Bundle Audit Committee 17 December 2020

1 10:00 - OPENING BUSINESS - OPEN SESSION

1.1 10:01 - AC20.85: Apologies for Absence

1.2 10:02 - AC20.86: Declarations of Interest

1.3 10:03 - AC20.87: Procedural Matters

1. To confirm the Minutes of the last meeting of the Committee held on 17/09/20 as a correct record (appendix a) and to discuss any matter arising; and
2. review the Summary Action Log (appendix b)
3. note the details of breaches to the Standing Orders (appendix c)
4. note that the Clinical Audit Annual report was approved at the Joint Audit & Quality, Safety & Experience Committee (JAQS)
5. note Chair's Action in respect of the deferment of the Internal Audit Leaver Management Review
6. note the Joint Chair's Action in respect of the COVID-19 Cabinet Terms of Reference
7. note the Audit Wales consultation which invites views and comments on proposals for fee rates and other aspects of the statutory fee regime for audit work. Following the consultation, Audit Wales will submit a Fee Scheme 2021-22 for consideration by the Senedd Finance Committee early in 2021.
8. approve the amended Terms of Reference for the Remuneration & Terms of Service Committee. (appendix d)
9. note Chair's Action in respect of the approval of the following Committee Annual Reports:

** Mental Health Act Committee (including an overview of the work of the Power of Discharge Sub-Committee) (appendix e)*
** Digital and Information Governance Committee (appendix f)*
** Local Partnership Forum (appendix g)*

AC20.87a: PUBLIC_Draft Minutes_Audit Committee_17.09.20_V0.01.docx

AC20.87b: Public Summary Action Log_Audit Committee_live.docx

AC20.87d: RATS ToR V6.02 Draft 6 10 20 awaiting approval.docx

AC20.87c: Breach log extract_.docx

AC20.87e: MHA Committee Annual Report V1.0 2019-2020.docx

AC20.87f: DIG Committee Annual Report V1.0 2019-2020.docx

AC20.87g: LPF Annual Report 2019-20 v1.0.docx

1.4 10:13 - AC20.88: Issues Discussed in Previous Private Session

The Audit Committee is asked to note the report on matters previously considered in private session.

AC20.88: Private Session Items Reported in Public_Dec_20.docx

2.0 10:14 - AC20.89: Chair's Assurance Report: Risk Management Group

The Audit Committee is asked to note the Risk Management Group (RMG) Chair's Assurance Report

AC20.89: RMG Committee Chair's Assurance Report (1) - RMG 30-Nov-2020.docx

2.1 10:24 - AC20.90: Board Assurance Framework and Corporate Risk Register

The Audit Committee is asked to:

1. Review and note the progress on the management of the BAF and Corporate Tier 1 Operational Risks (appendix a and b)
2. Approve the Board Assurance Framework format for submission to the Board for ratification (appendix c)

AC20.90a: BAF and CRR Report for AC - v1.2.docx

AC20.90c: Appendix 1 BAF 2020-21-as at 7 December 2020-v0.5.xlsx

AC20.90b: Appendix 2 - Corporate Risk Register Report.docx

3.0 10:54 - AC20.91: Internal Audit Progress Report

The Audit Committee is asked to:

1. Receive the progress report and Internal Audit Plan 2020/21 - to complete (appendix a and b);
2. Approve the deferment of the reviews listed in the report;
3. Receive and discuss the following Limited Assurance report:

** Delivery of Savings - Ysbyty Glan Clwyd Hospital (appendix c)*
** NHS Wales Staff Survey (appendix d)*
** Recruitment - Medical and Dental Staff (appendix e)*
** Quality Impact Assessment (appendix f)*

AC20.91: Internal Audit Committee cover sheet November 2020.docx

AC20.91a: Internal Audit progress report December 2020.docx

AC20.91b: Internal Audit Plan to Complete Paper 271120.docx

AC20.91c: Final Internal Audit Report - Delivery of Savings Ysbyty Glan Clwyd Hospital.pdf

AC20.91d: Final Internal Audit Report Staff Survey.pdf

AC20.91e: Final Internal Audit report Recruitment - Medical and Dental staff.pdf

AC20.91f: Final Internal Audit Report - Quality Impact Assessment.pdf

3.1 11:24 - AC20.92: Audit Wales Update Report

The Audit Committee is requested to:

1. Receive the programme update (appendix a)
2. Receive and discuss the Structured Assessment 2020 report (appendix b)
3. Receive and discuss the Annual Audit Report (appendix c)
4. Receive and discuss the Review of Continuing Healthcare Management Arrangements (appendix d)
5. Receive and discuss the Welsh Community Care Information System report (appendix e)
6. Verbal update On North Wales Pooled Fund Report from Acting Executive Director of Finance

AC20.91: Audit Wales Coversheet - Audit Wales.docx

AC20.91a: Audit Wales Update Dec 2020.pdf

AC20.91b: Audit Wales_BCU_structured_assessment_final.pdf

AC20.91c: Audit Wales Annual Audit Report.pdf

AC20.91d: Audit Wales_BCU_CHC_report_Final.pdf

AC20.91e: Audit Wales_Welsh Community Care Information System.pdf

4.0 11:54 - AC20.93: Financial Governance during Covid-19 Update Report

The Committee is asked to:
a) Note the level of collaborative work undertaken through the Financial Governance Cell to date
b) Note the planned next steps, through the establishment of a Financial Improvement Group.

AC20.93: financial governance update docx.docx

AC20.93a: Financial governance self assessment COVID19 Updated Review.docx

5.0 12:09 - AC20.94: Charitable Funds Annual Report and Accounts

The Audit Committee is asked to receive the Charitable Funds Annual Report and Accounts

AC20.94: Charity Annual Report and Accounts 2019-20 - Paper for Audit Committee.docx

AC20.94a: FINAL_Annual Report 2019_20_compressed.pdf

6.0 12:19 - AC20.95: Schedule of Financial Claims

The Audit Committee is asked to receive this report for assurance.

AC20.95: Front Sheet Claims Report - Over 50k Spend Closed Q2 2020-21.docx

AC20.95a: Closed Claims Over 50k Spend - Q2 2020-21 FINAL.xlsx

7.0 12:34 - AC20.96: Ablett Redevelopment Report

That the Committee note:-

(1) the Capital Investment Group which has met twice and will provide monthly reports to the Executive Team and specifically highlight any changes in assumptions etc. or any schemes that might be off track;

(2) the role of Senior Responsible Owners has been clarified by the Executive Team and SRO reporting into the Executive Team is being formalised;

(3) that the Finance and Performance Committee has reverted to having a standing agenda item on progress against approved capital projects; and

(4) that any future planning consultations will specifically be drawn to the attention of Board Members well in advance of their publication, in the same way as service consultations.

AC20.96: Ablett Redevelopment V1.0.docx

8.0 12:54 - AC20.97: Performance & Accountability Framework

The Audit Committee are asked to:

1. note the implementation of the Performance and Accountability Framework;
2. review the impact and effectiveness of the framework in September 2021.

AC20.97: Performance and Accountability Framework coversheet.docx

AC20.97a: Performance and Accountability Framework 1.09 - final.docx

9.0 13:14 - AC20.98 Clinical Audit Plan

The Audit Committee is asked to approve the draft 2020/21 Clinical Audit Plan for BCUHB.

AC20.98: Clinical Audit plan 2021 DEC 2020.docx

AC20.98a: Clinical Audit Plan 2020-21_Appendix 1.pdf

10.0 13:34 - AC20.99: Issues of Significance for reporting to Board

10.1 13:35 - AC20.100: Date of Next Meeting: 18/03/21

10.2 13:35 - AC20.101: Exclusion of Press and Public and Short Recess

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."

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

AUDIT COMMITTEE PUBLIC MEETING DRAFT

Minutes of the Meeting Held on 17.09.20

Via WebEx - the Health Board has determined that the public are excluded from attending the Committee's meeting in order to protect public health

Present	
Richard Medwyn Hughes	Independent Member (Chair)
Eifion Jones	Independent Member
Jacqueline Hughes	Independent Member
Lyn Meadows	Independent Member

In Attendance	
Mike Buckle	Assistant Director of North Wales Dental Services (for Minute AC20.73)
Andrew Doughton	Performance Audit Lead, Audit Wales
Sue Green	Executive Director of Workforce and Organisational Development (for Minute AC20.71)
Dave Harries	Head of Internal Audit, NWSSP
Debra Hickman	Acting Executive Director, Nursing & Midwifery (for Minute AC20.71)
Sue Hill	Acting Executive Director of Finance
Amanda Hughes	Audit Manager, Audit Wales
Matt Joyes	Acting Associate Director of Quality Assurance (for Minute AC20.69)
Justine Parry	Assistant Director of Information Governance & Risk (for Minute AC20.68)
Dawn Sharp	Acting Board Secretary
Wendy Welsh	Deputy Head of Internal Audit (intermittent attendance due to network/IT issues)
Bethan Wassell	Statutory Compliance, Governance & Policy Manager
Karl Woodward	Head of Counter Fraud (for Minute AC20.72)

Agenda Item	Action
AC20/64: Opening Business and Apologies for Absence. The Chair welcomed members and attendees to the meeting. No apologies were received.	
AC20/65: Declarations of Interest. No declarations of interest were made at the meeting	

Agenda Item	Action
AC20/66: Procedural Matters. The Acting Board Secretary presented the items. Members noted that the Workforce & Organisation Development Scheme of Reservation and Delegation had since been agreed. **RESOLVED:** That 1. the Minutes of the last meeting of the Committee held on 28/07/20 (Annex a) be confirmed as a correct record; and 2. the Public Summary Action Log (Annex b) be received; and 3. the Standing Orders Amendments / Details of Breaches (Annex c) be noted; 4. the briefing paper in response to Action Log ref AC20/32.04: Summary of changes: standing down Health Emergency Control Centre (HECC) (Annex d) be noted: 5. the Chair's Action in respect of the Digital Strategy deferment (Annex e) be noted; 6. the Chair's Action in respect of final approval of the Annual Report and Accounts (Annex f) be noted; 7. the revised Finance & Performance Committee Terms of Reference (Annex g) be recommended to the Board for approval 8. the revised Strategy, Partnerships & Population Health Committee Terms of Reference (Annex h) be recommended to the Board for approval; 9. it be noted that all operational Schemes of Reservation and Delegation (SORDs) are now agreed with the exception of Public Health which in the process of being progressed. 10. the Chair's Action in respect of final approval of the Annual Quality Statement be noted	
AC20/67: Issues Discussed in Previous Private Committee Session. **RESOLVED**: That the report on issues discussed in previous Private Committee be noted.	
AC20/68: Chair's Assurance Report: Risk Management Group **AC20/68.01:** The Assistant Director of Information Governance & Risk joined the meeting and proceeded to provide Members with highlights from the report. A full review of all Tier 1 risks had now been undertaken. As to Divisional compliance, there had been four areas of concern. However, there were review meetings scheduled and the Assistant Director of Information Governance & Risk was confident that the organisation was on target for the 1st of October implementation date. Scheduled training sessions were fully booked with 92 members of staff enrolled. The Chair queried the compliance level and the Assistant Director of Information Governance & Risk confirmed that 50% was only	

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in relation to the previously mentioned areas of concern. The remaining areas were at 70-80% compliance. The Chair went on to express concern that neither the Chair nor the Vice Chair had been in attendance for one of the meetings – it was vitally important that the group was quorate. **AC20/68.02:** An Independent Member commented that the report failed to highlight that many of the Divisions had progressed significantly. The Assistant Director of Information Governance & Risk advised that at the time of writing the report, the validation exercises were ongoing, thus not possible to reflect in report. **AC20/68.03:** An Independent Member queried whether the Assistant Director of Information Governance & Risk was confident as to the Health Board's position. Members noted that whilst there was confidence in the transition from a 5 to 3 tier, a full implementation of the Risk Management Strategy would be dependent on the organisational objectives being set. The Acting Board Secretary provided an overview of the work planned to confirm the objectives, and the risks to achieving the objectives (which would then form the basis of the Board Assurance Framework). A session with Kingsfund had been completed with a further session planned. The Acting Executive Director of Finance further added that the organisation submitted quarterly plans to Welsh Government. Undoubtedly, COVID-19 had caused issues but the Health Board were not an outlier in this regard. There was a need to be flexible and wait for the necessary guidance from Welsh Government. The Head of Internal Audit added that it would be beneficial for the Health Board to confirm and publish the objectives. There was an Internal Audit Risk Management Review pencilled in for Q4 and the opinion on Risk Management would be affected if the Risk Management arrangements were not in place. It was important that the Strategy was implemented by March. The Performance Audit Lead, Audit Wales noted that the appointment of the new Chief Executive could also impact timings as they would likely want to be part of discussions. **AC20/68.04:** An Independent Member raised two final points. Firstly, the style of the report needed improvement in terms of language (less 'note' form) and requested the addition of numbering. The second point related to the actions and whether they would be picked up by the previous or incoming Chair – it was important that the actions were worked through with the right person. The Assistant Director of Information Governance & Risk confirmed that the actions would be picked up by the new Chair (the Acting Executive Medical Director). The Assistant Director of Information Governance & Risk left the meeting. **RESOLVED:** That the paper be noted.	JP

Agenda Item	Action
AC20.69: Schedule of Financial Claims **AC20/69.01:** The Acting Associate Director of Quality Assurance joined the meeting and presented the report whilst addressing some of the queries relating to lessons learnt that had been raised at the pre meeting. An Independent Member confirmed that discussions/evidence of lessons learnt was overseen by the Quality, Safety & Experience Committee but queried whether the QSE Tracker could be developed to become more sophisticated and track lessons learnt against each claim. The Acting Associate Director of Quality Assurance advised that the intention was to move the (currently paper based) process into the electronic Datix system which would in turn make the information accessible and improve reporting functionality. Estimated implementation time was six months. **AC20/69.02:** An Independent Member queried whether the Health Board was anticipating the risk of an increase in claims due to COVID-19. The Acting Associate Director of Quality Assurance advised that to date, there had been no specific COVID-19 claims but there was a three-year period in which a claim could be brought from the point of harm being incurred. It was therefore, too soon to see any claims, but it was anticipated that there would be an increase in the coming months. **AC20/69.03:** Members noted that the Health Board had undertook a piece of work with the Welsh Risk Pool to review potential COVID-19 related harms. The output of the review was pending. **AC20/69.04:** The Acting Associate Director of Quality Assurance concluded by informing Members that the Health Board have seen an increase in complaints. The Claims department were in the process of writing to the patients and families who had been impacted by a recent COVID-19 outbreak in the East. The Acting Associate Director of Quality Assurance left the meeting **RESOLVED:** That the claims and payments listed in the schedule be noted and reported to the Board as part of the Chair's assurance report.	
AC20.70: Annual Review of Gifts & Hospitality and Declarations of Interest Register **AC20.70.01:** The Acting Board Secretary presented the report. Following the introduction of the electronic system there had been a continuous drive to increase the compliance figures for declarations of interest. Unfortunately, the return rate figures for the last financial year were significantly down on the previous year reporting period (40%	

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compared with 88% in the previous year). Members noted that the impact of Covid might have had some impact on this coupled with vacancies and staff absences within the Office of the Board Secretary however it was envisaged that compliance figures should revert to their previous levels this year. Adjustments to the electronic system were awaited to improve the process, particularly in terms of recording authorisations, the ability to distinguish between gifts which have been donated to Awyr Las and those gifts which had been received which were for example for use on wards but may have been logged in an individual's name. It was hoped that these upgrades to the system would be implemented by the Systems Team shortly however staff vacancies together with the advent of COVID had presented this so far. **AC20.70.02:** An Independent Member clarified their personal declaration that should read that two of their children were employed by the Health Board and that one was employed by the Royal Voluntary Society at Ysbyty Gwynedd. The Acting Board Secretary noted the amendment but advised that the report had been included in the Annual Report, which was finalised for the Board. Members agreed that the correction would be noted in the Minutes. **AC20.70.03:** The Chair queried the green highlighted areas of the report as asked as to the significance. The Acting Board Secretary advised that for the purposes of this meeting, the green highlighted areas had no significance. **AC20.70.04:** The Performance Audit Lead, Audit Wales observed that there was an obvious reduction in the number of declarations from the Estates department and queried whether there would be anymore focus on this area in the future. The Acting Board Secretary advised that there had been further declarations received across the organisation and that they would feature in the next iteration of the report. The Acting Executive Director of Finance concurred with the Performance Audit Lead, Audit Wales and stated that it was important that the Health Board reviewed the declarations position with the Director of Estates. **RESOLVED:** That the Annual Declarations of Interests/Gifts and Hospitality for 2019/20 report be received.	DS
AC20.71: Internal Audit Progress Report **AC20.71.01**: The Head of Internal Audit presented the progress report and highlighted the following key points: **AC20.71.02:** Internal Audit were yet to receive a management response for the Quality Impact Assessment review. An Independent Member	

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expressed concern and queried whether the current escalation process was effective. The Acting Board Secretary agreed to review in discussion with the Head of Internal Audit. **AC20.71.03:** The Acting Director of Mental Health and Head of Internal Audit were scheduled to meet Conwy's Strategic Director of Social Care and Education and Internal Audit on the 23rd March 2020 to progress the combined draft report for the review on Conwy Community Mental Health Team. However, the meeting had been cancelled due to COVID-19. **AC20.71.04:** The Head of Internal Audit advised that following discussions with the Director of Performance with regard to the Performance measure reporting to the Board – Accuracy of information, Internal Audit had been advised that referral to treatment (RTT) would now focus on shifting towards risk stratified component waits rather than RTT nationally. The Head of Internal Audit requested direction from Members as to whether continuing with the scope/review would add any value. A discussion ensued. An Independent Member raised concerns whether it would be appropriate to set aside the review entirely. Another Independent Member concurred and queried whether it was possible to examine RTTs in a different way. The Performance Audit Lead, Audit Wales advised that Welsh Government were reviewing RTT overall. The Acting Executive Director of Finance added that the Finance and Performance (F&P) Committee were also focusing on this issue. There was an extraordinary meeting planned for September which would focus on the risk of harm. The Chair enquired as to how information was being captured if RTT reporting had been formally stood down. The Acting Executive Director of Finance advised that the data collation had continued, it was only the formal reporting that had ceased. Members agreed that the Head of Internal Audit would liaise with the Acting Executive Director of Finance and the Performance Audit Lead, Audit Wales to refine the scope. **AC20.71.05**: The Head of Internal Audit drew Member's attention to paragraph 12 of the report and asked the Committee to consider whether the Approved Clinicians and Section 12 (2) review should be incorporated into this year's plan or placed on hold and incorporated into the 2021/22 plan. The Acting Board Secretary advised that her preference was to include in this year's plan as a standalone review (from the leadership and governance review), recognising the all Wales role it played. The Committee agreed. **AC20.71.06:** An Independent Member raised a query as to the scope of the 'Violence and Aggression – Obligatory responses to violence in healthcare' review and whether it included the Mental Health & Learning Disabilities (MH&LD) Division. The Head of Internal Audit confirmed that the review would cover the entire Health Board, including MH&LD.	DS

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AC20.71.07: As a final point, the Head of Internal Audit advised that they would like to revisit the plan with the Acting Executive Director of Finance and the Acting Board Secretary, which was agreed. The Head of Internal Audit concluded by expressing thanks to those involved in supporting the reviews. **AC20.71.08**: The Acting Executive Director, Nursing & Midwifery joined the meeting and provided the Committee with an overview of the progress being made to address the recommendations from the Decontamination Limited Assurance Report. In particular, Members noted that the Terms of Reference (ToR) of the groups had been reviewed, senior management were in attendance and there was evidence of self-assessment at the meetings. The Acting Executive Director, Nursing & Midwifery drew Members attention to the third recommendation. The COSHH assessment had been relaunched in December 2019 but an issue of resources remained. A review of the Infection Prevention structure was required. An Independent Member asked whether the Acting Executive Director, Nursing & Midwifery was confident that there was sufficient COSSH training in place. The Acting Executive Director, Nursing & Midwifery advised that she would need to look into this. The Chair asked whether the decontamination/infection Nurse role, identified in the Management Response had been appointed. The Acting Executive Director, Nursing & Midwifery advised that interviews had taken place and an offer had been made but the individual was not yet in post. The Acting Executive Director, Nursing & Midwifery was progressing the matter. The Acting Executive Director, Nursing & Midwifery left the meeting. **AC20.71.08:** The Acting Executive Director of Finance provided Members with an overview of the findings from the Salary Overpayments review and emphasised the importance of training for budget holders. An Independent Member requested clarity on where the F14 procedure was being consulted on. The Acting Executive Director of Finance advised that the procedure would be circulated with both Finance and WOD colleagues but would expect this to also include Trade Union partners. A discussion ensued as to the process of repayments. Members noted that a particular problem arose when the overpayment related to a member of staff who had left the employment of the Health Board and it was not possible to recover via the usual process (salary deduction). This was usually as a result of managers not submitting the necessary leavers form in time. The Chair queried whether budget holders received a monthly statement and an Independent Member further queried whether this was in fact a performance/disciplinary matter. The Acting Executive Director of Finance confirmed that this was monitored, i.e. repeated occurrences by the same manager, but the issue more often than not was one of unawareness as to the procedure – hence the critical importance of training and education. An Independent Member concurred that it was important that the procedure was robust in the first instance (for example, processing faults attributed to the electronic	DS DH

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system) before disciplinary options were considered. A balanced approach was necessary. The Head of Internal Audit noted that there were legacy issues inherited from predecessor organisations and offered the support of the Internal Audit Team for training support. **AC20.71.09**: The Executive Director of Workforce & Organisational Development (WOD) joined the meeting to discuss the Roster Management review and stated that it had been a useful report. It had highlighted that the concerns as to locking down shifts were well founded. However, COVID-19 had presented additional challenges and there was a requirement to re audit, as this was a key area of focus. The Chair acknowledged the difficulties presented by COVID-19 but advised that it was not necessary to wait for another report, assurance was required that work was being done to address the highlighted risks and gaps in assurance. The Executive Director of WOD assured Members that the team were continuing to work with divisional managers. A number of checks had been put in place though there was further work to do. An Independent Member queried whether there was more than one level of 'lockdown' and the Executive Director of WOD advised that there was a 'pre and post' level. The Executive Director of WOD concluded by noting that the re audits would provide the necessary assurance and this was where the Health Board needed to focus its efforts. **AC20.71.10:** The Head of Internal Audit presented the Governance Arrangements during Covid-19 pandemic report. A discussion ensued as to the requirement to hold meetings virtually and Members noted that the Health Board had adapted well overall though there were considerations as to a lack of the ability to speak Welsh during meetings. The Acting Board Secretary advised Members that options were being progressed with Informatics as to the different digital platforms that could provide the functionality. Members proceeded to review the Cross-Border flow agreements, expressing concern as to the value of the monthly payments that continued to be made without any recourse and queried whether the risk was adequately reflected on the risk register. The Acting Executive Director of Finance advised Members that a meeting between England and Wales would be held to establish an effective solution for the flow of money over the border. As to the documentation of the risk, this was covered via several different risks but would be raised at F&P to establish whether a specific risk was required. An Independent Member noted that the report detailed instances where information had not been forthcoming despite being requested by Auditors. Members expressed concern and requested that this be addressed. **AC20.71.11:** An Independent Member requested further information around the overtime payments detailed in the report and the Head of Internal Audit provided the background and further advised that a more detailed review was being undertaken by the Financial Governance Cell.	SH DS

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AC20.71.12: The Acting Executive Director of Finance considered that there was evidence to demonstrate that the Health Board had implemented some robust procedures during the pandemic. Though, there were some key issues that the Health Board needed to ensure did not happen again. The Performance Audit Lead, Audit Wales noted that some of the issues would be picked up by the Audit Wales Structured Assessment. In addition, the Acting Board Secretary advised Members that whilst there were no formal recommendations to the report, the Executive team had agreed that the items detailed in the 'priority considerations for the future' section would be logged in the Audit Tracker and received at Audit Committee for monitoring. The Head of Internal Audit concluded by advising that the report would be taken to the all-Wales Directors of Finance (DoF) meeting and the positive steps (establishment of the Cabinet meeting and Financial Governance Cell) taken by the Health Board would be recorded as good practice. **RESOLVED:** That 1. the progress report be received 2. the Limited Assurance reports be received and discussions noted.	DS/BW
AC20.72: Audit Wales Update Report **AC20.72.01**: The Audit Manager, Audit Wales and the Performance Audit Lead, Audit Wales presented the report and provided Members with an overview of the highlights. In particular, the new review on Test, Track and Protect (TTP) and the potential postponement/replacement of the planned work on ophthalmology. An Independent Member noted that it was important that the QSE Committee were sighted on this matter. **AC20.72.02**: The Head of Counter Fraud joined the meeting and the Performance Audit Lead, Audit Wales presented the National and Local Counter Fraud reports. Members noted that due to an administrative error, the Local report did not contain the full Health Board Management Response. **the final report was circulated to Members immediately and picked up again at a later stage in the meeting after a short break. Agenda items were taken out of order at the request of Audit Wales to consider the National/Local report adjacent to the Counter Fraud Progress Report considered in private Committee. The Health Board's Website would be updated to reflect the full report including the Management Response.* AC20.72.03: The Performance Audit Lead, Audit Wales continued to present an overview of the national report. Overall, the report was quite positive though there were areas for improvement. The main point being	BW BW

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training and awareness, noting that within other Health Boards, the Counter Fraud e-learning module formed part of mandatory training for staff. The Chair observed that this issue had been raised previously and queried as to what the barrier was to its inclusion in the programme. The Acting Executive Director of Finance added that whilst there were no objections to its inclusion in principle (the issue related to the current length of the induction programme); a decision would be required by the Executive team. The Chair requested that this was actioned. **RESOLVED:** That 1. the Audit Wales programme update be received; and 2. the reports on Counter Fraud services be received.	DS
AC20.73: Primary Care Dental Assurance Report AC20.73.01: The Assistant Director of North Wales Dental Services joined the meeting and provided Members with an overview of the report. COVID-19 had had a significant impact on the service and the requirement for continued contract payments at 80% of full contract value, initially for the three-month period to the end of June, had meant that the Health Board were paying a significant amount for a considerably reduced service. The Chair noted this and asked for further information in terms of risk management. The Assistant Director of North Wales Dental Services provided the background to the management processes and the assurances in place. The Chair asked the Acting Executive Director of Finance whether she was aware of the issue in terms of lost income for the Health Board. The Acting Executive Director of Finance confirmed that Finance were sighted on the loss of patient charge revenue. AC20.73.02: A discussion ensued as to Members experience and awareness of what dental services were available during the pandemic. Members highlighted that equally, patients may not be fully aware as to what services were available, i.e. that practices remain 'open for contact'. The Assistant Director of North Wales Dental Services advised that all contractors had signed and returned an initial declaration at the onset of the pandemic indicating their compliance with the 'open for contact' requirement. However, access was limited due to the requirement to deep clean etc. A second declaration for the Amber phase conditions (commencing 22nd June) had been issued. An Independent Member queried the level of non-compliance and the Assistant Director of North Wales Dental Services advised that one contractor had confirmed they were not fully compliant, and the decision had been made to no longer provide NHS services. The Contracting team would now contact all local providers to enquire whether the additional sessions could be picked up.	

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AC20.73.03: An Independent Member raised a concern as to service provision within care homes. The Assistant Director of North Wales Dental Services assured Members that the team continued to work closely with the community teams. AC20.73.04: A further query was raised in relation to the risk of patient harm due to non-treatment and antibiotic resistance due to increased prescribing. The Assistant Director of North Wales Dental Services advised that the service continued to provide urgent and emergency care for all patients. When a patient called the dental help line, they were prioritised on a clinical need basis to receive treatment in either the Community Dental Service (CDS) red centre or the commissioned GDS / high street practice. Though again, COVID-19 requirements meant there were restrictions on how many patients could be seen (usually a three-hour session would see 15 patients treated or approximately one patient per hour). AC20.73.05: The Chair enquired whether the service was utilising additional voluntary support and the Assistant Director of North Wales Dental Services confirmed that the team had written out to the services to advise of the support available. The Chair concluded that the matter should receive further oversight at the QSE Committee and Members agreed that a report should be prepared. The Assistant Director of North Wales Dental Services left the meeting. **RESOLVED:** That the Primary Care Dental Assurance report be noted.	MB
AC20.74: End of Year Reporting - Committee Annual Reports AC20.74.1: Members noted concerns previously raised at the Audit Committee pre meeting with regard to attendance at the Stakeholder Reference Group (SRG). It was agreed that the Chair of SRG would write to the attendees to request further information. **RESOLVED:** That the following annual reports be received:- **1.** Finance & Performance Committee **2.** Remuneration & Terms of Service Committee **3.** Strategy, Partnership & Population Health Committee **4.** Stakeholder Reference Annual Report **5.** Healthcare Professionals Forum and;	DS
AC20.75: Legislation Assurance Framework **AC20.75.01:** The Statutory Compliance, Governance & Policy Manager presented the report and drew Members attention to the following points: **AC20.75.02:** Divisional engagement as to meeting with leads and completing the assurance criteria remained limited due to staffing	

Agenda Item	Action
capacity with the Office of the Board Secretary and the requirement for operational management to focus on the COVID-19 response. **AC20.75.03:** An overview of the Health and Social Care (Quality and Engagement) (Wales) Act 2020 was provided at appendix 1. This was a significant and important piece of legislation. The Acting Associate Director of Quality Assurance had provided an update on the work undertake to address the future requirements (delayed due to COVID-19). An Independent Member queried the inclusion of the impending socio-economic duty (provided for in powers under the Equality Act 2010). Members noted that a Task & Finish Group had been convened to assess the requirements though the commencement of the duty had been postponed due to COVID-19 and would now come into force 31st March 2021. The Statutory Compliance, Governance & Policy Manager confirmed that the duty would be input into appendix 1 once commenced. **AC20.75.04:** Following communication with the Executive Director of Public Health, it was proposed to Members that the Public Health Wales Act 2017 be reported as 'reasonable assurance' on the understanding that the specific duties arising from subordinate legislation would be reported as individual items (most notably, the smoke free premises regulations and the pharmaceutical services regulations). **AC20.75.05:** Clarity on the requirements under the Information and Consultation with Employees Regulations 2004 was provided at appendix 2, following a query at the March Audit Committee meeting. **AC20.75.06:** Members were advised that the future Board Assurance Framework (BAF) would be influenced by the outcome of the Governance Review being undertaken by the Acting Chief Executive. As the Legislation Assurance Framework formed part of the BAF, future reporting/format might also be influenced. **RESOLVED:** That 1. the Legislation Assurance Framework report be noted; and 2. items of previous 'no' or 'limited' assurance in appendix 2, now reporting as reasonable or substantial be removed from the next iteration of the report.	BW
AC20/76: Issues of Significance for Reporting to Board **RESOLVED: That** the Chair prepare his assurance report for the Board.	
AC20/77: Date of Next Meeting: 19/12/20	
AC20/78: Exclusion of Press and Public	

Agenda Item	Action
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".	

Audit Committee Summary Action Log: Public Committee

Officer	Minute Reference and Action Agreed	Original Timescale	Latest Update Position	Revised Timescale
Justine Parry	**AC20/68.04:** RMG Chair's Assurance Report style/format: Paragraph numbering to be added and change from 'note' form.	December	Complete. Assistant Director of Information Governance & Risk confirmed improvements will be visible in next iteration of report 13/10/20	close
Dawn Sharp	**AC20.70.04:** DOIs. Review Estates & Facilities submissions with Director of Estates	December	Complete. Acting Board Secretary discussed with Director of Estates & Facilities – reminder sent out to all those who have not yet submitted declarations	close
Dawn Sharp	**AC20.71.02:** Internal Audit escalation procedure: Acting Board Secretary to review / discuss with Internal Audit	December	Meeting held between Acting Board Secretary, Acting Executive Director of Finance and Internal Audit. Agreed escalation report to go monthly to Executive team. First iteration of report presented 11/11/20	close
Dawn Sharp	**AC20.71.07:** Head of Internal Audit to review the Plan with the Acting Executive Director of Finance and the Acting Board Secretary	December	Meeting held between Acting Board Secretary, Acting Executive Director of Finance and Internal Audit. Plan reviewed and discussed at Executive Team	close
Debra Hickman	**AC20.71.08:** Decontamination Audit – confirmation on COSHH training and recruitment	December	COSHH training is undertaken as part of the competence required for those working with these substances and is audited on a 6 monthly basis for assurance with an annual spot check. The decontamination role is still not in post as identified at the last Audit committee, an offer made has subsequently been declined. Clarity is being sought as to delays that have occurred during the recruitment to this role.	close

Officer	Minute Reference and Action Agreed	Original Timescale	Latest Update Position	Revised Timescale
Sue Hill	**AC20.71.10:** Cross-border flow risk to be raised at F&P to establish whether separate risk required.	December	Issue raised at F&P. Decision not to log as a separate risk due to being funded by Welsh Government.	close
Dawn Sharp	**AC20.71.10:** Governance during Covd Review – issues of information not being submitted to be addressed	December	Matter escalated to gold command. No further evidence available.	Close
Bethan Wassell	**AC20.71.12:** Governance during COVID Review - logged in the Audit Tracker and received at Audit Committee for monitoring	December	12/10/20 Management response prepared and tracking in TeamCentral.	close
Bethan Wassell	**AC20.72.01:** QSE Committee to be sighted on Audit Wales new review on Test, Track and Protect (TPP)	December	Complete. Information and report sent to QSE Secretariat 12/10/20 for distribution	close
Bethan Wassell	**AC20.72.02:** Audit Wales, Local Counter Fraud reports. Updated/final	December	Complete. Final report re uploaded to ibabs/external website 12/10/20	close
Dawn Sharp	**AC20.72.03:** Consideration as to Counter Fraud e-learning module forming part of mandatory training for decision at Exec team	December	Complete. 02/11/20 Head Of Organisational & Employee Development to liaise with Head of Counter Fraud with a view to submitting a proposal to the Statutory & Mandatory Training Group in the first instance. This is also addressed by a recommendation from the review and will be monitored via the Audit Tracker report.	close
Bethan Wassell	**AC20.73.05**: Dental Assurance Report to be received at QSE	December	Complete. Notification sent to Assistant Director of North Wales Dental Services / QSE Secretariat. Scheduled for January QSE	close
Dawn Sharp	AC20.74.1: Attendance at the Stakeholder Reference Group (SRG). Chair of SRG to write to the attendees to request further information.	December	Matter escalated to SRG secretariat.	close

Betsi Cadwaladr University Health Board
Terms of Reference and Operating Arrangements

REMUNERATION AND TERMS OF SERVICE COMMITTEE

1. INTRODUCTION

1.1 The Board shall establish a committee to be known as the Remuneration and Terms of Service Committee **(R&TS)**. The detailed terms of reference and operating arrangements in respect of this Committee are set out below.

2. PURPOSE

2.1 The purpose of the Committee is to provide:

- advice to the Board on remuneration and terms of service for the Chief Executive, Executive Directors and other senior staff within the framework set by the Welsh Government;

- assurance to the Board in relation to the Health Board's arrangements for the remuneration and terms of service, including contractual arrangements, for *all staff*, in accordance with the requirements and standards determined for the NHS in Wales; and

- to perform certain, specific functions as delegated by the Board and listed below.

3. DELEGATED POWERS AND AUTHORITY

3.1 The Committee, in respect of its provision of advice and assurance will and is authorised by the Board to: -

3.1.1 comment specifically upon

- the remuneration and terms of service for the Chief Executive, Executive Directors and other Very Senior Managers (VSMs) not covered by Agenda for Change; ensuring that the policies on remuneration and terms of service as determined from time to time by the Welsh Government are applied consistently;
- and to be sighted on the objectives set by the Chief Executive for his immediate team, confirm that Directors have had objectives set, and that appropriate and timely performance reviews have taken place
- proposals to make additional payments to consultants;
- proposals regarding termination arrangements, ensuring the proper calculation and scrutiny of termination payments in accordance with the relevant Welsh Government guidance.
- removal and relocation expenses

3.1.2 consider and approve Voluntary Early Release scheme applications and severance payments in line with Standing Orders and extant Welsh Government guidance.

3.1.3 monitor compliance with issues of professional registration, including the revalidation processes for medical and dental staff and registered nurses, midwifes and health visitors and Allied professionals.

3.1.4 monitor and review risks from the Corporate Risk Register that are assigned to the Committee by the Board and advise the Board on the appropriateness of the scoring and mitigating actions in place;

3.1.5 investigate or have investigated any activity (clinical and non-clinical) within its terms of reference. It may seek relevant information from any:

- employee (and all employees are directed to cooperate with any legitimate request made by the Committee); and

- other committee, sub-committee or group set up by the Board to assist it in the delivery of its functions.

3.1.6 obtain outside legal or other independent professional advice and to secure the attendance of outsiders with relevant experience and expertise if it considers it necessary, in accordance with the Board's procurement, budgetary and other requirements;

3.1.7 consider and where appropriate, approve on behalf of the Board any policy within the remit of the Committee's business including approval of Workforce policies.

3.1.8 consider reports on behalf of the Board giving an account of progress where any exclusion in respect of Upholding Professional Standards in Wales (UPSW) has lasted more than six months.

