ensure that only those who need the services are on the relevant waiting lists.

Ensuring patient safety while awaiting care packages

R5 The Health Board should ensure processes are in place to notify social services before patients are discharged home, where those patients require ongoing support in their own home, and where such support is not in place at the time of discharge.

R6 The Health Board and local authorities should ensure mechanisms are in place to regularly monitor patients who are discharged home without arranged ongoing social care and to escalate issues to the appropriate service where necessary.

Improving the quality and sharing of information

R7 The Health Board and local authorities should ensure that all relevant staff across each organisation has consistent access to up-to-date information on services available in the community that support hospital discharge. This will ensure that opportunities to discharge earlier with support from services beyond social care are not missed.

R8 The Health Board should improve record keeping by:

8.1. ensuring all staff involved in discharge planning fully understand the importance of documenting comprehensive information in patient case-notes to support effective discharge planning.

Recommendations

8.2. establishing a programme of case-note audits focused on the quality of record keeping.

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.

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.

Maximising the use of the Regional Integration Fund

R11 The Health Board and local authorities, through the Regional Partnership Board (RPB), should demonstrate how it is working to increasingly mainstream long-standing schemes funded through RIF which are considered core services.

R12 The Health Board and local authorities, through the Regional Partnership Board, should agree a process for utilising any future RIF slippage monies, ensuring that appropriate value and benefit is obtained from such spending.

R13 To help inform decision-making and discussions, the Health Board and local authorities should:

13.1. ensure that the Regional Partnership Board has routine access to key performance indicators relevant to effective and timely flow out of hospital, including urgent and emergency care performance within the Health Board and waiting lists for social services and care packages; and

13.2. use the Regional Partnership Board working arrangement to develop a regional risk register which pulls together the risks associated with delayed discharges.

Improving oversight and impact

R14 The Health Board and local authorities should ensure that information setting out progress with significant activities and initiatives being undertaken to support effective and timely discharge is routinely available at a corporate and partnership level. This should include activities and initiatives undertaken individually and jointly, both within and outside of the RPB structure, their

Recommendations

impact and how they collectively contribute to addressing the challenges. This will help to provide assurance that resources are being invested to best effect.

Embedding learning from actions taken to address delayed discharges

R15 The Health Board and local authorities should ensure that mechanisms are in place to implement learning from actions taken to address delayed discharges, such as the Multi Agency Discharge Events (MADE), and to maintain regular oversight to ensure the learning is being implemented.

R16 The Health Board should strengthen escalation arrangements for reporting adverse incidents or concerns relating to discharge by:

16.1. addressing any outstanding adverse incidents or concerns, communicating clearly with the relevant local authority; and

16.2. ensuring a consistent approach to reporting adverse incidents and concerns relating to discharge is in place across the Health Board.

Exhibit source: Audit Wales

Detailed report

What is the scale of the challenge?

15 This section sets out the scale of the challenge that the region is facing in respect of delayed discharges and the subsequent impact on patient flow and the patient experience.

16 We found that **there are significant numbers of delayed discharges across the region which are reducing patient flow through the hospitals with consequential impact on urgent and emergency care services and the ability to meet patients' needs.**

Delayed discharges

17 We found that **significant numbers of patients are not leaving hospital in a timely way once they are considered medically well enough to do so, with completion of assessments, social care worker allocations and waits for home care packages the main causes for delay.**

18 Delays discharging patients from hospital has been a longstanding issue for bodies in Wales and other parts of the UK. The available data shows that this issue has become significantly worse in recent years.

19 **Exhibit 2** sets out the number of delayed discharges experienced by the Health Board between April 2023 and February 2024, compared with other Health Boards across Wales. These relate to patients who are considered medically fit but remain in a hospital bed 48 hours after the decision was made that they were well enough to leave hospital. The rate of delayed discharges across the region is broadly in line with the average for Wales.

Exhibit 2: number of delayed discharges per 100,000 head of population (April 2023 – February 2024)

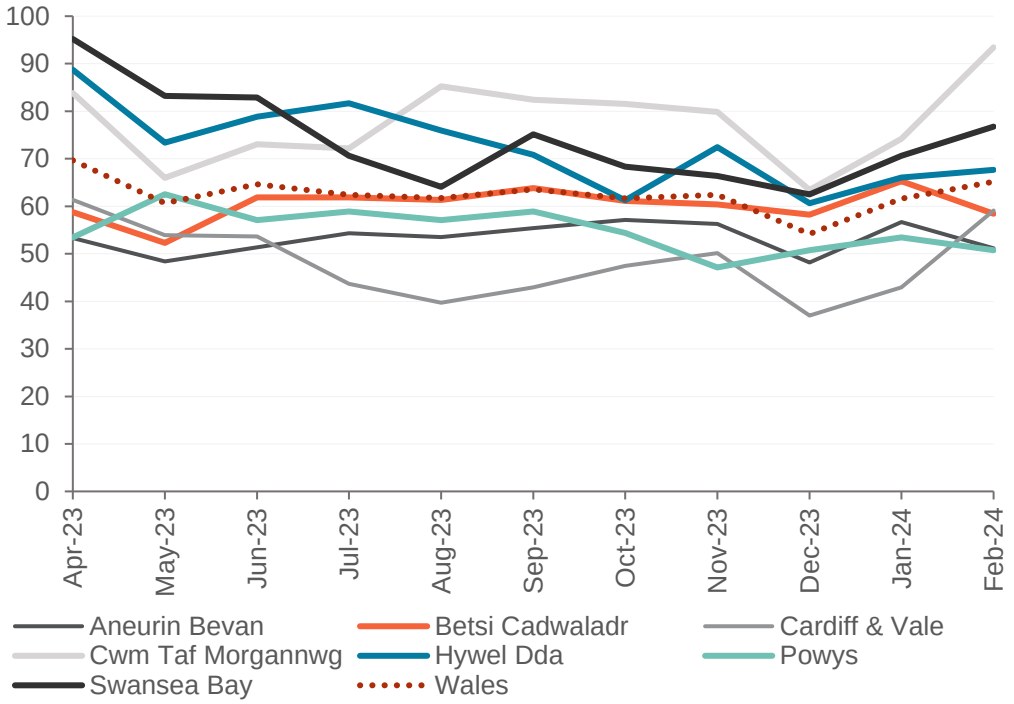


Exhibit source: Welsh Government

20 Since the pandemic, the way in which delayed discharges are measured has changed. No data on delayed discharges was formally reported between the period March 2020 and March 2023. Prior to the pandemic, delayed discharges were reported as 'delayed transfers of care' which were defined as those who continue to occupy a bed after the date in which the patient is declared to be ready to move on to the next stage of their care. This compares with the current method for counting delays which focuses on those who remain in a hospital bed 48 hours after being identified as 'medically fit'.

21 Although not a direct comparison, in February 2020 the Health Board reported 81 delayed transfers of care. The position at the end of February 2024 of 324 delayed discharges equates to 16.1% of the Health Board's total bed capacity[3]. However, this is below the all-Wales average of 17.9% (ranging between 13.7% and 31.3%) and the second lowest in Wales.

[3] Based on general and acute bed availability data in July 2023, StatsWales website (https://statswales.gov.wales/Catalogue/Health-and-Social-Care/NHS-Hospital-Activity/NHS-Beds/nhsbeds-by-organisation-site)

22 The top five reasons for delays at the Health Board compared to the all-Wales position is set out in **Exhibit 3,** with the most common reasons being awaiting a joint assessment (between health and social care) and awaiting a social worker allocation. A full list of reasons for delay in the Health Board are set out in **Appendix 2,** and by local authority.

Exhibit 3: top five reasons for delayed discharge (February 2024)

Reason for delay	Percentage delayed	All-Wales average
Awaiting joint assessment	15.7	9.0
Awaiting social worker allocation	15.1	8.5
Awaiting completion of clinical assessment (nursing / allied health professional / medical / pharmacy)	13.3	10.3
Awaiting start of new home care package	10.5	8.0
Awaiting completion of assessment by social care	5.6	15.7

Exhibit source: Welsh Government

23 When broken down by local authority, the rate of delayed discharges per 100,000 head of population is generally higher than the all-Wales position except for Flintshire. Awaiting joint assessment is the highest cause of delay in the west of the region, and in Denbighshire. Awaiting social worker allocation is the highest cause of delay in the east of the region. Awaiting clinical assessments is the highest cause of delay in Conwy, accounting for a quarter of all delays.

24 Based on data reported in February 2024, the total number of patients accounted for 6,524 bed days. Based on a typical cost per bed day[4], this equates to costs in the region of £3.262 million, and a full year effect of £39.202 million.

25 Our hospital patient case note review relating to a sample of medical emergency patients identified that the length of time patients remained in a hospital bed after 48 hours of being declared medically fit varied across the Health Board's main hospital sites, with the average number of days patients remained in a hospital bed the longest at Ysbyty Maelor (**Exhibit 4**).

[4] Based on £500 per bed-day as set out in the NHS Confederation briefing for the statement by the Minister for Finance and Local Government on the 2023-24 financial position

Exhibit 4: average length of time after 48 hours of being declared medically fit (based on a sample of patients with a length of stay greater than 21 days)

Hospital site	Average number of days
Ysbyty Glan Clwyd	16
Ysbyty Gwynedd	20
Ysbyty Maelor	43

Source: Audit Wales

Impact on patient flow

26 We found that **delayed discharges are having a significant impact on patient flow with worrying knock-on effects elsewhere in the urgent and emergency care system.**

27 Delays in discharging patients from hospital have consequences for patient flow and in particular, the ability of patients to access services when they need them. Beds being used by patients who no longer need them means that they are not available for those who do, resulting, for example, in longer waits in emergency departments. This in turn impacts on the ability for ambulance crews to handover patients and respond to 999 calls in the community.

28 **Appendix 3** sets out the region's performance across a range of urgent and emergency care performance indicators in comparison to the position across Wales since April 2022. In summary:

- the percentage of ambulance red calls responded within 8 minutes has broadly been in line with the all-Wales position at around 50%, but below the national target of 65% (**Exhibit 20**);
- the median amber response time has been significantly above the target of 20 minutes at around 3.5 hours, falling to around an hour over the summer of 2023, but rising again in recent months (**Exhibit 21**);
- the percentage of ambulance handovers within 15 minutes at the Health Board's major emergency departments is generally below the all-Wales average and some of the lowest in Wales, particularly at Ysbyty Glan Clwyd and Ysbyty Maelor, and significantly below the national target (**Exhibit 22**);
- the percentage of ambulance handovers taking over one hour has broadly been above the all-Wales average fluctuating between 38.5% and 55%, compared to a national target of zero (**Exhibit 23**);
- the total number of hours lost following notification to handover over 15 minutes is well above the all-Wales average, fluctuating between 6,000 and 10,000 hours per month over recent months (**Exhibit 24**);

- once the patient is in the emergency department, the median time from arrival to triage has reduced and is now just below the all-Wales position at 21 minutes (**Exhibit 25**);
- the median time from arrival to being assessed by a senior clinical decision maker has been significantly higher than all other health boards, at around five and a half hours, but since March 2023 has reduced to around two hours which remains above the all-Wales average (**Exhibit 26**);
- the percentage of patients seen within 4 hours in a major emergency department is some of the lowest in Wales. Performance varies across the three hospital sites, with performance better in Ysbyty Maelor (**Exhibit 27**);
- the percentage of patients spending less than 12 hours in an emergency department is also some of the lowest in Wales, with performance worse at Ysbyty Glan Clwyd and Ysbyty Gwynedd (**Exhibit 28**); and
- the proportion of bed days accrued by patients with a length of stay over 21 days has been better than the all-Wales average (**Exhibit 29**).

29 Based on our analysis of Health Board data relating to all emergency medicine patients discharged in October 2022, we found the average total length of stay for patients staying over 21 days in the acute sites was 51 days (compared to 56 days across Wales). This varied across the three acute sites, with the average total length of stay increasing to 64 days at Ysbyty Maelor. The average total length of stay at Ysbyty Glan Clwyd and Ysbyty Gwynedd was 39 and 50 days, respectively.

30 The Health Board's total bed capacity has fluctuated over recent years, with 2,123 total beds available in 2022-23, with just under half allocated to acute medicine (975). Bed occupancy in the acute medicine beds has been at 88.3%, compared with an optimal level of 85%. The Health Board is one of four health boards to have community hospital beds managed by GPs. These beds provide step-down facilities for patients who no longer need acute care. However, the number of these beds available in the Health Board has reduced from 109 in 2019-20 to 88 in 2022-23, and occupancy levels have been running high at 97.2%. Most of these beds are in Denbighshire and Gwynedd.

31 Pressure on available beds because of delayed discharges means that health boards are not always able to ensure that patients are placed on the best wards for their clinical needs. For example, health boards will usually hold vacant beds on stroke units to ensure that stroke patients have fast and direct access, enabling them to access stroke specialists and equipment.