3.1.9 consider reports on behalf of the Board giving an account of progress on performers list regulatory cases.

3.1.10 consider reports on behalf of the Board on the position as regards whistleblowing and Safe haven.

4. SUB-COMMITTEES

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

5. MEMBERSHIP

5.1 Members

- Four Independent Members of the Board
- The Chair of the Audit Committee will be appointed to this Committee either as Vice-Chair or a member.

5.2 In attendance

- Chief Executive Officer
- Executive Director of Workforce and Organisational Development (Lead Director)
- Executive Medical Director

Other Directors will attend as required by the Committee Chair, as well any others from within or outside the organisation who the Committee considers should attend, taking into account the matters under consideration at each meeting. A Trade Union Partner Chair of the Local Partnership Forum will be in attendance at meetings held in public as an ex-officio member.
The Executive Director of Finance may be invited to attend as required, and will be consulted on any paper to be submitted to the Committee which may have financial implications.

5.3 Member Appointments

5.3.1 The membership of the Committee shall be determined by the Chairman of the Board taking account of the balance of skills and expertise necessary to deliver the Committee's remit and subject to any specific requirements or directions made by the Welsh Government. This includes the appointment of the Chair and Vice-Chair of the Committee who shall be Independent Members.

5.3.2 Appointed Independent Members shall hold office on the Committee for a period of up to 4 years. Tenure of appointments will be staggered to ensure business continuity. A member may resign or be removed by the Chairman of the Board. Independent Members may be reappointed to the Committee up to a maximum period of 8 years.

5.4 Secretariat

5.4.1 Secretary: as determined by the Board Secretary.

5.5 Support to Committee Members

5.5.1 The Board Secretary, on behalf of the Committee Chair, shall:

- Arrange the provision of advice and support to Committee members on any aspect related to the conduct of their role; and
- Ensure the provision of a programme of development for Committee members as part of the overall Board Development programme.

6. COMMITTEE MEETINGS

6.1 Quorum

6.1.1 At least two Independent Members must be present to ensure the quorum of the Committee, one of whom should be the Committee Chair or Vice-Chair. In the interests of effective governance it is expected that at least two Executive Directors will also be in attendance.

6.2 Frequency of Meetings

6.2.1 The Chair of the Committee, in agreement with Committee Members, shall determine the timing and frequency of meetings, as deemed necessary. It is expected that the Committee shall meet at least once a year, consistent with the Health Board's annual plan of Board Business.

6.3 Withdrawal of individuals in attendance

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

7. RELATIONSHIP AND ACCOUNTABILITIES WITH THE BOARD AND ITS COMMITTEES

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

7.2 The Committee is directly accountable to the Board for its performance in exercising the functions set out in these Terms of Reference.

7.3 The Committee, through its Chair and members, shall work closely with the Board's other Committees to provide advice and assurance to the Board through the:

7.3.1 joint planning and co-ordination of Board and Committee business; and

7.3.2 sharing of information

in doing so, contributing to the integration of good governance across the organisation, ensuring that all sources of assurance are incorporated into the Board's overall risk and assurance arrangements.

7.4 The Committee shall embed the corporate goals and priorities through the conduct of its business and in doing and transacting its business shall seek assurance that adequate consideration has been given to the sustainable

development principle and in meeting the requirements of the Well-Being of Future Generations Act.

8. REPORTING AND ASSURANCE ARRANGEMENTS

8.1 The Committee Chair shall:

8.1.1 report formally, regularly and on a timely basis to the Board on the Committee's activities, via the Chair's assurance report as well as the presentation of an annual Committee report;

8.1.2 ensure appropriate escalation arrangements are in place to alert the Health Board Chair, Chief Executive or Chairs' of other relevant committees of any urgent/critical matters that may affect the operation and/or reputation of the Health Board.

8.2 The Board Secretary, on behalf of the Board, shall oversee a process of regular and rigorous self-assessment and evaluation of the Committee's performance and operation.

9. APPLICABILITY OF STANDING ORDERS TO COMMITTEE BUSINESS

9.1 The requirements for the conduct of business as set out in the Standing Orders are equally applicable to the operation of the Committee, except in the following areas:

• Quorum

10. REVIEW

10.1 These terms of reference and operating arrangements shall be reviewed annually by the Committee and any changes recommended to the Board for approval.

Date of approval
Audit Committee
Health Board –

Audit Committee

17.12.20

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

Meeting Date	Committee	Standing Order Requirement	Issue/Reason for Breach
16.10.20	Healthcare Professionals Forum	Publication of papers 7 days before meeting	Ibabs publication achieved. Web publication of agenda delayed due to website being unavailable
10.12.20	Strategy Partnerships and Population Health	Publication of papers 7 days before meeting	Insufficient papers received to publish

Dawn Sharp

Acting Board Secretary

Mental Health Act Committee* Annual Report 2019-20

*Including an overview of the work of the Power of Discharge Sub-Committee

1. Title of Committee

Mental Health Act Committee

2. Name and role of person submitting this report:

Matthew Joyes, Acting Associate Director of Quality Assurance

3. Dates covered by this report:

01/04/2019-31/03/2020

4. Number of times the Committee and Sub-committee met during this period:

The **Mental Health Act Committee** was routinely scheduled to meet 4 times and otherwise as the Chair deemed necessary. During the reporting period, it met on 3 occasions with 1 cancellation in March 2020 due to the COVID-19 pandemic and in-line with Welsh Government governance requirements.

Attendance at meetings of the Committee are detailed within the table below:

Members of the Mental Health Act Committee	28/06/19	27/09/19	20/12/19	27/03/20
Marian Wyn Jones (Chair)	P	P	◆	Meeting cancelled due to COVID-19 pandemic
Lucy Reid (Chair)	◆	◆	P	
Cheryl Carlisle Independent Member	P	P	A	
Lyn Meadows Independent Member	P	P	P	
Eifion Jones Independent Member	◆	◆	P	

Formally In Attendance	28/06/19	27/09/19	20/12/19	27/03/20
Alberto Salmoiraghi - Medical Director for Mental Health	P	P	P	Meeting cancelled due to COVID-19 pandemic
Alison Cowell - Assistant Area Director Centre - Childrens	P	P	P	
Andy Roach (Lead Director) - Director of Mental Health & Learning Disabilities Lesley Singleton (Interim) Lead Director of Mental Health & Learning Disabilities	P	P	A	
Steve Forsyth Nursing Director for Mental Health	A	P	A	
Wendy Lappin - Mental Health Act Manager	P	P	P	
Gill Harris - Executive Director of Nursing and Midwifery	A	A	A	
Mark Jones - Social Services	A	A	A	
Satya Schofield Associate Hospital Manager	A	◆	◆	
Christine Robinson Associate Hospital Manager	A	A	◆	
Frank Brown Associate Hospital Manager	P	P	P	
Vacant Associate Hospital Manager	◆	◆	◆	
Joan Doyle – Unillas IMCA Advocacy IMHA Advocacy	A	A	A	
Caniad Service User Representative & Carer Representative	A	X	X	
Neil Coppack North Wales Police	X	X	X	
Chris Pearson MCA representative DoLS representative	P	P	A	

Heulwen Hughes All Wales Approval Manager For Approved Clinicians And Section 12(2) Doctors	P	P	P	
Hilary Owen Head Of Governance And Compliance	P	P	A	

Key:

P - Present
P* **-** Present for part meeting
A - Apologies submitted
X - Not present
◆ Not a member of the Committee at this time.

The **Power of Discharge Sub-Committee** was routinely scheduled to meet 4 times and otherwise as the Chair deemed necessary. During the reporting period, it met on 3 occasions with 1 cancellation in March 2020 due to the COVID-19 pandemic and in-line with Welsh Government governance requirements..

Attendance at meetings of the Committee are detailed within the table below:

Members of the Power of Discharge Sub-Committee	28/06/19	27/09/19	20/12/19	27/03/20
Marian Wyn Jones (Chair)	P	P	◆	Meeting cancelled due to COVID-19 pandemic
Lucy Reid (Chair)	◆	◆	P	
Cheryl Carlisle Independent Member	P	P	A	
Lyn Meadows Independent Member	P	P	P	
Eifion Jones Independent Member	◆	◆	P	
Formally In attendance	28/06/19	27/09/19	20/12/19	27/03/20
Frank Brown Associate Hospital Manager	P	P	P	Meeting cancelled due to
Jackie Parry Associate Hospital Manager	P	P	P	

Satya Schofield Associate Hospital Manager	A	P	P	
Shirley Cox (Resigned as from March 2020) Associate Hospital Manager	P	A	A	
Shirley Davies Associate Hospital Manager	P	P	A	
Delia Fellows Associate Hospital Manager	P	A	A	
Ann Owens Associate Hospital Manager	P	P	P	
Diane Arbabi Associate Hospital Manager	A	P	A	
John Williams Associate Hospital Manager	A	A	P	
Christine Robinson Associate Hospital Manager	A	A	◆	
Hugh E Jones Associate Hospital Manager To be welcomed on the group:	◆	◆	◆	
Helena A Thomas Associate Hospital Manager	◆	◆	◆	COVID-19 pandemic

Key:

P - Present
P* - Present for part meeting
A - Apologies submitted
X - Not present
◆ Not a member of the Committee at this time.

In addition to the above core membership, other Directors and Officers from the Health Board may attend meetings of the Committee or Sub-committee as requires. For a full list of attendance, please see the approved minutes which can be accessed on the Health Board's website via the following pages:- https://bcuhb.nhs.wales/about-us/committees-and-advisory-groups/

5. Assurances the Committee is designed to provide:

The Health Board's Mental Health Act Committee has a very narrow remit. The purpose of the Committee is to consider and monitor the use of the Mental Health Act 1983 (MHA), Mental Capacity Act 2005 (which includes the Deprivation of Liberty Safeguards (DoLS) (MCA) and the Mental Health (Wales) Measure 2010 (the Measure) and provide assurance to the Board. Governance, leadership, quality and safety matters relating to mental health fall within the remit of the Quality, Safety and Experience Committee.

The **Committee** is designed to provide assurance to the Board on the following key areas as set out in its Terms of Reference as follows:-

- ensure that those acting on behalf of the Board in relation to the provisions of Mental Health and Capacity legislation, including the Measure, have the requisite skills and competencies to discharge the Board's responsibilities;
- identify matters of risk relating to Mental Health and Capacity legislation and seek assurance that such risks are being mitigated;
- monitor the use of the legislation and consider local trends and benchmarks;
- consider matters arising from the Hospital Managers' Power of Discharge Sub-Committee;
- ensure that **all** other relevant associated legislation is considered in relation to Mental Health and Capacity legislation;
- consider matters arising from visits undertaken by Healthcare Inspectorate Wales Review* Service for Mental Health in particular, issues relating to Mental Health Act 1983 and monitor action plans that inform responses to HIW reports;
- consider any reports made by the Public Services Ombudsman for Wales regarding complaints about Mental Health and Capacity legislation;
- receive and review reports on the approval for all Wales Approved Clinicians and Section 12(2) Doctors;
- consider and approve on behalf of the Board any LHB policy which relates to the implementation of mental health and capacity legislation as well as any other information, reports etc. that the Committee deems appropriate;
- receive and review DoLS reports regarding authorisations and associated reasons;
- receive and review reports on the implementation of the Mental Health Measure and be satisfied that positive outcomes for people are being achieved;
- receive and review the results of internal audit reports relating to care and treatment plans, as well as any other relevant reports relating to the Mental Health Measure;
- receive the results of clinical audits and any other reviews relating to the use of the Mental Health Act and oversee the implementation of recommendations;
- consider any other information, reports, etc. that the Committee deems appropriate.
- investigate or have investigated any activity (clinical and non-clinical) within its terms of reference. It may seek relevant information from any:
  - employee (and all employees are directed to cooperate with any legitimate request made by the Committee); and
  - other committee, sub-committee or group set up by the Board to assist it in the delivery of its functions.
- obtain outside legal or other independent professional advice and to secure the attendance of non members with relevant experience and expertise if it considers it necessary, in accordance with the Board's procurement, budgetary and other requirements;

*Note – HIW report recommendations are the remit of Quality Safety and Experience Committee (QSE) however any specific recommendations relating to the Mental Health Act or the Mental Capacity Act will be the remit of this Committee who will respond as appropriate ensuring the Board and QSE are appraised accordingly.

During the period that this Annual Report covers, the Committee operated in accordance with its terms of reference which were operative for the whole of the term this Annual Report covers. The terms of reference are appended at Appendix 1.

The work programmes, cycles of business and overall performance of each Committee is the responsibility of the Committee Business Management Group (CBMG). The CBMG oversees effective communication between Committees, avoiding duplication and ensuring all appropriate business is managed effectively and efficiently through the Health Board's Governance framework.

The Committee is required to publish its agenda and papers 7 days ahead of the meeting, and a breach log is maintained by the Office of the Board Secretary where there are exceptions to this requirement. During the reporting period there were zero breaches of this nature.

6. Overall *RAG status against Committee's annual objectives / plan: Amber

The summary below reflects the Committee's assessment of the degree to which it has met these objectives. The supporting narrative included alongside the assessment below describes this in more detail.

Objective as set out in Terms of Reference	Assurance Status (RAG)*	Supporting narrative
Ensure that those acting on behalf of the Board in relation to the provisions of Mental Health and Capacity legislation, including the Measure, have the requisite skills and competencies to discharge the Board's responsibilities.		In relation to the Mental Health Act legislation, the Associate Hospital Managers and Responsible Clinicians can discharge patients from their detention. Associate Hospital Managers discharges are monitored and reported at every Mental Health Act Committee meeting and documented within the quarterly report. Training in relation to the Mental Health Act is provided to the Associate Hospital Managers and Health Board staff on a rolling programme. Associate Hospital Managers receive training twice yearly and also receive a PADR format supervision review on an annual basis which identifies any additional training needs. The Committee noted training compliance was below target.

Identify matters of risk relating to Mental Health and Capacity legislation and seek assurance that such risks are being mitigated;		The quarterly Mental Health Act reports detail any areas of legislation that have been breached this includes lapses and illegal detentions. The Mental Health Act report also considers any errors that are rectifiable and these are benchmarked against other Health Boards in Wales. In order to improve quality and safety the Mental Health Act Manager has instigated KPIs for BCU an example of this is the timescale for hearing a renewal of section. In terms of the Mental Capacity Act this is monitored by the Corporate Safeguarding Team and any issues of concern are reported through local safeguarding forums and reported to the Mental Health Act Committee quarterly. However, the Committee has not received a specific report regarding risk management or risk register and is therefore unable to provide full assurance on mitigating measures.
Monitor the use of the legislation and consider local trends and benchmarks;		Trends, benchmarks and performance is managed by the Mental Health Act Manager and the team and is reported comprehensively on a quarterly basis through the Divisional QSE meeting to the Mental Health Act Committee. Mental Health Act Activity is also benchmarked across Wales and is evident via a quarterly report produced by Cardiff and Vale. In relation to the other health boards throughout Wales BCUHB accounted for 50% of all rectifiable errors for the period of

		April - June 2019 (latest data reviewed).
Consider matters arising from the Hospital Managers' Power of Discharge Sub-Committee;		There is a report produced for the Power of Discharge Sub-Committee on activities undertaken by Associate Hospital Managers. This not only includes hearings activity but also the scrutiny of detentions that is undertaken as a separate part of the role. These reports are received by Divisional QSE, Power of Discharge Sub-Committee and the Mental Health Act Committee. The Mental Health Act Manager has established an Associate Hospital Managers Forum and any issues that require escalation are raised in the Power of Discharge Sub-Committee and escalated to Mental Health Act Committee as necessary.
Ensure that **all** other relevant associated legislation is considered in relation to Mental Health Act and Capacity legislation;		The Committee has received reports in relation to MHA compliance and DoLS however limited assurance has been provided on compliance with the MCA.
Consider matters arising from visits undertaken by Healthcare Inspectorate Wales Review* Service for Mental Health in particular, issues relating to Mental Health Act 1983 and monitor action plans that inform responses to HIW reports		Any actions arising in relation to Mental Health Act legislation from external inspections e.g. HIW are monitored locally via the QSE sub groups which in turn report to Divisional QSE to corporate QSE and the Mental Health Act Committee.
Consider any reports made by the Public Services Ombudsman for Wales regarding complaints about Mental Health and Capacity legislation		There have been no relevant reports during the reporting period.
Receive and review reports on the approval for		The Committee has received reports in relation to the approval

all Wales Approved Clinicians and Section 12(2) Doctors		for all Wales Approved Clinicians and Section 12(2) Doctors. The Committee noted concerns in relation to the lack of doctors and was made aware of concerns regarding this from Gwynedd Council. The Committee was informed a task and finish group was to be established.
Consider and approve on behalf of the Board any LHB policy which relates to the implementation of mental health and capacity legislation as well as any other information, reports etc. that the Committee deems appropriate		The Committee received assurance that a list of policies was in place that met the requirements of legislation but was not assured that all policies were reviewed and in-date. A number of policies were identified that were out of date. Assurance was offered that the MHLD Policy Group was addressing this.
Receive and review DoLS reports regarding authorisations and associated reasons		The Committee received DoLS information for part of the year, however not for the full year which may be due to meeting scheduling.
Receive and review reports on the implementation of the Mental Health Measure and be satisfied that positive outcomes for people are being achieved		The Committee received information on compliance with the Measure however not for the full year which may be due to meeting scheduling. The Committee noted the MHLD Division continues to work on achieving the target across all teams, however, high referral rates, sickness and recruitment to vacancies continues to impact on delivery.
Receive and review the results of internal audit reports relating to care and treatment plans, as well as any other relevant reports relating to the Mental Health Measure		No internal audits were presented to the Committee in the reporting period. No internal audits were presented in the previous reporting period either, which is in itself a risk. The Committee will need to consider how it directs internal audit to provide assurance.
Receive the results of clinical audits and any other reviews relating to the use of the Mental Health Act and oversee		No clinical audits were presented to the Committee in the reporting period. No audits were registered in the previous reporting period either, which is in itself a risk. The Committee will need to

the implementation of recommendations		consider how it directs clinical audit to provide assurance.
Consider any other information, reports, etc. that the Committee deems appropriate		The Committee has received ad-hoc reports as required.
Investigate or have investigated any activity (clinical and non-clinical) within its terms of reference		The Committee has not needed to commission investigations during the reporting period but is aware of its right to do so.
Obtain outside legal or other independent professional advice and to secure the attendance of non members with relevant experience and expertise if it considers it necessary, in accordance with the Board's procurement, budgetary and other requirements;		The Committee has not needed to obtain outside independent or legal advice during the reporting period but is aware of its right to do so.

**Key:*

Red	*= the Committee did not receive assurance against the objective*
Amber	*= the Committee received assurance but it was not positive or the Committee were partly assured but further action is needed*
Green	*= the Committee received adequate assurance against the objective*

7. Main tasks completed / evidence considered by the Committee during this reporting period:

The following summarises the main evidence received by the Committee during the reporting period:

Standing Items:

- Patient story scheduled at each meeting.
- Deprivation of Liberty Safeguards: Quarterly Report
- Hospital Manager's Update Report
- Performance Summary Report
- Report on Approval for All Wales Approved Clinicians and Section 12(2) Doctors)
- Consideration of HIW inspection reports and audit reports as appropriate to the meeting remit.

Governance Items:

- Cycle of Business Review
- Committee Annual Report and review of Terms of Reference (including the Power of Discharge Sub-Committee Terms of Reference).

Full details of the issues considered and discussed by the Committee are documented within the agenda and minutes which are available on the Health Board's website and can be accessed from the following pages: https://bcuhb.nhs.wales/about-us/committees-and-advisory-groups/

8. Key risks and concerns identified by this Committee in-year which have been highlighted and addressed as part of the Chair's reports to the Board:

Meeting Date	Key risks including mitigating actions and milestones
28.06.2019	• Recruitment of Section 12[2] doctors remained a concern, discussions were being held with Executive Director of Primary Care & Communities, particular concerns have been raised by Gwynedd County Council. • The Committee remained concerned about the inappropriate DoLs referrals and the timing of such referrals. Discussions were taking place with the Executive Director of Nursing and Midwifery to address matters.
27/09/2019	• Healthcare Inspectorate Wales (HIW) Monitoring Report - the theme of continuous improvement was been noted, along with significant improvements across the Division.
20/12/2019	• A Task and Finish Group chaired by the Medical Director for MHLDs has identified a number of recommendations to increase the number of Section 12(2) doctors for North Wales. The Committee supported the recommendations which will now be referred through the appropriate forums to consider the actions to address the shortage identified.

9. Focus for the year ahead:

The primary focus of the Committee over the next twelve months will be the objectives set out in the Terms of Reference. This is attached as Appendix 1.

The Committee has established a Cycle of Business for the year ahead covering the breadth of its work, and primarily focussing on its key areas of risk, as defined in the Board's Corporate Risk and Assurance Framework. This is attached as Appendix 2.

Appendix 1

Betsi Cadwaladr University Health Board
Terms of Reference and Operating Arrangements

MENTAL HEALTH ACT COMMITTEE

1. INTRODUCTION

1.1 The Board shall establish a committee to be known as the **Mental Health Act Committee**. The detailed terms of reference and operating arrangements in respect of this Committee are set out below. Background information in relation to the Mental Health Act, the Mental Health Measure and the Mental Capacity Act is set out in Annex 1. The Committee will also consider, when appropriate, any other legislation that impacts on mental health and mental capacity. It will regularly report to the Board and advise it of any areas of concern.

2. PURPOSE

2.1 The purpose of the Committee is to consider and monitor the use of the Mental Health Act 1983 (MHA), Mental Capacity Act 2005 (which includes the Deprivation of Liberty Safeguards (DoLS) (MCA) and the Mental Health (Wales) Measure 2010 (the Measure) and give assurance to the Board that:

- Hospital Managers' duties under the Mental Health Act 1983;
- the functions and processes of discharge under section 23 of the Act;
- the provisions set out in the Mental Capacity Act 2005, and
- in the Mental Health Measure (Wales) 2010

are all exercised in accordance with statute and that there is compliance with:

- the Mental Health Act 1983 Code of Practice for Wales
- the Mental Capacity Act 2005 Code of Practice
- the Mental Capacity Act 2005 Deprivation of Liberty Safeguards Code of Practice
- the Human Rights Act 1998
- the United Nations Convention on the Rights of People with Disabilities
- the associated Regulations and local Policies

3. DELEGATED POWERS AND AUTHORITY

3.1 The Committee, in respect of its provision of advice and assurance will and is authorised by the Board to: -

- ensure that those acting on behalf of the Board in relation to the provisions of Mental Health and Capacity legislation, including the Measure, have the requisite skills and competencies to discharge the Board's responsibilities;
- identify matters of risk relating to Mental Health and Capacity legislation and

seek assurance that such risks are being mitigated;

- monitor the use of the legislation and consider local trends and benchmarks;
- consider matters arising from the Hospital Managers' Power of Discharge Sub-Committee;
- ensure that **all** other relevant associated legislation is considered in relation to Mental Health and Capacity legislation;
- consider matters arising from visits undertaken by Healthcare Inspectorate Wales Review* Service for Mental Health in particular, issues relating to Mental Health Act 1983 and monitor action plans that inform responses to HIW reports;
- consider any reports made by the Public Services Ombudsman for Wales regarding complaints about Mental Health and Capacity legislation;
- receive and review reports on the approval for all Wales Approved Clinicians and Section 12(2) Doctors;
- consider and approve on behalf of the Board any LHB policy which relates to the implementation of mental health and capacity legislation as well as any other information, reports etc. that the Committee deems appropriate;
- receive and review DoLS reports regarding authorisations and associated reasons;
- receive and review reports on the implementation of the Mental Health Measure and be satisfied that positive outcomes for people are being achieved;
- receive and review the results of internal audit reports relating to care and treatment plans, as well as any other relevant reports relating to the Mental Health Measure;
- receive the results of clinical audits and any other reviews relating to the use of the Mental Health Act and oversee the implementation of recommendations;
- consider any other information, reports, etc. that the Committee deems appropriate.
- investigate or have investigated any activity (clinical and non-clinical) within its terms of reference. It may seek relevant information from any:
  - employee (and all employees are directed to cooperate with any legitimate request made by the Committee); and
  - other committee, sub-committee or group set up by the Board to assist it in the delivery of its functions.
- obtain outside legal or other independent professional advice and to secure the attendance of non members with relevant experience and expertise if it considers it necessary, in accordance with the Board's procurement, budgetary and other requirements;

*Note – HIW report recommendations are the remit of Quality Safety and Experience Committee (QSE) however any specific recommendations relating to Mental Health or the Mental Capacity Act will be the remit of this Committee who will respond as appropriate ensuring the Board and QSE are appraised accordingly.

Sub Committees/Panels

3.2 The Committee may, subject to the approval of the Health Board, establish Sub-Committees or task and finish groups to carry out on its behalf specific aspects of Committee business.

3.3 Sub-Committee - In accordance with Regulation 12 of the Local Health

Boards (Constitution, Procedure and Membership) (Wales) Regulations 2003 (SI 2003/149 (W.19), the Board has appointed a Sub-Committee of this Committee, to be known as the Power of Discharge Sub-Committee, terms of reference for which are attached as Annex 2.

3.4 Panel -Three members drawn from the pool of designated Associate Hospital Managers will constitute a panel to consider the possible discharge or continued detention under the MHA of unrestricted patients and those subject to Supervised Community Treatment Order(SCT).

3.5 The Board retains final responsibility for the performance of the Hospital Managers' duties delegated to particular people on the staff of Betsi Cadwaladr University Local Health Board, as well as the Power of Discharge Sub-Committee.

4. MEMBERSHIP

4.1 Members

Four Independent Members of the Board to include one who is a Member of the Quality, Safety and Experience Committee and one who shall be the Chair of the Power of Discharge Sub-Committee.

4.2 In attendance

Director of Mental Health & Learning Disabilities
Executive Director of Nursing and Midwifery
Medical Director for Mental Health
Nursing Director for Mental Health
Mental Health Director
Mental Health Act Manager
Service User Representative
Carer Representative
Social Services Representative
North Wales Police Representative
Welsh Ambulance Services NHS Trust Representative
IMCA Advocacy provider Representative
IMHA Advocacy provider Representative
MCA representative
DoLS representative
Two Associate Hospital Managers (as nominated by the Power of Discharge Sub-Committee) appointed for a period of four years with re-appointment not to exceed a maximum of eight years in total.

4.3 Other Directors will attend as required by the Committee Chair, as well any others from within or outside the organisation who the Committee considers should attend, taking into account the matters under consideration at each meeting.

4.4 Trade Union Partners are welcome to attend the public session of the

Committee

4.4 Member Appointments

4.4.1 The membership of the Committee shall be determined by the Board, based on the recommendation of the Health Board Chair - taking account of the balance of skills and expertise necessary to deliver the Committee's remit and subject to any specific requirements or directions made by the Welsh Government. This includes the appointment of the Chair and Vice-Chair of the Committee who shall be Independent Members. The Vice-Chair of the Health Board will be the Chair of this Committee and shall retain the role of Chair of this Committee throughout their tenure of appointment.

4.4.2 Other appointed Independent Members shall hold office on the Committee for a period of up to 4 years. Tenure of appointments will be staggered to ensure business continuity. A member may resign or be removed from the Committee by the Board. Independent Members may be reappointed up to a maximum period of 8 years.

4.5 Secretariat

4.5.1 Secretary: as determined by the Board Secretary.

4.6 Support to Committee Members

4.6.1 The Board Secretary, on behalf of the Committee Chair, shall:

- Arrange the provision of advice and support to Committee members on any aspect related to the conduct of their role; and

- Ensure the provision of a programme of development for Committee members as part of the overall Board Development programme.

5. COMMITTEE MEETINGS

5.1 Quorum

5.1.1 At least two Independent Members must be present to ensure the quorum of the Committee, one of whom should be the Committee Chair or Vice-Chair.

5.2 Frequency of Meetings

5.2.1 Meetings shall routinely be held on a quarterly basis.

5.3 Withdrawal of individuals in attendance

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

6. RELATIONSHIP AND ACCOUNTABILITIES WITH THE BOARD AND ITS COMMITTEES

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

6.2 The Committee is directly accountable to the Board for its performance in exercising the functions set out in these Terms of Reference.

6.3 The Committee, through its Chair and members, shall work closely with the Board's other Committees to provide advice and assurance to the Board through the:

6.3.1 joint planning and co-ordination of Board and Committee business; and
6.3.2 sharing of information

in doing so, contributing to the integration of good governance across the organisation, ensuring that all sources of assurance are incorporated into the Board's overall risk and assurance arrangements.

6.4 The Committee shall embed the corporate goals and priorities through the conduct of its business, , and in doing and transacting its business shall seek assurance that adequate consideration has been given to the sustainable development principle and in meeting the requirements of the Well-Being of Future Generations Act.

7. REPORTING AND ASSURANCE ARRANGEMENTS

7.1 The Committee Chair shall:

7.1.1 report formally, regularly and on a timely basis to the Board on the Committee's activities, via the Chair's assurance report as well as the presentation of an annual Committee report;

7.1.2 ensure appropriate escalation arrangements are in place to alert the Health Board Chair, Chief Executive or Chairs' of other relevant committees of any urgent/critical matters that may affect the operation and/or reputation of the Health Board.

7.2 The Board Secretary, on behalf of the Board, shall oversee a process of regular and rigorous self-assessment and evaluation of the Committee's performance and operation.

8. APPLICABILITY OF STANDING ORDERS TO COMMITTEE BUSINESS

8.1 The requirements for the conduct of business as set out in the Standing Orders are equally applicable to the operation of the Committee, except in the following areas:

• Quorum

9. REVIEW

9.1 These terms of reference and operating arrangements shall be reviewed annually by the Committee and any changes recommended to the Board for approval.

V4.0 Approved:

Audit Committee 30.5.19

Chair's Report to Board 25.7.19

Annex 1

BACKGROUND INFORMATION REGARDING THE ASSOCIATED LEGISLATION

Mental Health Act 1983 (as amended by the Mental Health Act 2007)

The Mental Health Act 1983 covers the legal framework to allow the care and treatment of mentally disordered persons to be detained if deemed to be a risk to themselves or others.
It also provides the legislation by which people suffering from a mental disorder can be detained in hospital to have their disorder assessed or treated against their wishes.

The MHA introduced the concept of "Hospital Managers" which for hospitals managed by a Local Health Board are the Board Members. The term "Hospital Managers" does not occur in any other legislation.

Hospital Managers have a central role in operating the provisions of the MHA; specifically, they have the authority to detain patients admitted and transferred under the MHA. For those patients who become subject to Supervised Community Treatment (SCT), the Hospital Managers are those of the hospital where the patient was detained immediately before going on to SCT - i.e. the responsible hospital or the hospital to which responsibility has subsequently been assigned.

Hospital Managers must ensure that patients are detained only as the MHA allows, that their treatment and care is fully compliant with the MHA and that patients are fully informed of and supported in exercising their statutory rights. Hospital Managers must also ensure that a patient's case is dealt with in line with associated legislation. With the exception of the Power of Discharge Sub-Committee, arrangements for authorising day to day decisions made on behalf of Hospital Managers have been set out in the Health Board's Scheme of Delegation.

Mental Health Measure

The Mental Health (Wales) Measure received Royal Assent in December 2010 and is concerned with:

- providing mental health services at an earlier stage for individuals who are experiencing mental health problems to reduce the risk of further decline in mental health;
- making provision for care and treatment plans for those in secondary mental health care and ensure those previously discharged from secondary mental health services have access to those services when they believe their mental health may be deteriorating;
- extending mental health advocacy provision.

Mental Capacity Act

The MCA came into force mainly in October 2007. It was amended by the Mental Health
Act 2007 to include the Deprivation of Liberty Safeguards (DoLS). DoLS came into force in
April 2009.

The MCA covers three main issues:

- The process to be followed where there is doubt about a person's decision-making abilities and decisions therefore where 'Best Interest' may need to be made on their behalf (e.g. about treatment and care)
- How people can make plans and/or appoint other people to make decisions for them at a time in the future when they can't take their own decisions
- The legal framework for caring for adult, mentally disordered, incapacitated people in situations where they are deprived of their liberty in hospitals or care homes (DoLS) and/or where Court of Protection judgements are required.

Thus the scope of MCA extends beyond those patients who have a mental disorder.

Annex 2

POWER OF DISCHARGE SUB-COMMITTEE
TERMS OF REFERENCE AND OPERATING ARRANGEMENTS

1. INTRODUCTION

1.1 The Board shall establish a sub-committee to be known as the Power of Discharge Sub-Committee. The detailed terms of reference and operating arrangements in respect of this Sub-Committee are set out below.

2. PURPOSE

2.1 The purpose of the Power of Discharge Sub-Committee (hereafter, the Sub-Committee) is to advise and assure the Board that the processes associated with the discharge of patients from compulsory powers that are used by the Sub-Committee are being performed correctly and in accordance with legal requirements.

3. DELEGATED POWERS AND AUTHORITY

3.1 The Sub-Committee, in respect of its provision of advice and assurance will and is authorised by the Board to:-

- Comment specifically upon the processes employed by the Sub-Committee's Panel in relation to the discharge of patients from compulsory powers, and whether these processes are fair, reasonable and compliant with the Mental Health Act and are in line with other related legislation, including, the Mental Capacity Act 2005, the Human Rights Act 1998 and the Data protection Act 1998 and that the appropriate systems are in place to ensure the effective scrutiny of associated discharge documentation.

- undertake the functions of Section 23 of the Mental Health Act 1983, in relation to hearing cases of detained powers ensuring that three or more members of the Sub-Committee form a Panel and only a minimum of three members in agreement may exercise the Power of Discharge Sub-Committee. The Panel will be drawn from the pool of members formally designated as Hospital Manager as reported to the Sub-Committee.

- investigate or have investigated any activity (clinical and non-clinical) within its terms of reference. It may seek relevant information from any:

    - employee (and all employees are directed to cooperate with any legitimate request made by the Committee); and

    - other committee, sub-committee or group set up by the Board to assist it in the delivery of its functions.

- obtain outside legal or other independent professional advice and to secure the attendance of outsiders with relevant experience and expertise if it considers it necessary, in accordance with the Board's procurement, budgetary and other requirements;

3.2 The Sub-Committee will, as part of its process of hearing cases, be made aware of operational issues affecting the patient's care and treatment, including discharge arrangements. These are not matters for which the Sub-Committee shall have responsibility. Even so, Sub-Committee members are not precluded from raising such matters with those holding operational responsibility. In addition, such issues can be raised on an anonymised basis or through the Board itself.

4. MEMBERSHIP

4.1 Members

Three Independent Members of the Board.
A maximum of ten (10) appointed MHA Managers (as nominated and agreed by the Sub-Committee) (Appointed for a period of four years with appointment not to exceed a maximum of eight years in total).

4.2 Attendees

Director of Mental Health
Senior Mental Health Clinicians
Mental Health Act Manager
Officer Representatives for Learning Disabilities and Children's Services

Other Directors will attend as required by the Committee Chair, as well any others from within or outside the organisation who the Committee considers should attend, taking into account the matters under consideration at each meeting.

Trade Union Partners are welcome to attend the public session of the sub-committee

4.3 Member Appointments

4.3.1 The membership of the Committee shall be determined by the Board, based on the recommendation of the Health Board Chair - taking account of the balance of skills and expertise necessary to deliver the Committee's remit and subject to any specific requirements or directions made by the Welsh Government. This includes the appointment of the Chair and Vice-Chair of the Committee who shall be Independent Members. The Vice-Chair of the Board shall be the Chair of this Sub-Committee.

4.3.2 Appointed Independent Members shall hold office on the Committee for a period of up to 4 years. Tenure of appointments will be staggered to ensure business continuity. A member may resign or be removed from the Committee by the Board. Independent Members may be reappointed up to a maximum period of 8 years.

4.4 Secretariat

4.4.1 Secretary: as determined by the Board Secretary.

4.5 Support to Committee Members

4.5.1 The Board Secretary, on behalf of the Committee Chair, shall:

- Arrange the provision of advice and support to Committee members on any aspect related to the conduct of their role; and
- Ensure the provision of a programme of development for Committee members as part of the overall Board Development programme.

5. SUB-COMMITTEE MEETINGS

5.1 Quorum

At least two Independent Members and four Associate Hospital Managers must be present to ensure the quorum of the Sub-Committee one of whom should be the Chair or Vice-Chair.

5.2 Frequency of Meetings

Meetings shall routinely be held on a quarterly basis.

5.3 Withdrawal of individuals in attendance

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

6. RELATIONSHIP & ACCOUNTABILITIES WITH THE BOARD AND ITS COMMITTEES/GROUPS

6.1 Although the Board has delegated authority to the Sub-Committee for the exercise of certain functions as set out within these terms of reference, it retains overall responsibility and accountability for ensuring the quality and safety of healthcare for its citizens through the effective governance of the organisation.

6.2 The Sub-Committee is directly accountable to the Board (via the Mental Health Act Committee) for its performance in exercising the functions set out in these Terms of Reference.