32 Health boards have increasingly experienced difficulties in admitting stroke patients to a stroke ward as problems with patient flow and bed availability mean that these beds have been needed for non-stroke patients. Over the last 12 months, only a quarter of stroke patients admitted to the Health Board have had direct admission to a stroke unit within four hours. Performance, however, is marginally better than the all-Wales position.

33 The impact of poor patient flow is also often felt within scheduled (or planned) care, as patients with their booked procedures are increasingly having their treatments cancelled due to the lack of available beds. During 2022-23, 641 planned care admissions were cancelled due to the lack of an available ward bed in the Health Board, with over half of those during December 2022 and January 2023. For the period, 2023-24 up to and including February 2024, 1,036 planned care admissions were cancelled. This level of cancellation represents poor patient experience and risks the conditions of planned care patients further deteriorating while they wait for their treatment to be rescheduled.

Meeting patients' needs

34 We found that **delayed discharges are impacting on the ability of organisations to meet some patients needs effectively with a significant proportion of patients in the west of the region being discharged into temporary accommodation.**

35 The pressure to discharge patients and the lack of available care options can lead to patients being discharged to settings that are not always the most appropriate ones for their needs including:

- being discharged home before a proper care package is in place;
- being discharged to a residential care home when they could have gone home with a support package;
- being discharged to a temporary residential care home to await availability of longer-term placement;
- being discharged to a community hospital bed to await availability of a package of care; and
- being discharged to a setting which is far away from family and friends.

36 Patients who are delayed within hospital can become deconditioned, are at higher risk of experiencing an injury from a fall or contracting a hospital acquired infection which can exacerbate their care needs, lengthening their hospital stay and making them more vulnerable to re-admission after they have been discharged.

37 Within the region, the impact of delays on patient experience and outcomes is something we found that both health and social care staff are very aware of and working hard to avoid. However, patient choice and experience are increasingly being compromised to secure a timelier patient discharge, and staff we spoke to often cited the increased need to manage patient and family expectations. With limited options for ongoing care, we found that staff are often left looking at alternative options to enable patients to be discharged. We heard examples of staff adding patients to multiple waiting lists, such as for reablement[5], home care

[5] Reablement describes services for people with poor physical or mental health to help them accommodate their illness by learning or re-learning the skills necessary for daily living.

packages and residential care, to facilitate a timelier discharge regardless of patients' specific needs**.**

38 We also heard of examples where patients were discharged home without support to await a package of care to become available. Partners work to minimise such cases as much as possible, adopting a risk-based approach and exploring various options to bridge gaps in the provision of formal support such as by requesting the patients' families or friends provide short-term support. While some councils, including Conwy, Gwynedd, and Wrexham, have arrangements in place to monitor the wellbeing of patients awaiting a package of care, some do not. We also heard of rare but concerning situations where patients are discharged home to await a package of care without social service teams being notified**.**

39 **Exhibit 5** sets out the extent to which unplanned short-term care home accommodation is used across the region. Since July 2023, the region has had some of the highest number of adults per 100,000 population placed in unplanned short term care home accommodation. This is particularly the case in the west of the region. The proportion of adults in unplanned placements longer than 6 months in Gwynedd is the highest in Wales, with the proportion of adults staying in temporary placements between 3 and 6 months on the Isle of Anglesey the second highest in Wales.

Exhibit 5: number of adults per 100,000 head of population waiting in a care home with no planned end date, regardless of the reason they are waiting (+3 months) July 2023 – February 2024

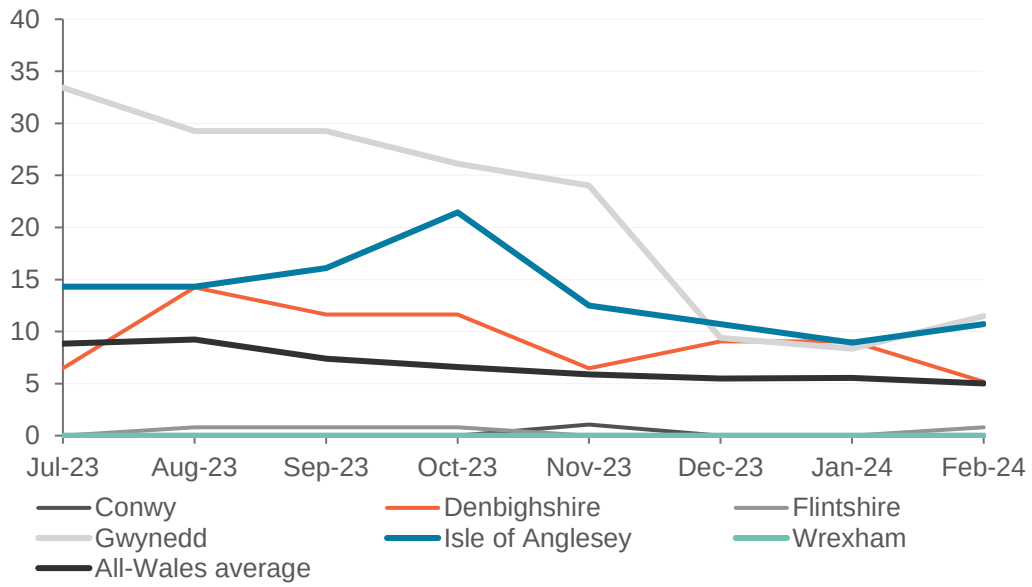


Exhibit source: Welsh Government

* Note – no data submitted for Wrexham for the period.

What is impacting effective and timely flow of patients out of hospital?

40 This section sets out the issues impacting on effective discharge planning and the timely flow of patients out of hospital across the region.

41 We found that **while complexity of demand is increasing, health and social care capacity has reduced leaving limited options for ongoing care and these challenges are exacerbated by a lack of information sharing and beginning discharge planning too late in a patient's journey.**

Volume and complexity of demand

42 We found that **there have been increases in the complexity of demand and the number of elderly patients with mental health problems.**

43 In North Wales people over the age of 65 accounted for 20% of the population in 2020, but that figure is expected to increase to 29% by 2040[6]. As people live for longer, there is a correlating increase in the numbers of people who live with multiple long-term conditions and complex health needs and who will therefore need to rely on health and care services for support.

44 Those we spoke to during this review spoke of significant increases they see in demand, particularly in terms of more complex, higher acuity demand. We were often told that patients come in with one problem, but routine tests can quickly uncover several other conditions that need to be treated and managed, which will typically require more complex discharge planning.

45 COVID-19 exacerbated this increase in complex demand. During the pandemic, demand for emergency departments declined rapidly as people followed national advice to protect core frontline services. In addition, families provided additional care and support to avoid their loved ones being admitted to hospital or long-term care out of fear of contracting COVID-19. We were told that as the pandemic eased, demand began presenting through the emergency departments which was much more complex than before as people's conditions had deteriorated at home.

46 Care homes have also seen increasing complexity amongst their patients. Elderly mental health was often raised as a significant pressure, with greater numbers of elderly patients presenting at hospital with mental health conditions which care homes find increasingly difficult or impossible to accommodate post discharge.

[6] Population projection data sourced from the Older People's Commissioner for Wales https://olderpeople.wales/wp-content/uploads/2023/01/221222-Understanding-Wales-ageing-population-24-November.pdf

Workforce capacity

47 We found that **there are workforce capacity challenges, particularly within the Health Board and in Gwynedd and Wrexham adult social services, with waits for social care assessments in some councils amongst the highest in Wales.**

48 Increasingly staff involved in discharge planning are finding their capacity stretched due to factors such as high vacancy rates and unplanned absence rates. Reduced numbers of staff leads either to a reliance on agency staff or to fewer permanent staff attempting to manage increasingly complex patients and organise the ongoing care they need for discharge. High usage of agency staff has inevitable impacts on continuity within the workforce.

49 As of January 2024, the Health Board was reporting 9.0% vacancies as a percentage of its total establishment, with nursing and midwifery vacancies at 11.7%, and medical vacancies at 6.2%. Vacancy rates were highest in the centre of the region. The unplanned absence rate was at 6.7% for nursing and midwifery staff, but much lower at 2.2% for medical staff. Bank and agency use accounted for 8.9% of nursing and midwifery posts, with the greatest use of bank and agency also in the centre of the region.

50 In June 2023, the North Wales councils were reporting between 0%-45% vacancies in adult social services, with the highest rate of vacancies in Wrexham and the lowest in Flintshire[7]. In February 2024, the unplanned absence rate in adult social services ranged between 6%-10%, as shown in **Exhibit 6**.

Exhibit 6: percentage of unplanned absence in adult social services (February 2024)

Local authority	Unplanned absence
Conwy	7
Denbighshire	10
Flintshire	6
Gwynedd	10
Isle of Anglesey	8
Wrexham	8
All-Wales average	**7.9**

Exhibit source: Welsh Government

[7] Flintshire 0%, Isle of Anglesey 5%, Conwy 6%, Denbighshire 6%, Gwynedd 9%, and Wrexham 45%. No data has been made available since June 2023.

51 Both Gwynedd and Wrexham have experienced higher rates of unplanned absence and vacancies compared with the all-Wales position, with Wrexham council carrying a significant level of vacancies for several months. The use of agency staff across the six authorities is generally low (ranging between 1%-3%), compared with the all-Wales position of 2%. The highest rate was reported in Conwy at 3%. For the previous six months, the agency rate in Gwynedd had been significantly higher, ranging between 11%-21% per month, reflecting the vacancy and unplanned absence rates that the council has been experiencing.

52 Workforce capacity constraints can adversely affect the discharge planning process. For example, pressure on ward nursing numbers means that time for proper discharge planning is constrained which may be exacerbated using agency staff who are less familiar with discharge processes, or social workers may not be able to complete assessments for a patient in a timely way. As highlighted in **Exhibit 3**, delays in joint assessments between health and social care staff and clinical assessments by hospital staff are some of the main reasons for delayed discharges across the region, accounting for 28% of all delays. Delays awaiting social care worker allocation and social care assessments account for a further 20.7% of all delays as of February 2024. **Exhibit 7** sets out the extent to which adult social services across the six local authorities can meet demand for assessment. The number of patients waiting for a social care assessment in hospital account for a small proportion of the total number of people waiting for assessment.

Exhibit 7: number of social care assessments completed and awaiting to be completed per 100,000 head of population per month (February 2024)

Local authority	Social care assessments completed	Adults waiting for a social care assessment	% of those waiting for a social care assessment that are in hospital
Conwy	252	48	4.3%
Denbighshire	263	178	0.7%
Flintshire	195	136	1.8%
Gwynedd	148	153	1.3%
Isle of Anglesey	298	226	3.1%
Wrexham	152	-	-
All-Wales average	**250**	**125**	**8.7%**

Exhibit source: Welsh Government

* Note - no data submitted by Wrexham for adults waiting.

53 Waiting lists for social care assessments are higher than the all-Wales average in Denbighshire, Flintshire, Gwynedd, and Isle of Anglesey, and some of the highest in Wales. The waiting list in Gwynedd is similar or higher than the number of assessments completed suggesting that it is struggling to keep on top of demand for social care assessments.

54 Conversely, although Wrexham has experienced a significant number of vacancies, the number of social care assessments completed during the summer of 2023 were some of the highest in Wales (at around 470 per month), dropping below the all-Wales average to be between 100 and 150 each month. To address staff shortfalls, Wrexham council has made use of micro enterprises to support its provision of social services, and complete social care assessments.

Care sector capacity

55 We found that **there is stretched capacity across the social care sector, particularly with respect to domiciliary care provision.**

56 Availability of home (domiciliary) care packages and long-term residential care home accommodation can be key causes of discharge delay across Wales. Within the region, during our interviews we repeatedly heard about the impact of shortages of domiciliary care staff across North Wales with delays starting new home care packages accounting for 10.5% of all delays in February 2024. Awaiting residential home availability accounted for a further 8.6% of all delays. **Exhibit 8** sets out the number of adults receiving care sector support and the extent to which there are waits for provision. **Appendix 4** sets out waiting list performance for social care assessments and care packages since November 2022.

Exhibit 8: number of adults receiving (and waiting for) care packages and placements per 100,000 head of population per month (February 2024)

Local authority	Domiciliary care[8] in receipt (waits)	Reablement[9] in receipt (waits)	Long-term care home accommodation[10] in receipt (waits)
Conwy	896 (39)	56 (4)	677 (5)
Denbighshire	534 (66)	17 (0)	625 (9)
Flintshire	615 (42)	34 (18)	494 (-)
Gwynedd	796 (123)	73 (-)	752 (27)
Isle of Anglesey	585 (42)	18 (7)	536 (19)

[8] Includes domiciliary care both provided and commissioned by local authorities.

[9] Includes reablement provided by local authorities.

[10] Includes long-term care home accommodation commissioned by local authorities.