6.3 The Sub-Committee, through its Chair and members, shall work closely with the Board's other Committees to provide advice and assurance to the Board through the:

6.3.1 joint planning and co-ordination of Board and Committee business; and
6.3.2 sharing of information

in doing so, contributing to the integration of good governance across the organisation, ensuring that all sources of assurance are incorporated into the Board's overall risk and assurance arrangements.

6.4 In terms of the Board's assurance on the Mental Health Act requirements, the remit of the Sub-Committee is limited to the exercise of powers under Section 23 of the Mental Health Act 1983, rather than the wider operation, which would be the remit of the Mental Health Act Committee.

6.5 The Sub-Committee shall embed the corporate goals and priorities through the conduct of its business, , and in doing and transacting its business shall seek assurance that adequate consideration has been given to the sustainable development principle and in meeting the requirements of the Well-Being of Future Generations Act.

7. REPORTING AND ASSURANCE ARRANGEMENTS

7.1 The Committee Chair shall:

7.1.1 report formally, regularly and on a timely basis to the Board on the Sub-Committee's activities, via the Chair's assurance report;

7.1.2 ensure appropriate escalation arrangements are in place to alert the Health Board Chair, Chief Executive or Chairs' of other relevant committees of any urgent/critical matters that may affect the operation and/or reputation of the Health Board.

7.2 The Board Secretary, on behalf of the Board, shall oversee a process of regular and rigorous self-assessment and evaluation of the Sub-Committee's performance and operation as part of the overall review of the Mental Health Act Committee.

8. APPLICABILITY OF STANDING ORDERS TO COMMITTEE BUSINESS

8.1 The requirements for the conduct of business as set out in the Health Board's Standing Orders are equally applicable to the operation of the Sub-Committee, except in the following areas:

- Quorum
- owing to the nature of the business of the Sub-Committee, meetings will not be held in public.

9. REVIEW

9.1 These terms of reference and operating arrangements shall be reviewed annually by the Sub-Committee and any changes recommended to the Board, with reference to the Mental Health Act Committee for approval.

Appendix 2

Agenda Item	18.09.20	11.12.20	12.03.21
Opening Business			
Apologies	**x**	**x**	**x**
Declaration of Interests	**x**	**x**	**x**
Previous Minutes, Matters Arising and Summary Action Plan	**x**	**x**	**x**
Minutes of previous POWER OF DISCHARGE SUB-COMMITTEE COMMITTEE meeting and oral update from the earlier	**x**	**x**	**x**
CANIAD – Patient Story	**x**	**x**	**x**
Deprivation of Liberty Safeguards: Quarterly Report	**x**	**x**	**x**
Hospital Manager's Update Report (Oral summary only based on feedback from earlier POWER OF DISCHARGE	**x**	**x**	**x**
Performance Report	**x**	**x**	**x**
Approval for All Wales Approved Clinicians and Section 12(2) Doctors)	**x**	**x**	**x**
Consideration of any HIW/Inspection reports/Audit reports etc as appropriate to meetings remit.	**x**	**x**	**x**
Agree CoB for coming year			**x**
Committee Annual Report and review of TOR and Power of Discharge Sub-Committee			**x**
Issues of Significance	**x**	**x**	**x**
Any Other Business	**x**	**x**	**x**
Date of Next meeting(s)	**x**	**x**	**x**

Digital and Information Governance Committee
Annual Report 2019-20

1. Digital and Information Governance Committee

At the meeting held on 29th September 2019 the Committee updated the title of the Committee from:

- The Information Governance and Informatics Committee

To the:

- Digital and Information Governance Committee

2. Name and role of person submitting this report:

Dr David Fearnley, Executive Medical Director

3. Dates covered by this report:

01/04/2019-31/03/2020

4. Number of times the Committee met during this period:

The Committee was routinely scheduled to meet 4 times and otherwise as the Chair deemed necessary. During the reporting period, it met on 4 occasions.

Attendance at meetings is detailed within the table below:

Members of the Committee	9.5.19	29.9.19	21.11.19	13.2.20
Independent Members				
Mr John Cunliffe	P	P	P	P
Cllr Cheryl Carlisle	A	P	A	A
Mrs Lucy Reid	P	P	P	◆
Mr Medwyn Hughes	◆	◆	◆	A
Professor Nicky Callow	◆	P	P	A

Formally In attendance (as per Terms of Reference)	9.5.19	29.9.19	21.11.19	13.2.19
Directors				
Dr David Fearnley Executive Medical Director (Lead Director)	◆	P	P	P
Dr Evan Moore Executive Medical Director (Lead Director)	P	◆	◆	◆
Dr Melanie Maxwell Senior Associate Caldicott Guardian	P	P	A	A
Mr Dylan Williams Chief Information Officer	A	P	P	P
Ms Grace Lewis Parry Board Secretary/Senior Information Risk Owner (SIRO)	P	◆	◆	◆
Mrs Justine Parry Assistant Director Information Governance and Assurance / Data Protection Officer (DPO)	P	P	A	P
Ms Sue Hill Executive Director Of Finance/ Senior Information Risk Owner (SIRO)	◆	◆	◆	A

Key:

P - Present

P* - Present for part meeting

A - Apologies submitted

X - Not present

◆ Not a member of the Committee at this time.

In addition to the above core membership, other Directors and Officers from the Health Board regularly attend meetings of the Committee/Group/Forum. For a full list of attendance, please see the approved minutes which can be accessed on the Health Board's website via the following pages:- https://bcuhb.nhs.wales/about-us/committees-and-advisory-groups/

5. Assurances the Committee is designed to provide:

The Digital and Information Governance Committee is designed to provide assurance to the Board on the following key areas as set out in its Terms of Reference as follows:-

- oversee the development of the Health Board's strategies and plans for maintaining the trust of patients and public through its arrangements for handling and using information, including personal information, safely and securely, consistent with the Board's overall strategic direction and any requirements and standards set for NHS bodies in Wales;

- oversee the direction and delivery of the Health Board's digital and information governance strategies to drive change and transformation in line with the Health Board's integrated medium term plan that will support modernisation through the use of information and technology;

- consider the information governance and digital implications arising from the development of the Health Board's corporate strategies and plans or those of its stakeholders and partners;

- consider the information governance and digital implications for the Health Board of internal and external reviews and reports;

- oversee the development and implementation of a culture and process for data protection by design and default (including Privacy Impact Assessments) in line with legislation (e.g. General Data Protection Regulation).

The Committee will, in respect of its assurance role, seek assurances that information governance and the digital (including patient records) arrangements are appropriately designed and operating effectively to ensure the safety, security, integrity and effective use of information to support the delivery of high quality, safe healthcare across the whole of the Health Board's activities.

To achieve this, the Committee's programme of work will be designed to ensure that, in relation to information governance, digital and patient records:

- there is clear, consistent strategic direction, strong leadership and transparent lines of accountability;
- there is a citizen centred approach, striking an appropriate balance between openness and confidentiality in the management and use of information and technology;
- the handling and use of information and information systems across the organisation is consistent, and based upon agreed standards;
- there is effective communication, engagement and the workforce is appropriately trained, supported and responsive to requirements in relation to the effective handling and use of information (including IT Systems) –

consistent with the interests of patients and the public;

- there is effective collaboration with partner organisations and other stakeholders in relation to the sharing of information in a controlled manner, to provide the best possible outcomes for its citizens (in accordance with the Wales Accord for the Sharing of Personal Information and Caldicott requirements);
- the integrity of information is protected, ensuring valid, accurate, complete and timely information is available to support decision making across the organisation;
- the Health Board is meeting its responsibilities with regard to the General Data Protection Regulation, the Freedom of Information Act, Caldicott, Information Security, Records Management, Information Sharing, national Information Governance policies and Information Commissioner's Office Guidance;
- The Health Board is safeguarding its information, technology and networks through monitoring compliance with the Security of Network and Information Systems regulations and relevant standards;
- all reasonable steps are taken to prevent, detect and rectify irregularities or deficiencies in the safety, security and use of information, and in particular that:
    - Sources of internal assurance are reliable, and have the capacity and capability to deliver;
    - Recommendations made by internal and external reviewers are considered and acted upon on a timely basis;
    - Lessons are learned from breaches in the safe, secure and effective use of information, as identified for example through reported incidents, complaints and claims; and
    - Training needs are assessed and met.

- receive assurance on the delivery of the digital and information governance operational plans including performance against the annual Digital Capital Programme;
- seek assurance on the effectiveness and impact of the Health Board's Digital Transformation Plans;
- seek assurance on the performance and delivery of the rollout of the core national IT systems which could have significant impact on the Health Board's operational services and escalate to the Board as appropriate.

The Committee will receive assurance on compliance with key performance indicators in relation to the quality and effectiveness of information and information systems against which the Health Board's performance will be regularly assessed.

Maintain oversight of the effectiveness of the relationships and governance arrangements with partner organisations in relation to digital and information governance. This will include NHS Wales Informatics Service (NWIS).

During the period that this Annual Report covers, the Digital and Information Governance Committee operated in accordance with its terms of reference. For the term that this Annual Report covers there were three versions of Terms of Reference

in operation and all are appended. The terms of reference are appended at Appendix 1.

The work programmes, cycles of business and overall performance of each Committee/Group/Forum are reviewed by the Committee Business Management Group (CBMG) which meets quarterly. The CBMG oversees effective communication between Committees, avoiding duplication and ensuring all appropriate business is managed effectively and efficiently through the Health Board's Governance framework.

The Committee is required to publish its agenda and papers 7 days ahead of the meeting, and a breach log is maintained by the Office of the Board Secretary where there are exceptions to this requirement. During the reporting period there were no breaches of this nature

6. Overall *RAG status against Committee's annual objectives / plan: RED/AMBER/GREEN –Amber

The summary below reflects the Committee's assessment of the degree to which it has met these objectives. The supporting narrative included alongside the assessment below describes this in more detail.

Objective as set out in Terms of Reference	**Assurance Status (RAG)***	**Supporting narrative**
Oversee the development of the Health Board's strategies and plans for maintaining the trust of patients and public through its arrangements for handling and using information, including personal information, safely and securely, consistent with the Board's overall strategic direction and any requirements and standards set for NHS bodies in Wales;	Green	• Draft operational and finalised plans submitted to the Committee. • Approved the Information Governance Strategy • Approved the Information Governance Annual Report. • Approved the Caldicott Outturn Report. • Extracts from the overall Annual

		Plan for informatics assured by the Committee. • Strategic updates provided regularly including early draft of the Digital Enabled Clinical Strategy. • The Committee has received updates on key projects such as the Digital Health Record business case and WCCIS. • Regular operational plan and assurance reports provided. • Regular Information Governance key performance indicator reports provided. • Regular Chair Reports from the Digital Improvement Group and the Information Governance Group
Oversee the direction and delivery of the Health Board's digital and information governance strategies to drive change and transformation in line with the Health Board's integrated medium term plan that will support modernisation through the use of information and technology;	Amber	As above and updates on national governance and architecture reviews and digital priorities funding. Amber - Due to progress of national programmes.

Consider the information governance and informatics implications arising from the development of the Health Board's corporate strategies and plans or those of its stakeholders and partners;	Green	Corporate risks relating to National Systems, Local Digital and Health records are on the cycle of business. Regular updates on Information Governance Risks provided as part of the Chairs Assurance Report from the Information Governance Group.
Consider the information governance and informatics implications for the Health Board of internal and external reviews and reports;	Green	External reviews presented from the Information Commissioners Office, internal audit and Wales Audit Office including: • Data Protection Compliance follow up Audit review. • Clinical coding review. • Asset Management Review. Updates on national system outages have been provided – including national data centre outage reports by NWIS. Quarterly Information Governance assurance reports received.
Oversee the development and implementation of a culture and	Green	Quarterly Information

process for data protection by design and default (including Privacy Impact Assessments) in line with legislation (e.g. General Data Protection Regulation).		Governance Key Performance Indicator reports provided which include compliance with legislation, details of incidents, actions taken, outcomes and lessons learnt. Reports also include details of all Information Sharing Arrangements approved for implementation.
The Committee will, in respect of its assurance role, seek assurances that information governance and the informatics (including patient records) arrangements are appropriately designed and operating effectively to ensure the safety, security, integrity and effective use of information to support the delivery of high quality, safe healthcare across the whole of the Health Board's activities.	Amber	Outline business case for Digital Health Record reviewed by the Committee and regular operational plan and assurance reports developed and presented. We continue to refine the reports in in line with best practice. Storage implications due National Infected Blood Inquiry remain an ongoing concern.
To achieve this, the Committee's programme of work will be designed to ensure that, in relation to information governance, informatics and patient records:		
• there is clear, consistent strategic direction, strong leadership and transparent lines of accountability;	Amber	During the year the transfer of responsibility for Information Governance moved

		to the Deputy Chief Executive Office. Whilst the Executive Medical Director has the overall responsibility for Patient Records across the Health Board, a requirement to clearly identify responsibility for Corporate and Staff records remains outstanding. The operational plan is clear but the overall strategic direction is under development – alignment with clinical service strategy and national digital governance arrangements need clarifying.
• there is a citizen centred approach, striking an appropriate balance between openness and confidentiality in the management and use of information and technology;	Amber	Implementation of the Data Protection Impact Assessment has identified risks to achieving this balance by ensuring appropriate mitigations are considered. New Digital strategy in development will enhance this.
• the handling and use of information and information systems across the organisation is consistent, and based upon agreed standards;	Amber	The continued review and embedding of the Information and Asset Register is

		supporting compliance with standards. Some gaps identified with respect to system owners and change control which is being addressed.
• there is effective communication, engagement and the workforce is appropriately trained, supported and responsive to requirements in relation to the effective handling and use of information (including IT Systems) – consistent with the interests of patients and the public;	Amber	Compliance with mandatory Information Governance Training has remained steady at just over 80% and is regularly reported as part of the Information Governance Key Performance Indicator reports.
• there is effective collaboration with partner organisations and other stakeholders in relation to the sharing of information in a controlled manner, to provide the best possible outcomes for its citizens (in accordance with the Wales Accord for the Sharing of Personal Information and Caldicott requirements);	Green	All appropriate information sharing arrangements remain in line with WASPI requirements and data is shared in an appropriate manner. Further requirements to safely share information are also considered and addressed as part of Data Protection Impact Assessment.
• the integrity of information is protected, ensuring valid, accurate, complete and timely information is available to support decision making across the organisation;	Green	The Committee has received assurances regarding protection of information, as part of the Quarterly

		Information Governance Key Performance Indicators and IT update reports
• the Health Board is meeting its responsibilities with regard to the General Data Protection Regulation, the Freedom of Information Act, Caldicott, Information Security, Records Management, Information Sharing, national Information Governance policies and Information Commissioner's Office (ICO) Guidance;	Green	Regular reports received to provide assurance plus partnership with ICO to assess and make recommendations for improvement.
• The Health Board is safeguarding its information, technology and networks through monitoring compliance with the Security of Network and Information Systems regulations and relevant standards;	Amber	Regular assurance report received which covers IT assurance. To be redesigned going forward as we undertake assessment such as Cyber Essentials.
• all reasonable steps are taken to prevent, detect and rectify irregularities or deficiencies in the safety, security and use of information, and in particular that: • Sources of internal assurance are reliable, and have the capacity and capability to deliver; • Recommendations made by internal and external reviewers are considered and acted upon on a timely basis; • Lessons are learned from breaches in the safe, secure and effective use of information, as identified for example through	Green	Assurances provided that all reasonable steps to protect information are taken. Breaches are reported and currently the format of completed actions, outcomes and lessons learnt are being enhanced.

reported incidents, complaints and claims; and • Training needs are assessed and met.		
• receive assurance on the delivery of the informatics and information governance operational plans including performance against the annual Informatics Capital Programme;	Green	Part of operational plan and regular assurance reports.
• seek assurance on the effectiveness and impact of the Health Board's Digital Transformation Plans;	Amber	Plans assured by the Committee and regular monitoring reports provided.
• seek assurance on the performance and delivery of the rollout of the core national IT systems which could have significant impact on the Health Board's operational services and escalate to the Board as appropriate.	Red	National rollout plans included within operational plan and NWIS provide updates. This element will be developed further as NWIS become a special health authority.
The Committee will receive assurance on compliance with key performance indicators in relation to the quality and effectiveness of information and information systems against which the Health Board's performance will be regularly assessed.	Amber	Included within assurance reports e.g. patch management and clinical coding performance.
Maintain oversight of the effectiveness of the relationships and governance arrangements with partner organisations in relation to informatics and information governance. This will include NHS Wales Informatics Service (NWIS).	Amber	NWIS in attendance and outputs of national reviews provided to the Committee. Further work needed for NWIS to demonstrate alignment with BCU objectives. BCUHB Data Protection Officer is the current Chair of

		the National Information Governance Group and in attendance at the Wales Information Governance Board.

*Key:

Red	*= the Committee did not receive assurance against the objective*
Amber	*= the Committee received assurance but it was not positive or the Committee were partly assured but further action is needed*
Green	*= the Committee received adequate assurance against the objective*

7. Main tasks completed / evidence considered by the Committee during this reporting period:

Standing Items

- Digital Operational plan – quarterly update including National Infected Blood Inquiry update
- NWIS update report
- Information Governance - quarterly assurance report (KPI, Lessons learned and compliance report)

Regular Items

- Digital and Information Governance Strategy reviews
- Informatics – Operational Planning
- Annual IG and Caldicott Report Reviews
- Integrated Quality Performance monitoring report – relevant dimensions
- Governance Matters/items
- Review of minutes and actions
- Approval of Committee terms of reference
- Approval of Cycle of Business
- Agreement and review of corporate risks assigned to the Committee
- Endorsement of annual reports 2018/2019
- Review performance against the Board Approved plan 2019/20
- Policies – approval of national and local and compliance with national policy and development of organisational policy) – *as arise*
- Improvement Group Updates

Ad-Hoc

- CHAI digital nursing
- Digital Strategy
- Change management Policy
- WAO Clinical Coding

- Transformation Fund allocation and planning for future Transformation fund opportunities
- Information Commissioner's Office Follow up Data Protection Audit Report

In committee items

- Delivering an Acute Digital Health Record (DHR)
- Digital Strategy
- Transformation Fund allocation and planning for future Transformation fund opportunities
- Police Requests for Medical Statements
- ICT Asset Management review

Full details of the issues considered and discussed by the Committee are documented within the agenda and minutes which are available on the Health Board's website and can be accessed from the following pages https://bcuhb.nhs.wales/about-us/committees-and-advisory-groups/

8. Key risks and concerns identified by this Committee in-year which have been highlighted and addressed as part of the Chair's reports to the Board:

Meeting Date	Key risks including mitigating actions and milestones
09/05/2019	• Of particular concern were the delays, functionality and prioritisation of National systems and programmes which were brought to the attention of the NWIS Director present. • Delays in progress with the national WCCIS System remained of great concern, the impacts of which were drawn to the attention of the NWIS Director present. • Risks from continued (and unavoidable) use of obsolete operating systems. • Lack of change management for 200+ system owners outside of Informatics management. • The Committee continued to raise a general point regarding the accurate completion of coversheets and that where risks or concerns were included within the accompanying narrative paper, these should also be highlighted on the coversheet.
27/09/19	• Continued Delay in progress with the national WCCIS and other national systems. • Further concern regarding business continuity following another major national data centre failure/outage. • Capacity to roll out digital mobile workforce plans and funding required for Office 365 implementation. • Paper health records storage
21/11/20	• Progress against Informatics Operational Plans. • BCU's Digital strategy continuing to be developed and taken forward.

	• Continued progress on good Information Governance.
13/02/20	• Major risks covered by CRR10a, 10b and 10c. • There is significant financial risk from potential fines imposed by the ICO for poor health records management. • The transition of NWIS to a SHA represents a risk that: o Governance and supplier relationship with BCU not clear. o Transition not considering architecture review. o "Lift and shift" of NWIS doesn't address existing structural failings.

9. Focus for the year ahead:

The primary focus of the Committee over the next twelve months will be;

- To oversee the development and approval of the digitally enabled strategy with a particular focus on the core digital bundle including the Digital Health Record, Digital Dictation & Speech Recognition, a single patient administration system coupled with the accelerated rollout of Office 365 to support agile working for staff.

- Reviewing the learning from the impact of the coronavirus pandemic and influencing the prioritisation of technology that will aid virtual working – including technology enhanced care, virtual consultation and providing patient access to their own data.

- To ensure that digital priorities will mitigate the three corporate risk relating to health records, delivery of national solutions and the local capacity to provide digital services to support improved service delivery

The Committee has established a Cycle of Business for the year ahead covering the breadth of its work, and primarily focussing on its key areas of risk, as defined in the Board's Corporate Risk and Assurance Framework. This is attached as Appendix 2

V6.0

Appendix 1

Betsi Cadwaladr University Health Board
Terms of Reference and Operating Arrangements

DIGITAL AND INFORMATION GOVERNANCE COMMITTEE

1. INTRODUCTION

The Board shall establish a committee to be known as the Digital and Information Governance Committee (DIG). The detailed terms of reference and operating arrangements in respect of this Committee are set out below.

2. PURPOSE

The purpose of the Committee is to advise and assure the Board in discharging its responsibilities with regard to the quality and integrity; safety and security and appropriate access and use of information to support health improvement and the provision of high quality healthcare.

The Committee will seek assurance on behalf of the Board in relation to the Health Board's arrangements for appropriate and effective management and protection of information (including patient and personal information) in line with legislative and regulatory responsibilities.

The Committee will also provide advice and assurance to the Board in relation to the direction and delivery of the Digital and Information Governance Strategies to drive continuous improvement and support IT enabled health care to achieve the objectives of the Health Board's integrated medium term plan.

3. DELEGATED POWERS

3.1 The Committee, in respect of its provision of advice and assurance will, and is authorised by the Board to: -

- oversee the development of the Health Board's strategies and plans for maintaining the trust of patients and public through its arrangements for handling and using information, including personal information, safely and securely, consistent with the Board's overall strategic direction and any requirements and standards set for NHS bodies in Wales;

- oversee the direction and delivery of the Health Board's digital and information governance strategies to drive change and transformation in line with the Health Board's integrated medium term plan that will support modernisation through the use of information and technology;

- consider the information governance and digital implications arising from the development of the Health Board's corporate strategies and plans or those of its stakeholders and partners;

- consider the information governance and digital implications for the Health Board of internal and external reviews and reports;

- oversee the development and implementation of a culture and process for data protection by design and default (including Privacy Impact Assessments) in line with legislation (e.g. General Data Protection Regulation).

3.2 The Committee will, in respect of its assurance role, seek assurances that information governance and the digital (including patient records) arrangements are appropriately designed and operating effectively to ensure the safety, security, integrity and effective use of information to support the delivery of high quality, safe healthcare across the whole of the Health Board's activities.

3.3 To achieve this, the Committee's programme of work will be designed to ensure that, in relation to information governance, digital and patient records:

- there is clear, consistent strategic direction, strong leadership and transparent lines of accountability;

- there is a citizen centred approach, striking an appropriate balance between openness and confidentiality in the management and use of information and technology;

- the handling and use of information and information systems across the organisation is consistent, and based upon agreed standards;

- there is effective communication, engagement and the workforce is appropriately trained, supported and responsive to requirements in relation to the effective handling and use of information (including IT Systems) – consistent with the interests of patients and the public;

- there is effective collaboration with partner organisations and other stakeholders in relation to the sharing of information in a controlled manner, to provide the best possible outcomes for its citizens (in accordance with the Wales Accord for the Sharing of Personal Information and Caldicott requirements);

- the integrity of information is protected, ensuring valid, accurate, complete and timely information is available to support decision making across the organisation;

- the Health Board is meeting its responsibilities with regard to the General Data Protection Regulation, the Freedom of Information Act, Caldicott, Information Security, Records Management, Information Sharing, national

Information Governance policies and Information Commissioner's Office Guidance;

- The Health Board is safeguarding its information, technology and networks through monitoring compliance with the Security of Network and Information Systems regulations and relevant standards;

- all reasonable steps are taken to prevent, detect and rectify irregularities or deficiencies in the safety, security and use of information, and in particular that:

    - Sources of internal assurance are reliable, and have the capacity and capability to deliver;
    - Recommendations made by internal and external reviewers are considered and acted upon on a timely basis;
    - Lessons are learned from breaches in the safe, secure and effective use of information, as identified for example through reported incidents, complaints and claims; and
    - Training needs are assessed and met.

- receive assurance on the delivery of the digital and information governance operational plans including performance against the annual Digital Capital Programme;

- seek assurance on the effectiveness and impact of the Health Board's Digital Transformation Plans;

- seek assurance on the performance and delivery of the rollout of the core national IT systems which could have significant impact on the Health Board's operational services and escalate to the Board as appropriate.

3.4 The Committee will receive assurance on compliance with key performance indicators in relation to the quality and effectiveness of information and information systems against which the Health Board's performance will be regularly assessed.

3.5 Maintain oversight of the effectiveness of the relationships and governance arrangements with partner organisations in relation to digital and information governance. This will include NHS Wales Informatics Service (NWIS).

4. AUTHORITY

4.1 The Committee may investigate or have investigated any activity within its terms of reference. It may seek relevant information from any:

- employee (and all employees are directed to cooperate with any legitimate request made by the Committee); and

- other committee, sub-committee or group set up by the Board to assist it in the delivery of its functions.

4.2 May obtain outside legal or other independent professional advice and to secure the attendance of outsiders with relevant experience and expertise if it considers it necessary, in accordance with the Board's procurement, budgetary and other requirements;

4.3 May consider and where appropriate, approve on behalf of the Board any policy within the remit of the Committee's business;

4.4 Will review risks from the Corporate Risk Register that are assigned to the Committee by the Board and advise the Board on the appropriateness of the scoring and mitigating actions in place.

5. SUB-COMMITTEES

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

6. MEMBERSHIP

6.1 Members

Four Independent Members of the Board

6.2 In Attendance

Executive Medical Director (lead director)
Chief Information Officer, Digital
Senior Information Risk Owner (SIRO)
Caldicott Guardian
Lead Director of Information Governance Department
Assistant Director Information Governance & Assurance/ Data Protection Officer (DPO)

6.2.1 Other Directors/Officers will attend as required by the Committee Chair, as well any others from within or outside the organisation who the Committee considers should attend, taking into account the matters under consideration at each meeting.

6.2.2 Trade Union Partners are welcome to attend the public session of the Committee

6.3 Member Appointments

6.3.1 The membership of the Committee shall be determined by the Chairman of the Board taking account of the balance of skills and expertise necessary to deliver

the Committee's remit and subject to any specific requirements or directions made by the Welsh Government. This includes the appointment of the Chair and Vice-Chair of the Committee who shall be Independent Members.

6.3.2 Appointed Independent Members shall hold office on the Committee for a period of up to 4 years. Tenure of appointments will be staggered to ensure business continuity. A member may resign or be removed by the Chairman of the Board. Independent Members may be reappointed to the Committee up to a maximum period of 8 years.

6.4 Secretariat

6.4.1 Secretary: as determined by the Board Secretary.

6.5 Support to Committee Members

6.5.1 The Board Secretary, on behalf of the Committee Chair, shall:

- Arrange the provision of advice and support to Committee members on any aspect related to the conduct of their role; and

- Ensure the provision of a programme of development for Committee members as part of the overall Board Development programme.

7. COMMITTEE MEETINGS

7.1 Quorum

7.1.1 At least two Independent Members must be present to ensure the quorum of the Committee, this should include either the Chair or the Vice-Chair of the Committee. In the interests of effective governance it is expected that at least one of those named officers listed above will also be in attendance.

7.2 Frequency of Meetings

7.2.1 Meetings shall be routinely be held on a quarterly basis.

7.3 Withdrawal of individuals in attendance

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

8. RELATIONSHIP & ACCOUNTABILITIES WITH THE BOARD AND ITS COMMITTEES/GROUPS

8.1 Although the Board has delegated authority to the Committee for the exercise of certain functions as set out within these terms of reference, it retains overall

responsibility and accountability for ensuring the quality and safety of healthcare for its citizens through the effective governance of the organisation.

8.2 The Committee is directly accountable to the Board for its performance in exercising the functions set out in these Terms of Reference,

8.3 The Committee, through its Chair and members, shall work closely with the Board's other Committees including joint committees/Advisory Groups to provide advice and assurance to the Board through the:

8.3.1 joint planning and co-ordination of Board and Committee business; and
8.3.2 sharing of information

in doing so, contributing to the integration of good governance across the organisation, ensuring that all sources of assurance are incorporated into the Board's overall risk and assurance arrangements.

8.4 The Committee shall embed the corporate goals and priorities through the conduct of its business, and in doing and transacting its business shall seek assurance that adequate consideration has been given to the sustainable development principle and in meeting the requirements of the Well-Being of Future Generations Act.

9. REPORTING AND ASSURANCE ARRANGEMENTS

9.1 The Committee Chair shall:

9.1.1 report formally, regularly and on a timely basis to the Board on the Committee's activities via the Chair's assurance report, the presentation of an annual report; and membership of the Health Board's committee business management group.

9.1.2 ensure appropriate escalation arrangements are in place to alert the Health Board Chair, Chief Executive or Chairs of other relevant committees of any urgent/critical matters that may affect the operation and/or reputation of the Health Board.

9.2 The Board Secretary, on behalf of the Board, shall oversee a process of regular and rigorous self-assessment and evaluation of the Committee's performance and operation.

10. APPLICABILITY OF STANDING ORDERS TO COMMITTEE BUSINESS

10.1 The requirements for the conduct of business as set out in the Standing Orders are equally applicable to the operation of the Committee, except in the following areas:

- Quorum

11. REVIEW

11.1 These terms of reference and operating arrangements shall be reviewed annually by the Committee and any changes recommended to the Board for approval.

Approved by Audit Committee 12.12.19
V2.02

DIGITAL and INFORMATION GOVERNANCE COMMITTEE CYCLE OF ANNUAL BUSINESS AND FORWARD PLANNER 2020/21 v1.04 draft last updated 24/11/2020 13:23

Part 1 – Annual Recurring Business

Agenda Items	Notes	Feb	June	Sept	Dec	Mar
Apologies	Standard Committee item	x	x	x	x	x
Declarations of Interest	Standard Committee item	x	x	x	x	x
Draft minutes of previous meeting, matters arising and review of Summary Action Plan	Standard Committee item	x	x	x	x	x
Digital						
Digital Strategy – annual review	ToR 3.1.1					x
Approval of Informatics – Operational Plan	ToR 3.1.2/10	x				x
Digital Operational plan – quarterly update incl National Infected Blood Inquiry update		x	x	x	x	x
System Demonstrations (ad hoc as relevant)						
Partner organisation arrangements – other partners to be identified / advised	ToR 3.5					
NWIS update report NWIS Director in attendance		x	x	x	x	x
Information Governance						
Information Governance Strategy – annual review	ToR 3.1.1				x	
Information Governance quarterly assurance report (KPI, Lessons learned and compliance report)	ToR	x	x	x	x	x
Information Governance Annual Report	ToR 3.1.2 /10			x		

Agenda Items	Notes	Feb	June	Sept	Dec	Mar
Caldicott report	ToR 3.3.5			x		
To be determined:						
Implications of internal and external reviews and reports (as arise)	ToR					
Strategy / plan development (as arise)	ToR					
Governance matters						
Committee Annual Report (including annual review of ToR and cycle of business)	Submission to May Audit Committee prior to Board	x				x
Terms of Reference review	Annual review					x
Review of Corporate Risks allocated to the Committee	ToR 4.4		x		x	
Performance against the Board approved 2019/20 annual plan		x	x	x	x	x
Policies (compliance with national policy and development of organisational policy) – *as arise*	ToR	x	x	x	x	x
Periodic updates on Limited Assurance Audit reports	As advised by Audit Committee					
Closing Business (standing items)						
Summary of InCommittee business to be reported in public (if applicable)	Standard Committee item	x	x	x	x	x
Issues of significance to inform Chair assurance report	Standard Committee item	x	x	x	x	x
Date of next meeting	Standard Committee item	x	x	x	x	x

Agenda Items	Notes	Feb	June	Sept	Dec	Mar
Exclusion of press and public (if applicable)	Standard Committee item	x	x	x	x	x
InCommittee Business (if applicable)						
Draft minutes of previous InCommittee meeting, matters arising and summary action plan	Standard Committee item	x	x	x	x	x

DRAFT Local Partnership Forum Annual Report 2019/20

1. Title of Advisory Group:

Local Partnership Forum.

2. Name and role of person submitting this report:

Mrs Sue Green, Executive Director Workforce & Organisation Development.

3. Dates covered by this report:

01/04/2019-31/03/2020

4. Number of times the LPF met during this period:

The Advisory Group met five times during this period. The Advisory Group was routinely scheduled to meet 4 times however an extra-ordinary meeting was held in November 2019.

Attendance at meetings is detailed within the table below:

Members of the Local Partnership Forum	25/4/19	9/7/19	8/10/19	8/11/19	7/1/20
Members					
GMB – Britain's General Union	P	X	P	P x 2	X
British Dental Association	P	A	X	X	A
British Orthoptic Society	X	X	X	X	P
Chartered Society of Physiotherapy	P	A	X	X	X
Royal College of Midwives	P	P x 3	X	X	X
Royal College of Nursing	A x 3 P x 6	A x 3 P	P x 5	P x 5	P x 5
Society of Chiropodists & Podiatrists	X	X	A	X	A

Society of Radiographers **(See Independent Members)**	P	P	P	P	P
UNISON	A P	P x 6	AAA P x 3	P x 6	AAA P x 4
UNITE		P x 2	P	P x 2	P x 2
Area Director	A	A	A		A
Assistant Director of Corporate Planning	A	A	X	X	X
Assistant Director of Primary Care Contracting	A	A	A	X	A
Associate Director of Human Resources	P	P	P	P	P
Chief Executive	P	P	A	P	A
Director of Estate and Facilities	Deputy in attendance	X	X	X	X
Director of Mental Health and Learning Disabilities	X	X	X	X	A
Director of Nursing and Midwifery	Deputy in attendance	A	A	Deputy in attendance	X
Executive Director of Finance	Deputy in attendance	P	P	P	Deputy in attendance
Executive Director of Workforce and Organisational Development	P	P	P	P	A
Head of Human Resources	X	X	X	X	West Central East
Head of Organisational & Employee Development	X	X	P	X	X
Hospital Directors	X	X	X	X	East
Independent Members *(TU) and SoR*	P	P	P	P	P

Ms S Baxter *(Assistant Director, Health & Strategy)*	X	P	P	X	X
Mr S Harmes (Assistant Director West, Therapy Services)	X	P	X	X	X
Ms J Jones *(Interim Head of Secondary Care)*	P	P	X	X	X
Mrs J Newman *(Director of Performance)*	X	P	A	X	A
Mr M Townson *(Senior Equalities Manager)*	P	P	X	X	X
Ms K Thomson *(Head of Fundraising)*	X	X	X	X	X

P Present
P* Present for part of the meeting
A Apologies received
X Not present
◆ Not a member at the time of the Committee

In addition to the above core membership, other Directors and Officers from the Health Board regularly attend meetings of the Forum as required.

For a full list of attendance, please see the detailed Minutes which can be accessed on the Health Board's website via the following link: http://www.wales.nhs.uk/sitesplus/861/page/88168

5. Assurances the Forum is designed to provide:

The Forum is designed to provide assurance to the Board on the following key areas, as set out in its Terms of Reference, which are as follows:-

- Consider national developments in NHS Wales Workforce and Organisational Strategy and its implications for the Board.
- Negotiate on matters subject to local determination.
- Ensure staff organisation representatives time off and facilities agreement provides reasonable paid time off to undertake their duties and that they are afforded appropriate facilities using A4C facilities agreement as a minimum standard.

- Establish a regular and formal dialogue between the Board's executive and the trade unions on matters relating to workforce and service issues
- In addition the LPF can establish Local Partnership Forum sub groups to establish ongoing dialogue, communication and consultation on service and operational management issues. Where these sub-groups are developed they must report to the LHB PF as per the cycle of business

During the period that this Annual Report covers, the Forum operated in accordance with its Terms of Reference which were operative for the whole of the term this Annual Report covers. The Terms of Reference are appended at **Appendix 1**.

The Committee is required to publish its agenda and papers 7 days ahead of the meeting, and a breach log is maintained by the Office of the Board Secretary where there are exceptions to this requirement. During the reporting period there were no breaches of this nature.

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5. Overall *RAG status against Forum's annual objectives / plan: RED / AMBER / GREEN –

Choose one of the above.

The summary below reflects the Forum's assessment of the degree to which it has met these objectives. The supporting narrative included alongside the assessment below describes this in more detail.

Objective as set out in Terms of Reference	Was sufficient assurance provided? RAG	Was the assurance positive? RAG	Supporting narrative (Please provide detail for all actions showing amber or red assurance levels in terms of actions being taken to address these issues).
Consider national developments in NHS Wales workforce and organisational strategy and their implications for the board	GREEN	GREEN	
Negotiate on matters subject to local determination	GREEN	GREEN	
Ensure staff organisation representatives time off and facilities agreement provides reasonable paid time off to undertake their duties and	GREEN	AMBER	Further work required in relation to

that they are afforded appropriate facilities using A4C facilities agreement as a minimum standard			provision of adequate facilities
Establish a regular and formal dialogue between the Board's executive and the trade unions on matters relating to workforce and service issues	GREEN	GREEN	
In addition the LPF can establish Local Partnership Forum sub groups to establish ongoing dialogue, communication and consultation on service and operational management issues. Where these sub-groups are developed they must report to the LHB PF as per the cycle of business	GREEN	GREEN	

7. Main tasks completed / evidence considered by the Forum during this reporting period:

Workshop sessions were held to discuss Workforce strategy and Attendance Management.

Received regular updates on:

- Corporate Planning including Annual Operating Plan
- Finance
- Prevention and Control of Infection
- Job Evaluation
- Special Measures
- Workforce & Organisational Development

Received updates on:

- Annual Quality Statement 2018/2019
- Corporate Risk Assurance Framework
- Cycle of Business
- Health and Safety Improvement
- Integrated Quality and Performance Report
- Nurse Staffing Act
- Organisational Change Policy
- Staff Health and Wellbeing
- Staff Flu Vaccination Programme
- Staff survey
- Welsh Language Standards
- Workforce Engagement
- Workforce Issues within the IQPR
- Workforce Metrics Report

- Workforce Partnership Group
- Workforce Policies and Procedures Working Group
- Workforce Report

Received strategy development presentations on drafts for

- Estate and Facilities – Review of Weekly to Monthly Pay for Staff
- Reimbursement of Travel
- Welsh Union Learning Fund – Proposal to set up a steering group.
- Workforce Issues within the IQPR
- Workforce Working Longer and Sickness Absence Review Group

Approved:

- LPF Annual Report 2018/19 and Cycle of Business 2019/2020

Received for Information:

- Integrated Quality and Performance Report
- Annual Audit Report
- Welsh Partnership Forum Minutes
- Strategic Occupational Health & Safety Group Minutes

Discussed items raised by Trade Union Members.

Full details of the issues considered and discussed by the Forum are documented within the agenda and minutes which are available on the Health Board's website and can be accessed from the following link:-
http://www.wales.nhs.uk/sitesplus/861/page/88168

8. Key risks and concerns identified by this Forum in-year which have been highlighted and addressed as part of the Chair's reports to the Board:

Meeting Date	Key risks including mitigating actions and milestones
25/04/2019	• Before a staff lottery is allowed to go ahead – clarity must be sought on the need to limit the number of plays per week, the need to ensure that there would be good governance and management, concern regarding gambling awareness, that staff health and wellbeing should be considered a priority and finally the need to ensure that pan-BCUHB applicants should be able to apply for grants from the monies raised, irrespective of whether they have additional charitable funds available. • The Communications Department must be encouraged to assist getting nominations for the RCN Wales Nurse of the Year Awards 2019. • There is a need to utilise existing facilities more effectively and efficiently.
09/07/2019	All members agreed with the vision for Occupational Health and Safety, but suggested various areas that needed addressing:

	• A security review required concerning violence and aggression towards staff. • More standardisation, training and competency checks. • More face to face engagement required with local teams. • Better sign-posting on the intranet required • Improved focus in leadership programmes • More robust reporting required with improved staff feedback to when issues raised on Datix. • There is a need to increase the visibility of Health and Safety teams with the possibility that Health and Safety should be a standard agenda item.
08/10/2019	• There had been very positive feedback from the 'Better Care, Spending Well' workshops that had taken place. • Staff had shown themselves to be very open and up for the challenges that lie ahead. • Emphasis now to be placed on prevention and early intervention along with environmental issues such as the carbon footprint and sustainability of projects. It was felt that consistency must be felt across the Health Board. • Despite the Health Board writing to European staff offering drop-in sessions where advice could be sought regarding the effects of 'Brexit', there had been very little uptake on the offer. • It was confirmed that much work is currently taking place to try to identify the reasons for staff sickness and that they are recorded correctly. Greater effort needs to be made to get mental health issues reported; staff tend to feel that it showed a weakness. • The Head of Organisations and Employee Development noted that there had been significant improvement in many areas and that the rate of improvement has been greater than or equal to that seen across the whole of Wales. • Following discussions around shift proposals, it was felt that the situation is more positive than it has been in recent years
08/11/2019	• The Trade Unions felt that the consultation on shift patterns that had taken place was not meaningful. • The Trade Unions wish to have a timetable agreed regarding the process followed by this consultation but a greater understanding of what was needed to solve the problems around taking breaks must be sought via more collaboration with the Trade Unions before any progress is possible.
07/01/2020	• It was agreed that there needs to be an increase in senior management representation at LPF meetings. • The LPF agreed that additional pre-meetings should be held by the Trade Unions to discuss future agenda items to enable BCU to provide clear and accurate responses to their queries. • The LPF raised concerns regarding the impact on BCU's services due to the current financial situation.

	• Regular pan-BCU communications should be sent as soon as possible to include information about the LPF's role and more regularly to provide key discussion topics in LPF meeting.

9. Focus for the year ahead:

The primary focus of the Forum over the next twelve months will be to support the delivery of the Annual Plan, with particular focus on actions required as a result of Covid-19 and Year 2 of the Workforce Strategy, in partnership.

The Forum has established a Cycle of Business for the year ahead covering the breadth of its work, and primarily focussing on its key areas of risk, as defined in the Board's Corporate Risk and Assurance Framework. This is attached as **Appendix 2**.

**Key:*

Red	*= not on target to achieve all actions, and may not achieve these actions by the next quarter*
Amber	*= not on target to achieve all actions, but has plans in place to see these actions achieved by the next quarter*
Green	*= on target to achieve all actions*

Cyfarfod a dyddiad: Meeting and date:	**Audit Committee 17/12/20**
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:	Acting Board Secretary
Awdur yr Adroddiad Report Author:	Statutory Compliance, Governance & Policy Manager
Craffu blaenorol: Prior Scrutiny:	Acting Board Secretary
Atodiadau Appendices:	None

Argymhelliad / Recommendation:

The Committee is asked to note the report.

Please tick one as appropriate (note the Chair of the meeting will review and may determine the document should be viewed under a different category)

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.

The issues listed below were considered by the Audit Committee at the extraordinary private Committee meeting of 17/09/20:

- Financial Conformance Report
- Counter Fraud Progress Report
- Update on Internal/External Audit Actions (Tracker Tool).
- Members noted that NHS Wales Shared Services Partnership (NWSSP) have advised that Post Payment Verification (PPV) reporting was stood down by the Welsh Government on 19/03/20 due to COVID-19 and there is therefore no data to provide. PPV will be reinstated 01/10/20.

Asesiad / Assessment & Analysis

Strategy Implications

This report is purely administrative. There are no associated strategic implications other than those that may be included in the individual reports.

Financial Implications

This report is purely administrative. There are no associated financial implications other than those that may be included in the individual reports.

Risk Analysis

This report is purely administrative. There are no associated risk implications other than those that may be included in the individual reports.

Legal and Compliance

Compliance with Standing Order 6.5.3

Impact Assessment

This report is purely administrative. There are no associated impacts or specific assessments required.

Audit Committee 17th December 2020	GIG CYMRU NHS WALES Bwrdd Iechyd Prifysgol Betsi Cadwaladr University Health Board *To improve health and provide excellent care*

Chair's Report

Name of Group:	Risk Management Group (RMG)
Meeting date:	30th November 2020
Name of Chair:	Sue Green, Executive Director of Workforce and Organisational Development
Responsible Director:	Simon Evans-Evans, Interim Governance Director
Summary of business discussed:	This report summarises the activity of the Risk Management Group (RMG) and the Corporate Risk Management Team. The Group was not quorate and the Chair agreed to raise this at the Executive Team meeting and request approval of any items discussed during the meeting. The RMG members noted: 1. A progress update on the development of the Board Assurance Framework, noting completion of each Principal Risk was required by 27th November 2020. The deadline date for submission for inclusion in the Audit Committee papers was the 7th December 2020. 9 risks had been completed and approved by the Executive Directors with 8 risks still awaiting Executive approval and 7 risks with no final draft completed or approved. These related to 3 from the Executive Nursing Office, 3 from the Executive Workforce and Organisational Development Office and 1 from the Mental Health Division currently residing with the Executive Director of Public Health. 2. A report on the alignment of risks into the new 3 Tier system, noting that Tiers 4 and 5 were no longer accessible within the system. During the transfer by the 1st October 2020 it was noted that some anomalies in the scoring had been identified. These related to 106 at Tier 3 and 43 at Tier 2 scoring over 15. Work is continuing with the Corporate Risk Team and individual Risk Owners to rectify these anomalies and present any risk which is outside the appropriate scoring matrix for Executive scrutiny and consideration for escalation onto the Corporate Tier 1 Risk Register. This report also included a summary of the Extreme Covid-19 risks scoring 15 and above. 3. A report on a review by the Corporate Risk Team of those risks at Tier 2 and 3 scoring above 15 was presented with proposals to review and agree to escalate 10 risks. On further review and

	scrutiny, the RMG agreed to escalate to the Executive Team the following 3 risks: o 3415 - Risk of rapid development of Covid-19, by Patients and Staff due to inadequate ventilation within Holywell Hospital o 3629 - Failure to comply with HSE Improvement Notice regarding Fit Testing o 2783 - Cancellation of vascular cases requiring HDU / ITU beds Following a review and agreement for escalation by the Executive Team, each risk would be prepared and presented for oversight at the appropriate Board Committee. 4. A Template Divisional Risk Report was presented. Following feedback, it was agreed that the Corporate Risk Team would review the requirements of the Risk Management Group and what was available to populate the report from Datix to automate as much as possible to reduce the resources required by the Divisions to complete the reports. 5. The following Divisions provided an update on their Risk Management processes and maturity: o Office of the Executive Director of Nursing o Informatics o Office of the Board Secretary o Finance 6. The Interim Nursing Director provided a presentation on the outcome of the Risk Management Self-Assessment and Improvement Action Plan at YGC. This was viewed as a positive step forward from the site and the Risk Management Team will work with the Quality and Safety Team to agree a roll out plan across all of the Health Board. 7. The updated Terms of Reference was discussed and it was agreed to present these to the Executive Team for further discussion on membership and to approve. 8. A verbal update on the progress with the Once for Wales Integrated Risk Management Project was provided noting that the Complaints, Claims and Incident Module was intended to go live from April 2021. A local implementation plan is being developed which will include a communication and training strategy in the absence of a national plan. 9. The updated RM02 – Risk Management Procedure and Guide was presented and agreed to be submitted to the Executive Team for approval.

	10. The updated RM03 – Risk Management Training Plan was presented and agreed to be submitted to the Executive Team for approval. 11. The updated RM04 – Model Risk Management Procedure was not agreed and further work was required to establish the need for this additional documentation, noting that RM02 should be implemented and followed throughout the Health Board.
Key assurances provided at this meeting:	• Progress with the implementation of the revised Risk Management Strategy and Policy and supporting documentation. • Continued representation and presentation of Divisional Risk Management arrangements. • Follow up of outstanding actions to be incorporated into future improvement plans. • Completion of the comprehensive training needs and gap analysis to influence the Risk Management Training Programme for delivery in 2020/21.
Key risks including mitigating actions and milestones	Compliance with the Risk Management Strategy and Policy
Special Measures Improvement Framework Theme/Expectation addressed	Area: Leadership and Improvement Capability
Issues to be referred to another Committee	None of note
Matters requiring escalation to the Board:	None of note
Well-being of Future Generations Act Sustainable Development Principle	The work of the Risk Management Group will help to underpin the delivery of the sustainable development principles by: • Fully embedding Enterprise Risk Management to proactively manage risk to the delivery of the Health Board's planning and risk assessment processes. • Working collaboratively across Wales to deliver solutions with partners to improve planning and system delivery.
Planned business for the next meeting:	Range of regular reports plus • Review of Corporate Risks • Review of Tier 2 Directorate and Divisional Risks • Review of Extreme Covid-19 Risks • Update on Once for Wales Integrated Risk Management Project • 2020/21 Risk Management Improvement Plan

Date of next meeting:	18th January 2021

V6.0

Audit Committee Report

Cyfarfod a dyddiad: **Meeting and date:**	17th December, 2020
Cyhoeddus neu Breifat: **Public or Private:**	Public
Teitl yr Adroddiad **Report Title:**	Board Assurance Framework and Corporate Risk Register (CRR) Report
Cyfarwyddwr Cyfrifol: **Responsible Director:**	Simon Evans-Evans Interim Director of Governance
Awdur yr Adroddiad **Report Author:**	David Tita – Head of Risk Management Justine Parry - Assistant Director of Information Governance & Risk
Craffu blaenorol: **Prior Scrutiny:**	Approved by the Interim Director of Governance
Atodiadau **Appendices:**	1) Board Assurance Framework – Principal Risk Report 2) Corporate Risk Register Report

Argymhelliad / Recommendation:

Recommendation:
The Audit Committee is asked to:

1) Review and note the progress on the management of the BAF and Corporate Tier 1 Operational Risks.
2) Approve the Board Assurance Framework format for submission to the Board for ratification.

Please tick as appropriate

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

Sefyllfa / Situation:

The Health Board has over the last few months held two Board Workshops aimed at facilitating the identification of its Priority Areas and the design of a new Board Assurance Framework (BAF) to support the effective management of the agreed principal risks which could affect the achievement of its agreed Priorities. This has also led to a streamlining and re-design of a new Corporate Risk Register (CRR) which more effectively focuses on highlighting and demonstrating how the Health Board is robustly mitigating and managing extreme risks to the achievement of its operational objectives.

Appendix 1 highlights the format and details of the Board Assurance Framework which will be regularly scrutinised by the Executive Team.

Appendix 2 highlights details of the new look Corporate Risk Register which has been reviewed and agreed at the Risk Management Group (RMG) and will be regularly scrutinised by the Executive Team.

Cefndir / Background:

Board Assurance Framework

The design of the a new BAF and CRR for the Health Board underlines its commitment to placing effective risk management at the heart of everything it does while embedding a risk-based approach into its core business processes, objective setting, strategy design and better decision making. The design of both the new BAF and CRR emphasises their distinctive roles in underpinning the effective management of both strategic and operational risks respectively as well as underlines their symbiotic relationship as both mechanisms have been designed to inform and feed-off each other.

During November 2020, once the Principal Risks had been agreed by the Executive Team, a series of meetings took place with all Principal Risk Lead Officers to populate each risk template. Support was provided by the Corporate Risk Management Team and each risk was quality assured and required Executive approval prior to inclusion onto the full report.

As at the 4th December 2020, whilst the majority of the Principal Risks have been completed, the below remain outstanding:

BAF20-13 – Culture / Staff Engagement – draft returned but no Executive approval received.
BAF20-14 – Security Services – draft not completed / no Executive approval received.
BAF20-15 – Health and Safety – draft returned but no Executive approval received.
BAF20-21 – Workforce Optimisation – draft not completed / no Executive approval received.

Once approval for the BAF concept has been received, the intention is for the Principal Risks to be regularly reviewed the Executive Team with oversight at each Board Committee on a bi-monthly basis and twice yearly to the Board. Oversight of the system and process will remain with the Audit Committee, who will receive an update twice a year and a copy of the full BAF. The BAF narrative supporting document will then be updated and reflect the agree arrangements and frequency of reporting and will be submitted to the Board in January 2021 for ratification.

In line with the presentation of the Corporate Risks, for all future reports a detailed analysis of any changes to the Principal Risks will be included within the body of this report. As this is the first presentation of the BAF, the full risk and assurance report is provided in Appendix 1 with the heat map below.

Below is a heat map representation of the BAF of its current risk scores:

Current Risk Level	**Impact**				
	Very Low - 1	Low - 2	Moderate - 3	High - 4	Very high - 5

Likelihood						
	Very Likely - 5			BAF20-22	BAF20-02 BAF20-06 BAF20-18	BAF20-05
	Likely - 4				BAF20-01 BAF20-13	BAF20-04 BAF20-08 BAF20-11 BAF20-12 BAF20-15 BAF20-16
	Possible - 3			BAF20-07 BAF20-10 BAF20-19 BAF20-20	BAF20-03 BAF20-17 BAF20-23	BAF20-09
	Unlikely - 2					
	Rare - 1					

Corporate Risk Register:
It is important to note that the Health Board`s new CRR has been updated following feedback received on the previous version. Changes have been made to the terminology used for example the “Initial Risk Score” has now changed to Inherent and the continued use of the “Action Plan Module” as a key driver to capture and monitor the completion of actions is proving beneficial for all leads as regular reminders are issued once the completion date has expired. The use of this module is planned to be rolled out across the remaining Tiers, with anticipated completion by March 2021, however this is subject to the full risk team being in place and not redeployed to support other areas of activity as it currently the case.

Staff engagement, training, capacity building and development in risk management continues to be explored by the Corporate Risk Management Team as drivers for embedding the new CRR and a positive risk-aware culture across the Health Board. For example, an external risk management specialist was recently commissioned to deliver six bespoke risk management training sessions to senior staff across the Health Board during which 100 staff were trained. Trainees were issued certificates of completion of course and they also provided very positive feedback which have in turn enabled us to improve and tailor the training resources to the needs of our staff and organisation.

Further risk management training commensurate with the roles and responsibilities of staff across the Health Board will be delivered as part of our campaign to get 1000 staff trained in risk management in 2021/22. Another strand of this drive will be to take risk management training to our medical Doctors and Consultants through already existing meetings and networks e.g. Junior Doctor`s meetings or Consultant`s meetings.

A close look at the CRR in Appendix 2 demonstrates that, the following risks have their target risk scores set outside the Health Board`s risk appetite. A conscious decision will be made by Executive Management Team to accept and actively mitigate and manage these risks as the benefits for doing so outweighs inaction.

- **CRR20-01 - Asbestos Management and Control**
  (Target risk score set at 10 instead at between 1 – 6 as per the Health Board`s risk appetite).

- **CRR20-02 - Contractor Management and Control**
  (Target risk score set at 10 instead at between 1 – 6 as per the Health Board`s risk appetite).

- **CRR20-03 – Legionella Management and Control.**
  (Target risk score set at 10 instead at between 1 – 6 as per the Health Board`s risk appetite).

- **CRR20-04 - Non-Compliance of Fire Safety Systems**
  (Target risk score set at 10 instead at between 1 – 6 as per the Health Board`s risk appetite).

The following summary reflects those risks which have been approved by the Executive Management Team for inclusion onto the CRR (Please check Appendix 2 for details).

Risk CRR ID	Division/Specialty	Risk Title	Score
CRR20-01	(Planning & Performance) Estates and Facilities	Asbestos Management and Control	20
CRR20-02	(Planning & Performance) Estates and Facilities	Contractor Management and Control	20
CRR20-03	(Planning & Performance) Estates and Facilities	Legionella Management and Control.	20
CRR20-04	(Planning & Performance) Estates and Facilities	Non-Compliance of Fire Safety Systems	20
CRR20-05	(Primary and Community Services (Area)	Timely access to care homes	20
CRR20-06	(Office of the Medical Director (Corporate) Informatics	Informatics - Patient Records pan BCU	16
CRR20-07	(Office of the Medical Director (Corporate) Informatics	Informatics infrastructure capacity, resource and demand	16

The following summary captures 3 new risks which were reviewed, scrutinised and recommended by the Risk Management Group (RMG) to the Executive Team for approval for inclusion onto the CRR. Once approved by the Executive Team, escalation to the appropriate Board Committee will commence : -

Risk ID	Division/Specialty	Risk Title	Score
3415	Primary and Community Services (Area) Holywell Community Hospital	Risk of rapid development of Covid-19, by Patients and Staff due to inadequate ventilation within Holywell Hospital	16
3629	Workforce and Organisational Development (Corporate)	Failure to comply with HSE Improvement Notice regarding Fit Testing	15

2783	Surgery (Secondary) Vascular Surgery (Secondary)	Cancellation of vascular cases requiring HDU / ITU beds	15

Below is a heat map and a one-page representation of the CRR:

Current Risk Level		Impact				
		Very Low - 1	Low - 2	Moderate - 3	High - 4	Very high - 5
Likelihood	Very Likely - 5				CRR20-04	
	Likely - 4				CRR20-06 CRR20-07	CRR20-01 CRR20-02 CRR20-03 CRR20-05
	Possible - 3					
	Unlikely - 2					
	Rare - 1					

Asesiad / Assessment & Analysis

Strategy Implications
The implementation of the Board Assurance Framework and the revised Risk Management Strategy and Policy aligns with the Health Board`s strategy to embed effective risk management in fostering its culture of safety, learning to prevent recurrence and continuous improvements in patient, quality and enhanced experience.

Options considered
Not applicable.

Financial Implications
Depending on the agreement of reporting arrangements, the management of the BAF and CRR is resource intensive and so additional resources may be required once the regularity of reporting has been agreed.

Risk Analysis
See the various risks for details of any related risk implications.

There is a risk (Risk ID 3739) that the new Risk Management Strategy and Policy may not be timely and robustly implemented. This risk is currently scored at 8 due to the controls and mitigations in place, whilst also recognising the re-distribution of the workload within the Board Secretary's Office and the Corporate Risk Team and the use of virtual tools in delivering support and training to staff across the Health Board.

Legal and Compliance
There are no legal and compliance issues associated with the delivery of the new BAF and Risk Management Strategy and Policy.

Impact Assessment
No specific or separate EqIA has been done as one had already been completed in relation to the new Risk Management Strategy and Policy to which this BAF and CRR are aligned.

Board Assurance Framework 2020/21

Strategic Priority 1: Safe Unscheduled Care

Risk Reference: BAF20-01		Risk Rating	Impact		Likelihood		Score		Appetite
Surge Plan / Winter Plan									
There is a risk that the Health Board may not be able to deliver the winter plan due to the appropriate availability of capacity and capability of its resources and external collaboration. This could negatively impact on the quality of planned patient care services and the reputation of the organisation.		Inherent Risk	5		5		25		Low 1 - 6
		Current Risk	4	↓	4	↓	16	↓	
		Target Risk	4	↔	3	↓	12	↓	

Key Controls	Assurance level *	Key mitigations	Assurance level *	Gaps *(actions to achieve target risk score)*	Date
BCUHB Winter Resilience plan approved by Board underpinned by Local Health Community plans which includes acute surge plans for increased capacity.	2	Programme of check and challenge meetings in place to review and prioritise winter schemes including prioritisation of the workforce elements.	2	Identify improvement and project support for delivery of some of the schemes. Identify recruitment requirements and related workforce processes.	31 December 2020
Established surge plans in place to manage Covid-19 demand which are regularly reported to F&P Committee.	2	i) Intelligence cells in place, regularly tracking against Swansea University modelling work. ii) Ysbyty Enfys Deeside opened (4/11) to accept up to 30 recovering covid positive patients from East and Centre which reports to the Strategic & Assurance Group which reports to Exec Team.	2	Finalisation of nursing workforce capacity to staff the current model (up to 30 patients) and any expansion of future model at Ysbyty Enfys Deeside. Post implementation review of the suitability of the acute to community pathways is underway, including staffing model and patient cohort to ensure fit for purpose.	31 December 2020

Review comments since last report:

Executive Lead:	**Board / Committee:**	**Review Date:**
Mark Wilkinson, Executive Director of Planning and Performance	Finance and Performance Committee	1 December 2020

Linked to Operational Corporate Risks:

Board Assurance Framework 2020/21

Strategic Priority 1: Safe Unscheduled Care

Risk Reference: BAF20-02		Risk Rating	Impact		Likelihood		Score		Appetite
Emergency Care Review Recommendations									
There is a risk that the Health Board may not be able to deliver safe and effective care due to being unable to commit support processes. This could negatively impact on the quality of patient care provided.		Inherent Risk	5		5		25		Low 1 - 6
		Current Risk	4	↓	5	↔	20	↓	
		Target Risk	4	↔	3	↓	12	↓	

Key Controls	Assurance level *	Key mitigations	Assurance level *	Gaps *(actions to achieve target risk score)*	Date
Unscheduled Care Improvement Group in place to oversee the improvement programme of work and monitor performance which provides regular reports to the Finance & Performance.	2	1) Ysbyty Glan Clwyd (YGC) improvement plans in place and approved by Executive Team for ambulance handover and flow including EDQDF. 2) Emergency Department (ED) dashboard established which monitors performance. 3) Established Tactical Control Centres in place. 4) Standardised SITREP / escalation reports submitted 3 x day.	2	1) Roll out of YGC improvement plan to other sites as appropriate. 2) Identify improvement and project support for delivery of the objectives. 3) In line with Welsh Government (WG) directive, implement Phone First programme that will ensure patients are seen by the right person, in the right place, first time. 4) In line with WG directive, implement the national EDQDF / Welsh Access Model to identify best practice, agree care standards and implement a uniform model for patient access to and from EDs.	31 March 2021 31 March 2021 31 March 2021 31 January 2021
Q3 and Q4 Plan in place and agreed by the Board, with regular monitoring through Access meeting (weekly) & Unscheduled Care (USC) Improvement Group (monthly).	2	Weekly access meeting chaired by the Executive Director of Planning and Performance, to review assurance against the delivery of the plan.	1	USC scoping review to be undertaken to develop strategic blueprint solution for unscheduled care. Implement recommendations of Kendal Bluck Emergency Department workforce review related to unscheduled care.	31 January 2021 31 March 2021
Interim COO / Interim Director of USC overseeing the Q3/4 plan and variance to the plan with regular reporting to the Finance and Performance Committee.	2	Bi-monthly report to Finance & Performance Committee to provide assurance on unscheduled care strategic developments.	2	Establish permanent substantive posts currently covered on an interim basis, providing continuity and sustained leadership for unscheduled care.	31 March 2021

Review comments since last report:

Executive Lead:	**Board / Committee:**	**Review Date:**
Debra Hickman, Acting Executive Director of Nursing and Midwifery	Quality, Safety and Experience Committee	1 December 2020

Linked to Operational Corporate Risks:

Board Assurance Framework 2020/21

Strategic Priority 2: Essential Services and Planned Care

Risk Reference: BAF20-03		Risk Rating	Impact		Likelihood		Score		Appetite
Sustainable Key Health Services									
There is a risk that the Health Board may not be able to deliver sustainable key population health services to the wider population of North Wales due to diminishing capacity to meet an ever-growing demand.		Inherent Risk	4		4		16		Low
		Current Risk	4	↔	3	↓	12	↓	1 - 9
		Target Risk	4	↔	2	↓	8	↓	

Key Controls	Assurance level *	Key mitigations	Assurance level *	Gaps *(actions to achieve target risk score)*	Date
Health Improvement & Reducing Inequalities Group (HIRIG) provide strategic direction and monitors delivery of the Population Health Services. HIRIG reports to Executive Team.	2	Health Board commitment to establishing priority services including: Programme management and recruitment to posts.	2	1) Fully integrated the Smoking Cessation service. 2) Implement a Tier 3 Childrens Obesity service. 3) Implement a Healthy Weight pathway T1-3. 4) Implement and delivery the Immunisation Strategy. 5) Implement and deliver the Infant feeding strategy. 6) Implement and deliver a suite of Buliding a Healthier Wales projects.	31 March 2021 1 April 2021 31 March 2022 31 March 2023 31 March 2023 31 December 2022
Strategy, Partnership and Population Health Committee have oversight via standard reports by exception on progress.	2	Contribution to national delivery programmes and the Public Health Outcomes Framework with monitoring of key indicators in place.	2	Embed BCUHB North Wales population health priorites within its operational and strategic plans.	1 April 2022
Welsh Government have oversight of Smoking Cessation, Building a Healthier Wales, Infant Feeding, Healthy Weight Healthy Wales, Immunisation programmes and provide an element of funding.	3	HIRIG provide reports nationally regarding expenditure and performance.	3	Standardised reporting and meet submission requirements.	1 December 2020
The Executive Director of Public Health provides consistency to the regional strategic approach for North Wales in the form of expertise and prioritisation and through leadership of the Local Public Health Team.	2	Regional evidence based priorities are developed to meet the needs of the population in North Wales and deliver the greatest impact.	3	Embed Public Health Outcomes Framework into local planning through Local partners and Health Board.	1 April 2021

Review comments since last report:

Executive Lead:	**Board / Committee:**	**Review Date:**
Teresa Owen, Acting Deputy Chief Executive / Executive Director of Public Health	Strategy, Partnership and Population Health Committee	1 December 2020

Linked to Operational Corporate Risks:
CRR20-05 - Timely access to Care Homes

Board Assurance Framework 2020/21

Strategic Priority 2: Essential Services and Planned Care

Risk Reference: BAF20-04		Risk Rating	Impact		Likelihood		Score		Appetite
Primary Care Sustainable Health Services									
There is a risk that the Health Board will be unable to ensure timely access to Primary Care (GMS) Services for the population due to growing demand and complexity, an ageing workforce and a shift of more services out of hospital. As a gateway to health care, this could result in an deterioration in the population health, impacting on other health & care services and the wellbeing of the primary care workforce.		Inherent Risk	5		5		25		Low 1 - 6
		Current Risk	5	↔	4	↓	20	↓	
		Target Risk	4	↓	3	↓	12	↓	

Key Controls	Assurance level *	Key mitigations	Assurance level *	Gaps *(actions to achieve target risk score)*	Date
Each Area Team reviews GP practice sustainability and provides bespoke support to individual practices.	1	Regular review of 5 domains matrix. Escalation tool implemented and monitored by the Primary Care Panel, chaired by the Executive Director of Primary and Community Care, with reports provided to Quality, Safety and Experience Committee.	2	Delivery of Quality Assurance Visiting Programme across all contractors, in-depth review/visits which will be supportive for practices where concerns are identified.	31 March 2022
Delivery of All Wales Primary Care Model in place, which is monitored by the Strategic Programme for Primary Care.	3	Review of current workforce profiles. Delivery of milestones set by the national strategic programme. Contribution and leadership in the national priorities.	2	1) Primary Care Strategy for north wales embedded in the clinical strategy of BCUHB. 2) Further development of primary care workforce plans.	31 March 2022
Provision of alternative services to increase capacity in GP practices in place.	1	Development of Urgent Primary Care Centre (UPCCs) pathfinders. Delivery of digital solutions (accelerated in response to C-19) Commissioning of community pharmacy enhanced services.	1	Full roll out of UPCCs (subject to national evaluation & pathways).	31 March 2022
Primary & Community Care Academy in place with further development and roll out planned.	2	Academy work plan 2019/22 in place, monitored by the Strategic Leadership Group for the Academy and as part of the performance monitoring of the Health Board's Operational Plan which feeds through to the Strategy, Partnership and Population Health Committee.	2	1) Increase in Academy outputs to have a greater impact on primary care workforce modernisation & capacity. Business case to be presented for consideration. 2) Strengthen coordination and implementation of work placements for training, mentorship and formal internship.	31 March 2021 31 March 2022
Cluster working/Health & Social care Localities in place with further development planned, with oversight by Area Teams, Regional Partnership Board Leadership Group and Integrated Care Boards (partnerships).	2	GP clusters have increased maturity throughout Covid-19 with practices working closely together with oversight by the Area Directors.	1	Development of broader cluster membership with the further integration with locality services.	30 September 2021

Review comments since last report:

Executive Lead:	**Board / Committee:**	**Review Date:**
Chris Stockport, Executive Director of Primary and Community Services	Strategy, Partnership and Population Health Committee	1 December 2020

Linked to Operational Corporate Risks:
CRR20-05 Timely Access to Care Homes

Board Assurance Framework 2020/21

Strategic Priority 2: Essential Services and Planned Care

Risk Reference: BAF20-05		Risk Rating	Impact		Likelihood		Score		Appetite
Timely Access to Planned Care									
There is a risk that the Health Board may be unable to deliver timely access to Planned Care due a mismatch between demand and capacity and Covid-19, which could result in a significant backlog and potential clinical deterioration in some patient conditions.		Inherent Risk	5		5		25		Low 1 - 6
		Current Risk	5	↔	5	↔	25	↔	
		Target Risk	5	↔	3	↓	15	↓	

Key Controls	Assurance level *	Key mitigations	Assurance level *	Gaps *(actions to achieve target risk score)*	Date
Q3 and Q4 Plan in place and agreed by the Board, with regular monitoring and updates provided to Access Group and Finance and Performance Committee.	2	Weekly access meeting chaired by the Director of Performance, to review assurance against the delivery of the plan.	2	Introduction of further validation staff in Q3/4 non recurring. Scoping of Artificial Intelligence approach to validation.	31 March 2021
Implemented risk stratification system and process for stage 4 patients providing clinical priority with regular monitoring by local Primary targeting list (PTL) and access group.	1	Ensure the waiting list size is continually validated and patients appropriately communicated with.	1	Waiting list initiatives introduced in Q3/4, Business case for Insourcing to support Q3/4 plan and long waiting patients is awaiting approval. Introduce a system that allows patients to "opt in" for treatment. allowing a communication strategy to support the q3/4 plan.	4 January 2021
Head of Planned Care overseeing the Q3/4 plan and variance to the plan with monthly reporting to the Chief Operating Officer and bi-monthly reporting to the Finance and Performance Committee.	2	Bi-monthly report to Finance and Performance Committee to provide assurance on planned care strategic and tactical developments.	2	Introduce substantive post into the organisation, currently covered on an interim solution. Thus providing continuity and sustained leadership for planned care.	31 March 2021
Once for North Wales approach introduced to standardise and ensure consistent delivery of general surgery, orthopaedics, Ophthalmology (Stage 4), Urology and Endoscopy to reduce health inequalities.	2	Weekly operational group with Divisional general Managers (DGM's) to ensure operational co-ordination of the once for north wales approach.	1	Introduction of non-surgical treatment for the long waiters. Supporting patients who will be waiting for a significant time before getting their treatment and keeping them informed and healthy.	31 March 2021
		Weekly meeting of the planned care operational group overseeing planed care transformation. Introduction of the planned care six point plan.	1	Introduction of insourcing into the organisation to undertake activity that supports P2-3 activity and over 52 week waiters, therefore reducing the overall waiting times .Scoping of new strategic model of care known as the diagnostic and treatment centre approach for planned care. Strategic outline case to be presented to board and welsh government -	31 March 2021
				Agree a strategy for planned care over the next 3 years that will improve the business process and reduce long waiting patients.	31 March 2021

Review comments since last report:

Executive Lead:	**Board / Committee:**	**Review Date:**
Mark Wilkinson, Executive Director of Planning and Performance	Finance and Performance Committee	1 December 2020

Linked to Operational Corporate Risks:

Awaiting Escalation Approval 2783 - Cancellation of vascular cases requiring HDU / ITU beds

Board Assurance Framework 2020/21

Strategic Priority 2: Essential Services and Planned Care

Risk Reference: BAF20-06		Risk Rating	Impact		Likelihood		Score		Appetite
Pandemic Management									
There is a risk that the ongoing Covid-19 pandemic, through the second wave, could inhibit the Health Board's ability to deliver timely access to high quality planned care to its patients. This may be caused by workforce absences or redeployment; infrastructure impact; reductions in, or overly cautious use of capacity; failure to prioritise or undertake risk stratification effectively; lack of support and collaboration across the whole healthcare system. This could lead to an impact on patient safety; deterioration in health; poor patient experience and reduction in well-being and impact on staff of being unable to meet patient needs.		Inherent Risk	4		5		20		Low 1 - 6
		Current Risk	4	↔	5	↔	20	↔	
		Target Risk	3	🡻	2	🡻	6	🡻	

Key Controls	Assurance level *	Key mitigations	Assurance level *	Gaps *(actions to achieve target risk score)*	Date
Primary Care Covid management forum meets weekly and reports into Primary Care Senior Management Team and Director of Primary Care and Community Services. Any issues requiring escalation are reported into Executive Team. Primary care pressures are reported nationally to WG.	1	Business continuity plans are continually reviewed, supported by the Emergency Preparedness and Resilience team, in line with requirements of the Civil Contingencies Forum. WG recovery plans in place and national toolkits circulated. Operational measures taken to support the overarching plan and response to Covid-19 include: Amended care pathways including remote consultations Provision of PPE across all contractors Regular Primary Care pressures report Red hubs available if required Escalation levels reported Area support to delivery of services at a cluster level Regular briefings/guidance to contractors.	2	Urgent Primary Care Centres being developed from Welsh Government grant. Options appraisal regarding dental capacity being undertaken at pace.	31 December 2020
Area Senior Management Teams have oversight of pressures on community services and feed into the Primary Care Senior Management Team. Any issues requiring escalation re reported to Executive Team.	1	Business continuity plans are in place and are currently being reviewed - see identified gaps. Management oversight continues for service changes to accommodate Covid-19 response, reported as described through Senior Management Teams.	2	Business continuity plans currently being reviewed and updated with support from Emergency Planning Team for all community hospitals and health / wellbeing centres. Amended pathways submitted through Clinical Advisory Group as appropriate.	Ongoing 31 March 2021
Access meeting weekly chaired by Performance Director, reports into Planned Care Improvement Group	1	Assurance against delivery of plan Risk stratification in place for Stage 4 planned care provides clinical priority for Stage 4 patients Head of planned care overseeing the Q3/4 plan and variance to the plan, reported through the monthly Operational Plan monitoring report to SPPH Committee and FP Committee	3	Introduction of further validation staff in Q3/4 non-recurring. Scoping of Artificial Intelligence approach to validation. Waiting list initiatives introduced in Q3/4, planned introduction of insourcing to support Q3/4 and long waiting patients.	31 March 2021
Weekly operational group with DGMs to ensure operational co-ordination of the Once for North Wales approach	1	Provides assurance that patients are booked across North Wales based on the risk stratification, reporting into the Access Group highlighted above	2	Scoping of need to bring in further capacity in the form of theatres or wards to reduce long waiters backlog clearance.	29 January 2021
Planned Care Improvement Group has oversight of the service models and delivery of planned care performance.	1	business continuity plans Q3/4 plans for planned care amended pathways (agreed via Clinical Advisory Group). Once for North Wales approach introduced to general surgery, orthopaedics, ophthalmology stage 4, urology and endoscopy reporting into the Planned Care Improvement Group and onward to Finance & Performance Committee.	2	Scoping of new strategic model of care known as the diagnostic and treatment centre approach for planned care. Strategic outline case to be presented to board and Welsh Government.	Ongoing 31 March 2021
Finance & Performance Committee receive regular Quality and Performance Reports which are reported on to the Health Board.	2	Regular performance reporting on delivery and quality Assurance reports on planned care to COO and F&P on a monthly basis. Accountability framework in place.	2		
WG Quality & Delivery Group meets on a regular basis to review and respond to quality and performance risks and impacts, framed around the NHS Wales performance framework.	3	Assurance against delivery of plan Risk stratification in place for Stage 4 planned care provides clinical priority for Stage 4 patients Head of planned care overseeing the Q3/4 plan and variance to the plan, reported to Quality & Delivery Group as an external scrutiny process as well as internally.	3		