Local authority	Domiciliary care[8] in receipt (waits)	Reablement[9] in receipt (waits)	Long-term care home accommodation[10] in receipt (waits)
Wrexham	388 (21)	28 (21)	497 (-)
All-Wales average	**665 (34)**	**46 (9)**	**536 (11)**

Exhibit source: Welsh Government

57 The exhibit shows difficulties matching demand and capacity for domiciliary care and/or reablement services across most local authorities in North Wales, with the number of people waiting for care above the all-Wales position for some of these services. Conversely, the number of adults in receipt of domiciliary services in the Conwy and Denbighshire council and Cyngor Gwynedd areas, and reablement services in Conwy is higher than the all-Wales average, suggesting the availability of domiciliary care and reablement is greater in these areas than in other parts of Wales. The provision of long-term care home is also greater in the Conwy, Denbighshire, Gwynedd, and Isle of Anglesey council areas.

58 **Exhibit 9** indicates the extent to which there are domiciliary care hours unfilled, and the average number of hours provided per adult.

Exhibit 9: unfilled domiciliary hours and average hours of domiciliary care provided per adult, per 100,000 head of population (February 2024)

Local authority	Domiciliary care hours waiting to be filled	Average hours per adult in receipt of domiciliary care
Conwy	525	11.2
Denbighshire	875	9.5
Flintshire	481	12.7
Gwynedd	1001	10.9
Isle of Anglesey	356	12.7
Wrexham	165	15.3
All-Wales average	**353**	**13.2**

Exhibit source: Welsh Government

59 The data suggests a very mixed picture across the region with Wrexham reporting a low level of domiciliary care hours waiting to be filled, whilst the number of unfilled domiciliary care hours in Conwy, Denbighshire, Gwynedd, and Isle of Anglesey are amongst the highest in Wales. Interestingly the average number of domiciliary care hours provided per adult in some council areas is less than the all-

Wales average. Whilst this may reflect the care that people need, it could also be indicative of problems with the supply of domiciliary care with councils potentially trying to spread a limited resource thinly to ensure that as many people are being supported with domiciliary care but not necessarily at the level that they need.

Discharge process

60 We found that **there are weaknesses in the practice and documentation of discharge planning which are exacerbated by an overcautious approach and an absence of jointly agreed training and guidance.**

61 Good discharge planning is reliant on good communication and co-ordination across different professional groups, with consideration of discharge as soon as a patient is presented to services. Good discharge planning is also facilitated by having clearly documented processes which are shared with all staff involved to promote understanding and awareness of the different roles in the discharge process.

62 Our hospital patient case note review suggested that discharge planning is not considered early enough in the patient journey and is not well-documented. We found variable quality and completeness of discharge documentation between clinicians, wards, and sites. Referral information between specialties, as well as 'What Matters to Me'[11] forms were largely incomplete or absent in the notes we reviewed. Physiotherapy and occupational therapy notes were generally comprehensive and thorough, and we saw some notes had been completed by social workers.

63 However, further documentation that we expected to see, for example, Single Point of Access referrals or nursing assessments, were rare. None of the case notes we reviewed had a completed section within the Emergency Department form which gave an indication of a predicted date of discharge. Though we recognise it may not always be possible to provide this indication at such an early stage, it is good practice for discharge to be considered as soon as a patient encounters hospital services, and particularly at the point in which admission is deemed appropriate.

64 Largely, references to discharge planning within case notes occurred only once the patient was deemed medically fit for discharge, and often they simply referred to 'discharge planning' with lack of detail of what was required for ongoing care (if any) or what the patients and their families wishes were. While case notes showed some limited evidence of discussion with patients and families, insufficient use of 'What Matters to Me' conversations are hindering discharge planning as decisions for ongoing care are made without direct knowledge from the patient or their family of their capabilities, limitations, and usual home environment. Fewer than half the

[11] What Matters to me refers to conversations' hospital staff are expected to undertake with patients. The conversations are structured around what the patient can do for themselves and what they will require ongoing support with.

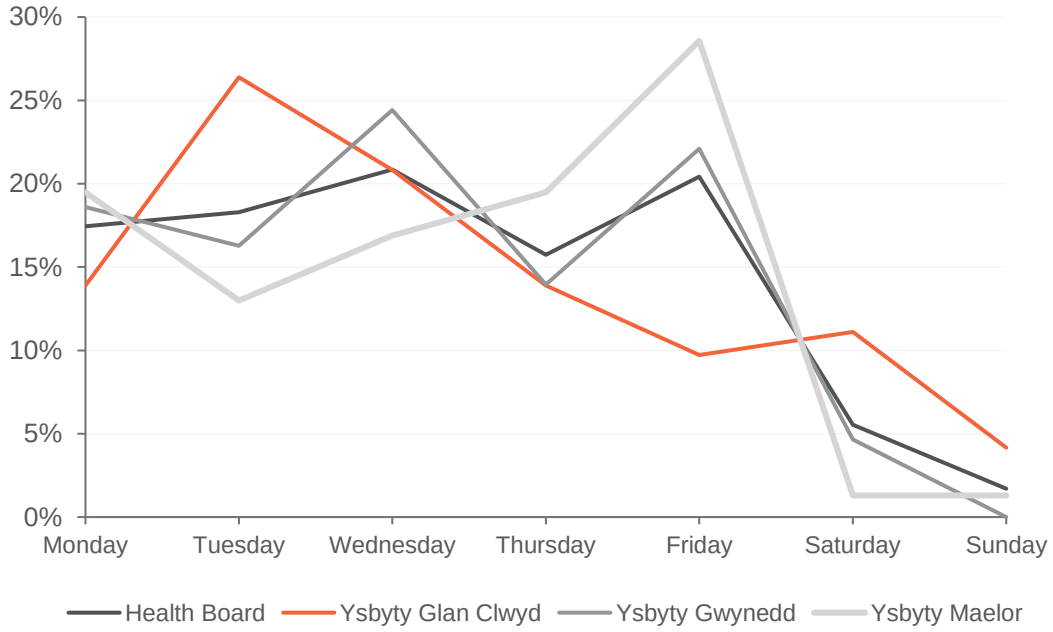
case notes reviewed showed the family was kept informed of the patient's care plan.

65 Delays to discharges were not well described within case notes, often limited to references to 'awaiting packages of care' or 'awaiting best interest meetings'[12] without describing what was causing the delay and when next steps were anticipated to take place. The results of best interest meetings were not formally recorded in the case notes we reviewed. Once discharges were progressing, logistical arrangements were rarely described i.e., whether the patient required transport or whether their medications had been prepared. In some cases, it was unclear where the patient had been discharged to (i.e., lack of care transfer form or notes on form).

66 We also noted that discharging patients from hospital remains an activity which largely takes place on weekdays, with very few (and mostly simple) discharges occurring on weekends due to staff working patterns in both health and social care. A review of data relating to all patients discharged from the Health Board's acute sites in October 2022, indicated that only 7.2% of patients were discharged at the weekend (**Exhibit 10**). This is due to working patterns of staff within social services and within hospital settings, as well as the fact that most providers will not accept admissions over the weekend. During the week, discharges peak on a Friday across all the acute sites, with the greatest proportion of Friday discharges taking place at Ysbyty Maelor. Discharging on a Friday poses risks that necessary support services at home may not available over the weekend period.

[12] A Best Interest Meeting is a multidisciplinary meeting that is arranged for a specific decision around a patient's care / treatment, when a person is deemed to lack the mental capacity to make that decision for themselves.

Exhibit 10: day of discharge of all patients discharged from acute hospital sites in October 2022, as a percentage of total discharges[13]



Source: Audit Wales

67 When we spoke to those involved in the discharge process from both a health and social care perspective, we found differences in perception about how the discharge process should work. Of primary concern were differences in opinion on when referrals should occur as part of discharge planning with concerns from social workers that they were either notified too early or too late to facilitate effective and timely flow out of hospital. These different perspectives are causing further delays in patient discharges as well as some tensions in the working relationships between health and social care workers.

68 Ward staff also spoke of a culture of risk aversion, whereby staff, particularly junior doctors, are reluctant to declare a patient medically fit and discharge them because they fear the patient may not cope as well at home. Whilst staff may be acting out of kindness, they may not be acting in a patient's best interest. Keeping patients in hospital for longer than they medically need has a negative impact on patient experience and outcome as well as broader patient flow within the hospital. While many we spoke to recognise the negative impact that delayed discharging has on the independence and wellbeing of patients, there is a continued reluctance to take

[13] Excludes patients who died.

measured risks and to recognise the significant knock-on impact delayed discharges have on patient flow and the wider system.

69 Across North Wales, we found differences in arrangements between hospital sites and between local authorities in relation to discharging patients, including how referrals are made and to whom. High agency and bank staff usage in the Health Board adds to the challenge of maintaining a consistent and clear approach. Although training and guidance could address inconsistencies, during our fieldwork staff reported that they had not received discharge planning training. The Health Board recently introduced Criteria Led Discharge training, but awareness and completion rates vary across sites. A draft discharge standard operating procedure exists, specifying responsibilities and standards, but it appears unfinished, and many Health Board staff were unaware of its existence.

70 In 2018, the Welsh Government introduced the Discharge to Recover then Assess (D2RA) model, which is designed to support people to recover at home before being assessed for any ongoing need, thereby reducing length of stay in hospital. Implementation of the model was accelerated during the pandemic, and the Welsh Government has subsequently supported regions with additional monies to embed D2RA further.

71 National data submitted to Welsh Government in early 2023 indicates the Health Board has difficulty in discharging patients to an appropriate setting for their assessment, as is advocated by D2RA. Data for the Health Board showed it had high proportions of patients waiting to transfer to D2RA pathways. Many of these patients were waiting to be discharged to their own homes, which indicates delays due to factors such as awaiting social care assessments, packages of care or housing adaptations. Other patients are waiting to be discharged to step-down beds but are unable to leave hospital due to the lack of availability of such beds in the community.

72 The Health Board has been awaiting updated national guidance on D2RA before developing its own guidance which should support it to further embed the policy. However, given some of the disparities in understanding between health and social care about how the discharge process should work, jointly agreed guidance and training would help establish and clarify shared expectations to be used in practice by all staff involved in the discharge planning process. The national guidance was issued in December 2023.

Information sharing

73 We found that **difficulties in communicating and sharing information across organisational boundaries is adding to delays.**

74 Professionals within and across organisations will typically be required to share information about the patient to facilitate appropriate discharge arrangements and ongoing care, especially where the patient has more complex needs. During our fieldwork, we found that while arrangements for sharing information between staff

within hospitals are improving, sharing of information between organisations appears to be a significant barrier.

75 For patients who are likely to require ongoing social care support, the sharing of information from the hospitals to social services is not starting early enough following admission. In most cases, social workers will not become aware of a patient until the point the patient is considered medically well enough to leave hospital. Given the social care capacity constraints described in **Exhibit 6**, and the delays in social care assessments (**Exhibit 7**), it is important that referrals are made as early as possible in the patients' admission to enable effective planning and assessment. Once a referral has been made, ward and social services staff reported difficulty in contacting one another to discuss the patient's case, which can also cause delays. The Health Board has implemented a Home First Hub to help co-ordinate referrals, but this is not yet fully embedded and consistently used.

76 Systems holding patient information have not been connected or viewable to all staff involved in the care of individual patients as various IT systems have not been accessible across organisations. While four of the local authorities have implemented the Welsh Community Care Information System[14], Denbighshire and Flintshire council have not and although the Health Board has committed to using the system and undertaken a small pilot in the community nursing and therapy teams, it has not yet implemented the system across the Health Board. While we saw the positive impact of the STREAM[15] system in place within some hospital wards, this useful patient information was not able to be shared more broadly across the organisation or with key partners, such as social services. Since the time of our review, we have heard that the Home First teams have begun to have direct access to local authority client systems to enable better information sharing.

77 Services run by the voluntary sector along with community-based services are fundamental to supporting discharge for many patients. It is therefore best practice to involve these services in the discharge planning process. Understanding of the landscape of services outside of hospital however was patchy, meaning opportunities to discharge earlier with support from services beyond social care were missed. We found that access to information on community and voluntary services was often variable and there was an absence of training to provide information to relevant staff**.**

What action is being taken?

[14] The Welsh Community Care Information System (WCCIS) is a single system and a shared electronic record for use across a wide range of adult and children's services. The idea being that all 22 local authorities and seven health boards should implement it, with the initial intended implementation date of the end of 2018.

[15] STREAM is a clinical discharge planning tool that supports patient flow in an acute setting.

78 This section considers the actions being taken by the statutory organisations, including through the RPB to improve the flow of patients out of hospital.