Review comments since last report:

Executive Lead:	**Board / Committee:**	**Review Date:**
Chris Stockport, Executive Director of Primary Care and Community Services	Finance and Performance Committee	1 December 2020

Linked to Operational Corporate Risks:

Board Assurance Framework 2020/21

Strategic Priority 3: Mental Health Services

Risk Reference: BAF20-07		Risk Rating	Impact		Likelihood		Score		Appetite
Effective Stakeholder Relationships									
There is a risk that our relationships (internal and external) are ineffective. This could be caused by a lack of engagement, poorer communication, a lack of a co-productive approach, lack of direction, shared purpose and culture or insufficient service and organisational development. This could lead to a lack of trust, poor morale, high staff turnover, reduced stakeholder credibility plus reduced staff and public confidence, and an impact on services.		Inherent Risk	3		4		12		Moderate 8 - 10
		Current Risk	3	↔	3	↓	9	↓	
		Target Risk	2	↓	2	↓	6	↓	

Key Controls	Assurance level *	Key mitigations	Assurance level *	Gaps *(actions to achieve target risk score)*	Date
Together for Mental Health (T4MH) Strategy implemented with key stakeholders which sets out the direction of travel for Mental Health and Learning Disabilities services.	2	T4MH Partnership Board which oversees implementation of the strategy and includes key partners.	2	Confirmation of diary dates for Partnership Board meetings which will ensure full engagement with key stakeholders and assurance that actions outlined in the strategy are undertaken.	1 December 2020
Deputy Director attendance at Regional Leadership group with regular feedback into the MHLD Division to ensure two-way communication and engagement.	3	Consistent and regular communication with senior Local Authority partners in relation to service redesign.	3		
Divisional CAG meetings whereby senior clinicians and managers discuss and agree service model across the division.	1	Recommendations from meetings presented to BCU Clinical Advisory Group and presented for sign off via Divisional Finance and Performance meeting.	1	To present update of service model to Regional Leadership Group.	1 February 2021
In line with Divisional Wellness, Work and Us Strategy, oversight of all vacancies and sickness overseen by Divisional Workforce Group to ensure any identified demand and capacity pressures.	1	The MHLD division has introduced a workforce group which oversees key actions and identifies and escalates risks to Divisional Directors.	1		
Regular and concise communication with all staff groups across the division.	1	Fortnightly divisional staff engagement newsletter which highlights significant issues/service changes and celebrates staff achievements which reduces the risk of breakdown in communication.	1	Divisional Directors to continue to sign off fortnightly communications newsletter prior to circulation.	Commenced 24 November 2020
Service users, carers and the public to have the opportunity to be involved in the development, planning, design and delivery of the services.	2	Divisional Patient and Carer Engagement Group re-introduced in order to listen better and use feedback from consultation and engagement to make mental health and learning disability services more relevant to service users and carers' needs.	2		
Closer and regular working with North Wales CHC to ensure the population of North Wales have the opportunity to feedback on their experiences of local services and to contribute to the future design.	3	Safe space events starting in December 2020 have been set up with CHC to engage with North Wales population to seek views/experiences of MHLD services.	3	MHLD Division to agree process for sharing feedback from events with staff groups.	1 December 2020

Review comments since last report:

Executive Lead:	**Board / Committee:**	**Review Date:**
Teresa Owen, Acting Deputy Chief Executive / Executive Director of Public Health	Strategy, Partnership and Population Health Committee	1 December 2020

Linked to Operational Corporate Risks:

Board Assurance Framework 2020/21

Strategic Priority 3: Mental Health Services

Risk Reference: BAF20-08		Risk Rating	Impact		Likelihood		Score		Appetite
Safe and Effective Mental Health Service Delivery									
There is a risk to the safe and effective delivery of MHLD services. This could be due to unwarranted variation and inefficiencies. This could lead to poorer and inconsistent outcomes, poorer use of resources, failure to learn from events or inequity of access.		Inherent Risk	5		5		25		Low 1 - 6
		Current Risk	5	↔	4	↓	20	↓	
		Target Risk	3	↓	3	↓	9	↓	

Key Controls	Assurance level *	Key mitigations	Assurance level *	Gaps *(actions to achieve target risk score)*	Date
Mental Health and Learning Disabilities Divisional Governance Structure is in place and aligned to corporate governance requirements, providing consistent approach across the Division.	1	Key divisional roles in governance and safety are in the process of aligning to corporate reporting from the 1.11.20.	2	Agree date for formal reporting and financial transfer of budget finalising the alignment of governance and associated roles to BCUHB corporate.	1 December 2020
Partnership and assurance structures are in place. These are: Together for mental health partnership board (T4MHPB), Local Authority Scrutiny meetings, Local Implementation Teams (LIT), North Wales Adult Safeguarding Board is in place and the division is represented in attendance, all meetings are formerly minuted and reported with membership regularly reviewed according to their Terms of reference.	2	Partnership working and reporting assures flow of information and raising of any concerns over delivery or equity. North Wales Community Health Council have agreed and planned to hold 6 formal stakeholder events for the division reporting back to BCUHB and the division. The Director of Mental Health meets meeting formally with the 6 local authority directors.	2	Local implementation meetings are not currently meeting due to Covid 19 cessation of non urgent work. Refresh the Together for Mental Health Partnership approach.	1 January 2021
The Mental Health Learning Disabilities Divisions Senior Leadership Team report to the Joint Executive Team (JET) of BCUHB. This is a control for the delivery of safe and effective services. Regular reports are presented to the Quality and Safety Executive (QSE) on patient safety and quality issues.	2	The Mental Health Learning Disability Division has an agreed management structure (2019) reporting to the Executive Team and Board, following the agreed governance and management structure of BCUHB. It provides timely reports to the agreed Committees of the Board and the Executive Team and is held to account by them for delivery of a safe and effective Mental health and Learning Disability service.	2	The divisional triumvirate is in place. The division has 1 of 4 strategic priorities in its Special Measures Improvement framework being to "Review capacity and capability" of the Senior Leadership team. This work is ongoing and interim roles are in place. The division has created 2 additional Deputy Directors reporting to the Director of Mental health to fill operating gaps in partnership and strategy development. There is a role of "Head of Psychology" role vacant through 2020 in the Senior Leadership Team, action is in place to engage with Clinical psychology in the division to replace this role meeting 30.11.20.	1 January 2021

Review comments since last report:

Executive Lead:	**Board / Committee:**	**Review Date:**
Teresa Owen, Acting Deputy Chief Executive / Executive Director of Public Health	Quality, Safety and Experience Committee	1 December 2020

Linked to Operational Corporate Risks:

Board Assurance Framework 2020/21

Strategic Priority 3: Mental Health Services

Risk Reference: BAF20-09		Risk Rating	Impact		Likelihood		Score		Appetite
Mental Health Leadership Model									
There is a risk that the leadership model is ineffective and unstable. This maybe caused by temporary staffing, unattractive recruitment and high turnover of staff. This could lead to an unstable team structure, poor performance, a lack of assurance and governance, and ineffective service delivery.		Inherent Risk	5		5		25		Low 1 - 6
		Current Risk	5	↔	3	↓	15	↓	
		Target Risk	4	↓	2	↓	8	↓	

Key Controls	Assurance level *	Key mitigations	Assurance level *	Gaps *(actions to achieve target risk score)*	Date
Interim Senior Leaders in place and working within division. This is alongside other key posts; Interim Director of Nursing and Interim Deputy Directors x2. Each lead specific programmes and will further support and develop leadership, governance and management.	1	Interim Leadership changes are regularly reviewed by the Executive Director to ensure the model is effective in discharging it's roles and responsibilities.	2	Stabilise Senior Management with substantive posts.	1 June 2021
Strategy approved and regular updates reported via Special Measures to Welsh Government.	3	All key actions will be further developed and underpins the required work to have a well developed, fully integrated, Integrated Medium Term Plan (IMTP), which will further strengthen and support an effective model. Oversight will be via the Clinical Advisory Group (CAG).	2	Review Mental Health Structure to ensure fit for purpose and reflects new clinical pathways.	1 June 2021
		Engagement has been re-established through the Pathway Development Groups (e.g. Rehab / OPMH) with regular and consistent attendance with Regional Partners and stakeholders via North Wales leadership groups.	3	Implement the Mental Health Strategy in a consistent manner across the Health Board.	1 December 2021
		Pathway groups are clinically led and partners working to deliver the strategy, patients groups are members of those groups. All pathway groups report via Clinical Advisory Group (CAG) and / or Quality and Safety (QSE).	2	Evaluate regional management and pathway structure approach to delivery of strategy via a pilot and report findings to the Executive Team.	1 December 2021
		Business Case developed with additional funding from Welsh Government secured. Scrutiny of financial governance monitored by Head of Finance.	1		
Business Continuity Plan including essential service sustainability in place, with engagement from the Corporate Business Continuity Team.	2	Business Continuity Plans are updated within the Area with final scrutiny and approval at the Divisional monthly Finance and Performance Meeting.	1	Finalise all 4 service areas draft Business Continuity Plans for implementation.	31 January 2021
Quality, Safety and Experience Group restarted and meeting monthly, chaired by the Interim Director of Nursing to oversee Divisional governance arrangements and reporting, with oversight at the QSE Board Committee.	2	Dedicated Governance Structure and Team in place. QSE, Clinical Effectiveness Group, Mortality, Medicine Management all meeting regularly. This will allow regular reviews of performance and safety in service delivery.	2	Re-evaluate the governance structure and arrangements in line with Corporate Governance Review to ensure fit for purpose.	1 December 2021

Review comments since last report:

Executive Lead:	**Board / Committee:**	**Review Date:**
Teresa Owen, Acting Chief Executive / Executive Director of Public Health	Quality, Safety and Experience Committee	1 December 2020

Linked to Operational Corporate Risks:

Board Assurance Framework 2020/21

Strategic Priority 3: Mental Health Services

Risk Reference: BAF20-10		**Risk Rating**	**Impact**		**Likelihood**		**Score**		**Appetite**
Mental Health Service Delivery During Pandemic Management									
There is a risk to the safe and effective delivery of MHLD services. This could be due to the consequences of the COVID-19 pandemic. This could lead to changing type and level of demand across the region, a lack of appropriate staff and resources, poorer outcomes for our population.		Inherent Risk	4		4		16		Low 1 - 6
		Current Risk	3	↓	3	↓	9	↓	
		Target Risk	3	↔	2	↓	6	↓	

Key Controls	Assurance level *	Key mitigations	Assurance level *	Gaps *(actions to achieve target risk score)*	Date
MH&LD Covid19 Lead has been identified, and reports into the Divisional Governance meetings, Covid19 Divisional meetings and Covid19 Corporate meetings.	1	MH&LD Covid19 Winter Plan discussed and agreed in both the Divisional and Corporate Clinical Advisory Group (CAG).	2	MH&LD Finalise and fully implement Operational Covid19 Winter Plan.	30 December 2020
MH&LD Covid19 Winter Plan approved in both the Divisional Covid19 CAG meeting 3.11.20, and Corporate CAG meeting 6.11.20.	1	MH&LD Engagement and Communication Plan in place to ensure effective and efficient communication across the MHLD Division and also to all key stakeholders, both external and internal. This includes sharing the MH&LD Covid19 Winter plan.	2	Revisit and assess gaps in recruitment processes to support additional staff requirements.	30 December 2020
Wellness, Work and Us Strategy Launched in October 2020, to ensure staff are supported. Approved by the MH&LD Divisional Directors within the Divisional Business meeting September 2020.	1	Engagement sessions held across the MH&LD Division regarding the Wellness, Work and Us Strategies. Reviewed Year One priorities aligned to Covid19, ongoing implementation.	1	Approval by Corporate Business Continuity Lead for quality checking, and final sign of by the Divisional SLT at the appropriate Governance meeting of Business Continuity Plans and MH&LD Covid19 Action Cards.	30 December 2020
Business Impact Analysis, Business Continuity Plans and MH&LD Covid19 Action Cards implemented November 2020.	1	Support being delivered by Corporate Business Continuity Lead to quality check the MH&LD Business Continuity Plans.	2	Strengthen timely recruitment of staff to clinical posts.	31 March 2021
MH&LD Divisional PPE Task and Finish Group in place, reporting into MH&LD Divisional daily SITREP call, MH&LD Covid19 Briefing meeting and Corporate PPE Task and Finish Group.	2	Monitoring and reviewing PPE availability, MH&LD Divisional plan developed and monitored to ensure all staff are appropriately FIT testing as part of key mitigation, feeds into Corporate PPE Task and Finish Group. Also reports to the Corporate FIT testing Steering Group.	2	Revisit mapping of staff to enable redeployment decisions.	30 December 2020
Clinical Patient Pathway, approved by Clinical Advisory Group, monitored and reviewed by the MH&LD Clinical Pathway Group and changes made aligned to the Covid19 Winter Plan.	1	MH&LD SITREPS completed daily, with oversight by Covid MH&LD Lead. MH&LD SITREPS sent daily to Executive Nurse Director. Staffing pressures reviewed in daily SITREPS and Divisional Safety Huddle, any issue escalated to Corporate Staff Redeployment meeting.	1		
Covid 19 Training in place with compliance monitored and reviewed through Workforce Work stream.	2	MH&LD Covid19 Senior Leadership Team briefing meeting in place, currently meeting twice weekly, but flexible and responsive to need, which reports inot the Corporate Covid19	2		
MH&LD Divisional Workforce meeting, currently meeting fortnightly to review workforce plan, reports into MH&LD Covid19 briefing meeting and the Divisional Governance meetings.	1				
Attend Anywhere in operation across the MH&LD Division to provide a virtual consultation platform to allow the continuation of appropriate services, approved by the Divisional Clinical Advisory Group and is part of the MH&LD Winter Plan.	1			To source and procure additional IT equipment, primarily laptops, to increase the roll out of Attend Anywhere across the MH&LD Division.	31 March 2021

Review comments since last report:

Executive Lead:	**Board / Committee:**	**Review Date:**
Teresa Owen, Acting Deputy Chief Executive / Executive Director of Public Health	Quality, Safety and Experience Committee	1 December 2020

Linked to Operational Corporate Risks:

Board Assurance Framework 2020/21

Strategic Priority 4: Safe and Secure Environment

Risk Reference: BAF20-11		Risk Rating	Impact		Likelihood		Score		Appetite
Infection Prevention and Control									
There is a risk that Health Board may not be able to deliver appropriate care to patients and they may suffer harm due to healthcare associated infection. This may be caused by a failure to put in place systems, processes and practices that would prevent avoidable infection. The impact of this may increase morbidity and mortality, increase admissions and longer length of stay, increase treatment costs, reputational damage and loss of public confidence.		Inherent Risk	5		5		25		Low 1 - 6
		Current Risk	5	↔	4	↓	20	↓	
		Target Risk	5	↔	1	↓	5	↓	

Key Controls	Assurance level *	Key mitigations	Assurance level *	Gaps *(actions to achieve target risk score)*	Date
New leadership in place with revised governance arrangements reported via Infection Prevention Sub Group (IPSG).	2	Business case approved and recruitment commenced to increase IPC team/resource. Risk register monitored and escalated via IPSG and Patient Safety & Quality Group.	2	Finalise recruitment to increase IPC Team resource.	31 March 2021
Infection Prevention Sub Group in place providing regular performance reporting.	2	Monitoring of performance and risk in place by Public Health Wales and Welsh Government.	3		
Major Outbreak policy currently in place for managing Covid 19 infections.	2	Work, policy and risk register review programmes in place. Microbiology and Antimicrobial stewardship activity overseen by Infection Prevention Sub Group, Audit Committee/ Patient Safety & Quality Group and Quality and Safety Executive.	2		

Review comments since last report:

Executive Lead:	**Board / Committee:**	**Review Date:**
Debra Hickman, Acting Executive Director of Nursing and Midwifery	Quality, Safety and Experience Committee	1 December 2020

Linked to Operational Corporate Risks:

Board Assurance Framework 2020/21

Strategic Priority 4: Safe and Secure Environment

Risk Reference: BAF20-12		Risk Rating	Impact		Likelihood		Score		Appetite
Listening and Learning									
There is a risk that adverse events occur, or re-occur, in the organisation due to: 1) Lack of a clear and easy mechanism for patients or staff to raise incidents or complaints, 2) lack of a clear, effective and transparent mechanism for reviewing, addressing, sharing learning and feedback from reviews/investigations, 3) lack of trust and confidence in the systems and process. These adverse events could result in avoidable harm to patients or staff, disruption to clinical and support services, avoidable costs and loss of public and stakeholder confidence.		Inherent Risk	5		5		25		Low 1 - 6
		Current Risk	5	↔	4	↓	20	↓	
		Target Risk	5	↔	1	↓	5	↓	

Key Controls	Assurance level *	Key mitigations	Assurance level *	Gaps *(actions to achieve target risk score)*	Date
Incident reporting and investigation procedure, systems and processes in place - includes lessons learning learned being shared and actions tracked with reporting to Patient Safety and Quality Group (PSQ) and Quality, Safety and Experience Committee (QSE).	2	Training programme implemented for staff involved in investigations and sharing of learning.	2	Implementation of new procedures and processes for incidents, complaints, claims, redress, safety alerts and inquests - new processes will focus on learning and improvement, with improved use of technology.	30 September 2021
Complaint reporting and investigation procedure, systems and processes in place - includes lessons learned being shared and actions tracked and fed back to patients, families and carers with reporting to PSQ and QSE.	2	Use of the Datix concerns management system to track events, investigations and actions with reporting to PSQ and QSE.	2	Implementation of the new Datix IQ Cloud system for incidents, complaints, redress, claims and mortality reviews - new system will improve the quality of information (including across Wales) and the ability to triangulate information better.	30 June 2021
Safety alerts procedure, systems and processes (both national and local alerts) - includes actions being tracked and WG Compliance Returns completed with reporting to PSQ and QSE.	3	Reporting on patient safety and patient and carer experience to local, divisional and Health Board groups and committees.	2	Implementation of a new skills pathway and passport for those involved in investigations and sharing of learning.	31 March 2021
Claims and redress investigation procedure, systems and processes - includes completion of Welsh Risk Pool (WRP) Learning from Events Reports evidencing learning which are reviewed by the WRP Committee with reporting to PSQ and QSE.	3	Dashboards and information available at local, divisional and Health Board level to provide oversight of quality and safety indicators.	2	Implementation of a new digital learning library to bring together the access, cascade, and sharing of lessons learned.	30 September 2021
Learning from deaths procedure, systems and processes including mortality reviews, inquest coordination and interaction with Medical Examiners in place with reporting to CEG and QSE.	2			Implementation of safety culture initiatives including development of a human factors community of practice, embedding of just culture principles into processes, embedding of Safety II considerations, learning from excellence reporting, annual safety culture survey, and safety culture promotion initiatives.	31 March 2022
Local and organisation-wide safety culture and quality improvement initiatives based on identified themes, trends and areas of concern with reporting to PSQ and QSE	2			Implementation of a new Quality Strategy (developed with patients, partners and staff) containing organisational improvement priorities and enabling measures aligned to the organisational strategy.	31 March 2022
				Implementation of an organisation-wide integrated Quality Dashboard.	31 March 2021

Review comments since last report:

Executive Lead:	**Board / Committee:**	**Review Date:**
Debra Hickman, Acting Executive Director of Nursing and Midwifery	Quality, Safety and Experience Committee	1 December 2020

Linked to Operational Corporate Risks:

Board Assurance Framework 2020/21

Strategic Priority 4: Safe and Secure Environment

Risk Reference: BAF20-13		Risk Rating	Impact		Likelihood		Score		Appetite
Culture - Staff Engagement									
There is a risk that the Health Board loses the engagement and empowerment of its workforce as a result of staff not feeling that it is safe and/or worthwhile highlighting concerns due to: Lack of clear mechanisms for raising concerns at any and every level, lack of a clear, effective and transparent mechanism for listening, reviewing, addressing, sharing learning and feedback, lack of trust and confidence regarding the reception of and impact of raising concerns, lack of support and guidance for all parties involved. This could lead to an impact on the organisation being able to learn from experience or improve services, which could result in poor staff morale, leading to poor outcomes impacting on the delivery of safe and sustainable services and the reputation of the Health Board.		Inherent Risk	4		5		20		Low 1 - 6
		Current Risk	4	↔	4	↓	16	↓	
		Target Risk	4	↔	3	↓	12	↓	

Key Controls	Assurance level *	Key mitigations	Assurance level *	Gaps *(actions to achieve target risk score)*	Date
Key Policies: 1.Raising Concerns Policy 2.Safehaven Guidance Given IMs feedback previous about what they expect to see as a control, I have been quite critical with other returns, in that for these to truly be controls, please note if there are in place, embedded and where are they monitored, as it stands just stating them will not give you the level 2 assurance.	2	Multi Disciplinary Reviews underway to establish an integrated system for reporting, managing, recording and reporting of concerns and learning/improvement action. Any monitoring of this taking place at operational or Exec level?	1	Raising Concerns and Safe Haven managed separately with separate process for management, recording, reporting and importantly sharing for learning and improvement. Review recommendations to include: 1. Establishment of 2 Board level "champions" and a role of Speak out Safely Guardian 2. Introduction of a system to support accessible reporting and engagement with reporters to enable two way conversations (including when reporter anonymous) 3. Establishment of a Mutli-Disciplinary Speak out Safely Resolution & Improvement Group 4. Development of a learning and reporting cycle 5. Review and revision of the existing Policy and guidance 6. Develop roles for speak out safely leads / aligned with listening / wellbeing leads.	31 March 2021
3. Dignity At Work Policy 4. Grievance Policy Given IMs feedback previous about what they expect to see as a control, I have been quite critical with other returns, in that for these to truly be controls, please note if there are in place, embedded and where are they monitored, as it stands just stating them will not give you the level 2 assurance.	2	Assessment of cases upon submission to determine most appropriate process undertaken. Case management review takes place monthly. Thematic review in place at operational level. Anything reported to Exec or Committee level?	1	1. Dignity at Work Policy under review at All Wales level. 2. Triangulation of themes to be included within the reporting outlined in Raising concerns review. 3. Simplified Guidance to be developed for managers and staff to follow to promote early resolution. 4. Current training to be reviewed to align to revised approach.	31 March 2021
5.Performance & Development Review Policy Given IMs feedback previous about what they expect to see as a control, I have been quite critical with other returns, in that for these to truly be controls, please note if there are in place, embedded and where are they monitored, as it stands just stating them will not give you the level 2 assurance.	2	Monthly analysis and reporting at operational level undertaken (as well as strategic level) to enable managers to identify areas with low compliance with PADR. Staff Engagement, Organisational Development and HR Teams work with challenged areas to support and improve in terms of engagement / feedback / recognition / development.	2	1. Identify improvements to the process and documentation to support specific areas/teams. 2. Develop a programme for "Dip testing" of quality of PADRs against key metrics / feedback. 3. Utilise the survey function of the system implemented for Speak Out Safely to support identification of examples of outstanding / good and requires improvement. 4. Build "role contribution" into Strategic Organisational Development programme specification. 5. Review feedback from NHS Staff Survey and update divisional improvement plans.	31 March 2021

Review comments since last report:

Executive Lead:	**Board / Committee:**	**Review Date:**
Sue Green, Executive Director of Workforce and Organisational Development	Quality, Safety and Experience Committee	1 December 2020

Linked to Operational Corporate Risks:

Board Assurance Framework 2020/21

Strategic Priority 4: Safe and Secure Environment

Risk Reference: BAF20-14		Risk Rating	Impact		Likelihood		Score		Appetite	
Security Services										
There is a risk that the Health Board does not provide effective security services across the organisation. This is due to lack of formal arrangements in place to protect premises and people in relation to CCTV, Security Contract issues (personnel), lone working, lock down systems, access control and training that provides assurance that Security is effectively managed. This could lead to a breach in the Health Board's statutory security duties.		Inherent Risk							Low 1 - 6	
		Current Risk								
		Target Risk								

Key Controls	Assurance level *	Key mitigations	Assurance level *	Gaps *(actions to achieve target risk score)*	Date

NOT COMPLETED

Review comments since last report:

Executive Lead:	**Board / Committee:**	**Review Date:**
Sue Green, Executive Director of Workforce and Organisational Development	Quality, Safety and Experience Committee	

Linked to Operational Corporate Risks:

Board Assurance Framework 2020/21

Strategic Priority 4: Safe and Secure Environment

Risk Reference: BAF20-15		Risk Rating	Impact		Likelihood		Score		Appetite
Health and Safety									
There is a risk that the Health Board fails in its statutory duty to provide safe systems of delivery and work in accordance with the Health and Safety at Work Act 1974 and associated legislation that could result in avoidable harm or loss.		Inherent Risk	5		4		20		Low 1 - 6
		Current Risk	5	↔	4	↔	20	↔	
		Target Risk	5	↔	2	↓	10	↓	

Key Controls	Assurance level *	Key mitigations	Assurance level *	Gaps *(actions to achieve target risk score)*	Date
Health and Safety Leadership and Management Training Programme in place across the Health Board, approved by ?? with regular monitoring reported to ??. ~~within BCUHB has had a number of training activities. The Board being provided with Corporate Manslaughter training in 2019. The H&S Team delivers H&S Managers Training and a risk assessment training programme to staff. Self assessment programme and H&S reviews in place to support safety~~	1	Competence in training in service areas has been reviewed. Plan in place through business case to establish robust Safety Competence and leadership training programme including IOSH Managing Safely and Directing Safely Modules. There is a three year strategy that requires implementing to support the Strategic Objectives of BCUHB. if it has not been implemented or in place currently it cannot be a control or a mitigation as it will not support the reduction in the risk until it has	2	The gap analysis of 31 pieces of legislation,117 site specific inspections including Acute, Mental Health Community Services GP and Wrexham HMP. Identified significant areas of none compliance. The OHS team continues to have significant support from our trade union partners. Further evaluation of H&S systems has been led by Internal Audit. A clear plan and framework for action to firstly identify hazards and place suitable controls in place has been developed. acronyms. Keep high level, but I am struggling to see what is the action, I can see the gap?	31st December 2020
Policies and Sub groups have been established including Asbestos, Water Safety, Fire Electrical Safety etc. to monitor and report into the Strategic Occupational Health & Safety Group and escalate via Quarterly Reports to QSE. This provides clear evidence I would seperate our your policy from a group. Need to state the policy is	1	Clearly identified objectives for Q3/Q4 planning to achieve and transfer of risk ownership for a number of high level risks to E/F as duty holder for asbestos, legionella, contractor management and control, Electricity and Fire. How is transferring a risk a mitigation?	1	Clearly identified issues escalated to Board via business case to be reviewed November 2020. Gaps in Fire safety for a number of premises including YG working with North Wales Fire and Rescue service on action plans. Close working relationship with HSE to ensure key risks and information required is provided in a timely manner. acronyms. I am struggling to see what is the action, I can see the gap?	30th November 2020
Lessons Learnt analysis from COVID reported to Executive Team, Through Covid Group and with action to progressed to appropriate Executives. Clear strategy from Board to deal with PPE and suitable control measures to minimise risk of transmission of Covid through risk assessment, safe distancing advice, FAQ's, ICT Audits, guidance and standard operating procedures.	2	RIDDOR reporting in place with robust timeline and tracking through outbreak groups of Datix 72 hour reviews. PPE steering group has weekly meetings and a 'triple A' assurance report is provided to QSG and key issues escalated via QSE. Over 200 site safety visits undertaken by the H&S Team to review Covid safe environments. Action cards in place to ensure movement of staff effectively managed during outbreak. QSG no longer in place? you'vve got multiple mitigations in here so it's a little difficult to follow, can they be seperated, or refer to the whole system and process	3	HSE have identified gaps in COSHH Regulations specifically fit testing which requires fit2fit training programme to be in place. Improvement Notice from HSE against BCUHB provided on 24th October. Appeal against notice has been adjourned until April 2021. There has been significant investment with fit testing equipment with further plans in place to continue fit testing on new masks. There will be a requirement to release fit testers and staff to comply with legal compliance required. I am struggling to see what is the action, I can see the gap?	31st December 2020
Executive Team understand the range and types of risks identified through Annual Report and Gap analysis. Gaps in safety including areas of inefficiency to be addressed. Internal Audit have reviewed structure of meetings and Governance procedures. I am struggling to understand how this would be a control?	1	Strategic OHS Group established to monitor performance and workshop with OD support has looked at leadership styles and developing a positive culture with partners from finance, procurement, Estates and Facilities and Occupational Health. Please don't use acronyms, this is a public Board report	2	Robust action plan with clear objectives for Team difficult to deal with all elements of legislative compliance with limited capacity. **Action:** Recommending specialist support to review key areas of risk and attendance at operational groups to further understand significant risks.	31st December 2020

Review comments since last report:

Executive Lead:	**Board / Committee:**	**Review Date:**
Sue Green, Executive Director of Workforce and Organisational Development	Quality, Safety and Experience Committee	01/02/2021

Linked to Operational Corporate Risks:

NOT APPROVED BY EXEC. ENTRY REQUIRES FURTHER WORK

Board Assurance Framework 2020/21

Strategic Priority 4: Safe and Secure Environment

Risk Reference: BA20-16		Risk Rating	Impact		Likelihood		Score		Appetite
Pandemic Exposure									
There is risk that patients, staff or visitors are exposed to COVID -19 due to inadequate/inappropriate resources, lack of compliance with prevention/protection measures across all settings, lack of understanding, skills, ownership of responsibilities, lack of systems and/or capacity and/or capability to identify, analyse, adapt, address immediate themes arising from intelligence both internal and external in a dynamic way. This could impact or effect avoidable harm caused to our patients, staff, visitors, increase in demand/length of stay/risk to other patients, reduction in availability of staff to support the delivery of safe care and services. This could led to prosecution for breach of statutory/legal duty and reputational damage to trust and confidence.		Inherent Risk	5		5		25		Low 1 - 6
		Current Risk	5	↔	4	↓	20	↓	
		Target Risk	5	↔	1	↓	6	↓	

Key Controls	Assurance level *	Key mitigations	Assurance level *	Gaps *(actions to achieve target risk score)*	Date
PPE monitoring and management in place with regular reporting to the Patient Safety and Quality Group.	1	PPE steering group (PPESG) and Covid Delivery Group reporting into Infection Prevention Sub Group, Patient Safety & Quality Group and Quality & Safety Executive with governance structure in place.	2	Continuous supply is not secure, training availability limited due to staffing resource in PPE and IPC teams. BCUHB to approve second admission screen.	31 December 2020
Fit testing in place to prevent avoidable infection. This is monitored via IPSG and OH&SG.	1	Fit testing programme, Accreditation training and business case in place to increase assurance monitored by PPESG.	2	Finalisation of ongoing plan and sign off at PPESG.	31 December 2020
Environmental considerations in place to meet new guidance in relation to the built environment and mitigating risks.	1	Ventilation and Environmental groups reporting into Infection Prevention Sub Group and Patient Safety & Quality Group with governance structure in place. Implementation of segregation and screening to clinical areas.	1	Some buildings are a risk due to infrastructure (dialysis and community hospitals). Improvement plans in place via Planning and Estates.	31 March 2021

Review comments since last report:

Executive Lead:	**Board / Committee:**	**Review Date:**
Debra Hickman, Acting Executive Director of Nursing and Midwifery	Quality, Safety and Experience Committee	1 December 2020

Linked to Operational Corporate Risks:

Awaiting Escalation Approval 3415 - Risk of rapid development of Covid-19, by Patients and Staff due to inadequate ventilation within Holywell Hospital

Board Assurance Framework 2020/21

Strategic Priority 5: Effective Use of Resources

Risk Reference: BAF20-17		Risk Rating	Impact		Likelihood		Score		Appetite
Value Based Improvement Programme (VBHC)									
There is a risk that the Health Board doesn't understand or use it's resources effectively and efficiently due to a lack of implementing an appropriately resourced value based improvement programme. This could impact on the quality of outcomes for the services it delivers.		Inherent Risk	4		4		16		Moderate
		Current Risk	4	↔	3	↓	12	↓	8 - 10
		Target Risk	4	↔	2	↓	8	↓	

Key Controls	Assurance level *	Key mitigations	Assurance level *	Gaps *(actions to achieve target risk score)*	Date
Finance and Performance Committee oversight via standard reporting of opportunities in place and savings delivered.	2	Contribution to national benchmarking programmes, providing detailed analysis of service areas and opportunities.	3	Organisational commitment to VBHC and Leadership to be restated.	31 December 2020
Finance and Performance Committee oversight of benchmarking data & follow up work in place e.g. Mental Health.	2	Drivers of the Deficit analysis used to inform Q3/Q4 planning and to identify priorities for tackling efficiency opportunities.	1	Resources to facilitate and support the VBHC programme to be secured, with recruitment commenced.	31 December 2020
Lessons Learnt analysis from COVID reported to Executive Team, with action to mainstream innovation and value opportunities. Reporting of progress to delivering opportunities in place to Finance and Performance Committee.	2	National efficiency framework analysis to identify opportunities and cascade to Improvement Groups and Divisions.	1	Planning and business case approach to be reviewed to capture VBHC principles.	31 December 2020
Clinical Effectiveness Group re-established with oversight of Value Based Healthcare within its brief.	1			Register of VBHC projects and interventions to be established.	31 December 2020
Executive Team reviewing the opportunities analysis produced for Improvement Groups to identify potential areas of inefficiency to be addressed.	2			Steering group to be established to drive the programme of work, supported by the VBHC structure. Progress reports to be provided to the Clinical Effectiveness Group.	31 December 2020
				Priority interventions to be identified within the Board's VBHC delivery plan.	29 January 2021
				Data capture and reporting systems for VBHC to be developed.	26 February 2021

Review comments since last report:

Executive Lead:	**Board / Committee:**	**Review Date:**
Sue Hill, Acting Executive Finance Director	Finance and Performance Committee	1 December 2020

Linked to Operational Corporate Risks:

Board Assurance Framework 2020/21

Strategic Priority 5: Effective Use of Resources

Risk Reference: BAF20-18		Risk Rating	Impact		Likelihood		Score		Appetite
Digital Estate and Assets									
There is a risk that Informatics cannot implement digital solutions due available resource not keeping step with an organisational wish to become more digitally focused. This could impact on the safety of our patients, service efficiency and the reputation of the Health Board, the ability to recruit and retain staff or impact on compliance with legislation resulting in significant financial penalties.		Inherent Risk	4		5		20		Moderate to High 8 - 15
		Current Risk	4	↔	5	↔	20	↔	
		Target Risk	4	↔	3	🡻	12	🡻	

Key Controls	Assurance level *	Key mitigations	Assurance level *	Gaps *(actions to achieve target risk score)*	Date
Monthly budget reviews take place with finance. Finance attendance at Informatics Senior Management Team (SMT) on a monthly basis as part of the Cycle of Business.	1	Contribution to national informatics programmes through representation both informatics and clinical i.e. Virtual Consultations, Digital Services for Patients and the Public Programme.	3	Development of a Digital Strategy.	1 April 2021
Quarterly review of Operational Plan at SMT with Digital and Information Governance Committee (DIGC) oversight of the delivery of the Informatics Operational Plan and budget on a quarterly basis.	2	Review of required business cases through the Business Case Review Group and to the Finance & Performance Committee (F&P) Committee for approval.	2	Implementation of the Digital Strategy Year 1 to 2.	1 March 2022
Capital and Revenue Programmes are in place and are reported through the DIGC on a quarterly basis.	2	Resource risks are identified and go through the escalation process as documented in the Risk Management Strategy. This governance includes SMT, DIGC and Risk Management Group.	2	Development of an established resource structure and revenue and capital requirements for 21/22.	1 December 2020
.		Programmes and Projects are managed using agreed standard methodologies (Tailored Prince2) and have governance structures.	1	Development of an established resource structure and revenue and capital requirements in line with the strategy delivery from 22/23.	1 December 2021
				Development a Management of Portfolio approach so that all digital solution change initiatives are well governed, controlled and prioritised.	30 January 2021
				Meet with the National Wales Informatics Service (NWIS) to discuss the BCUHB Priorities and Risks.	31 December 2020
				Implementation of the Management of Portfolio Approach.	1 September 2021

Review comments since last report:

Executive Lead:	**Board / Committee:**	**Review Date:**
Chris Stockport, Executive Director of Primary and Community Services	Digital and Information Governance Committee	1 December 2020

Linked to Operational Corporate Risks:

CRR20-06 - Informatics - Patient Records pan BCUHB

CRR20-07 - Informatics infrastructure capacity, resource and demand

Board Assurance Framework 2020/21

Strategic Priority 5: Effective Use of Resources

Risk Reference: BAF20-19		Risk Rating	Impact		Likelihood		Score		Appetite
Estates and Assets									
There is a risk that the Health Board does not understand its equipment, assets or digital landscape due to no clear leadership, oversight of agreed capital funding at the Board. This could impact on the Board's ability to implement safe and sustainable services through an appropriate refresh programme.		Inherent Risk	4		4		20		Moderate 8 - 10
		Current Risk	3	↓	3	↓	9	↓	
		Target Risk	3	↔	2	↓	6	↓	

Key Controls	Assurance level *	Key mitigations	Assurance level *	Gaps *(actions to achieve target risk score)*	Date
Estates Strategy in place and approved by the Board in January 2019 with updates provided to the Strategy, Partnership and Population Health Committee.	2	Development for business case for key projects identified in key strategies.	1	Secure WG funding to support Business Cases (short and long term).	31 March 2022
Annual Capital Programme in place and approved by the Finance and Performance Committee with bi-monthly reports provided to the committee.	2	Capital Investment Group with representation from all divisions with regular updates to the Executive Team in place.	2	Rationalisation of the Health Board Estate.	31 March 2022
		Capital Programme based on priorities as identified by divisions, Core Areas (Estates, Informatics and medical devices) feeding into the Capital Investment Group and onward to the Finance and Performance Committee.	2	Review and identify capacity to deliver all the projects.	31 March 2021
		Selection criteria signed off by the Executive Team which links back to risk, service continuity, service transformation and sustainability.	2	Development of revised Informatics Strategy.	31 March 2021
		Project Teams in place to deliver the business case and projects.	1		

Review comments since last report:

Executive Lead:	**Board / Committee:**	**Review Date:**
Mark Wilkinson, Executive Director of Planning and Performance	Finance and Performance Committee	1 December 2020

Linked to Operational Corporate Risks:
CRR20-06 - Informatics - Patient Records pan BCUHB
CRR20-07 - Informatics infrastructure capacity, resource and demand

Board Assurance Framework 2020/21

Strategic Priority 5: Effective Use of Resources

Risk Reference: BAF20-20		Risk Rating	Impact		Likelihood		Score		Appetite
Estates and Assets Development									
There is a risk that the Health Board does not systematically review and capitalise on the opportunity to develop its estates and assets due to changes in working practices (for example agile working) which could impact on recruitment, financial balance and the reputation of the Health Board.		Inherent Risk	3		4		12		Moderate 8 - 10
		Current Risk	3	↔	3	↓	9	↓	
		Target Risk	3	↔	2	↓	6	↓	

Key Controls	Assurance level *	Key mitigations	Assurance level *	Gaps *(actions to achieve target risk score)*	Date
Estates Strategy, monitored by Capital Investment Group with oversight at Finance and Performance, and Strategy Partnerships and Population Health Committees and Health Board.	2	Disposal or acquisition of assets are signed off by the Board and Welsh Government in line with the BCUHB Scheme of Reservation and Delegation (SoRD).	3	Health Board through the Workforce Strategy to agree the standards for workforce accommodation and changes in working practices through modern ways of working (e.g. Agile).	31 March 2022
Workforce Strategy monitored by the Health Board.	2	Business Case process in place with oversight by the Executive Team, Capital Investment Group, Finance and Performance Committee and onto Welsh Government.	3	Financial Planning to be agreed and secured to support the change in working practices.	31 March 2021
				Additional Resources for Asset Management function have been identified through the Health and Safety Business Care to be approved by Finance and Performance Committee.	31 March 2021
				Health Board agreed Estate rationalisation programme over three years 2021 to 2023. 2021-22 overview through Finance and Performance Committee and oversite through the Capital Investment Group.	1 April 2021
				Opportunities to progress corporate accommodation hubs in partnership with North Wales Regional Public Service Providers and Local Authorities.	31 March 2022
				Update Estates Strategy to reflect demands for flexible accommodation hubs and review current and future needs for Office accommodation.	1 April 2021

Review comments since last report:

Executive Lead:	**Board / Committee:**	**Review Date:**
Mark Wilkinson, Executive Director of Planning and Performance	Finance and Performance Committee	1 December 2020

Linked to Operational Corporate Risks:

CRR20-01 - Asbestos Management and Control
CRR20-03 - Legionella Management and Control
CRR20-04 - Non-Compliance of Fire Safety Systems
CRR20-07 - Informatics infrastructure capacity, resource and demand

Board Assurance Framework 2020/21

Strategic Priority 5: Effective Use of Resources

Risk Reference: BAF20-21		Risk Rating	Impact		Likelihood		Score		Appetite	
Workforce Optimisation										
There is a risk that the Health Board cannot attract or retain staff due to poor leadership, communication and an ageing estate/technology. This could impact on the Board's ability to deliver safe and sustainable services.		Inherent Risk							Low 1 - 6	
		Current Risk								
		Target Risk								

Key Controls	Assurance level *	Key mitigations	Assurance level *	Gaps *(actions to achieve target risk score)*	Date

NOT COMPLETED

Review comments since last report:

Executive Lead: Sue Green, Executive Director of Workforce and Organisational Development	**Board / Committee:** Strategy, Partnerships and Population Health Committee	**Review Date:**

Linked to Operational Corporate Risks:

Board Assurance Framework 2020/21

Strategic Priority 5: Effective Use of Resources

Risk Reference: BAF20-22		Risk Rating	Impact		Likelihood		Score		Appetite
Development of Integrated Medium Term Plan (IMTP)									
There is a risk the Health Board fails to deliver an approvable IMTP to Welsh Government and remains in breach of it's statutory duties whether due to inability to deliver financial balance or to present a plan that delivers key performance targets. This impacts on reputation, and reduces freedom to act.		Inherent Risk	3		3		9		Low 1 - 6
		Current Risk	3	↑	5	↔	15	↑	
		Target Risk	3	↔	1	↓	3	↓	

Key Controls	Assurance level *	Key mitigations	Assurance level *	Gaps *(actions to achieve target risk score)*	Date
Executive led planning process in place responsible for meeting the Welsh Government requirements for the development / implementation of an IMTP.	2	▪ Strong corporate, clinical, managerial and partnership engagement / collaboration with established and coordinated communication links including Welsh Government, Public Health Wales, and key internal and external stakeholders, e.g.: Executive led Planning Workstream, Stakeholder Reference Group, Regional Partnership Board. ▪ Clear accountability across the organisation - agreed actions/outputs have a designated Executive lead, programme lead and action lead. ▪ Process supported by Executive led prioritisation and decision making framework. (Welsh Government Guidance for 2021/22 expected December 2020).	3		
Planning cycle established with outline BCUHB Planning schedule/overall approach for 2021/2024 plan led by Assistant Director, Corporate Planning and reporting into the Executive Team and the Strategy, Partnership and Population Health Committee.	2	▪ Developed 2021/24 Cluster Plans to influence the Primary Care Recovery Plans. ▪ Planning arrangements established to support development of 2021/24 plan with identified support from Corporate Teams. ▪ Programme Groups led by designated programme lead with input from Divisional Teams with direct reporting to the Planning Workstream and the Assistant Director Corporate Planning.	2	▪ Co-produce 2021/24 Planning principles, timetable and key deliverables with ET, EMG and SPPH Committees. ▪ Develop and implement response/communication mechanisms to ensure consistency across the organisation in relation to developing the plan. ▪ Equip programmes with capacity and capability to deliver timely plans with clear service, activity, financial and workforce impacts through dedicated programme management and support comprising of planning, finance, informatics and workforce building on a commissioning programme approach.	31 December 2020 31 December 2020 31 March 2021
BCUHB Annual Planning cycle in place that responds to national NHS Wales IMTP planning timetable and requirements.	2	IMTP planning paused across NHS Wales in 2020/21 due to covid pandemic. Welsh Government NHS quarterly planning framework issued. BCUHB developed, approved and submitted quarterly plans for Q1, Q2 and a Q3/4 Winter Plan for 2020/21 in line with revised statutory requirements.	2	▪ Strengthen communication links with Communications Team to improve the engagement of the Plan and its development.	31 December 2020

Review comments since last report:

Executive Lead: Mark Wilkinson, Executive Director of Planning and Performance	**Board / Committee:** Strategy Partnerships and Population Health Committees.	**Review Date:** 1 December 2020
Linked to Operational Corporate Risks:		

Board Assurance Framework 2020/21

Strategic Priority 5: Effective Use of Resources

Risk Reference: BAF20-23		Risk Rating	Impact		Likelihood		Score		Appetite	
EU Exit										
There is a risk that the Health Board (HB) will fail to maintain a safe and effective healthcare service following the end of the EU Transition period on 31 December 2020. This may be caused by the UK government failure to conclude a trade deal with the EU, resulting in the UK leaving the EU on World Trade Organisation (WTO) terms. This could lead to a disruption of service delivery and thereby adversely impacting on outcomes for patients in terms of safety and access to services.		Inherent Risk	4		4		16		Low 1 - 6	
		Current Risk	4	↔	3	🡻	12	🡻		
		Target Risk	4	↔	1	🡻	4	🡻		

Key Controls	Assurance level *	Key mitigations	Assurance level *	Gaps *(actions to achieve target risk score)*	Date
BCUHB Task & Finish Group set up and in place reporting to Civil Contingencies Group.	2	Risk assessment and action planning to respond.	2	Risks to be reviewed and actions updated when UK Government position becomes clear.	30 November 2020
Business Continuity Plans including response to supply chain disruption in place and monitored by Civil Contingencies Group.	2	National and local procurement plans to hold increased levels of stocks; pharmacy and medicines management team work with pharmaceutical procurement and suppliers; food stocks and capacity to be maintained at increased levels.	1	Further checks on stock levels and supply arrangements for critical supplies as the end of the Transition Period approaches. Particular attention to areas where risks may be increased by Covid-19 response (medicines, PPE, clinical consumables).	31 December 2020
All Wales SROs' Group monitors Health Board action plans and reports into WG Leadership Group.	3	National scrutiny and support processes including escalation mechanisms; national procurement actions to address risks to supply chain.	3	Ensure BCUHB response mechanisms are consistent with national requirements as updated.	30 November 2020
National Emergency Planning Leads Group oversees Emergency Planning response.	3	National preparedness and response infrastructure in place.	3		

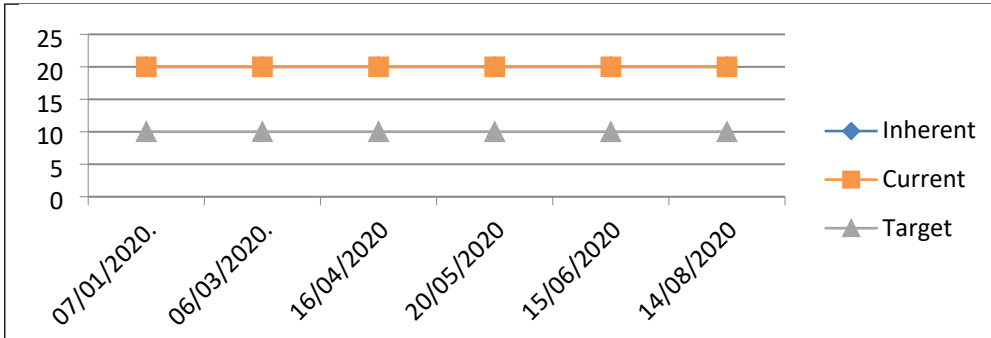
Review comments since last report:

Executive Lead:	**Board / Committee:**	**Review Date:**
Mark Wilkinson, Executive Director of Planning and Performance	Strategy, Partnership and Population Health Committee	1 December 2020

Linked to Operational Corporate Risks:

Appendix 2: Corporate Risk Register

CRR20-01	**Director Lead:** Executive Director of Planning and Performance	**Date Opened:** 7 January 2020
	Assuring Committee: Quality, Safety and Experience Committee	**Date Last Reviewed:** 1 December 2020
	Risk: Asbestos Management and Control	**Date of Committee Review:** 3 July 2020
		Target Risk Date: 1 December 2021
There is a significant risk that BCUHB is non-compliant with the Asbestos at Work Regulations 2012. This is due to the evidence that not all surveys have been completed and re-surveys are a copy of previous years surveys. There are actions outstanding in some areas from surveys. This may lead to the risk of contractors, staff and others being exposed to asbestos, and may result in death from mesothelioma or long term ill health conditions, claims, HSE enforcement action including fines, prosecution and reputation damage to BCUHB.		



	Impact	Likelihood	Score
Inherent Risk Rating	5	4	20
Current Risk Rating	5	4	20
Target Risk Score (Risk Appetite – *low level)*	5	2	10
Movement in Current Risk Rating Since last presented to the Board in April 2020	*unchanged*		

Controls in place	Assurances
1. Asbestos Policy in place and partially implemented due to lack of complete asbestos registers on all sites. 2. A number of surveys undertaken, quality not determined. 3. Asbestos management plan in place. 4. Asbestos register available on some sites, generally held centrally. 5. Targeted surveys were capital work is planned or decommissioning work undertaken. 6. Training for operatives in Estates. 7. Air monitoring undertaken in some premises where there is limited clarity on asbestos condition.	1. Health and Safety Leads Group. 2. Strategic Occupational Health and Safety Group. 3. Quality, Safety and Patient Experience Committee.

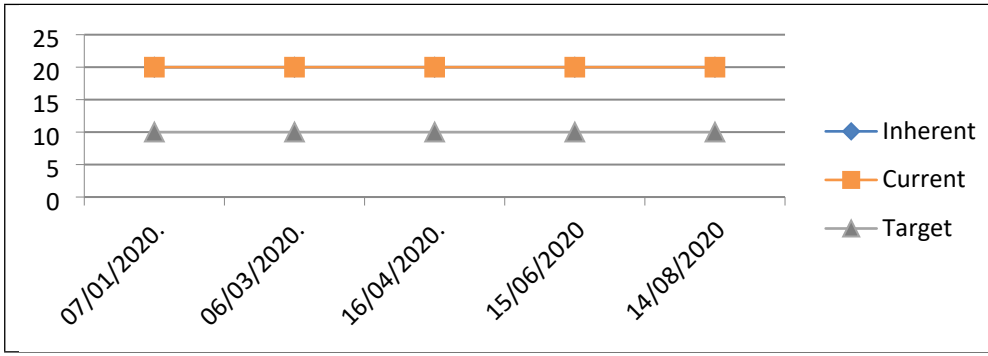
Links to		
Strategic Priorities	**Principal Risks**	**Special Measures Theme**
Effective use of our resources Safe, secure & healthy environment for our people	BAF20-15 BAF20-20	Governance Leadership

Risk Response Plan	Action ID	Action	Action Lead/ Owner	Due date	State how action will support risk mitigation and reduce score	RAG Status
Actions being implemented to achieve target risk score	12241	Undertaking a re-survey of 10-15 premises to determine if the original Asbestos surveys are valid. This is problematic as finances are not available for this work, increasing the risk of exposure to staff and contractors.	Mr Rod Taylor, Director of Estates & Facilities	31/01/2021		
	12242	Update and review the Asbestos Policy and Management Plan.	Mr Rod Taylor, Director of Estates & Facilities	31/01/2021		
	12243	Review schematic drawings and process to be implemented to update plans from Safety Files etc. This will require investment in MiCad or other planning data system.	Mr Rod Taylor, Director of Estates & Facilities	31/01/2021		
	12244	Ensure priority assessments are undertaken and highest risk escalated.	Mr Rod Taylor, Director of Estates & Facilities	30/01/2021		
	12245	Evaluate how contractors are provided with information and instruction on	Mr Rod Taylor, Director of	31/01/2021		

		asbestos within their work environment. Ensure work is monitored.	Estates & Facilities			
	12246	Ensure all asbestos surveys are available at all sites and there is a lead allocated for premises.	Mr Rod Taylor, Director of Estates & Facilities	30/01/2021		
	12247	Annual asbestos surveys to be tracked and monitor for actions providing positive assurance of actions taken to mitigate risks.	Mr Rod Taylor, Director of Estates & Facilities	30/01/2021		
	12248	Update intranet pages and raise awareness with staff who may be affected by asbestos.	Mrs Susan Morgan, Interim Head of Health and Safety	30/12/2020		
	12249	QR Code identification to be provided on all areas of work with identified asbestos signage in non-public areas.	Mr Rod Taylor, Director of Estates & Facilities	30/04/2021		
	12250	Lack of completed asbestos registers on all sites picked up in H&S Gap Analysis Action Plan.	Mrs Susan Morgan, Interim Head of Health and Safety	30/04/2021		

CRR20-02	**Director Lead:** Executive Director of Planning and Performance	**Date Opened:** 7 January 2020
	Assuring Committee: Quality, Safety and Experience Committee	**Date Last Reviewed:** 14 August 2020
	Risk: Contractor Management and Control	**Date of Committee Review:** 3 July 2020
		Target Risk Date: 1 December 2020

There is a risk that BCUHB fails to achieve compliance with Health and Safety Legislation due to lack of control of contractors on sites. This may lead to exposure to substances hazardous to health, non compliance with permit to work systems and result in injury, death, loss including prosecution, fines and reputation damage.



	Impact	Likelihood	Score
Inherent Risk Rating	5	4	20
Current Risk Rating	5	4	20
Target Risk Score (Risk Appetite – *low level)*	5	2	10
Movement in Current Risk Rating Since last presented to the Board in April 2020	*unchanged*		

Controls in place	**Assurances**
1. Control of contractors procedure in place and partially implemented due to lack of consistency and standardisation. 2. Induction process being delivered to new contractors. 3. There are a number of permit to work paper systems being implemented.	1.Health and Safety Leads Group. 2.Strategic Occupational Health and Safety Group. 3.Quality, Safety and Patient Experience Committee.

Links to		
Strategic Priorities	**Principal Risks**	**Special Measures Theme**
Safe, secure & healthy environment for our people	BAF20-15	Governance Leadership

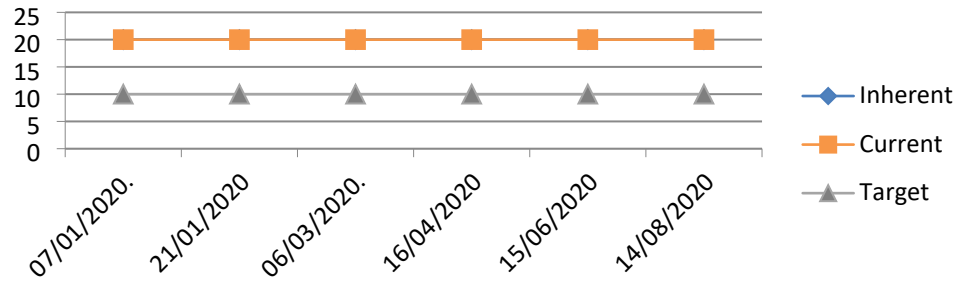
Risk Response Plan	Action ID	Action	Action Lead/ Owner	Due date	State how action will support risk mitigation and reduce score	RAG Status
Actions being implemented to achieve target risk score	12251	Identify current guidance documents and ensure they are fit for purpose.	Mrs Susan Morgan, Interim Head of Health and Safety	31/01/2021		
	12252	Identify service Lead on each site to take responsibility for Contractors and H&S Management within H&S Policy).	Mrs Susan Morgan, Interim Head of Health and Safety	31/01/2021		
	12253	Draft and implement a Control of Contractors Policy that all adhere to including IT and other services who work on BCUHB premises.	Mr Rod Taylor, Director of Estates & Facilities	31/03/2021		
	12254	Identify current tender process & evaluation of contractors, particularly for smaller contracts consider Contractor Health and Safety Scheme on all contractors. This will ensure minimum H&S are implemented and externally checked prior to coming to site.	Mr Rod Taylor, Director of Estates & Facilities	31/01/2021	Action against Rod Taylor / Peter Bohan with assistance from Sue Morgan	
	12255	Evaluate the current assessment of contractor requirements in respect of H&S, Insurance, competencies etc. Is the current system fit for purpose and robust?	Mrs Susan Morgan, Interim Head of Health and Safety	31/03/2021		

	12256	Identify the current system for signing in / out and/or monitoring of contractors whilst on site. Currently there is no robust system in place. Electronic system to be implemented such as SHE data base.	Mr Rod Taylor, Director of Estates & Facilities	31/01/2021		
	12257	Identify level of Local Induction and who carry it out and to what standard.	Mr Rod Taylor, Director of Estates & Facilities	31/03/2021		
	12258	Identify responsible person to review RA's and signs off Method Statements (RAMS), skills, knowledge and understanding to be competent to assess documents (Pathology, Radiology, IT etc.).	Mr Rod Taylor, Director of Estates & Facilities	31/01/2021		
	12259	Identify the current Permit To Work processes to determine whether is it fit for purpose and implemented on a pan BCUHB basis.	Mr Rod Taylor, Director of Estates & Facilities	31/01/2021		
	12260	Lack of consistency and standardisation in implementation of contractor management procedure picked up in H&S Gap Analysis Action Plan.	Mrs Susan Morgan, Interim Head of Health and Safety	31/03/2021		
	12552	Induction process to be completed by all contractors who have not yet already undertaken.	Mrs Susan Morgan, Interim Head of Health and Safety	31/03/2021		
	12553	Evaluation of standing orders and assessment under Construction	Mrs Susan Morgan,	31/03/2021		

		Design and Management Regulations.	Interim Head of Health and Safety			

03	**Assuring Committee:** Quality, Safety and Experience Committee	**Date Last Reviewed:** 1 December 2020
	Risk: Legionella Management and Control.	**Date of Committee Review:** 3 July 2020
		Target Risk Date: 31 March 2021

There is a significant risk that BCUHB is non-compliant with COSHH Legislation (L8 Legionella Management Guidelines). This is caused by a lack of formal processes and systems, to minimise the risk to staff, patients, visitors and General Public, from water-borne pathogens (such as Pseudomonas). This may ultimately lead to death, ill health conditions in those who are particularly susceptible to such risks, and a breach of relevant Health & Safety Legislation.



	Impact	Likelihood	Score
Inherent Risk Rating	4	5	20
Current Risk Rating	5	4	20
Target Risk Score (Risk Appetite – *low level)*	5	2	10
Movement in Current Risk Rating Since last presented to the Board in April 2020	*unchanged*		

Controls in place	**Assurances**
1. Legionella and Water Safety Policy in place and being partially impemented due to lack of consistency and standardisation. 2. Risk assessment undertaken by clear water. 3. High risk engineering work completed in line with clearwater risk assessment. 4. Bi-Annual risk assessment undertaken by clear water. 5. Water samples taken and evaluated for legionella and pseudomonis. 6. Authorising Engineer water safety in place who provides annual report.	1. Health and Safety Leads Group. 2. Strategic Occupational Health and Safety Group. 3. Quality, Safety and Patient Experience Committee.

Links to

Strategic Priorities	Principal Risks	Special Measures Theme
Effective use of our resources Safe, secure & healthy environment for our people	BAF20-15 BAF20-20	Governance Leadership

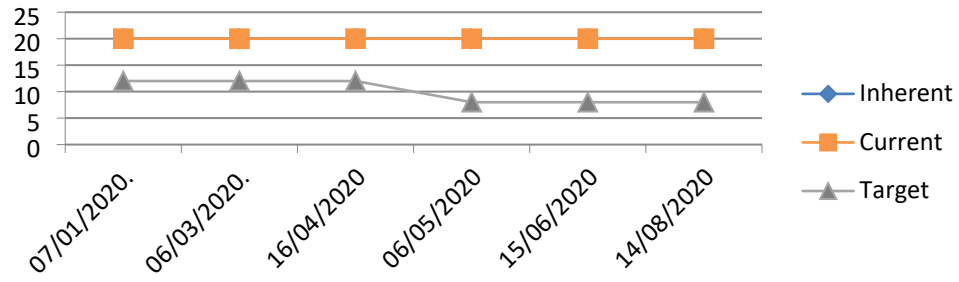
Risk Response Plan	Action ID	Action	Action Lead/ Owner	Due date	State how action will support risk mitigation and reduce score	RAG Status
Actions being implemented to achieve target risk score	12261	Update Corporate H&S Review template and H&S Self-Assessment Template to ensure that actions are completed by all wards and Departments to ensure systems are in place.	Mrs Susan Morgan, Interim Head of Health and Safety	**COMPLETE** 30/11/2020	There is an annual review of the Corporate H&S Review and Self-Assessment paperwork. This will continue to be included but due to the low return rates at the moment for the self-assessment and the reduced number of H&S reviews (due to COVID-19) this is not an effective action to reduce this risk at this time.	
	12262	Ensure that engineering schematics are in place for all departments and kept up to date under Estates control. Implement MiCAD/database system to ensure all schematics are up to date and deadlegs easily identified.	Mr Rod Taylor, Director of Estates & Facilities	31/03/2021		

	12263	Departments to have information on all outlets and deadlegs, identification of high risk areas within their services to ensure they can be effectively managed	Mr Rod Taylor, Director of Estates & Facilities	31/03/2021		
	12264	Departments to have a flushing and testing regime in place, defined in a Standard Operating Procedure, with designated responsibilities and recording mechanism Ward Manager or site responsible person.	Mr Rod Taylor, Director of Estates & Facilities	31/01/2021		
	12265	Water quality testing results and flushing to be logged on single system and shared with or accessible by departments/services - potential for dashboard/logging system (Public Health Wales).	Mr Rod Taylor, Director of Estates & Facilities	31/01/2021		
	12266	Standardised result tracking, escalation and notification procedure in place, with appropriate escalation route for exception reporting.	Mr Rod Taylor, Director of Estates & Facilities	31/01/2021		
	12267	Awareness and training programme in place to ensure all staff aware. Departmental Induction Checklist.	Mrs Susan Morgan, Interim Head of Health and Safety	31/12/2020	Date was amended by PB (Associate Director) due to delays to this program with the COVID -19 impact on the workload of the H&S team and other teams that are needed to support this action being completed	

	12268	BCUHB Policy and Procedure in place and ratified, along with any department-level templates for SOPs and check sheets.	Mr Rod Taylor, Director of Estates & Facilities	31/03/2021		
	12269	Water Safety Group provides assurance that the Policy is being effectively implemented across all sites, this requires appropriate clinical and microbiology support to be effective	Mr Rod Taylor, Director of Estates & Facilities	31/01/2021		
	12270	Lack of consistency and standardisation in the implementation of the Legionella and Water Safety Policy picked up in the H&S Gap Analysis Action Plan.	Mrs Susan Morgan, Interim Head of Health and Safety	31/12/2020		

	Risk: Non-Compliance of Fire Safety Systems	**Date of Committee Review:** 3 July 2020
		Target Risk Date: 31 March 2021

There is a risk that the Health Board is non-compliant with Fire Safety Procedures (in line with Regulatory Reform (Fire Safety Order 2005). This is caused by a lack of robust Fire Safety Governance in many service areas /infrastructure (such as compartmentation), a significant back-log of incomplete maintenance risks and lack of relevant operational Risks Assessments. This may lead to a major Fire, breach in Legislation and ultimately prosecution against BCUHB.



	Impact	Likelihood	Score
Inherent Risk Rating	4	5	20
Current Risk Rating	4	5	20
Target Risk Score (Risk Appetite – *low level)*	4	2	8
Movement in Current Risk Rating Since last presented to the Board in April 2020.	*unchanged*		

Controls in place	**Assurances**
1. Fire risk assessments in place in a number of service areas. 2. Evacuation routes Identified and evaluation drills established and implemented (across a number of areas). 3. Fire Safety Policy established and implemented. 4. Fire Engineer regularly monitor Fire Safety Systems. 5. Fire Safety Mandatory Training and Awareness session regularly delivered to BCUH Staff. 6. Fire Warden Mandatory Training established and being delivered to Nominated Fire Warden.	1. Health and Safety Leads Group. 2. Strategic Occupational Health and Safety Group. 3. Quality, Safety and Patient Experience Committee.

Links to		
Strategic Priorities	**Principal Risks**	**Special Measures Theme**

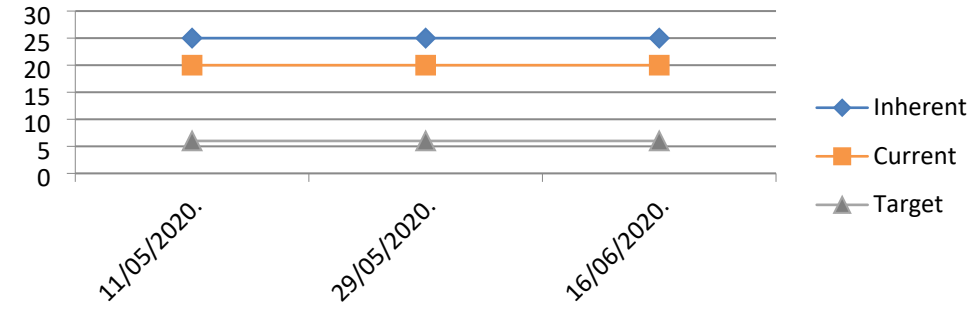
Effective use of our resources Safe, secure & healthy environment for our people	BAF20-15 BAF20-20	Governance Leadership

Risk Response Plan	Action ID	Action	Action Lead/ Owner	Due date	State how action will support risk mitigation and reduce score	RAG Status
Actions being implemented to achieve target risk score	12273	Review Internal Audit Fire findings and ensure all actions are taken.	Mr Rod Taylor, Director of Estates & Facilities	31/12/2020		
	12274	Identify how actions identified in the site FRA are escalated to senior staff and effectively implemented.	Mr Rod Taylor, Director of Estates & Facilities	31/01/2021		
	12275	Identify how site specific fire information and training is conducted and recorded.	Mr Rod Taylor, Director of Estates & Facilities	31/01/2021		
	12276	Consider how bariatric evacuation training - is undertaken define current plans for evacuation and how this is achieved?	Mr Rod Taylor, Director of Estates & Facilities	31/03/2021		
	12279	AlbaMat training - is required in all service areas a specific training package is required with Fire and Manual Handling Team involved.	Mr Rod Taylor, Director of Estates & Facilities	31/12/2020		
	12554	Commission independent shared services audits.	Mrs Susan Morgan, Interim Head of Health and Safety	31/12/2020	02.11.20 we are currently working with internal Audit reviewing Security and V&A	
	12555	Information from unwanted fire alarms and actual fires is collated and	Mrs Susan Morgan, Interim	31/01/2021		

		reviewed as part of the fire risk assessment process.	Head of Health and Safety			

CRR20-05	**Director Lead:** Executive Director of Public Health	**Date Opened:** 11 May 2020
	Assuring Committee: Quality, Safety and Experience Committee	**Date Last Reviewed:** 16 June 2020
	Risk: Timely access to care homes	**Date of Committee Review:** 3 July 2020

		Target Risk Date: 31 December 2020
There is a risk that there will be a delay in residents accessing placements in care homes and other communal facilities. This is caused by the need to protect these vulnerable communities from the transmission of the virus during the pandemic. This could lead to individual harm, debilitation and delay in hospital discharges impacting on wider capacity and patient flow.		



	Impact	Likelihood	Score
Inherent Risk Rating	5	5	25
Current Risk Rating	5	4	20
Target Risk Score (Risk Appetite – *low level)*	3	2	6
Movement in Current Risk Rating Since last presented to the Board in April 2020	*unchanged*		

Controls in place	**Assurances**
1. Multi-agency care home cell established as part of the emergency planning arrangements. 2. PPE distribution system operational including identification and support for residents with aerosol generating procedures. 3. Testing for residents and staff in place aligned with national guidance. 4. Unified “One contact a day“ data gathering from care homes established with 6 Local Authorities. 5. Systems for Access to specialist advice via Public Health Wales and the Environmental Health Teams in place to manage isolation and outbreaks. 6. Personalised care and support plans promoted led by specialist palliative care team. 7. New arrangements in place for the timely provision of pharmacy and medication support at the end of life. 8. Remote consulting offered by general practice. 9. Home first bureaus established by the 3 area teams to facilitate sensitive and collaborative decision making on hospital discharge, transfer between care homes and admissions from home.	1. Oversight via the Care Home Cell which includes representatives from Care Forum Wales, Local Authority members and Care Inspectorate Wales (CIW). 2. Oversight via Gold and Silver Strategic Emergency Planning. 3. Oversight as part of the Local Resilience Forum via SCG.

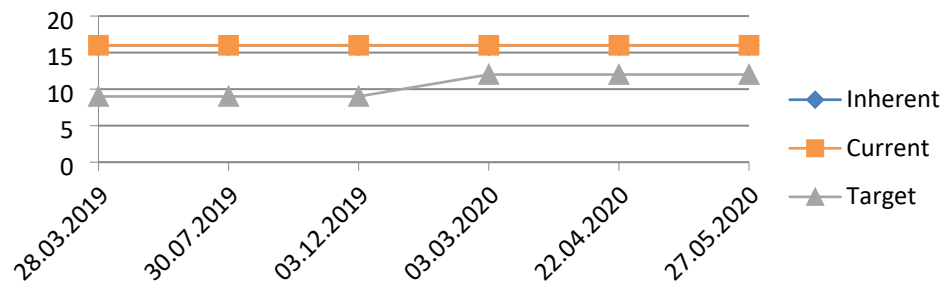
10. Regular communication with care homes at a local level and across BCU.	

Links to		
Strategic Priorities	**Principal Risks**	**Special Measures Theme**
Continuing to provide care under 'essential' services & safe stepping up planned care	BAF20-03 BAF20-04	Not Applicable

Risk Response Plan	**Action ID**	**Action**	**Action Lead/ Owner**	**Due date**	**State how action will support risk mitigation and reduce score**	**RAG Status**
Actions being implemented to achieve target risk score	12436	Ensure that all new national guidance on testing for care home staff and residents is widely communicated and implemented.	Ms Jane Trowman, Associate Chief of Staff - Operations		Ongoing weekly reviews	
	12437	Continue to refine and develop communication with care homes at a local level and across North Wales.	Ms Jane Trowman, Associate Chief of Staff - Operations	30/12/2020	Daily calls made. Twice weekly meetings continue with Care Forum Wales, CIW and partners. Weekly national briefings circulated supplemented by local information.	

CRR20-06	**Director Lead:** Director of Primary and Community Care	**Date Opened:** 28 March 2019
	Assuring Committee: Digital and Information Governance Committee	**Date Last Reviewed:** 1 December 2020
	Risk: Informatics - Patient Records pan BCU	**Date of Committee Review:** 19 June 2020

		Target Risk Date: 30 September 2024
There is a risk that patient information is not available when and where required. This may be caused by a lack of suitable storage space, uncertain retention periods, and the logistical challenges with sharing and maintaining standards associated with the paper record. This could result in substandard care, patient harm and an inability to meet our legislative duties.		



	Impact	Likelihood	Score
Inherent Risk Rating	4	4	16
Current Risk Rating	4	4	16
Target Risk Score (Risk Appetite – *high level)*	4	3	12
Movement in Current Risk Rating Since last presented to the Board in April 2020	*unchanged*		

Controls in place	**Assurances**
1. Corporate and Health Records Management policies and procedures are in place pan-BCUHB. 2. iFIT RFID casenote tracking software and asset register in place to govern the management and movement of patient records. 3. Escalation via appropriate committee reporting. 4. Key performance indicators monitored at BCUHB Patient Records Group (reported into the Information Governance Group).	1.Chairs reports from Patient Record Group. 2.ICO Audit. 3.HASCAS Audit.