Strategic and operational plans

79 We found that **improving patient flow is a key feature of plans across the partners which align to the Welsh Government's six goals for urgent and emergency care.**

80 We reviewed relevant health board and local authority plans in relation to discharge planning and unscheduled and social care more generally. We found that plans in the region reflect a good understanding of the challenges affecting the flow of patients out of hospital. Plans also reflect the commitment of partners to resolve some of the key challenges related to flow such as workforce gaps and limited care home availability. Plans are informed by data and demand projections, particularly from the North Wales Population Needs Assessment, developed by the RPB. Importantly, plans reflect key Welsh Government planning requirements, such as the six goals for urgent and emergency care, as well as the Welsh Government 1,000 bed challenge[16].

81 Introduced in 2021, the six goals for urgent and emergency care programme contains two goals that are linked to improving discharge: 'goal five - optimal hospital care and discharge practice from the point of admission', and 'goal six: home first approach and reduce risk of readmission'. The Health Board's existing urgent and emergency care programme was reframed in 2022 to align to the six goals programme. The Health Board's plan contains a variety of schemes aligned to the six goals. For example, a commitment to maximising use of the discharge lounge, including developing a seven-day discharge lounge. The Health Board is also prioritising implementation of the STREAM system across each ward to consistently capture actions in patient care to facilitate discharge, as well as implementing the Optimal Flow Framework, including embedding SAFER[17] patient flow principles across the Health Board.

82 The North Wales regional plan 2023-28 sets out high level principles, outcomes, and priorities for regional working across health and social care in North Wales, based on the Population Needs Assessment. While the plan does not discuss issues in relation to flow out of hospital directly, among its key priorities are working together to support people at home, as well as addressing the impact of wider social care workforce recruitment and retention on unpaid carers. It identifies that partners are committed to address these challenges through the RPB structure.

[16] In July 2022 the Health and Social Care Minister set a challenge for Health Boards and Local Authorities to establish an additional 1,000 bed spaces or their equivalents to support timely discharge https://www.gov.wales/written-statement-six-goals-urgent-and-emergency-care-programme-update

[17] Further information on the SAFER model can be found via https://www.adss.cymru/en/blog/view/patient-flow/fileAttachment

83 In our fieldwork, we examined the Health Board's winter plan for 2022-23, aligning with its urgent and emergency care and urgent and emergency care programme. However, some plan components aimed at enhancing routine practices rather than addressing surge demand. Examples include internal professional standards and a standard operating procedure for medically fit patients. The plan was approved by partners through the RPB in December 2022, potentially limiting its impact on managing demand for the winter. Local authorities' winter plans mirrored the Health Board's activities, emphasising capacity increase and providing alternatives for patients ready to leave the hospital. All plans acknowledged the need to boost staff capacity to handle demand.

84 Challenges in terms of recruitment and retention were recognised by partners as having a direct impact on service provision, particularly in relation to availability of domiciliary care and care home placements. The North Wales Social Care and Community Health Workforce Strategy 2018-21 aimed to develop a joined-up approach to the workforce challenges and opportunities. At the time of our fieldwork, the RPB's Workforce Board was working to refresh the strategy. Workforce challenges were referenced in most plans, strategies and reports we reviewed and was the focus of much activity including projects funded by the Regional Integration Fund (RIF) (such as Step into Work[18]) and activity commissioned by several groups and boards across the region.

Partnership working

85 We found that **partners are working together, both strategically and operationally, to improve patient flow, however pressures on the system create an unhelpful blame culture between the different parties involved in discharge planning.**

86 The structure and governance of the North Wales RPB is complicated due to the high number of groups locally and sub-regionally. However, feedback from members suggests that it has been successful in facilitating joint working on specific workstreams and partnership working more generally. More recently changes to membership following turnover of senior leadership, particularly within the Health Board, has presented a challenge in clarifying accountabilities and building relationships.

87 Minutes from the RPB, and the Leadership Group which reports to the RPB, reflect regular discussions around urgent and emergency care pressures and discharge planning, including regular updates surrounding the 1,000-bed challenge during late 2022. The Welsh Government requirement was for North Wales to supply 243

[18] Step into Work is a collaborative project between Health and Social Care to provide training and placements for individuals that are interested in pursuing a career in care with the aim that they can secure employment and become part of the care workforce. https://www.northwalescollaborative.wales/step-into-work/

of the 1,000-beds by October 2022. In November 2022, the region reported that it had identified 203 beds. These beds remain in place for 2023-24.

88 We found evidence that partners are investing their time heavily in facilitating timely flow, particularly within hospitals. Our observations of the discharge process at the Health Board's acute hospitals showed significant attention and resource being deployed to manage flow across the site. We observed a multitude of operational meetings including site manager meetings and ward rounds which take place several times a day and include a wide range of professionals. There are also various meetings between the Health Board and local authorities either daily or several times a week to escalate and manage delayed discharges in each of the areas.

89 Operationally, relationships between health and social care staff appeared to vary. Due to the high volume of complex discharges which require input from various professionals, health and social care staff are in very regular contact, and many told us they had positive working relationships. However, it was clear from our fieldwork that as problems with discharge delays have become more acute, there is increased tension in working relationships. Staff spoke of the pressure they face to get patients out of hospital, and how that can lead to a blame culture between health and social care wherein another professional or their organisation is seen as the cause of the delay. This blame culture, in turn creates a defensiveness which can have a negative impact on how staff interact with each other during the discharge process.

Use of funding

90 We found that **financial resources are being applied to improve discharge planning, however, there are some challenges with RIF funded schemes and an overall need to report more clearly on whether the funded initiatives have had the desired impact.**

91 The region makes use of the Health and Social Care Regional Integration Fund (RIF) to support schemes aimed to improve discharge planning. The RIF is a Welsh Government 5-year fund to deliver a programme of change from April 2022 to March 2027. The aim of the fund is to establish and mainstream at least six new national models of integrated care to provide a seamless and effective service for the people of Wales. Two contain a clear link to improving flow out of hospital for patients, namely: Home from Hospital Services; and Accommodation Based Solutions. There is a clear expectation within the RIF guidance that partners 'match fund' projects up to 50% by the end of year 5, with Welsh Government funding for each project tapering each year to allow for successful projects to become business as usual.

92 For 2022-23, the region received £32.5 million of RIF funding in total, some of which was ringfenced at a national level to support specific services including dementia. The RPB approved its regional 2022-23 RIF programme with allocations to each of the six models of care. The 2022-23 programme included 40 regional

schemes aligned to the six models of care. Five schemes related to Home from Hospital Services which received over £5.6 million in investment (including £261,650 match funded money) and four schemes related to Accommodation Based Solutions with over £1 million in investment (including £40,739 match-funded money). A small number of projects also continued previous Right-sizing Communities[19] work aimed at rebalancing care provision to meet demand. According to the RIF end of year report for 2022-23, partners contributed £13 million in total to schemes by way of match funding.

93 Although approved by the RPB, we found some limitations to the schemes that used RIF funding in 2022-23. For example, some schemes could be considered core services rather than new innovative projects, such as step-up beds, community resource teams and single point of access teams. We also found examples of schemes funded in 2022-23 which had previously been funded by the predecessor Integrated Care Fund in 2017-18. The continuous roll forward of schemes limits the potential to introduce new, innovative schemes to better manage demand. Those we spoke to explained that the requirement to match fund projects can create a reluctance to commit to new projects that will require match-funding in future years. In the context of the ongoing financial difficulties facing the partners in the region, they are finding it increasingly difficult to commit to future spending via new RIF projects.

94 The region submits financial information on how it is managing the RIF to Welsh Government each quarter and reports the latest position to its RPB meetings. At quarter three of 2022-23, the region was reporting slippage of £4.4 million. During our fieldwork we heard that it often takes longer to establish a project once it has been approved, including time to recruit, which can cause delays. We also heard that partners do not have an agreed process for utilising slippage, which is not covered by the national guidance. Some seek slippage to support community capacity in general, while others wish for slippage to be reallocated to existing successful projects for them to be expanded. Lack of an agreed process can be a cause of tension within the region and the risk that monies are not being used for their intended purposes.

95 The RIF Annual Report presents performance data for schemes, including the positive impact from two Home from Hospital schemes on 215 individuals[20]. Although the region has collected over 70 case studies highlighting the positive impact of funded schemes on individuals, these are not included in public reports submitted to the RPB or partner bodies. Incorporating these case studies would enhance transparency. Additionally, collaborative efforts between the Health Board

[19] Right-sizing communities refers to work to ensure that services are in line with true demand. It aims to ensure people are assessed in the most appropriate settings, that assessments are timely and are outcome focussed to maximise individual outcomes and patient flow.

[20] One scheme positively supported 146 individuals, and one scheme positively supported 69 individuals.

and local authorities outside the RPB structure focus on joint solutions for capacity, such as NHS-funded care homes and an integrated workforce. However, progress and impact of these initiatives are minimally reported within partner bodies.

Scrutiny and assurance

96 We found that **while there is regular monitoring within individual organisations, partners lack arrangements to oversee patient flow across the whole health and care system, embed learning and papers lack focus on the impact of activity.**

97 We reviewed the level of information that partners' committees, Board and Cabinet receive in relation to flow out of hospital and found a mixed picture. The Health Board monitors several indicators relating to urgent and emergency care and patient flow via the Board and, more specifically, the Performance, Finance, and Information Governance Committee, including:

- % of emergency ambulance responses to calls categorised as 'red' arriving within (up to and including) eight minutes;
- median time from a patient's arrival at an emergency department to triage by a clinician;
- % of patients who spend less than four hours in emergency units from arrival until admission, transfer, or discharge;
- number of patients who spent 12 hours or more in emergency units from arrival to admission, transfer, or discharge; and
- number of ambulance handovers over one hour.

98 Commentary within performance reports to the Committee provides additional information, such as numbers of medically fit patients remaining in a hospital bed. However, reports rarely discuss the differences between hospital sites. Reports do describe the actions that are in place across pathways to try and improve patient flow. The Committee also receives updates on Urgent and Emergency Care which include actions under the six goals programme. The Health Board's Partnerships, People and Population Health Committee routinely received updates relating to the work of the Regional Partnership Board during 2022. However, following the resignation of all the Health Board's previous Independent Members in February 2023, the committee was suspended, meaning that regular reporting of RPB activities to the Health Board was not received from March 2023. A new Planning, Population Health and Partnerships Committee has since been established and met for the first time in January.

99 Papers received by committees and Cabinets within the six local authorities contain many references to challenges related to social care aspects of patient flow. Performance reports contain indicators including the numbers of adults either accessing services or waiting to access services. More generally, papers often reference challenges in relation to lack of domiciliary care and care home provision. We found some instances of discussion within local authority papers of

the broader impact that lack of provision within social care and care homes has on patient flow. For example, Wrexham County Council's July and September 2023 meetings included updates on the challenges faced by Ysbyty Maelor Emergency Department and the activity underway to mitigate those challenges, including joint work between the Council and the Health Board.

100 Generally, however, partners' focus is on metrics and activity within their remit, rather than on the broader whole system picture. In addition, while we found evidence within some local authorities that they operationally monitor expenditure in relation to the RIF, we found little evidence of reporting of RIF schemes and their impact within the Board, Cabinet or committees of local authorities or the Health Board.

101 The RPB receives regular updates on RIF progress and periodic papers on key priority areas but does not receive regular operational performance reports. Consideration of performance reports would be valuable in understanding the impact of RIF activities on addressing long-standing performance challenges.

102 While partners generally have mechanisms to record key risks relating to delayed discharges, these again were very separate. Risks in relation to poor patient flow are documented within the Health Board with four tier one risks noted on the Corporate Risk Register, which includes a risk relating to the fragility of the independent sector, where activity taken with partners through the RPB is listed. There are also two strategic risks on the Health Board's Board Assurance Framework relating to the impact of poor flow on quality of care, safety, and patient experience. Challenges relating to aspects such as the fragility of the care home market and difficulty recruiting domiciliary care are documented on most local authority corporate risk registers. There is currently no mechanism for partners to agree and monitor shared risks in relation to delayed discharges. This is a weakness as it drives partners to focus on mitigating their own risks without consideration of how mitigation could impact on partners.

103 In line with the six goals for urgent and emergency care programme, the Health Board has established the Urgent and Emergency Care Board, chaired by the Executive Director of Operations[21]. This Board oversees the planning and delivery of the six goals programme, aiming to ensure collaborative planning and ownership among system-wide stakeholders. It replaces the previous six goals programme group which was in place prior to our fieldwork. Despite several requests to the Health Board, we were unable to observe the Board nor receive any relating documentation and as such, we were not able to review its effectiveness.