Links to		
Strategic Priorities	**Principal Risks**	**Special Measures Theme**

Effective use of our resources	BAF20-19 BAF20-20	Not Applicable

Risk Response Plan	Action ID	Action	Action Lead/ Owner	Due date	State how action will support risk mitigation and reduce score	RAG Status
Actions being implemented to achieve target risk score	12422	Enable actions to meet the regulatory recommendations from the ICO, HASCAS/Ockenden and Internal Audit reports.	Mrs Danielle Edwards, Head of Digital Records	31/03/2021	Full review of all outstanding regulatory recommendations across all regulators planned for Q1 of 2020/21 was delayed due to responding to the Covid crisis. This review is expected to take place end of Q1.	
	12423	Development of a local Digital Health Records system	Mrs Danielle Edwards, Head of Digital Records	30/09/2024	10.08.20 (DE) - UPDATE Aug 2020 - The DHR FBC has been presented to the HBRG, who unanimously determined it as an approvable business case. Subsequent presentation to Exec Team and DIGC gave unanimous support. Funding route has been agreed with the Executive Director of Finance and F&P Committee subsequently approved case. Health Board approval received on the 23rd July; Ministerial Brief now with the Welsh Government to allow us to award the contract.	
	12424	Improve the assurance of Results Management	Mrs Danielle Edwards, Head of Digital Records	30/09/2021	10.08.20 (DE) - UPDATE Aug 2020 - Interim measures to re-start printing for those that require implemented between Pathology and Informatics (from 6th July). WS1 (to request, notify, view and action) is being accelerated to deliver Oct2020 - with Secondary Care Medical	

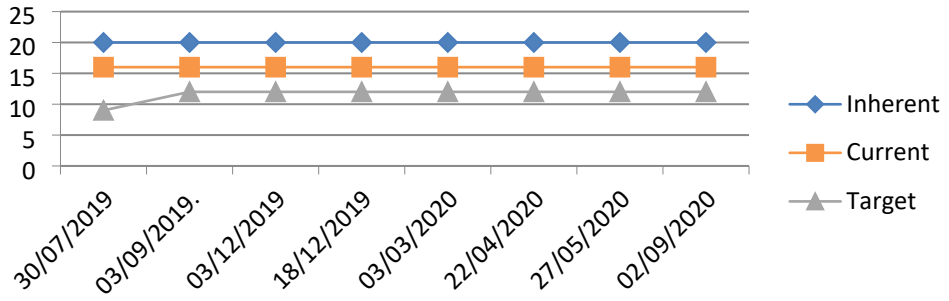
					Director identifying resources to enable Informatics to achieve this date. WS2 - Module Application pilot of new version successful and resources being explored to roll out. WS3 - ETR - NWIS have requested leads from BCU to join national advisory group to drive the future of the test requesting forms. WS4 Radiology - approach options are being appraised to identify the optimal development.	
	12425	Digitise the clinic letters for outpatients	Mrs Danielle Edwards, Head of Digital Records	30/04/2021	10.08.20 (DE) - UPDATE Aug 2020 - Contracts signed and PO issued to deploy both EPRO digital dictation and speech recognition pan-BCU. Draft implementation plan developed and will be finalised over coming weeks.	
	12426	Digitise nursing documentation through engaging in the WNCR	Mrs Danielle Edwards, Head of Digital Records	31/12/2020	10.08.20 (DE) - UPDATE Aug 2020 - Nursing Lead to write a Business Case to take through BCU the internal governance for approval to fund (transitional and ongoing revenue) and deploy the WNCR product.	
	12428	Baseline the; storage, processes, management arrangements and standards compliance	Mrs Danielle Edwards, Head of Digital Records	31/03/2021	10.08.20 (DE) - UPDATE Aug 2020 - work will commence this Q2	
	12429	Engage with the Estates Rationalisation Programme to secure the future of 'fit for	Mrs Danielle Edwards, Head of Digital Records	30/04/2021	10.08.20 (DE) - UPDATE Aug 20 - The preferred option for MH is now a complete new build and not using the existing land occupied by MH currently. Work is underway to prepare a report on	

		purpose' file libraries for legacy paper records.			the cost and suitability of locating the porta cabin file library (and possible off-site storage e.g. Abergele and BYN) into the Ablett to see if this would be a viable option, and to have it ready when the decision on a new build for MH is clear.	

CRR20-	**Director Lead:** Director of Primary and Community Care	**Date Opened:** 28 March 2019

07	**Assuring Committee:** Digital and Information Governance Committee	**Date Last Reviewed:** 1 December 2020
	Risk: Informatics infrastructure capacity, resource and demand	**Date of Committee Review:** 19 June 2020
		Target Risk Date: 15 December 2021

There is a risk that digital services within the Health Board are not fit for purpose. This may be due to:
(a) A lack of capacity and resource to deliver services / guide the organisation.
(b) Increasing demand (internally from users e.g. for devices/ training and externally from the public, government and regulators e.g. growing need for digital services).
(c) the moving pace of technology.
This could lead to failures in clinical and management systems, and a failure to support the delivery of the Health boards strategy / plans impacting negatively on patient safety/outcomes. It may also pose a greater risk to the Health board of infrastructure failures and cyber attack.



	Impact	Likelihood	Score
Inherent Risk Rating	4	5	20
Current Risk Rating	4	4	16
Target Risk Score (Risk Appetite – *high level)*	4	3	12
Movement in Current Risk Rating Since last presented to the Board in April 2020	*unchanged*		

Controls in place	**Assurances**
1. Governance structures in place to approve and monitor plans. Monitoring of approved plans for 2019 2020 (Capital, IMTP and Operational. Approved and established process for reviewing requests for services. 2. Integrated planning process and agreed timescales with BCU and third party suppliers. 3. Key performance metrics to monitor service delivery and increasing demand. 4. Risk based approach to decision making e.g. Local hosting v's National hosting for WPAS etc.	1. Annual Internal Audit Plan. 2. WAO reviews and reports e.g. structured assessments and data quality. 3. Scrutiny of Clinical Data Quality by CHKS. 4. Auditor General Report - Informatics Systems in NHS Wales.

5. National Infrasctructure Review (Independent Welsh Government Review undertaken by Channel 13).	5. Regular reporting to DIGC (for Governance).

Links to		
Strategic Priorities	**Principal Risks**	**Special Measures Theme**
Effective use of our resources	BAF20-18 BAF20-19 BAF20-20	Not Applicable

Risk Response Plan Actions being implemented to achieve target risk score	**Action ID**	**Action**	**Action Lead/ Owner**	**Due date**	**State how action will support risk mitigation and reduce score**	**RAG Status**
	12378	Develop associated business cases and secure funding for resource required based upon risks and opportunities e.g. Digital Health Record.	Ms Andrea Williams, Head of Informatics Programmes, Assurance and Improvement	27/11/2020	30/11/20 This overall risk will remain and we will add in the business cases as they are developed. Symphony Business Case was approved on the 29/10/20. MTed Business Case is with the Business Case Review Group.	
	12379	Review workforce plans and establish future proof informatics/digital capability and capacity.	Ms Andrea Williams, Head of Informatics Programmes, Assurance and Improvement	01/04/2021	29/10/20 (AW) - Informatics will be developing a Workforce Planning Strategy that will take into account the services capability and capacity. New action due date proposed to be 01/04/2021	
	12380	Review governance arrangements e.g. DTG whose remit includes review of resource	Mrs Danielle Edwards, Head of Digital Records	31/12/2020	03/06/2020 (DT) Covid-19 will mean that fill review will be difficult until impact of covid-19 is fully understood and the digital priorities are set. This	

		conflicts has not been replaced (April 2020).			could also be impacted by national strategic governance arrangements.	

Cyfarfod a dyddiad: **Meeting and date:**	**Audit Committee 17th December 2020**
Cyhoeddus neu Breifat: **Public or Private:**	Public
Teitl yr Adroddiad **Report Title:**	**Internal Audit Progress Report - 1st September to 30th November 2020** **Internal Audit Plan 2020/2021 – To complete**
Cyfarwyddwr Cyfrifol: **Responsible Director:**	Dawn Sharp – Acting Board Secretary
Awdur yr Adroddiad **Report Author:**	Dave Harries – Head of Internal Audit
Craffu blaenorol: **Prior Scrutiny:**	The progress report and audit plan to complete have been discussed with and agreed by the Acting Board Secretary and details the individual opinions issued by internal audit and provides a complete trail of changes made to the approved internal audit plan due to COVID-19.
Atodiadau **Appendices:**	• Appendix 1: Progress Report • Appendix 2: Delivery of Savings – Ysbyty Glan Clwyd Hospital • Appendix 3: NHS Wales staff survey – delivering the findings (19/20) • Appendix 4: Recruitment: Medical and Dental Staff (19/20) • Appendix 5: Quality Impact Assessment (QIA) (19/20) • Appendix 6: Internal Audit Plan 2020/2021 – To complete

Argymhelliad / Recommendation:

The Audit Committee is asked to:

- Receive the progress report;
- Approve the deferment of:
  - ❖ Improvement Groups.
  - ❖ Programme Management Office (PMO).
  - ❖ Clinical Audit.
  - ❖ Establishment Control: Leaver Management.
  - ❖ Sickness management: Recording the reason for sickness.
  - ❖ Recruitment – Employment of locum doctors.
  - ❖ On-call arrangements.

- ❖ Major capital integrated audit plans.

- Receive and agree the Internal Audit Plan 20/21 – To Complete

Please tick one as appropriate (note the Chair of the meeting will review and may determine the document should be viewed under a different category)

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

Sefyllfa / Situation:

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 and the Board.

Cefndir / Background:

The report summarises four assurance reviews finalised since the last Committee meeting in September 2020, with the recorded assurance as follows:

- Reasonable assurance (yellow) – six; and
- Limited assurance (amber) – four.

The report also details:

- Reviews issued at draft reporting stage, work in progress and recommendations subject to follow-up in the period.

With amendments made to the plan throughout the year due to the impact of COVID-19, a composite report has been prepared detailing changes made in year coupled with the Head of Internal Audit having sufficient coverage to provide a full year end opinion on the Health Board's governance and risk management arrangements.

Asesiad / Assessment & Analysis

Strategy Implications

The Internal Audit plan for 2020/21 was approved by the Audit Committee in March 2020, with subsequent amendments at the June and September 2020 meeting.

Financial Implications

The progress report may record issues/risks, identified as part of a specific review, which has financial implications for the Health Board.

Risk Analysis

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.

Legal and Compliance

The progress report is required in accordance with the Welsh Government NHS Wales Audit Committee Handbook – *Section 4.5 Reviewing internal audit assignment reports.*

Impact Assessment

The Internal Audit report provides independent assurance to the Board, through its

Committees, on the effectiveness of the Health Board's risk management arrangements, governance and internal controls.

This report does not, in our opinion, have an impact on equality nor human rights beyond what is drawn out specifically in respect of individual audits and is not discriminatory under equality or anti-discrimination legislation.

Internal Audit Progress Report

1st September 2020 to 30th November 2020

Audit Committee
2020/2021

Betsi Cadwaladr University Local Health Board

NHS Wales Shared Services Partnership

Audit and Assurance Service

Contents

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

Please note:

This 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.

Audit reports are prepared by the staff of the NHS Wales Shared Services Partnership – 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 Local 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.

Introduction

1. This progress report provides an update to the Audit Committee in respect of the assurances, key issues and progress against the Internal Audit (IA) Plan for 2020/21 which have been finalised since the last Committee meeting, as well as those pertaining to the 2019/20 financial year. Final reports detailing findings, recommendations and agreed actions are issued to the Committee's Independent Members through the Acting Board Secretary.

2. As a fundamental part of the audit process, agreed actions for limited and no assurance opinion reviews are followed-up to ensure that the control issues identified have been reviewed and addressed as appropriate. The follow-up review, by individual recommendation, is recorded within this report periodically.

Reports Issued

3. A number of reviews have been finalised in conjunction with Health Board management. A summary of these reviews is provided below in Table 1.

Table 1 – Summary of assurance reviews issued as final

Title	Assurance Level	High	Medium	Low	Key Messages
Annual Quality Statement Review completed September 2020 with Executive approval October 2020 *Consistency of data reported to Members and published in the AQS/performance measures (IQPR) need to be clearly identified/agreed at the outset of AQS compilation.*	Reasonable	1	-	1	We found governance arrangements were in place to oversee the development, monitoring and reporting of the AQS. Roles and Responsibilities were assigned and being directed by the Associate Director Quality Assurance and the Business Manager Corporate Nursing. We reviewed a sample of data within the AQS v5 to review the consistency of information previously reported to the Health Board meetings and the Quality & Safety Experience Committee (QSE). We were able to confirm that data used in the draft AQS had been consistently reported to QSE and HB in respect of Immunisation/MMR/5year olds. However, this testing was limited to one sample area only. We reviewed the draft AQS version 7 - at the time of the review, compilation of the AQS was in progress and further details, examples and updates were required to ensure compliance with the Welsh Health Circular.
Cyber security (19/20) Review completed April 2020 with Executive	Reasonable	2	2	-	In order to meet the regulatory needs of the Network and Information Systems (NIS), the Health Board works to the Cyber Assessment Framework (CAF) to ensure compliance. The review of minutes for the Digital and

Title	Assurance Level	High	Medium	Low	Key Messages
approval September 2020 *Policy requires formal approval and regular assurance reports to Committee require development.*					Information Governance Committee (DIG) highlighted a lack of assurance being reported to the Committee concerning cyber security. The Health Board Cyber Security Policy, at the time of our review was draft but yet to be finalised. The Health Board, as with all NHS Wales organisations has implemented Cyber Security as part of the online statutory and mandatory training.
North Denbighshire Community Hospital (19/20) Review completed March 2020 with Executive approval November 2020 *Project Board meetings did not follow the expected plan and membership should be reviewed to ensure quoracy.*	Reasonable	-	4	2	The Project Execution Plan (PEP) stated that Project Board meetings should be held monthly. However, the Project Board did not meet during September, November or December 2019. It was explained that the meetings in November/December 2019 were cancelled due to the ongoing Supply Chain Partner appointment process. At the October 2019 Project Board Meeting, to ensure quoracy, the Clinical Director-Therapies assumed the role of Project Board Chair, Project Director and clinical/user representative (noting Terms of Reference require two Senior Users present). This does not appear to be in the spirit of the Terms of Reference; Terms of Reference should be reviewed and requirements clarified for future reference Key Performance Indicators (KPIs) were completed up to 2017, but were not completed subsequently, however a return was expected in in October 2020. Management advised that there had been a period of hiatus and also a period where a Supply Chain Partner was not engaged. However, the Building for Wales KPIs also assess the performance of the Health Board and advisers, who were both engaged on the project during the period.
Substance Misuse Action funds (SMAF)(19/20) Review completed May 2020 with Executive approval	Reasonable	-	7	-	A review of the minutes of a sample of the Project Board Meetings for all three SMAF projects noted the following: • A lack of a formally approved Terms of Reference; • Meetings not consistently held on a monthly basis;

Title	Assurance Level	High	Medium	Low	Key Messages
November 2020 *Lack of Terms of Reference for the Project Board and benefits realisation plans require development.*					• The Project Director, who also held the role of the Chair of the Project Board meetings, was not present at the majority of meetings held. Whilst the respective Business Justification Cases provided comprehensive details of the anticipated benefits, a formal benefits realisation plan was not observed in respect of any of the projects examined. The Health Board's Capital Procedure Manual requires a benefits realisation plan be developed and approved by the Project Board from the outset.
Ysbyty Glan Clwyd (YGC) Redevelopment – Operation of the Pain/Gain Mechanism (19/20) Review completed April 2020 with Executive approval November 2020 *All recommendations were approved by management concerning process.*	Reasonable	-	3	-	The review identified three recommendations that were focused on confirming the costs associated with the scheme, with all recommendations being implemented by management.
Ysbyty Glan Clwyd (YGC) - Open Book Audit (19/20) Review completed April 2020 with Executive approval November 2020 *Queries were raised as part of the review with the Health Board/SCP/Cost*	Reasonable	-	2	-	The review sought assurance that expenses were charged in accordance with the contract, and to sample expenses, car and fuel charges for reasonableness of work related mileage apportionments, exclusion of hospitality etc. A defined expenses policy was found, including appropriate claim limits and excluded non-business related expenditure. The policy accorded with HMRC temporary workplace travel rules and expenses claimed were found to relate to business expenses/journeys in accordance with the policy and HMRC rules. 9.5% of staff costs were found to relate to expenses, and various queries were raised. Further supporting information was provided, and queries resolved

Title	Assurance Level	High	Medium	Low	Key Messages
Advisor in relation to charges made to the scheme.					in consultation with the Supply Chain Partner (SCP) and Cost Adviser. Other direct costs were valued at circa. £5.6m with a sample of £3.5m examined at the current audit. A significant amount of queries were raised in relation to the potential duplication of costs, whether costs were allowable under the contract and the substantiation of costs. We worked proactively with the SCP and Cost Adviser to resolve these issues, and were able to satisfactorily close our queries in March 2020. Insurance charges were reviewed and found to be site related only and allowable.
Delivery of Savings – Ysbyty Glan Clwyd Hospital Review completed May 2020 with Executive approval September 2020 *Only one saving scheme achieved its planned target raising concern over the robustness of the planning and proposals made and how realistic delivery of each scheme is.*	Limited	2	1	-	We were asked at the outset to focus the review on Ysbyty Glan Clwyd saving schemes. Of the Health Board's total 2019/20 cash releasing savings requirement of £34.5m, Ysbyty Glan Clwyd were allocated a target of £3.810m against which they identified saving schemes totalling £3.534m. The Ysbyty Glan Clwyd 2019/20 saving plan was made up of forty three projects incorporating both cost avoidance and cash-releasing saving schemes. Of these we selected a random sample of eight projects for review. The total full year effect of our sample was £1.937m, representing approximately 55% of the identified Ysbyty Glan Clwyd savings. Only one of the eight saving schemes in our sample had achieved (and had in-fact exceeded) the planned savings target as of Month 10 (January 2020). It was anticipated that our sample schemes would yield savings of approximately £1.2m by the end of January 2020. However the actual achieved savings reported at the end of this period were £566k (46% of projected savings). Of the £1.9m identified full-year savings for our sample schemes, £1.2m was forecast as unachievable as of Month 10. This raises concern over the robustness of controls during the planning, development, and proposal stages of savings project management. We reviewed the reconciliation process and

Title	Assurance Level	High	Medium	Low	Key Messages
					relevant backing documentation. We found the following issues and limitations: • Whilst we were able to verify the reported savings for each of the eight schemes in our sample to either the tracker document or other backing documentation the reconciliation process was not consistent between schemes. • Reconciliation to the ledger was not transparent as there is no provision in the current reporting arrangements to address the reduction, removal, or adjustment of previously reported savings, even in instances where savings have been reported in error. • Five of the eight saving schemes in our sample had erroneously reported savings which could not be corrected/adjusted.
NHS Wales staff survey – delivering the findings (19/20) Review completed February 2020 with Executive approval September 2020 *The review identified a lack of operational review and focus to ensure the agreed implementation plans were delivered.*	Limited	2	-	-	Monitoring performance against both the Organisational Improvement Plan and Divisional Plans was reported to be via the Workforce Improvement Group (WIG) - We found no reference in the Terms of Reference that relate to the scrutiny and review of divisional staff survey action plans per Minute SP19.52 of the Strategy, Partnership and Population Health Committee [4th July 2019] and could find only one meeting [29th November 2019] where divisional updates were reported to the WIG. Divisional Action Plans scrutiny is critical to ensure operational divisions deliver and act on the findings - With the exception of the Estates and Facilities Division, we were unable to identify that Ysbyty Gwynedd or Mental Health and Learning Disabilities had a standing agenda item for their respective staff survey action plans, thus ensuring staff feedback is acted on.
Recruitment: Medical and Dental Staff (19/20) Review completed March 2020 with	Limited	2	-	-	Our review is based upon source data provided by the Workforce Systems Development Officer and focused solely on medical and dental staff. The data extract totalled six hundred and one (601) records; refining this data to 'Recruitment only' requests amended the sample size to two

Title	Assurance Level	High	Medium	Low	Key Messages
Executive approval September 2020 *The EC process appears over controlled and our findings indicate that the whole recruitment process from EC to completion of pre-employment checks takes an average of 104 days, including relevant Royal College participation.*					hundred and thirty nine (239) records. The review identified that the length of time taken from submission of an EC request to completion of pre-employment checks takes an average of 104 days; this does not take into account the period of notice a successful candidate will then need to give their existing employer. The ability of services/divisions to provide services is undermined by the lengthy recruitment process. This in turn could be detrimental in efforts to reduce locum/agency costs. The overall EC approval process is essential to ensure the Health Board and its services/divisions comply with the Standing Financial Instruction 13.3 Staff Appointments. The process has six noted control steps which impact the recruitment process, on average, by over one month. In addition, three control steps are service/division specific – we consider this inefficient and adds unnecessary delay within the process. The review of EC request stages has noted only 3% were declined – management may wish to review whether the system is over-controlled and could be streamlined whilst maintaining control. The review of TRAC data notes the period between advert closing and shortlisting dates can add significant delay; it is unclear why closing date and shortlisting stage takes this amount of time as recruiting managers will know in advance the closing date and have adequate time to arrange to shortlist.
Quality Impact Assessment (QIA) (19/20) Review completed March 2020 with Executive approval September 2020 *Established process for ensuring both*	Limited	2	1	-	This review was requested to provide assurances that recommendation 2a of the Ockenden Report (June 2018) *'Review of the Governance Arrangements...'* in evidencing that 'Quality Impact Assessments' were reviewed and the clinical implication of financial savings plans were assessed. The findings from this review should be taken in the context of pre-COVID-19 impact on the Health Board and the standing down of groups etc. We were unable to match project information

Title	Assurance Level	High	Medium	Low	Key Messages
Clinical Executive Directors approved PIDs before progressing were not in the main completed.					held by the Programme Management Office's (PMO) to individual Improvement Groups for oversight of delivery. The Improvement Groups provided updates to the Finance Recovery Group (FRG) [per Minutes] however we were unable to identify any detailed assurance reports presented and note some were verbal updates. The Project Initiation Document (PID) approval process includes a step at stage three: Chief Executive and Director of Finance approval, who have the Executive right to veto a project. We could find no evidence that the Chief Executive and Director of Finance had completed this section within our sample; further, it was unclear whether a lack of formal response from both was taken as approval, whilst noting on the flow chart they are required to approve once the two clinical Executive Directors had approved. The review of PIDs, where both clinical Executive Directors (Medical and Nursing & Midwifery) must approve the QIA, from our sample of two hundred and eighteen (218) identified that eighty five (85) had been signed by both. Of the one hundred and thirty three (133) projects that were not fully authorised by both clinical Executives - one hundred and thirty had been started as there was a clear start date recorded on the PMO Tracker.

Work in Progress Summary

4. The following reviews are currently in progress:

Table 2 - Draft Reports issued

Review	Status	Date draft report issued
Joint follow-up with Conwy County Borough Council Internal Audit Service: Conwy Community Mental Health Team (CMHT)	The Health Board specific follow-up review was issued on the 5th December 2019 and we met with management on the 12th and 17th December 2019 to agree the report. We met with Conwy Internal Audit Services to discuss both reports on the 6th February 2020; the findings have been consolidated	5th December 2019

Review	Status	Date draft report issued
	into one report. The Acting Director and Head of Internal Audit were scheduled to meet Conwy's Strategic Director of Social Care and Education and Internal Audit on the 23rd March 2020 to progress the combined draft report however this was cancelled due to COVID-19.	
Mental Health & Learning Disabilities Division - Governance arrangements	A discussion draft report was issued on the 21st October 2020. We met to discuss the discussion draft on the 27th October 2020 and formally issued the draft report on the 4th November 2020 with the management response not due until the 3rd December 2020.	4th November 2020

Fieldwork

5. The following reviews are currently in progress:

- Health & Safety - The brief has been issued and we have been asked to delay the start of the review until Quarter 4.
- Security – Work is in progress although due to other operational challenges, we have agreed with management to continue with the review in January 2020.
- Violence and Aggression – Obligatory responses to violence in healthcare – Review has commenced and we have met key officers in the corporate team and plan to meet officers within Mental Health in the near future.
- Engaging of Interim Appointments – Review has commenced and we are currently reviewing information provided to us and plan to contact all appointing officers imminently concerning process followed where there are gaps in evidence.
- Performance measure reporting to the Board: Accuracy of information – The brief has been agreed and we are in the process of arranging meetings to progress the review.
- HASCAS & Ockenden external reports: Recommendation progress and reporting - We have been provided with further evidence to support recommendations that have been approved for closure.
- IM&T Control and risk assessment – We have concluded an element of the review but await further management evidence to enable us to conclude the review and issue a draft report.
- Disaster Recovery/Business Continuity Plan – Informatics - The review is almost complete and the draft report is being prepared.
- Control of contractors – The review has progressed and we have met with colleagues from both Operational Estates and Informatics as well as Corporate Health & Safety to ascertain controls in place and supporting evidence.

- Water management – We have agreed the brief and the review has commenced.
- Capital systems – The brief has been agreed and the review will commence in quarter 4.
- Patient monies and property - We are undertaking a review at two adult mental health wards following a request by the Division due to several reported losses. This is a focused, wards specific, desk-top review via a questionnaire for Ward managers across the two sites to complete and submit to us by the 9th December 2020.

Follow Up

6. Follow up reviews remain in progress as and when actions are noted as 'Implemented – Final Client Approved' for limited and no assurance internal audit reviews only. The follow-up is based solely upon the evidence and narrative included within TeamCentral which supports final approval by the relevant executive lead.

7. Table 3 details the follow-up review(s) of individual recommendations undertaken in the period and whether they have been implemented (Closed – Verified) or rejected (with supporting narrative).

Table 3: Follow-up status of recommendations reviewed

Review Title	Recommendation Title	Follow-up status
Blaenau Ffestiniog Primary Care Resource Centre	Adviser performance	Closed – Verified
Blaenau Ffestiniog Primary Care Resource Centre	Adviser appointments	Closed – Verified
Change Control	Formal Policy	Closed – Verified
Deprivation of Liberty Safeguards (DoLS)	Lack of local procedure	Closed – Verified
Deprivation of Liberty Safeguards (DoLS)	Shortage of Best Interest Assessors (BIAs)	Closed – Verified
Deprivation of Liberty Safeguards (DoLS)	Completion of DoLS paperwork	Closed – Verified
Deprivation of Liberty Safeguards (DoLS)	Lack of engagement from DoLS signatories	Closed – Verified
Deprivation of Liberty Safeguards (DoLS)	Reporting of Breaches through Datix	Closed – Verified
Job Evaluation	Notification Decision	Closed – Verified
Job Evaluation	Key Performance indicators/Performance Monitoring	Closed – Verified
Revenue business cases	Record of submitted business cases	Closed – Verified
Revenue business cases	Revenue Business Cases Guidance and Template	Closed – Verified

Contingency/Organisational Support/Advice

8. Internal Audit is supporting the Health Board through providing advice and guidance on areas of control, new systems and processes, with increased time being used to

support attendance and provide input at the three project meetings we are in attendance.

9. During the period, the following review/advice/guidance/support has been provided:
   - Attendance at the Health Board Symphony/National WEDS Project Board.
   - Provision of support to the Finance Directorate concerning consequential losses relating to the temporary hospital locations and what would be expected in terms of evidence to support any payments made.
   - Seeking evidence that risks associated with exiting the European Union on the 1st January 2021 are being actively reviewed, control measures actioned and relevant reports submitted to Committee/Board.

Delivering the Plan

10. The additional support provided to the Health Board with focused reviews is channelled through contingency.
11. As new risks are identified in year, the Board Secretary and internal audit consider the planned reviews against the emerging high level risks.
12. The impact of COVID-19 (C-19) on the Health Board has been one that has necessitated on-going discussion with both Acting Board Secretary and Acting Director of Finance with subsequent dialogue with the Executive Team.
13. Recognising the demands placed upon operational teams that many of our reviews impact on, coupled with risk assessment of those reviews yet to commence as the Health Board manages a second wave of the pandemic, the following reviews have been identified for deferment from the 2020/2021 original plan and been agreed in principle with the Acting Board Secretary and Executive Team prior to Audit Committee approval:

    Improvement Groups

    The Health Board are reviewing the governance arrangements and we have been advised that these groups form part of the review as well as not having met/been stood down since the pandemic.

    Programme Management Office (PMO)

    The responsibility for the PMO has transferred to Director of Finance but is the subject of a re-structure to identify what service is needed.

    Clinical Audit

    The recent Quality, Safety and Experience Committee (QSE) and Joint Audit and QSE Committee meetings received an update paper on the direction of travel for clinical audit within the Health Board that recognised the service requires review, with an interim Head in place. Undertaking a review of the service at this point would add no value to the Health Board due to planned development.

    Establishment Control: Leaver Management

    We agreed with the Director of Workforce & OD that due to operational challenges of C-19 through to the impact of winter pressures, this review would impact the

service and therefore considered as part of the 2021/22 plan.

Sickness management: Recording the reason for sickness

As with leaver management, we recognise the operational challenges the service faces and this review would impact the service and therefore will be considered as part of the 2021/22 plan.

Recruitment – Employment of locum doctors

As with leaver management coupled with the cyclical recruitment process for new staff, this review would impact the front-line service and therefore will be considered as part of the 2021/22 plan.

On-call arrangements

We have been advised that the Interim Chief Operating Officer is reviewing the current arrangements and therefore a review at this stage would add no value to the Health Board.

Major capital integrated audit plans

Following discussion with the Assistant Director and approval by the Director of Planning and Performance, the continuing pressures through to the year end and the status of delivery programmes for the major projects/programmes across NHS Wales, the reviews for North Denbighshire, Ablett Unit and Wrexham Maelor Business Continuity Programme Integrated Audit Plans are recommended for deferral.

Noting the current delivery programme updated integrated audit plans will be developed for inclusion within respective business cases.

It is recommended that the above reviews are deferred and considered as part of the 2021/22 risk assessment underpinning the development of the 2021/22 annual plan.

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

15. Table 4 is reporting a positive status across all indicators with management response to draft reports increased to 75% [5%] from the last Committee reporting period – Please note however this is based on a low number of final reports issued to date.

16. We are experiencing delays in receiving information/evidence to support our reviews which is having a direct impact on our ability to complete reviews in a timely manner. We continue to escalate issues concerning receipt of information and turnaround times for management response and work through the Acting Board Secretary per the Charter.

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%

Indicator	Status	Actual	Target	Red	Amber	Green
Report turnaround: time taken for management response to draft report [20 days per Internal Audit Charter and Service Level Agreement] with agreed extension by the Executive Lead at time of agreeing the audit brief	Green	75%	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 2019-20

Planned output	Outline timing	Status	Assurance
Corporate governance, risk and regulatory compliance			
Annual Governance Statement	Q1	Complete – Head of internal audit annual report.	N/A
Welsh Risk Pool Claims Management Standard	Q4		
Risk Management	Q4		
Health and Safety	Q4	Draft brief agreed.	
Security	Q2	Review in progress.	
Violence and Aggression – Obligatory responses to violence in healthcare	Q3	Review in progress.	
Engagement of interim appointments	Q2	Review in progress.	
Temporary Hospitals	Q2		We will follow-up the implementation of KPMG's action plan.
Decision making during COVID-19 – Advisory review	Q2	Final report issued.	Advisory Review
Mental Health & Learning Disabilities Division – Governance arrangements	Q2	Draft report issued.	
Strategic planning, performance management and reporting			
Performance measure reporting to the Board – Accuracy of information	Q2	Review is set to commence – Brief agreed.	
Improvement Groups	Q3		Recommended for deferment.
Financial governance and management			
Delivery of Savings – Ysbyty Glan Clwyd Hospital	Q1	Final report issued.	Limited
Budgetary Control & Financial Reporting	Q2-3	Review in progress.	

Planned output	Outline timing	Status	Assurance
Financial Governance Cell - Consultancy	Q1-2	Final advisory paper on capital expenditure issued.	Advisory Review
Quality and Safety			
Annual Quality Statement	Q2	Final report issued.	Reasonable
HASCAS & Ockenden external reports – Recommendation progress and reporting	Q2-4	On-going review as and when evidence is received.	
Clinical Audit	Q4		Recommended for deferment.
Patient Safety Notices/Alerts/ Medical Device Alerts/Field Safety Notices	Q2	Review in progress.	
Follow up of previous Healthcare Inspectorate Wales reports	Q2-4	Review in progress.	
Information governance and security			
IM&T Control and risk assessment	Q2	Review in progress.	
Caldicott Principles into Practice (CPiP)	Q2	Review in progress.	
Disaster Recovery/Business Continuity Plan - Informatics	Q2-3	Review in progress.	
Digital Strategy	Q3		Recommended for deferral by Committee.
Operational service and functional management			
Programme Management Office (PMO)	Q2-3		Recommended for deferral by Committee.
Patient monies and property	Q3/4	Review in progress.	
Workforce management			
Roster Management	Q1	Final report issued.	Limited
Recruitment – Employment of locum doctors	Q2-3	Draft brief issued.	Recommended for deferral by Committee.
Sickness management – Recording reason for the sickness episode	Q3		Recommended for deferral by Committee.
Establishment control – Leaver management	Q2-3	Draft brief issued.	Recommended for deferral by Committee.
On-Call arrangements	Q3		Recommended for deferral by Committee.
Capital and estates management			
Environmental sustainability report	Q2	Final report issued.	Substantial
Control of Contractors	Q2-3	Review in progress.	
Statutory Compliance: Water Safety	Q2	Review in progress.	

Planned output	Outline timing	Status	Assurance
Follow Up (capital and Estates)	Q1-4	On-going.	
Capital Systems	Q2	Draft brief issued.	
Integrated Audit and Assurance Plans: • North Denbighshire • Ablett Unit • Wrexham Maelor Hospital - Backlog maintenance requirements	Q1-4	The progression of the audit plans for these will be subject to Welsh Government approval of the projects. Noting the demands on the All Wales Capital Programme arising from the Covid 19 emergency, some slippage in the approval of these projects may be anticipated. Accordingly, we will continue to monitor progress and, as appropriate, revise/update the integrated audit plans to reflect any changes in the proposed deliver programmes.	
Compliance with the public sector internal audit standards – Contingency/assurance reviews			

Audit Assurance Ratings

Substantial assurance - The Board can take **substantial assurance** that arrangements to secure governance, risk management and internal control, within those areas under review, are suitably designed and applied effectively. Few matters require attention and are compliance or advisory in nature with **low impact on residual risk** exposure.

Reasonable assurance - The Board can take **reasonable assurance** that arrangements to secure governance, risk management and internal control, within those areas under review, are suitably designed and applied effectively. Some matters require management attention in control design or compliance with **low to moderate impact on residual risk** exposure until resolved.

Limited assurance - The Board can take **limited assurance** that arrangements to secure governance, risk management and internal control, within those areas under review, are suitably designed and applied effectively. More significant matters require management attention with **moderate impact on residual risk** exposure until resolved.

No assurance - The Board has **no assurance** that arrangements to secure governance, risk management and internal control, within those areas under review, are suitably designed and applied effectively. Action is required to address the whole control framework in this area with **high impact on residual risk** exposure until resolved.

Assurance not applicable is given to reviews and support provided to management which form part of the internal audit plan, to which the assurance definitions are **not appropriate** but which are relevant to the evidence base upon which the overall opinion is formed.

Prioritisation of Recommendations

In order to assist management in using our reports, we categorise our recommendations according to their level of priority as follows.

Priority Level	Explanation
High	Poor key control design OR widespread non-compliance with key controls. PLUS Significant risk to achievement of a system objective OR evidence present of material loss, error or misstatement.
Medium	Minor weakness in control design OR limited non-compliance with established controls. PLUS Some risk to achievement of a system objective.
Low	Potential to enhance system design to improve efficiency or effectiveness of controls. These are generally issues of good practice for management consideration.

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

Internal Audit Plan 2020/2021 – To complete

November 2020

NHS Wales Shared Services Partnership

Audit and Assurance Service

Contents

Appendix A – Internal Audit Plan to complete 2020/21
Appendix B – Public Sector Internal Audit Standard Requirements

Introduction

Internal Audit Operational Plans for all NHS Wales Health Boards ('Health Boards') for 2020/21 were reviewed and in the majority of cases re-issued, in late Spring 2020 to take into account the impact of Covid-19. In most Health Boards the revised plans include fewer audit reviews than previous years. However, they were produced following the established domain-based approach assuming that, if completed, they would support the provision of the Head of Internal Audit opinion in the usual way.

As time moves on and Health Boards continue to respond to the pandemic whilst seeking to re-commence or continue other services, we are coming to the view that it will not be possible to deliver these revised programmes in full.

The Head of Internal Audit for Betsi Cadwaladr University Health Board ('the Health Board') has reported to the June and September 2020 meetings of the Audit Committee that the second phase of the revised plan agreed in June 2020 may need further review towards the end of the 2020 calendar year when the first phase of audit reviews is nearing completion.

This paper sets out the results of that review and the plan to complete a programme of Internal Audit work that enables the provision of a full Head of Internal Audit Opinion for 2020/21.

Forming the Annual Head of Internal Audit Opinion

The Head of Internal Audit draws upon the following in order to produce an annual opinion that can meaningfully inform the annual governance statement:

1. The evidence obtained from a sufficient number of individual audit and advisory reviews.
2. The results of internal audit reviews at other NHS Wales Health Boards that are relevant to the governance, risk management and control processes of the Health Board, e.g. NHS Wales Shared Services Partnership ('NWSSP').
3. Cumulative knowledge of the Health Board based on the results of internal audit work undertaken in previous years.
4. Knowledge of governance and risk management arrangements obtained from ongoing observation of Board and Committee meetings and meetings with Executive Directors, senior managers and Independent Members.
5. Knowledge obtained undertaking other ad hoc work, including requests for advice, attending working groups and investigations.
6. The results of work undertaken by regulators and inspectors, including Audit Wales, Healthcare Inspectorate Wales, Health & Safety Executive.
7. Knowledge obtained through general research and understanding of the Health Board.

The Head of Internal Audit considers whether the above provides a sufficient basis to enable a professional conclusion to be drawn in respect of governance, risk management and control processes (the basis of the Head of Internal Audit opinion) and, in particular, whether the coverage of internal audit reviews is sufficient to be able to give an overall opinion.