104 Various mechanisms exist within and between partners for monitoring and escalating issues related to discharge planning, but their effectiveness varies. Social services, in particular, use 'Adverse Discharge' forms to highlight poorly managed discharges. However, at Ysbyty Glan Clwyd, there was a lack of response to these forms, raising concerns about the accountability for discharge

[21] Previously the Executive Director of Clinical Services

planning at a corporate level for this hospital. The Health Board did not respond to our requests to clarify the arrangements for processing these complaints or the accountability for discharge planning at a corporate level for this hospital**.**

105 The region took part in several Multi Agency Discharge Events (MADE) in 2022, which aimed to improve patient flow by providing protected time for partners to jointly recognise and agree to address challenges collaboratively. Those we spoke to as part of our fieldwork indicated that MADE discussions provide valuable opportunities for partners to work together and focus their resources on ensuring effective discharges take place. However, we found that areas for improvement that are identified through these events are not consistently actioned, with service pressures seemingly causing partners to continue with existing behaviours and practices. This was demonstrated through reports from the November 2022 MADE which reiterated several key issues that had been raised in September 2022 but not actioned, such as needing to use a multi-agency discharge approach and to continually monitor performance.

What more can be done?

106 Whilst there is a clear recognition by regional partners of the problems associated with discharge, a desire to sort them out, the right focus within strategies and plans, and the use of funding targeted schemes, none of these have driven any significant or sustainable improvement in the overall position. Our work has found that there are several further actions that could be taken which would help improve timely and effective flow out of hospital across the region and reduce some of the challenges currently being experienced by the health and social care system. These actions are explored in the following exhibit and align with the recommendations that are set out earlier in the report.

Exhibit 11: further actions for partners to help tackle the challenges for patient flow out of hospital

Improving training and guidance	Having access to **jointly agreed guidance** which clearly sets out roles and responsibilities, and expectations around when and how staff should share information, including referrals, is vital to ensuring consistency between wards, hospitals, professions, and organisations. Offering a **comprehensive training programme** for everyone involved in patient flow, including bank and agency staff as well as new starters, also ensures guidance is embedded.

Improving compliance with policies and guidance	Having a **regular cycle of audit** to assess the effectiveness and consistency of the application of discharge policies and guidance, including the application of D2RA. **Minimising multiple referrals** and ensuring only those people who need the service are on waiting lists for reablement, home care packages and residential care, minimises inefficiencies resulting from inappropriate referrals and provides better outcomes for patients.
Ensuring patient safety while awaiting care packages	Having **clear communication processes** in place to notify social services staff when patients are discharged to minimise the risks that patients are discharged without services in the community being notified. Maintaining **regular communication with patients** awaiting packages of care once discharged home ensures that patients are safe whilst waiting and provides better outcomes.
Improving the quality and sharing of information	Having an improved **understanding of the range of community services** that could support effective and timely discharge and how these can be accessed, enables staff to make more informed decisions when planning for discharge. Having **clear and comprehensive information** within patient case-notes which sets out the actions being taken to support discharge, enables a clearer understanding of what is happening with a patient and supports effective discharge planning by all professionals involved in the care of patients whilst in hospital. Having **joined-up systems** that are accessible by all staff (regardless of organisation) involved in the care of individual patients enables effective and efficient methods of communication between organisations and supports effective flow out of hospital.
Addressing key gaps in capacity	Looking at joint solutions across sectors to **address key gaps** such as domiciliary care and reablement services would enable timelier discharge of patients' home.

Maximising the use of the Regional Integration Fund	The additional regional money provides opportunities to develop **innovative and transformational schemes** that can support effective and timely discharge. These opportunities are lost when the fund is used to support core services which should be mainstreamed. Having clear processes in place to **manage slippage RIF money** enables streamlined decision-making which is supported by all partners. Regularly considering **operational performance and capturing risks** at a regional level, enables more effective decision making across partners when considering how best to use the regional funding.
Improving oversight and impact	Ensuring that all initiatives being undertaken to support timely and effective flow out of hospital (both within and outside the Regional Partnership Board) and their associated impacts are **collated and reported openly**, minimises the risk of duplication and provides transparency.
Embedding learning from actions taken to address delayed discharges	**Building in time after learning events** such as the MADE to embed learning into day-to-day practice minimises the risk of repeatedly facing the same challenges and improves patient experience and outcomes. **Adverse incidents or concerns** provide an opportunity to learn from when things go wrong with respect to discharge planning. Having clear processes to ensure consistent reporting of adverse incidents and concerns, along with timely responses enables lessons to be learnt.

Appendix 1

Audit methods

Exhibit 12 sets out the methods we used to deliver this work. Our evidence is limited to the information drawn from these methods.

Exhibit 12: audit methods

Element of audit methods	Description
Documents	We reviewed a range of documents, including: • Board, Cabinet, and committee papers • Updates on the six goals programme and urgent and emergency care to committees • Operational and strategic plans relating to urgent and emergency care • RPB papers, including case studies • Standard Operating Procedure for discharge planning • Corporate risk registers • MADE reports
Interviews	We interviewed the following: • Hospital Directors, East and Central • Interim Director of Regional Delivery • Programme Director for Urgent and emergency care • Clinical Lead for Urgent and emergency care • Deputy Executive Medical Director • Business Planning and Improvement Manager • Health Board lead for Ysbyty Glan Clwyd improvement work. • Health Board lead on care homes • Operational Leads for Emergency Department, Ysbyty Gwynedd, Ysbyty Glan Clwyd and Ysbyty Maelor • Directors of Social Services for Isle of Anglesey, Gwynedd, Conwy, Denbighshire, Flintshire, and Wrexham • Heads of Social Services for Isle of Anglesey, Gwynedd, Conwy, Denbighshire, Flintshire, and Wrexham • Lead for Regional Partnership Board • Chief Officer North Wales Community Health Council

Element of audit methods	Description
Observations	We observed the following meeting(s): • North Wales Regional Partnership Board • North Wales Leadership Group • Health Board Performance, Finance, and Information Governance Committee We also observed the following individual(s): • Head of Nursing and Site Manager, Ysbyty Gwynedd • Progress Chaser and Home Hub Officer, Ysbyty Maelor • Site Manager and Home First Officer, Ysbyty Glan Clwyd
Data analysis	We analysed the following national data: • Monthly social services dataset submitted to the Welsh Government • Monthly delayed discharges dataset submitted to the NHS Executive • StatsWales data • Ambulance service indicators We also analysed data provided by the Health Board relating to all emergency medicine patients discharged in October 2022 with a length of stay greater than 21 days (excluding those who died)
Focus groups	We undertook focus groups with social workers from each of the local authority areas, except for Isle of Anglesey.
Case note review	We reviewed a sample of 32 case notes relating to emergency medicine patients discharged in October 2022 with a length of stay greater than 21 days (excluding those who died).

Appendix 2

Reasons for delayed discharges

The following exhibit sets out the reasons for delayed discharges in the Health Board compared to the all-Wales position.

Exhibit 13: reasons for delayed discharges as a percentage of all delays (February 2024)

Reason for delay	Percentage delayed	All-Wales average
Awaiting joint assessment	15.7	9.0
Awaiting social worker allocation	15.1	8.5
Awaiting completion of clinical assessment (nursing /allied health professionals / medical / pharmacy)	13.3	10.3
Awaiting start of new home care package	10.5	8.0
Awaiting completion of assessment by social care	5.6	15.7
Awaiting nursing home availability	4.6	2.6
Awaiting residential care home manager to visit and assess (Standard 3 residential)	4.6	2.5
Awaiting Elderly Mental Illness (EMI) residential availability	4.3	2.3
Awaiting residential home availability	4.3	2.8
Awaiting reablement care package	3.1	3.0
Awaiting health completion of assessment/provision for equipment	2.8	1.4
Awaiting EMI nursing availability	1.9	2.0
Awaiting funding decision (funded nursing care (FNC) / continuing health care (CHC))	1.5	1.5
Awaiting completion of arrangements prior to placement	0.9	3.5
Awaiting funding decision	0.9	0.8
Awaiting nursing care home manager to visit and assess (Standard 3 residential)	0.9	2.1
Awaiting specialist bed availability	0.9	1.1
No suitable abode	0.9	2.3
Patient / family refusing to move to next stage of care/ discharge	0.9	1.6

Source: Welsh Government

DRAFT

Note: where the reasons for delay relate to two or less patients, these have been excluded to minimise any risk of identifying individual patients.

Top five reasons for delayed discharges by local authority

The following exhibits set out the top five reasons for delayed discharges for each of the local authorities compared to the Health Board wide and all-Wales position.

Exhibit 14: top five reasons for delayed discharges as a percentage of all delays (February 2024) – Conwy

Reason for delay	Percentage delayed	Health Board average	All-Wales average
Awaiting completion of clinical assessment (nursing / allied health professional / medical / pharmacy)	25.5	13.3	10.3
Awaiting health completion of assessment/ provision for equipment	12.8	2.8	1.4
Awaiting residential care home manager to visit and assess (Standard 3 residential)	12.8	4.6	2.5
Awaiting joint assessment	8.5	15.7	9.0
Awaiting start of a new home care package	6.4	10.5	8.0

Source: Welsh Government

Exhibit 15: top five[22] reasons for delayed discharges as a percentage of all delays (February 2024) – Denbighshire

Reason for delay	Percentage delayed	Health Board average	All-Wales average
Awaiting joint assessment	18.8	15.7	9.0
Awaiting residential care home manager to visit and assess (Standard 3 residential)	15.6	4.6	2.5
Awaiting completion of clinical assessment (nursing / allied health professional / medical / pharmacy)	12.5	13.3	10.3

Source: Welsh Government

[22] All other reasons related to two or less patients

Exhibit 16: top five reasons for delayed discharges as a percentage of all delays (February 2024) – Flintshire

Reason for delay	Percentage delayed	Health Board average	All-Wales average
Awaiting social worker allocation	20.4	15.1	8.5
Awaiting joint assessment	18.5	15.7	9.0
Awaiting completion of clinical assessment (nursing / allied health professional / medical / pharmacy)	16.7	13.3	10.3
Awaiting start of new home care package	11.1	10.5	8.0
Awaiting completion of assessment by social care	5.5	5.6	15.7

Source: Welsh Government

Exhibit 17: top five reasons for delayed discharges as a percentage of all delays (February 2024) – Gwynedd

Reason for delay	Percentage delayed	Health Board average	All-Wales average
Awaiting joint assessment	15.7	15.7	9.0
Awaiting start of new home care package	15.7	10.5	8.0
Awaiting nursing home availability	13.7	4.6	2.6
Awaiting social worker allocation	9.8	15.1	8.5
Awaiting EMI residential availability	7.8	4.3	2.3

Source: Welsh Government

Exhibit 18: top five reasons for delayed discharges as a percentage of all delays (February 2024) – Isle of Anglesey

Reason for delay	Percentage delayed	Health Board average	All-Wales average
Awaiting joint assessment	22.7	15.7	9.0
Awaiting social worker allocation	18.2	15.1	8.5
Awaiting completion of clinical assessment (nursing / allied health professional / medical / pharmacy)	11.4	13.3	10.3
Awaiting completion of assessment by social care	9.1	5.6	15.7
Awaiting start of new home care package	9.1	10.5	8.0

Source: Welsh Government

Exhibit 19: top five reasons for delayed discharges as a percentage of all delays (February 2024) – Wrexham

Reason for delay	Percentage delayed	Health Board average	All-Wales average
Awaiting social worker allocation	21.6	15.1	8.5
Awaiting joint assessment	13.4	15.7	9.0
Awaiting completion of clinical assessment (nursing / allied health professional / medical / pharmacy)	11.3	13.3	10.3
Awaiting start of new home care package	11.3	10.5	8.0
Awaiting completion of assessment by social care	6.2	5.6	15.7

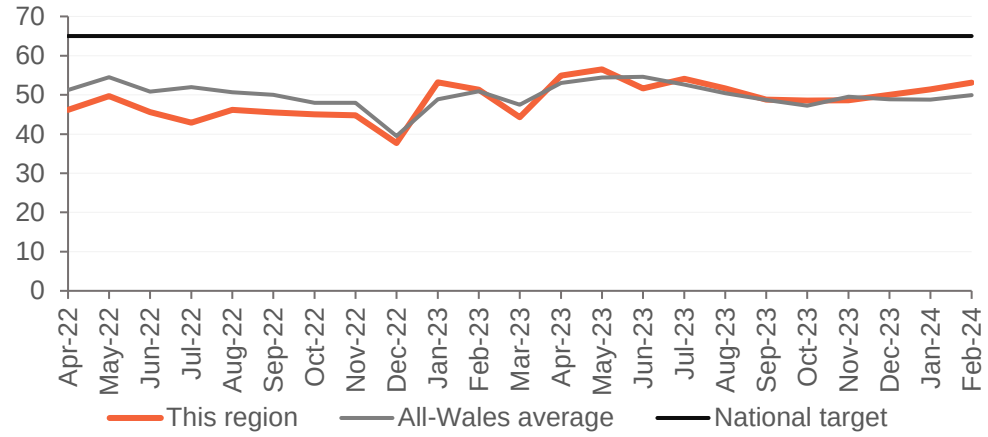
Source: Welsh Government

Appendix 3

Urgent and emergency care performance

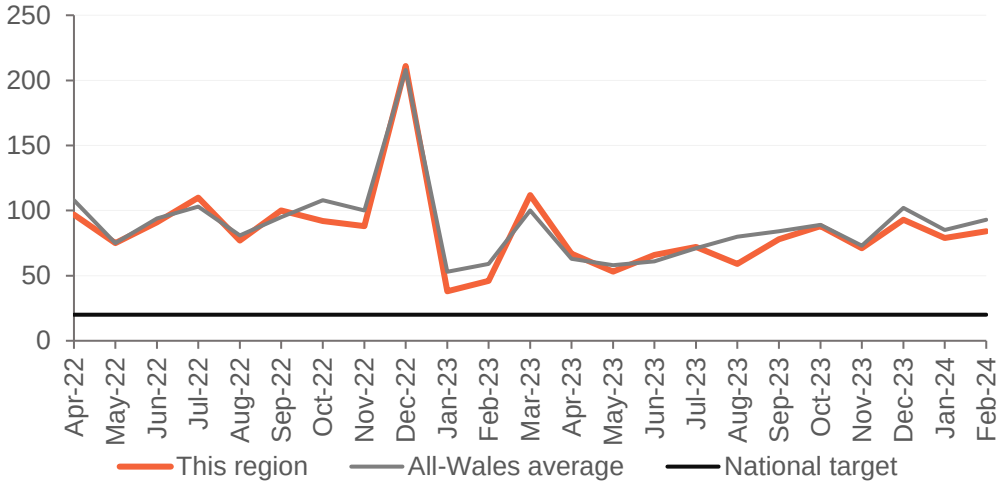
The following exhibits set out the region's performance across a range of urgent and emergency care performance indicators in comparison to the position across Wales since April 2022.

Exhibit 20: percentage of emergency responses to red calls arriving within (up to and including) 8 minutes – national target of 65%



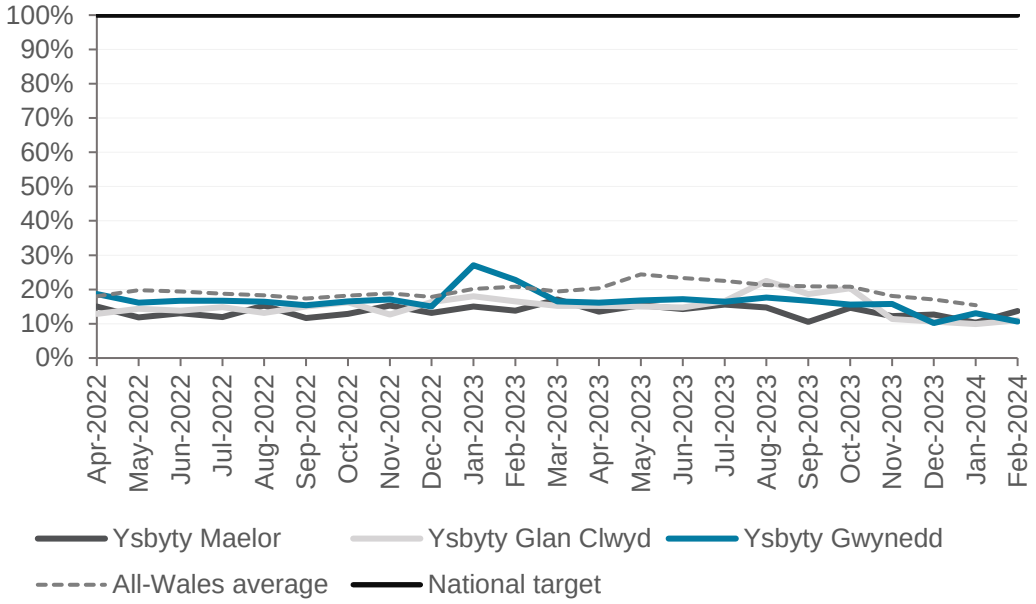
Source: Ambulance Services Indicators

Exhibit 21: median response time for amber calls (minutes) – 50th percentile – national target of 20 minutes



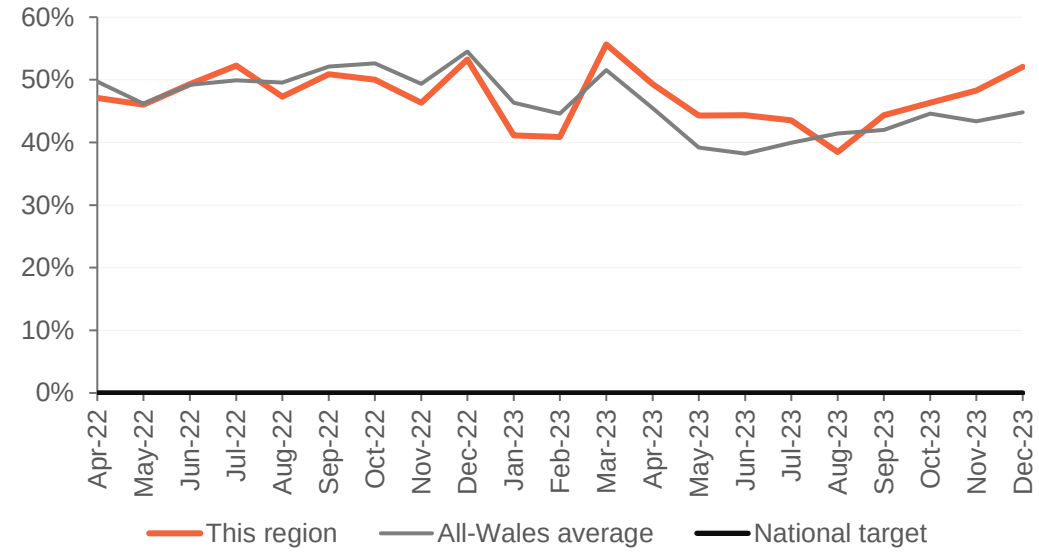
Source: Ambulance Services Indicators

Exhibit 22: percentage of ambulance handovers within 15 minutes at a major emergency department – national target of 100%



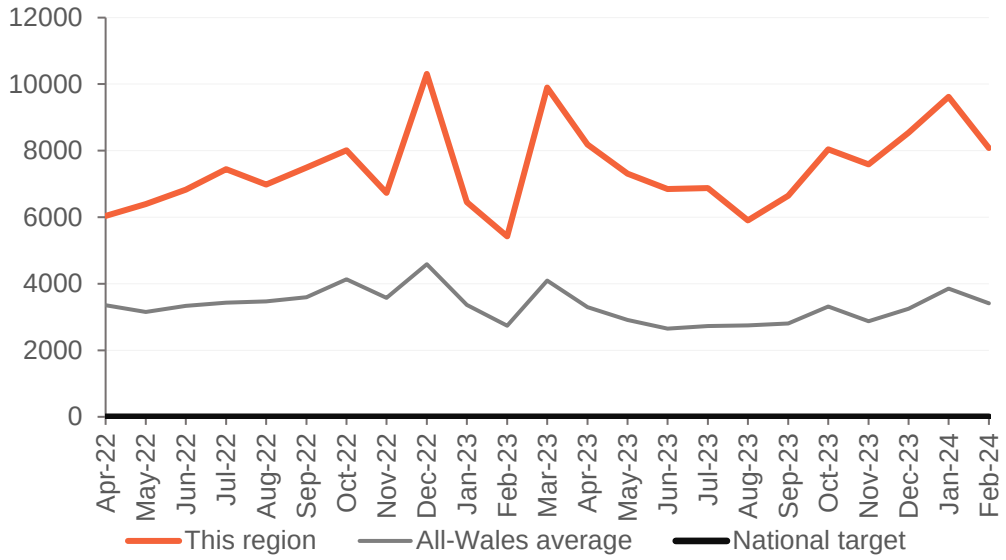
Source: Welsh Ambulance Services NHS Trust

Exhibit 23: percentage of ambulance handovers over 1 hour – national target of zero



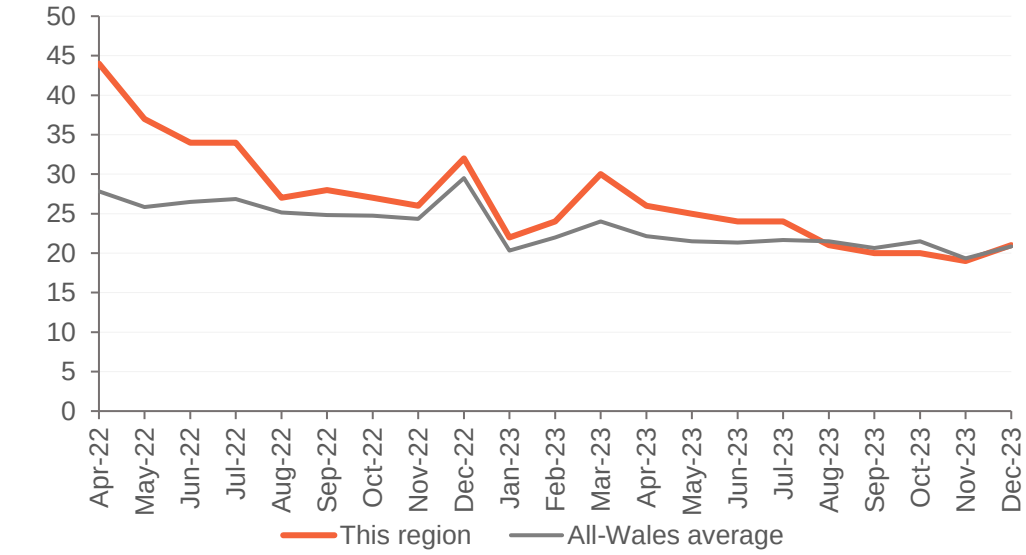
Source: Ambulance Services Indicators

Exhibit 24: total number of hours lost following notification to handover over 15 minutes



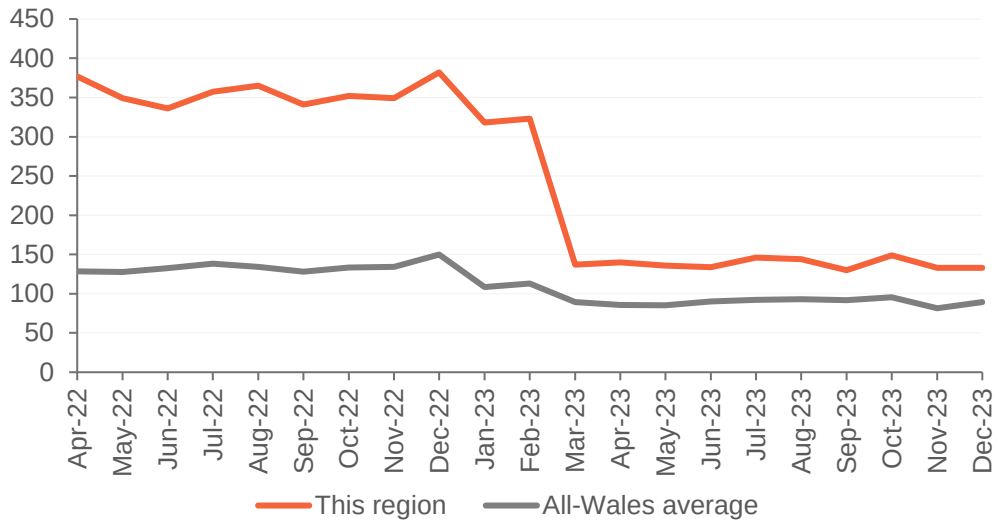
Source: Ambulance Services Indicators

Exhibit 25: median time (minutes) from arrival at an emergency department to triage by a clinician) – national target of 12-month reduction



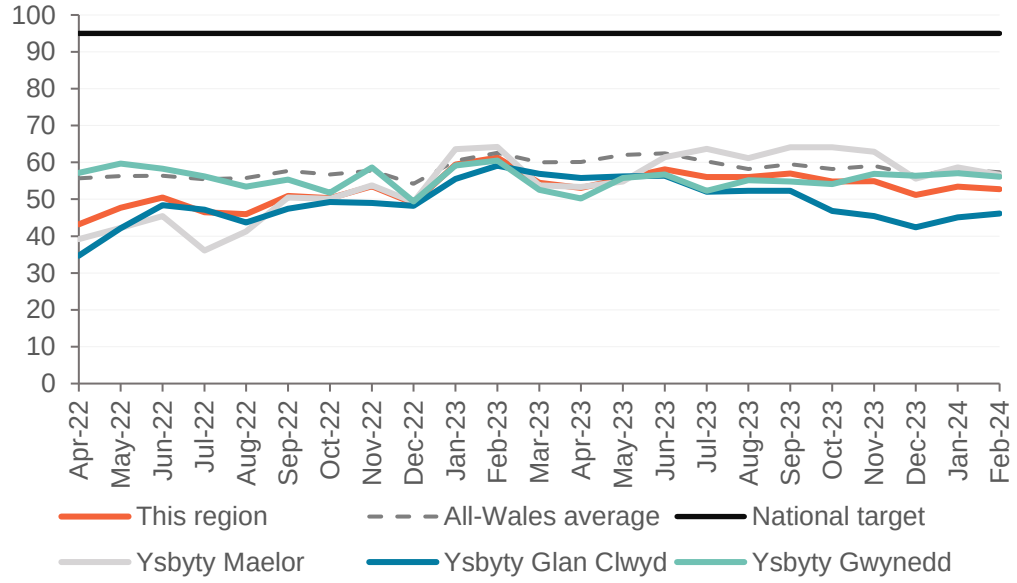
Source: StatsWales

Exhibit 26: Median time (minutes) from arrival at an emergency department to assessment by senior clinical decision maker – national target of 12-month reduction



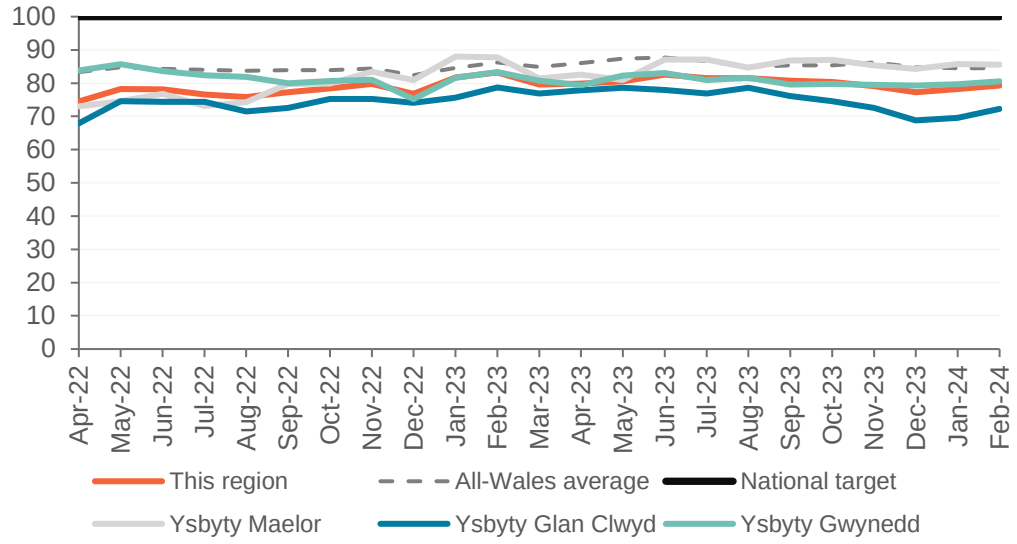
Source: StatsWales

Exhibit 27: Percentage of patients spending less than four hours in a major emergency department – national target of 95%



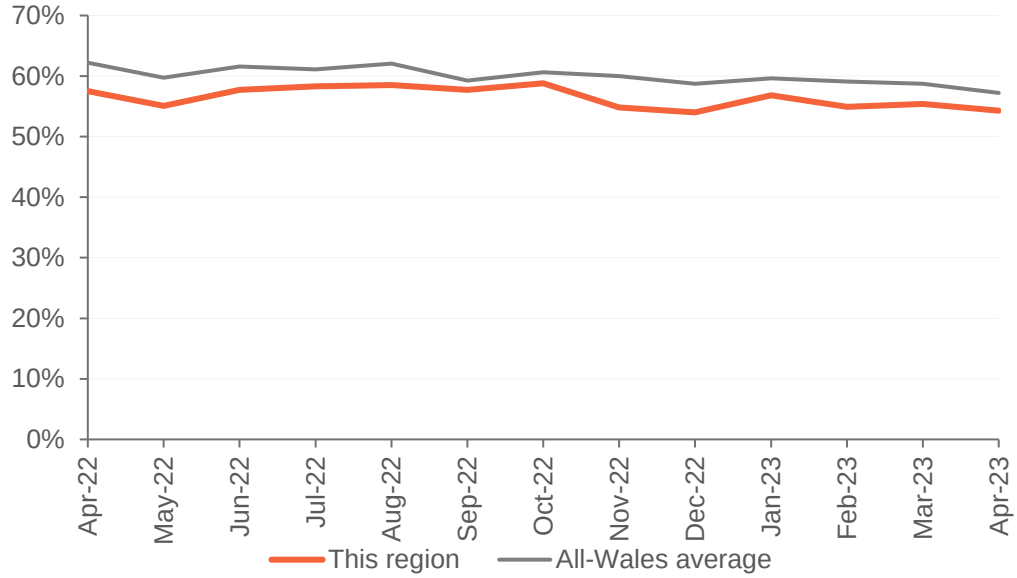
Source: StatsWales

Exhibit 28: Percentage of patients spending less than 12 hours in a major emergency department – national target of 100%



Source: StatsWales

Exhibit 29: Percentage of total emergency bed days accrued by people with a length of stay over 21 days – national target of 12-month reduction



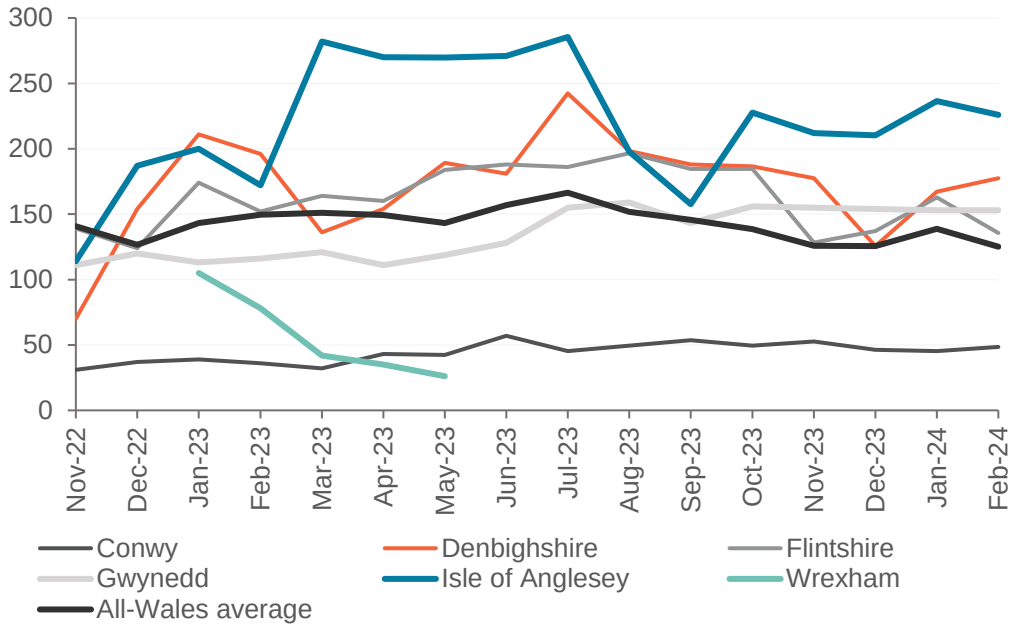
Source: StatsWales

Appendix 4

Waits for social care assessments and care packages

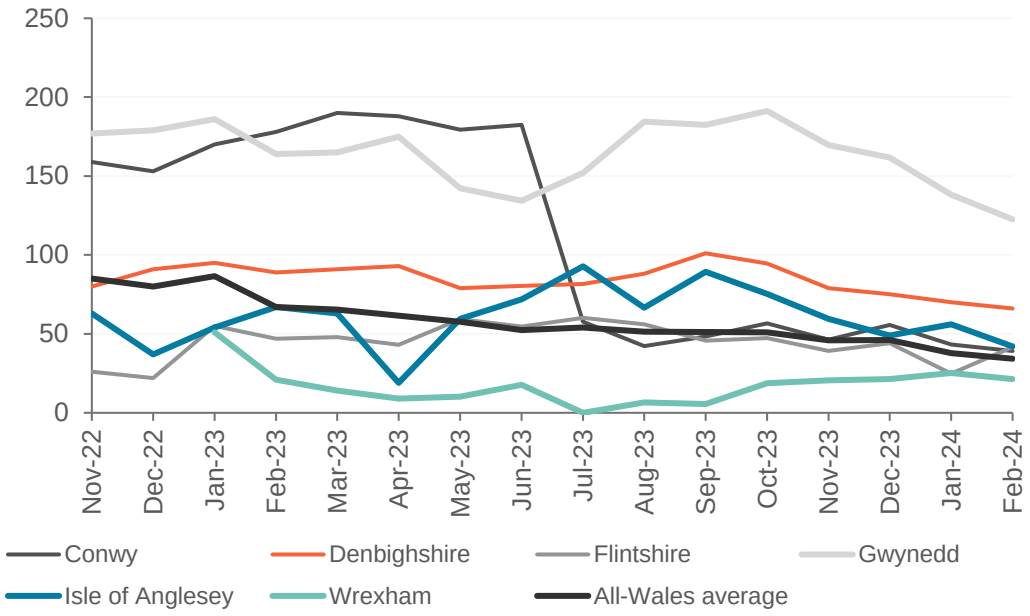
The following exhibits set out the region's waits performance for social care assessment and receipt of a range of care packages in comparison to the position across Wales since November 2022.

Exhibit 30: number of adults waiting for a social care assessment (per 100,000 head of population)



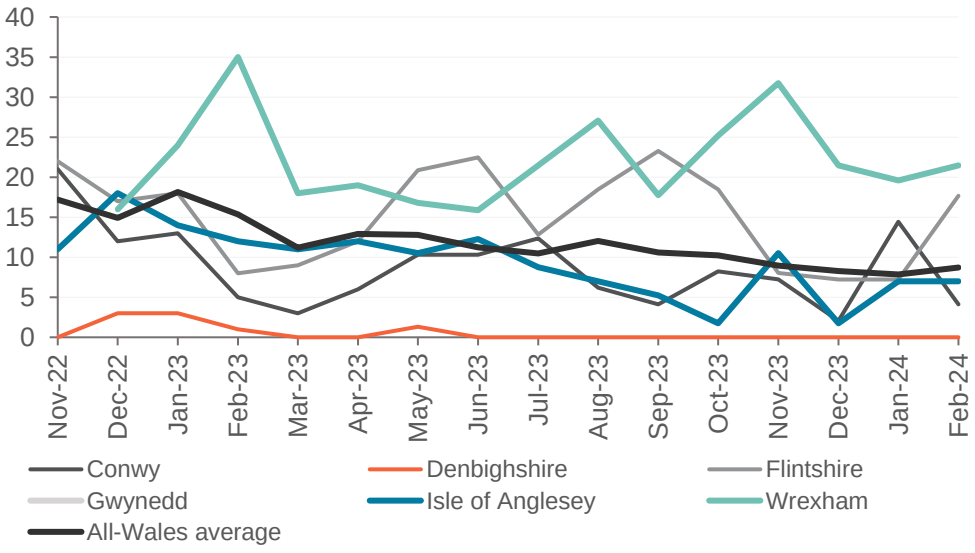
Source: Welsh Government

Exhibit 31: number of adults waiting for domiciliary care (per 100,000 head of population)



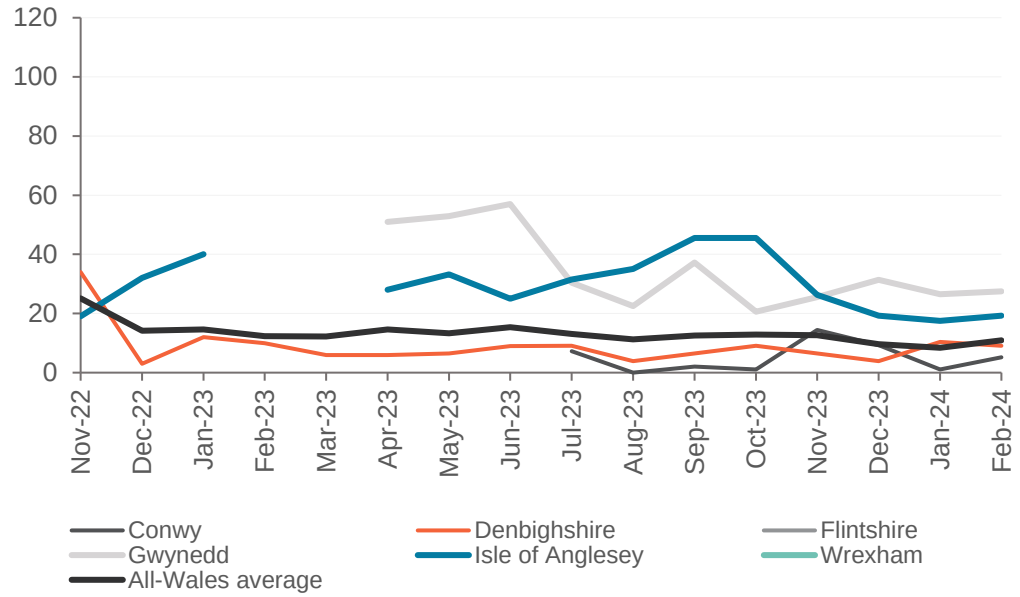
Source: Welsh Government

Exhibit 32: number of adults waiting for reablement (per 100,000 head of population)



Source: Welsh Government

Exhibit 33: number of adults waiting for long-term care home accommodation (per 100,000 head of population)



Source: Welsh Government

Appendix 5

Combined organisational response to audit recommendations

Exhibit 34: combined organisational response

Recommendation	Organisational response	Completion date	Responsible officer
Improving training and guidance R1 The Health Board, working with local authorities, should develop jointly agreed guidance to provide clarity to all staff on how the discharge planning process should work across the region. This should be based on the national guidance issued in December 2023 and should set out clearly defined roles and	**Sub-regional:** The national guidance document will be utilised to create a summary of the key considerations. This summary will provide a reference to the full document on-line and refer to additional support and guidance available for specific circumstances such as when Best Interest Decisions are required which has been a focus of recent activity. The guidance will focus on the imperative for effective MDT and	July 2024	Community Services Transformation Mgr, East IHC.

Recommendation	Organisational response	Completion date	Responsible officer
responsibilities, and expectations, including when referrals for ongoing care should be made.	multi-agency working and incorporate references to support avoidance of adverse discharges. Central Denbighshire Conwy and Flintshire County Council and BCUHB will work together to develop a guidance adhering to the national guidance, in line with optimal patient Flow. Considering any existing guidance that may already be in place across BCUHB to support consistency across the Health Board with pathway of care delay reporting. Ynys Môn Council, Cyngor Gwynedd, and BCUHB West will further develop such a guidance adhering to the national guidance, having considered existing guidance that may already be in place in other parts of north Wales. Building upon existing arrangements the Local Authorities and Health Board will share all new guidance on transfer of care from hospitals to home. This will be an integral part of the development in response to R1 above.		

Recommendation	Organisational response	Completion date	Responsible officer
R2 The Health Board and local authorities should ensure processes are in place to communicate discharge planning guidance to all relevant health and social services staff, including those working on a temporary basis, supported by an ongoing programme of refresher training and induction training for new staff.	**Sub-regional:** The East area guidance document referred to in relation to R1 will be: • Distributed to all social workers who support discharge planning in Wrexham and Flintshire • Incorporated into return to work discussions, supervision and other management approaches to ensure that team members are informed by the most up to date guidance. • Guidance will be referenced in induction information and staff bulletins and similar. • Home First leads will provide a constant reminder to all key staff members within East Area hospitals who support and lead on discharge planning. • Opportunities explored to include guidance within training programme for all staff including wider teams such as Safeguarding and Commissioning.	From August / Sept 2024	Senior Manager for Adults FCC, Heads of Service for Older People WCBC, Associate Directors, Community Services BCUHB East

Recommendation	Organisational response	Completion date	Responsible officer
	Building upon existing arrangements and those noted previously, the Local Authorities (East, Central & West) and Health Board will share all new guidance on transfer of care from hospitals to home. This will be an integral part of the development in response to R1 above.		
Improving compliance with policies and guidance R3 The Health Board should embed a regular cycle of audit to assess the effectiveness and consistency of the application of discharge policies and guidance, including the application of D2RA.	**Health Board:** Draft revised BCUHB Hospital Discharge policy has been developed to replace the Covid discharge requirements. The revised draft policy will be presented through the Health Board's governance process for approval, this will include a consultation period on the BCUHB website and sign off by relevant Health Board committee. Other supporting documentation including Choice & Reluctant Discharge Guidance and Criteria Led discharge is	September 2024	Acting Assistant Director – Care Homes Support & CHC Commissioning

Recommendation	Organisational response	Completion date	Responsible officer
	also being reviewed as part of this review of discharge documentation. As part of the discharge policy an audit cycle will be agreed and implemented	December 2024	
R4 The Health Board should establish controls to prevent staff adding patients to multiple waiting lists, such as for reablement, home care packages and residential care to facilitate a speedy discharge, regardless of need. This will ensure that only those who need the services are on the relevant waiting lists.	**Health Board:** As part of the D2RA Audit plan Management establish formal overarching policy or Standard Operating Procedure to support the operational management and controls to prevent patients on multiple waiting lists	December 2024	Acting Assistant Director – Care Homes Support & CHC Commissioning

Recommendation	Organisational response	Completion date	Responsible officer
Ensuring patient safety while awaiting care packages R5 The Health Board should ensure processes are in place to notify social services before patients are discharged home, where those patients require ongoing support in their own home, and where such support is not in place at the time of discharge.	**Health Board:** Review of process and ensure this is included in the Discharge SOP	December 2024	Acting Assistant Director – Care Homes Support & CHC Commissioning
R6 The Health Board and local authorities should ensure mechanisms are in place to regularly monitor patients who are discharged home without arranged ongoing social	**Sub-regional:** Where appropriate and capacity allows, Home First support patients with an assessed need for a package of care who	On-going	Head of Nursing, Community. Senior Manager for Adults

Recommendation	Organisational response	Completion date	Responsible officer
care and to escalate issues to the appropriate service where necessary.	are awaiting the start of an arranged POC as a bridging the gap Where family/friends provide short term support or where patients self-discharge, telephone numbers are provided to report escalated needs. All people with assessed needs will have a point of contact once home and will be supported as soon as capacity is available. If individuals are transferred home from hospital without an assessment and required care package in place, the Local Authorities will monitor those situations. Completing adverse discharge form where required to support Learning across the services and improved patient journey cross ref R16	June 2024 On-going	Heads of Service for Older People
Improving the quality and sharing of information	**Sub-regional:**	On-going	BCU Associate Directors

Recommendation	Organisational response	Completion date	Responsible officer
R7 The Health Board and local authorities should ensure that all relevant staff across each organisation has consistent access to up-to-date information on services available in the community that support hospital discharge. This will ensure that opportunities to discharge earlier with support from services beyond social care are not missed.	Dewis as the central point of information will continue to be promoted across all organisations. Guidance developed in response to R1 will refer to the fact that there are a broad range of community-based support on discharge and where to find information – direct to Dewis Councils operating sub-regionally operating together with the Health Board share such information on a regular basis via integrated working within the SPOA's of the Community Resource Teams, clinically optimised and length of stay and will continue to do so.	July 2024 On-going	Community Services and LA Heads of Service for Older People.
R8 The Health Board should improve record keeping by: a. ensuring all staff involved in discharge planning fully understand the importance of documenting	**Health Board:** As noted in R3, a draft revised BCUHB Hospital Discharge policy has been developed to replace the Covid discharge requirements.	September 2024	Acting Assistant Director – Care Homes Support & CHC Commissioning

Recommendation	Organisational response	Completion date	Responsible officer
comprehensive information in patient case-notes to support effective discharge planning. b. establishing a programme of case-note audits focused on the quality of record keeping.	The revised draft policy will be presented through the Health Board's governance process for approval, this will include a consultation period on the BCUHB website and sign off by relevant Health Board committee. Other supporting documentation including Choice & Reluctant Discharge Guidance and Criteria Led discharge is also being reviewed as part of this review of discharge documentation As part of the discharge policy an audit cycle will be agreed and implemented	December 2024	
R9 The Health Board and local authorities should implement ways in which information can be shared more effectively, including	**Sub-regional:**	October 2024	Heads of Services for Older People

Recommendation	Organisational response	Completion date	Responsible officer
opportunities to provide wider access to organisational systems and ultimately joint IT solutions.	Cyngor Sir Ynys Môn, Cyngor Gwynedd and the Health Board already have an information sharing pilot in place awaiting evaluation. Conwy, Denbighshire & Flintshire local authorities and the Health Board have a WASPI in place since the implementation of the SPOAs Further work required to improve information sharing on presentation in ED due to organisational systems not available to all. An integrated information sharing systems.is required to support this Central Area will consider how this can be incorporated into the scope of the new Connecting Care procurement process Seek options for Home First to be able to access Council WCCIS system in the East.	October 2024	Director of Allied Health Professionals

Recommendation	Organisational response	Completion date	Responsible officer
	Revisit schedule of multi-agency meetings to verify that those contact points achieve a shared position re updates on discharge planning as part of the ongoing Home First Review in the East Consider how the use of STREAM is consistently updated with potential for local authority access Actively seek ways to increase local authority access for systems held within BCUHB.		
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	**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	On-going	Leadership Group

Recommendation	Organisational response	Completion date	Responsible officer
discharge of patients to their own home.	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.		
Maximising the use of the Regional Integration Fund R11 The Health Board and local authorities, through the Regional Partnership Board (RPB), should	**Regional Partnership Board:** RPB and partners continue to make progress to mainstream long standing schemes funded through RIF. In 2023/24 there was £16.9m of investment in mainstreamed schemes.	On-going	Regional Head of Collaboration

Recommendation	Organisational response	Completion date	Responsible officer
demonstrate how it is working to increasingly mainstream long-standing schemes funded through RIF which are considered core services.			
R12 The Health Board and local authorities, through the Regional Partnership Board, should agree a process for utilising any future RIF slippage monies, ensuring that appropriate value and benefit is obtained from such spending.	**Regional Partnership Board:** The importance of appropriate use of slippage has been acknowledged and in response the *'Change Notification'* process was developed. The process is being audited and will be reviewed by the RPB's Leadership Group. RIF Change Notification Template	On-going. Process to be reviewed Autumn 2024	Regional Head of Collaboration

Recommendation	Organisational response	Completion date	Responsible officer
R13 To help inform decision-making and discussions, the Health Board and local authorities should: a. ensure that the Regional Partnership Board has routine access to key performance indicators relevant to effective and timely flow out of hospital, including urgent and emergency care performance within the Health Board and waiting lists for social services and care packages; and	**Regional Partnership Board:** Quarterly data re: flow out of hospital to be presented to the RPB's Leadership Group (inclusive of IHC Directors)	On-going quarterly	Regional Head of Collaboration / Assistant Director – Care Homes Support & CHC Commissioning

Recommendation	Organisational response	Completion date	Responsible officer
b. use the Regional Partnership Board working arrangement to develop a regional risk register which pulls together the risks associated with delayed discharges.	Risk register related to delayed discharges to be completed and presented to RPB twice annually	October / April annually	Regional Head of Collaboration
Improving oversight and impact R14 The Health Board and local authorities should ensure that information setting out progress with significant activities and initiatives being undertaken to support effective and timely discharge is routinely available at a corporate and partnership level. This should include	**Sub-regional:** The Pan Cluster Planning Group will become the leadership group to oversee partnership activity in this regard in the East. In addition to circulation of Key Performance Indicators outside of meetings (e.g Pathway of Care Delays Census Information), a standing item will be added to each agenda to consider current position, trends and responses required.	From September 2024 onwards	PCPG Chair

Recommendation	Organisational response	Completion date	Responsible officer
activities and initiatives undertaken individually and jointly, both within and outside of the RPB structure, their impact and how they collectively contribute to addressing the challenges. This will help to provide assurance that resources are being invested to best effect.	Regular reporting mechanisms and performance and progress monitoring across the Local Authorities and Health Boards to continue with added focus in the West & Central. This information is also considered at strategic integrated planning meetings. Work is ongoing to improve data analysis and reporting in order to provide further assurance across Local Authority governance.		
Embedding learning from actions taken to address delayed discharges R15 The Health Board and local authorities should ensure that mechanisms are in place to	**Regional Partnership Board:** Aligned to R13. and the associated work, regular learning events and sharing of good practice to be considered regularly.	Quarterly – on-going	Head of Regional Collaboration / Assistant Director – Care Homes

Recommendation	Organisational response	Completion date	Responsible officer
implement learning from actions taken to address delayed discharges, such as the Multi Agency Discharge Events (MADE), and to maintain regular oversight to ensure the learning is being implemented.			Support & CHC Commissioning
R16 The Health Board should strengthen escalation arrangements for reporting adverse incidents or concerns relating to discharge by: a. addressing any outstanding adverse incidents or concerns, communicating clearly with the relevant local authority; and	**Health Board:** Each IHC to establish an Adverse Discharge Group with clear ToRs Hold Discharge webinars with Care Homes across each IHC to improve communication and build trust between Health and Providers	October 2024	Acting Assistant Director – Care Homes Support & CHC Commissioning

Recommendation	Organisational response	Completion date	Responsible officer
b. ensuring a consistent approach to reporting adverse incidents and concerns relating to discharge is in place across the Health Board.			

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