While neither the Public Sector Internal Audit Standards (see Appendix B) nor guidance prescribe a minimum coverage of internal audit work required to support an annual opinion, it is implicit that the annual plan needs to cover a sufficient quantity of work for the Head of Internal Audit to be able to issue the opinion with confidence.

Our approach to date has combined a risk based focus, using the Health Board's assurance framework and risk management arrangements where appropriate, combined with a 'domain based' approach for Health Boards to ensure we undertake work across all the key areas of activity and that there is rotational coverage.

However, due to the fact we anticipate delivering fewer audits than in 2019/20, we have agreed with the Board Secretaries Group to remove the formal use of our domain approach to arrive at the Head of Internal Audit Annual Opinion at Health Boards in 2020/21.

In forming the annual opinion it is not necessarily the number of reviews that is important because the scopes of individual engagements can vary considerably depending upon the objectives and risks addressed. It is the quantity and quality of the cumulative evidence in respect of governance, risk management and control activities that is key.

Governance and Risk Management

Our audit approach provides coverage of governance and risk management arrangements in the majority of internal audit reviews. There is also broader evidence available to the Head of Internal Audit in respect of governance and risk management from other sources (please refer to 2 to 7 above).

The Head of Internal Audit therefore anticipates that sufficient evidence will be available to reach a conclusion on the adequacy and effectiveness of governance and risk management processes.

Control Activities

The primary source of evidence of the adequacy and effectiveness of control processes is testing and reviewing activity undertaken in audit and advisory reviews. The key question is therefore whether there is sufficient coverage of control activities from the programme of audit and advisory reviews to enable the Head of Internal Audit to form a robust and meaningful conclusion on their adequacy and effectiveness.

Progress to Date

The revised Phase 1 plan agreed in June 2020 included 15 audit/advisory reviews, the development of three integrated assurance plans for North

Denbighshire; Ablett Unit; and Wrexham Maelor Hospital - Backlog maintenance.

Reviews have progressed although there are delays being encountered in receipt of information/evidence as well as agreeing audit briefs/draft reports.

Review Activity

In addition to considering the reviews completed or planned to complete from the first phase, the review by the Head of Internal Audit has taken into account the following:

1. Engagement with the Acting Board Secretary and Acting Director of Finance coupled with Executive Team in order to ascertain which second phase audits can be progressed. In the majority of cases we have received requests for audits to be deferred either into quarter 4, as late as possible, or into next year due to operational pressures at the present time.
2. Re-assessment of the risk profile of the Health Board and the environment it is operating in, with reference to the pending Board Assurance Framework and latest available Corporate Risk Register.
3. Anticipated continuing difficulties with undertaking audit work remotely and capacity within the Health Board during what is likely to be a very challenging winter.
4. Consideration of professional guidance on the production of the Head of Internal Audit Opinion where internal audit work is impacted by Covid-19 and the interpretation of Audit & Assurance Services of that guidance, in consultation with the Board Secretaries Group and Welsh Government as our standard setter.

Having considered the above, the Head of Internal Audit has determined a programme of reviews to complete in sufficient detail to provide an appropriate level of evidence in respect of control activities.

As a result of this assessment, those reviews that have been planned will be deferred to 2021/22 and/or re-assessed as part of the risk assessment process.

From the original plan approved by Committee in March 2020, the following planned audit reviews have been deferred from the 2020/21 plan, coupled with reviews that we have been requested to include in year:

Audit Committee 29th June 2020

Deferred

- Travel & Expenses
- Health and Social Care Localities governance and accountability
- Community Mental Health Team partnership arrangements - Denbighshire
- Community Mental Health Team partnership arrangements – Ynys Môn

Added

- Mental Health & Learning Disabilities Division – Governance arrangements.

Audit Committee 17th September 2020

Deferred

- Digital Strategy

Added

- All Wales Approved Clinicians and Section 12 (2)

Following the September Audit Committee meeting, the Acting Board Secretary, Acting Director of Finance and Head of Internal Audit met, per the Committee's request, to revisit the plan recognising the second wave of the pandemic and winter pressures were anticipated. The following reviews were identified and supported by the Executive Team for deferment, subject to Audit Committee approval:

- Improvement Groups
- Programme Management Office (PMO)
- Clinical Audit
- Establishment Control: Leaver Management
- Sickness management: Recording the reason for sickness
- Recruitment – Employment of locum doctors
- On-call arrangements
- Wrexham Maelor Hospital – Redevelopment/backlog requirements
- North Denbighshire Integrated Audit Plan
- Ablett Unit Integrated Audit Plan
- Wrexham Maelor Business Continuity Programme Integrated Audit Plan

Added

- Ablett Unit
- Patient monies and property – Focused Mental Health Division wards

Appendix A details the full coverage for the 2020/21 year, including the audits completed or in progress from the first phase and those audits to be completed.

The traditional domain based presentation has been retained for reporting consistency with the following modifications to show the breadth of coverage:

1. Where a review provides evidence in respect of more than one domain this has been shown in italics (for example, Follow-up of High Priority Recommendations).
2. More direct assurance is being provided from individual reports for each Health Board from the national systems audits of Purchase to

Pay, Payroll and Primary Care Contractor Services Payments which is shown in the Financial Governance and Management domain.

As a sense check and whilst re-iterating the number of reviews in itself is not an accurate measure of sufficient coverage, the programme can be compared with 2019/20 as follows:

Final and draft reviews to date	**8**
Work in progress	14
To be commenced	7
Sub-total (refs 1 to 29 in Appendix A)	**29**
Reviews to be included in 2020/21 Opinion	**32**
Reviews included in 2019/20 Opinion	**37**

Conclusion

The Head of Internal Audit considers that this programme for the year provides sufficient coverage to enable the provision of a Head of Internal Audit Annual Opinion. This approach has been discussed and agreed with the Director of Audit & Assurance.

If it is not possible to compete this programme in full, alternative forms of Head of Internal Audit Annual Opinion will need to be considered, including potentially providing a limited scope opinion if the Head of Internal Audit considers that there is insufficient coverage to provide a full Opinion.

Planned output	Outline timing	Status	Assurance
Corporate Governance, Risk and Regulatory Compliance			
1. Annual Governance Statement	Q1	Complete – Head of internal audit annual report.	N/A
2. Welsh Risk Pool Claims Management Standard	Q4		
3. Risk Management	Q4		
4. Health and Safety	Q4		
5. Security	Q2	Review in progress.	
6. Violence and Aggression – Obligatory responses to violence in healthcare	Q3	Review in progress.	
7. Engagement of interim appointments	Q2	Review in progress.	
8. Temporary Hospitals	Q2		
9. Decision making during COVID-19 – Advisory review	Q2	Final report issued.	Advisory
Follow-up of COVID-19 implementation			
10. Mental Health & Learning Disabilities Division – Governance arrangements	Q2	Draft report issued.	
Strategic Planning, Performance Management and Reporting			
11. Performance measure reporting to the Board – Accuracy of information	Q2	Review is set to commence – Brief agreed.	
BREXIT preparedness			

Planned output	Outline timing	Status	Assurance
Quarter 3-4 Operational Plan			
Financial Governance and Management			
12. Delivery of Savings – Ysbyty Glan Clwyd Hospital	Q1	Final report issued.	Limited
13. Budgetary Control & Financial Reporting	Q2-3	Review in progress.	
14. Financial Governance Cell - Consultancy	Q1-2	Final advisory paper on capital expenditure issued.	Advisory
NWSSP – Payroll	Q3/4		
NWSSP – Accounts Payable	Q3/4		
NWSSP – PCS Contractor Payments	Q3/4		
Clinical Governance, Quality and Safety			
15. Annual Quality Statement	Q2	Final report issued.	Reasonable
16. HASCAS & Ockenden external reports – Recommendation progress and reporting	Q2-4	On-going review as and when evidence is received.	
17. Patient Safety Notices/Alerts/ Medical Device Alerts/Field Safety Notices	Q2	Review in progress.	
18. Follow up of previous Healthcare Inspectorate Wales reports	Q4	Review in progress.	
Information Governance and Security			
19. IM&T Control and risk assessment	Q2	Review in progress.	
20. Caldicott Principles into Practice (CPiP)	Q2	Review in progress.	

Planned output	Outline timing	Status	Assurance
21. Disaster Recovery/Business Continuity Plan - Informatics	Q2-3	Review in progress.	
Operational Service and Functional Management			
22. Patient monies and property	Q3-4	Review in progress.	
Workforce Management			
23. Roster Management	Q1	Final report issued.	Limited
Capital & Estates			
24. Environmental sustainability report	Q2	Final report issued.	Substantial
25. Control of Contractors	Q3-4	Review in progress.	
26. Statutory Compliance: Water Safety	Q2	Review in progress.	
27. Follow Up (capital and Estates)	Q4		
28. Capital Systems	Q2		
29. Ablett Unit	Q4		

Extract from the Public Sector Internal Audit Standard Requirements

2450 Overall Opinions

When an overall opinion is issued, it must take into account the strategies, objectives and risks of the Health Board and the expectations of senior management, the board and other stakeholders. The overall opinion must be supported by sufficient, reliable, relevant and useful information.

Public sector requirement

The chief audit executive must deliver an annual internal audit opinion and report that can be used by the Health Board to inform its governance statement.

The annual internal audit opinion must conclude on the overall adequacy and effectiveness of the Health Board's framework of governance, risk management and control.

Overall Opinion

The rating, conclusion and/or other description of results provided by the chief audit executive addressing, at a broad level, governance, risk management and/or control processes of the Health Board. An overall opinion is the professional judgement of the chief audit executive based on the results of a number of individual engagements and other activities for a specific time interval.

Betsi Cadwaladr University Health Board

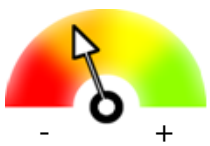
Delivery of Savings – Ysbyty Glan Clwyd Hospital

Final Internal Audit Report

BCU 2020/21

September 2020

NHS Wales Shared Services Partnership

Limited Assurance

Previous review rating N/A

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Review reference:	BCU-2021-10
Report status:	Final Internal Audit Report
Fieldwork commencement:	27th March 2020
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Draft discussion report issued:	29th May 2020
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2nd Revised disc. report issued:	22nd June 2020
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Final report issued:	25th August 2020
Date of Executive Approval	7th September 2020
Auditor/s:	Senior Internal Auditor Head of Internal Audit
Executive sign off:	Executive Director of Finance
Distribution:	Finance Director - Provider Services Interim Chief Finance Officer - YGC Site Acting Board Secretary Statutory Compliance, Governance & Policy Manager
Committee:	Audit Committee

Audit and Assurance Services conform with all Public Sector Internal Audit Standards as validated through the external quality assessment undertaken by the Institute of Internal Auditors.

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

Disclaimer notice - Please note:

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Audit reports are prepared by the staff of the NHS Wales Shared Services Partnership – 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.

1. Introduction and Background

Public sector organisations are under increasing pressure to ensure that their expenditure falls within the level of funding available within year, whilst meeting all of their operational goals and fulfilling statutory duties.

Recognising this, the Health Board have put in place a savings programme to enable the organisation to return to financial balance and ensure sustainable service delivery.

For the 2019/20 financial year, the Health Board has set itself a target of delivering £34.5million of savings, made up of a combination of cost containment and cash releasing savings.

If the Health Board intends to deliver its approved Interim Financial Plan for the 2019/20 financial year, it is imperative that the savings targets are met, and that saving schemes are implemented are delivered.

2. Scope and Objectives

The overall objective of the review was to establish whether there is a robust control environment in place within the Health Board to support the delivery of the Health Board savings plan. Our approach to this review was to identify and evaluate controls in place and highlight potential weaknesses.

The review focussed on the following:

- Delivery of savings; and
- Management and administration of the Health Board savings schemes.

3. Associated Risks

The potential risk considered at the outset of the review were:

- Savings target not met;
- Key financial targets not achieved;
- Disconnect between savings plan and actual implementation.

OPINION AND KEY FINDINGS

4. Overall Assurance Opinion

We are required to provide an opinion as to the adequacy and effectiveness of the system of internal control under review. The opinion is based on the work performed as set out in the scope and objectives within this report. An overall assurance rating is provided describing the effectiveness of the system of internal control in place to manage the identified risks associated with the objectives covered in this review.

The level of assurance given as to the effectiveness of the system of internal control in place to manage the risks associated with Delivery of Savings – Ysbyty Glan Clwyd Hospital is limited assurance.

RATING	INDICATOR	DEFINITION
Limited Assurance		The Board can take **limited assurance** that arrangements to secure governance, risk management and internal control, within those areas under review, are suitably designed and applied effectively. More significant matters require management attention with **moderate impact on residual risk** exposure until resolved.

The overall level of assurance that can be assigned to a review is dependent on the severity of the findings as applied against the specific review objectives and should therefore be considered in that context.

5. Assurance Summary

The summary of assurance given against the individual objectives is described in the table below:

Assurance Summary					
1	Process management and documentation			✓	
2	PID Approvals			✓	
3	Saving Scheme Performance		✓		
4	Finance reconciliation		✓		

** The above ratings are not necessarily given equal weighting when generating the audit opinion.*

Design of Systems/Controls

The findings from the review have highlighted one issue that is classified as a weakness in the system control/design for the Delivery of Savings – Ysbyty Glan Clwyd Hospital.

Operation of System/Controls

The findings from the review have highlighted two issues that are classified as a weakness in the operation of the designed system/control for the Delivery of Savings - Ysbyty Glan Clwyd Hospital.

6. Summary of Audit Findings

The key findings are reported in the Management Action Plan.

This report is based upon the information provided, responses during discussions and on documents provided to us.

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

To determine the robustness of controls supporting the delivery of savings we met with relevant key Finance officers to discuss the reporting of saving schemes and established what guidance documents, policies, and principles were in place.

We were asked at the outset to focus our review on Ysbyty Glan Clwyd saving schemes. Of the Health Board's total 2019/20 cash releasing savings requirement of £34.5m, Ysbyty Glan Clwyd were allocated a target of £3.810m against which they identified saving schemes totalling £3.534m.

The Ysbyty Glan Clwyd 2019/20 saving plan was made up of forty three projects incorporating both cost avoidance and cash-releasing saving schemes. Of these we selected a random sample of eight projects for review. The total full year effect of our sample was £1.937m, representing approximately 55% of the identified Ysbyty Glan Clwyd savings.

Process management and documentation

The Health Board had robust governance arrangements in place for the management and administration of the 2019/20 saving schemes.

In September 2016 the Health Board established an internal Programme Management Office (PMO) to provide a robust and comprehensive approach to project governance and management. The PMO approach, requirements, and governance arrangements were documented in the Health Board Guidance Pack for the Submission and Assurance of PMO Savings Projects/Schemes document. The guidance document was issued as final on January 3rd 2019 and set out the governance and assurance processes that must be followed and the documentation that must be completed.

Whilst the guidance document was comprehensive and provided the required submission document templates, we noted that both hyperlinks referring the reader to additional PMO Assurance Documents and CAMMS Project Training Guides were not working.

To determine the extent to which the eight saving schemes within our sample complied with the requirements of the guidance document, we reviewed copies of relevant project initiation documents (PID) and the BCU Director Approval Tracker, which is one of the primary documents used by the PMO to manage the approval process, against the guidance document. The following findings were noted:

- We obtained supporting Project Initiation Documents (PIDs) for seven of the eight saving schemes in our sample. One scheme was supported with a completed Clinical and Quality Impact Assessment.
- Whilst the content was largely similar three different PID templates had been used to support the schemes in our sample, with only one scheme

having utilised the template document provided in the 2019/20 PMO Guidance pack.

- However we acknowledge that the PMO went through three significant structural changes during the 2019/20 financial year with each group bringing their own ideas and practices. Early in the financial year the service was delivered by an internal PMO. This was then taken over by an external team (PwC UK), which was subsequently replaced by the current internal arrangement which is run primarily by agency staff.
- All PIDs reviewed had been completed appropriately.
- We noted that only one of the PID formats observed had provision to record approval dates. Where this provision was available the relevant dates had been completed in three out of four PIDs. There was no provision to record approval dates on the new PID template.
- We found two instances whereby the reported total 2019/20 savings was higher than that which was identified in the relevant PIDs. The amended savings total was consistently recorded between the finance report and the PMO approval tracker, however the increased savings had not been amended on the relevant PIDs.

Project Initiation Document Approval

Following submission all PIDs are subject to the following stages of approval:

- Stage one: Project development stage where Divisional/Improvement Group formal approval is sought;
- Stage two: Executive Medical Director and Executive Director of Nursing approval (the Director of Workforce and OD will review the EQIA); and
- Stage three: Chief Executive and Director of Finance approval, who have the Executive right to veto a project.

We reviewed the approval status of each project in our sample and noted the following:

- All saving schemes in our sample were noted as ready for Stage 2 approval.
- Seven of the eight schemes had attained Stage 2 approval and had been approved by both Executive Nursing Director and Executive Medical Director.
- The remaining scheme had been approved by the Executive Medical Director however was noted as awaiting response from the Executive Nursing Director.
- None of the schemes in our sample had been approved by either the Chief Executive or Director of Finance (Stage 3). All eight sample schemes were noted as not being ready for Stage 3 approval.
- However there is uncertainty around the requirements of this Stage of approval. It is unclear from the guidance and procedural documents whether a direct notice of approval from both Chief Executive and Director

of Finance is required, or whether the provision is there to record their right to veto a scheme. If it is the latter, there is no record on the tracker document confirming that either Executive has seen or reviewed the relevant PIDs.

Saving Scheme Performance

The following table summarises actual savings performance against planned performance for each project within our review sample. The information was taken directly from the January 2020 (Month 10) Finance master savings document.

Table 1 – Saving scheme sample reported performance January 2020

Project Name	Project code	2019/20 Project Savings	Planned Profile at Month 10	Delivered Year to Date	Undeliver-able	Delivered as % of planned	Undeliver-able as % of Project Savings
Junior Dr review	YGC 043	417,000	233,000	73,000	344,000	31%	82%
ABH	YGC 033	186,330	62,110	0	186,330	0%	100%
Agency spend - General Surgery	YGC 009	180,329	128,806	25,761	128,806	20%	71%
YGC control panel	YGC 031	270,000	170,000	22,560	232,400	13%	86%
Med	YGC 027	291,664	218,748	132,155	86,593	60%	30%
ED nursing	YGC 013	248,415	182,171	48,122	134,049	26%	54%
Med agency	YGC 008	248,473	168,793	263,283	0	156%	0%
Disc pay	YGC 044	94,796	58,683	1,090	91,525	2%	97%
TOTAL		**1,937,007**	**1,222,311**	**565,971**	**1,203,703**	**46%**	**62%**

Source: Data taken from the Health Board Finance master savings spreadsheet (January 2020)

Key points:

- Only one of the eight saving schemes in our sample had achieved (and had in-fact exceeded) the planned savings target as of Month 10 (January 2020).
- One scheme had not started (was due to start January 2020) therefore had not achieved any savings to date. We noted that this was the one scheme in our sample that had not attained full Stage 2 approval. We confirmed that the project had been deferred pending further consultation.
- It was anticipated that our sample schemes would yield savings of approximately £1.2m by the end of January 2020. However the actual achieved savings reported at the end of this period were £566k (46% of projected savings).
- Of the £1.9m identified full-year savings for our sample schemes £1.2m was forecast as unachievable as of Month 10. This raises concern over the

robustness of controls during the planning, development, and proposal stages of savings project management.

Finance Reconciliations

Each month following the accounting position close-down, assigned Project Accountants are required to submit their updated savings position to the PMO Accountant, detailing actual in month delivery of savings, year to date position, full year savings forecast, and projected shortfalls for each savings programme within their area of responsibility. This data forms the basis of all Health Board savings related reporting.

We were advised at the outset that the Ysbyty Glan Clwyd finance team had experienced management personnel changes mid-way through the 2019/20 financial year which could impact the knowledge and accountability of savings reported prior to the changes.

The Ysbyty Glan Clwyd Finance team maintain a tracker document in the form of an organised Excel spreadsheet to manage the savings data, extrapolating relevant information from a General Ledger download. Within the tracker document the data for each saving scheme is held within individual worksheets.

Whilst maintaining a robust reconciliation process is essential for transparency we noted that the savings tracker document was only implemented mid-way through the financial year by the new Ysbyty Glan Clwyd finance management team. We were advised that there was no documented reconciliation process in place prior to this.

We sought to verify the reported year to date saving figures for each scheme in our sample by reconciling the saving aggregates to the finance tracker document, Health Board General Ledger, and any other relevant backing documentation. The following findings and limitations were identified:

- As previously stated, one scheme in our sample (Abergele Hospital - Orthopaedic Reconfiguration), had been deferred pending further consultation therefore had no associated reported savings.
- We were able to reconcile the reported year to date savings aggregate directly to the finance tracker document for one of the seven remaining schemes in our sample.
- Relevant backing documentation was provided to support the reported savings for the five remaining schemes in our sample, with the exception of one saving entry for YGC013 which was unsupported (see below).
- The Month 10 data on the tracker document for one scheme (Medical Agency YGC008) was lower than that which was reported (£263,283 compared with £261,355). This was due to a reduction in actual savings from the previous month (December 2019). The reported savings (£263,283) reconciled with the Month 9 tracker document position.
- We queried this and were advised that the Finance teams had been instructed not to report a negative savings position in their monthly update. We previously reviewed the reporting of negative savings and

found that the practice was used to maintain accurate reconciliations and demonstrate fluctuations in costs impacting savings.

- In reviewing the tracking worksheet for the above named project we noted that the reported savings figure was based on a monthly reduction of actual costs compared to the average costs incurred during Months 1-5. Despite the reduction in costs over time the data indicated that the associated medical posts were overspent against their respective budgets in most months.
- The following explanation was given as to the reporting of a saving despite the overspend: *"YGC 008 scheme was to reduce Medical Agency spend in the Emergency Department. The ED department had worked over the budgeted establishment for approximately 2 years and a Business Case was produced for the new required rota and the increase in posts. During 2018/19 and the early part of 2019/20 a number of these posts were filled with Agency staff, therefore the ED budgets were historically overspent. As part of the plan the over established posts were recruited to on a temporary basis with NHS locums instead of Agency - pending the approval of the business case. Whereas the budgets remained overspent as the temporary posts were still over the budgeted establishment, the overspend reduced as the NHS locums were more cost effective than the previous Agency staff hence reducing the run rate and giving savings".*
- The tracker document data did not reconcile with the reported figures for two further schemes (YGC009 and YGC013). We found that this was due to an administrative error. Neither of the two schemes had achieved any savings during Month 10. The Ysbyty Glan Clwyd finance team noted this in their update position return however this was missed and the forecast position was reported as actual savings in error. Without the provision to adjust this with a negative entry in following months the incorrect savings position was maintained. No additional savings were reported for these schemes under the new management.
- One of the schemes above (YGC013) had previously reported savings of £15,000 in August 2019. This was prior to the implementation of the current Finance management team's tracker reconciliation process and therefore no backing documentation was available to support this reported saving.
- The tracker document worksheets for the three remaining projects in our sample (YGC031, YGC043, and YGC044) did not contain data but rather were annotated. We were advised that the reported savings for these schemes were driven centrally by the Programme Management Office outside the direct control of the Ysbyty Glan Clwyd finance team. The following backing documentation was provided to support the reported savings:
    - Savings totalling £22,560 (£7,520 per month for October, November and December 2019) were reported for YGC031 YGC Budget Control Panels (BCP). The savings related to the termination of a contracted Medical Staff recruitment subscription service. However it transpired

that the contract had not been formally terminated and that the service had been utilised during the year resulting in the contract fees being incurred. As such no actual savings were made, however as previously noted the current reporting arrangements do not allow for the reversal, removal, or adjustment of previously reported savings.

  - The Junior Doctors Review Phase 1 - YGC scheme (YGC043) reported savings of £73,000 in October 2019. The Ysbyty Glan Clwyd finance team reported a zero savings return for this period however following review day an Executive decision was made to report the forecast delivery as per the submitted plan across each division for this scheme. We were advised that by November 2019 it became apparent that the level of savings were not going to be achieved however there is no provision to remove/reduce previously reported savings.
  - A comprehensive reconciliation document was provided to support the reported savings for YGC044 Discretionary Non-Pay Non Medical – YGC.

- Concern was raised regarding the possible double counting of savings across multiple saving schemes, in particular between projects managed locally and those managed centrally. Whilst we did not have sufficient information to accurately evaluate this assertion, management must ensure that controls are in place to avoid the double counting of savings across multiple schemes.

Aggregate Year-end Savings Position

This supplementary information has been added to provide further context.

Whilst this review focussed on the performance of a sample of saving schemes at Month 10 (January 2020), delays in issue has provided an opportunity to report the aggregate 2019/20 year-end savings position (Month 12) for Ysbyty Glan Clwyd Hospital. We noted the following:

- The total identified saving schemes as of Month 12 had increased to £3.712m, against which £2.143m (58%) was reported as delivered.
- We were advised that of the forty three planned Ysbyty Glan Clwyd saving schemes twenty five had originally been identified with a further eighteen schemes added during the course of the financial year.
- The total planned savings of the original twenty five schemes was £1.949m against which £1.681 (86%) had been delivered.
- Of the eighteen additional schemes which proposed in-year savings of £1.763m, only £0.462m (26%) had been delivered.
- We were further advised that eleven of the eighteen additional schemes had been developed by the PMO under PwC in conjunction with the Hospital Management Team, with the seven remaining saving schemes having been allocated centrally.

- The centrally allocated schemes achieved £0.310m (36%) of their anticipated £0.866m projected savings target, whilst the schemes worked up by the PMO under PwC in conjunction with the Hospital Management Team achieved only £0.152m (17%) of their projected £0.897m savings target.

7. Summary of Recommendations

The audit findings, recommendations are detailed in Appendix A together with the management action plan and implementation timetable.

A summary of these recommendations by priority is outlined below.

Priority	H	M	L	Total
Number of recommendations	**2**	**1**	**0**	**3**

Finding - ISS.1 – Documentation Management and Approval (Operating effectiveness)	Risk
We reviewed a sample of Project Initiation Documents (PIDs) and their respective approvals as recorded on the PMO Approval Tracker and identified the following issues and limitations: • Various PID template documents were used to support saving projects. Only one schemes from our sample of eight had used the template provided in the 2019/20 PMO Guidance document. • We found two instances whereby the reported total savings were higher than that which was identified in the respective PIDs. • One project had not received full Stage 2 approval – it had not been approved by both relevant Executives. The scheme had not progressed and had been deferred. • None of the schemes in our review sample had attained Stage 3 approval – i.e. Chief Executive Officer and Executive Director of Finance approval. • It is unclear from the guidance and procedural documents whether Stage 3 approval requires a direct notice of approval from both Chief Executive and Director of Finance, or whether the provision is there only to record their right to veto a scheme. • If it is the latter, there is no record on the tracker document confirming that either Executive has seen or reviewed the relevant PIDs.	Lack of consistency. Failure to adhere to guidance documents. Lack of transparency.

Recommendation	Priority level
Management must ensure that the principles and requirements of the PMO Guidance document are adhered to in order to ensure that the Health Board has a consistent approach to project management. The PMO clarify the position regarding the requirements of Stage 3 approval. If direct Chief Executive Officer and Executive Director of Finance approval is not required, provision should be made to confirm that both Executives have had sight of the relevant PIDs.	**Medium**
Management Response	**Responsible Officer/ Deadline**
As a consequence of the changes in the PMO in 2019/20, different PIDs used at various times throughout the year. We will ensure the guidance for 2020/21 is clear and the need for Stage 3 approval is clarified.	Executive Director of Finance Sept 2020

Finding - ISS.2 – Saving Scheme Performance (Operating effectiveness)	Risk
We reviewed the financial performance data of the eight saving schemes in our sample and found the following: • Only one of the eight saving schemes had achieved its planned savings target as of Month 10 (January 2020). • It was anticipated that our sample schemes would yield savings of approximately £1.2m by the end of January 2020. However the actual achieved savings reported at the end of this period were £566k (46% of projected savings). • Of the £1.9m identified full-year savings for our sample schemes £1.2m was forecast as unachievable as of Month 10.	Overestimating and over-reporting potential savings. Failing to meet savings targets. Failure to adhere to guidance documents.
Recommendation	**Priority level**
Management must ensure that the controls in place during each phase of the project life cycle are sufficiently robust so as to ensure that any planned savings are accurate and deliverable within the stated timeframes.	**High**
Management Response	**Responsible Officer/ Deadline**
Agreed -Further work will be undertaken to develop robust savings plans before the PID is developed and agreed. Working in conjunction with Hospital Management, we will ensure forecasts are as accurate as possible.	CFO – YGC. September 2020

Finding - ISS.3 – Finance Reconciliations (Design of system/controls)	Risk
To verify the reported savings we reviewed the reconciliation process and relevant backing documentation. We found the following issues and limitations: • Whilst we were able to verify the reported savings for each of the eight schemes in our sample to either the tracker document or other backing documentation (with the exception of one saving entry for YGC013 which was unsupported) the reconciliation process was not consistent between schemes. • At Month 10 (January 2019) the YGC finance tracker document did not contain sufficient information to enable a comprehensive reconciliation of reported savings, resulting in reliance on other supplementary backing documentation and/or correspondences for reconciliation or verification purposes. • Reconciliation to the ledger was not transparent as there is no provision in the current reporting arrangements to address the reduction, removal, or adjustment of previously reported savings, even in instances where savings have been reported in error. • Five of the eight saving schemes in our sample had erroneously reported savings which could not be corrected/adjusted.	Lack of transparency and accountability. Inaccurate reported savings.
Recommendation	**Priority level**
Whilst we acknowledge the impact of mid-year management changes, the current Finance management team must ensure that all relevant savings reconciliation documentation are completed and retained.	**High**

To ensure transparency all Finance teams should maintain a robust audit trail of key information and reports informing the reported savings position. To ensure that the Health Board reported savings position is accurate and true, provision should be made to address instances where savings are reduced or where savings are under/over-stated.	
Management Response	**Responsible Officer/ Deadline**
The Finance Team will ensure that all relevant savings reconciliation documentation are completed and retained. Any savings not in the ledger will be clearly documented and reconciled.	Interim CFO YGC – September 2020

Appendix B - Assurance opinion and action plan risk rating

Audit Assurance Ratings

 **Substantial assurance** - The Board can take **substantial assurance** that arrangements to secure governance, risk management and internal control, within those areas under review, are suitably designed and applied effectively. Few matters require attention and are compliance or advisory in nature with **low impact on residual risk** exposure.

 **Reasonable assurance** - The Board can take **reasonable assurance** that arrangements to secure governance, risk management and internal control, within those areas under review, are suitably designed and applied effectively. Some matters require management attention in control design or compliance with low to **moderate impact on residual risk** exposure until resolved.

 **Limited assurance -** The Board can take **limited assurance** that arrangements to secure governance, risk management and internal control, within those areas under review, are suitably designed and applied effectively. More significant matters require management attention with **moderate impact on residual risk** exposure until resolved.

 **No assurance** - The Board can take **no assurance** that arrangements in place to secure governance, risk management and internal control, within those areas under review, are suitably designed and applied effectively. Action is required to address the whole control framework in this area with **high impact on residual risk** exposure until resolved.

 **Assurance not applicable** is given to reviews and support provided to management which form part of the internal audit plan, to which the assurance definitions are **not appropriate** but which are relevant to the evidence base upon which the overall opinion is formed.

Prioritisation of Recommendations

In order to assist management in using our reports, we categorise our recommendations according to their level of priority as follows.

Priority Level	Explanation	Management action
High	Poor key control design OR widespread non-compliance with key controls. PLUS Significant risk to achievement of a system objective OR evidence present of material loss, error or misstatement.	Immediate*
Medium	Minor weakness in control design OR limited non-compliance with established controls. PLUS Some risk to achievement of a system objective.	Within One Month*
Low	Potential to enhance system design to improve efficiency or effectiveness of controls. These are generally issues of good practice for management consideration.	Within Three Months*

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

Betsi Cadwaladr University Health Board

NHS Wales Staff Survey – Delivering the Findings

Internal Audit Report

BCU 2019/20

September 2020

NHS Wales Shared Services Partnership

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Executive sign off:	Executive Director of Workforce & Organisational Development
Distribution:	Associate Director Workforce Performance & Improvement Head of Organisational & Employee Development Acting Board Secretary Statutory Compliance, Governance & Policy Manager
Committee:	Audit Committee

Audit and Assurance Services conform with all Public Sector Internal Audit Standards as validated through the external quality assessment undertaken by the Institute of Internal Auditors.

ACKNOWLEDGEMENT
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Audit reports are prepared by the staff of the NHS Wales Shared Services Partnership – 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

1. Introduction and Background

NHS Wales regularly undertakes a national survey of directly employed staff which is considered to be an important way of obtaining feedback from staff about a range of issues which are critical to the success of NHS Wales.

The survey is structured as a series of questions asked about themes critical to the success of NHS Wales. Answers will be mostly submitted using a scale 'agreement' method, but for some questions the answer is submitted using a 'yes/no' choice.

The 2018 NHS Wales Staff Survey follows on from the 2016 survey and provides a full analysis of workforce engagement and the organisational climate for the NHS Wales workforce, giving an overall assessment of areas that require improvement. The questionnaire [in 2018] was largely the same as the 2016 questionnaire, enabling comparison for most questions.

Repeating the national survey on a frequent basis enables monitoring of staff opinion over time. Trends and themes can therefore be monitored on a national and organisational basis, and action taken to address any issues which are evident.

In delivering the result of the 2018 survey, draft organisational and divisional plans were submitted to the Strategy, Partnership and Public Health (SPPH) Committee on the 5th February 2019 with final plans being submitted and approved by the Board on the 28th March 2019.

Minutes of the Health Board Meeting 28th March 2019 recorded the following:

> *19.56 Staff Engagement – NHS Wales Staff Survey 2018: Delivering Improvement*
>
> *19.56.3 It was resolved that the Board*
>
> - *Approve the Organisational Improvement Plan.*
> - *Note the Divisional improvement plans.*
> - *Note and endorse the link between the national NHS Wales Staff Survey and the BCUHB ByddwchynFalch/Be Proud survey work.*
> - *Note the national changes to the approach of collecting colleague experiences.*

Strategy, Partnerships and Population Health Committee meeting of the 4th July 2019 recorded:

> *SP19/52 Staff Engagement - NHS Wales Staff Survey 2018 – Delivering Improvement Progress Report*
>
> *Monitoring performance against both the Organisational Improvement Plan and Divisional Plans will be through the Workforce Improvement Group with regular updates provided through the Strategy, Partnerships and Population Health Committee.*

2. Scope and Objectives

The objective of the review was to obtain evidence that underpins reported progress against the divisional improvement plans.

The overall scope was to review a sample of actions noted as implemented within the themes and the evidence supporting those actions in divisional improvement plans, as agreed with Workforce & OD, for:

- Estates Operational Services
- Mental Health & Learning Disabilities
- Secondary Care

We also reviewed the reports submitted to the Workforce Improvement Group and SPPH.

We reviewed reports submitted within the three divisions' governance structure to ensure the staff survey and plans feature as part of their relevant agendas.

3. Associated Risks

The risks considered at the out of the review were:

- Lack of focus by operational divisions to implement the outcome of the staff survey.
- Divisional governance arrangements are not robust and effective in ensuring implementation.

OPINION AND KEY FINDINGS

4. Overall Assurance Opinion

We are required to provide an opinion as to the adequacy and effectiveness of the system of internal control under review. The opinion is based on the work performed as set out in the scope and objectives within this report. An overall assurance rating is provided describing the effectiveness of the system of internal control in place to manage the identified risks associated with the objectives covered in this review.

The level of assurance given as to the effectiveness of the system of internal control in place to manage the risks associated with the NHS Wales Staff Survey – Delivering the Findings review is limited assurance.

RATING	INDICATOR	DEFINITION
Limited Assurance		The Board can take **limited assurance** that arrangements to secure governance, risk management and internal control, within those areas under review, are suitably designed and applied effectively. More significant matters require management attention with **moderate impact on residual risk** exposure until resolved.

The overall level of assurance that can be assigned to a review is dependent on the severity of the findings as applied against the specific review objectives and should therefore be considered in that context.

5. Assurance Summary

The summary of assurance given against the individual objectives is described in the table below:

Assurance Summary					
1	Staff Survey Divisional Action Plans Reporting into the Workforce Improvement Group Meetings (WIG)		✓		
2	Governance arrangements within the division to monitor the staff survey		✓		
3	Progress against the individual Divisional Staff Survey Action Plans		✓		

** The above ratings are not necessarily given equal weighting when generating the audit opinion.*

Design of Systems/Controls

The findings from the review have highlighted no issues that are classified as weakness in the system control/design for NHS Wales Staff Survey – Delivering the Findings.

Operation of System/Controls

The findings from the review have highlighted two issues that are classified as weakness in the operation of the designed system/control for NHS Wales Staff Survey – Delivering the Findings.

6. Summary of Audit Findings

The key findings are reported in the Management Action Plan.

This report is based upon the information provided by Divisional leads, and the Workforce Optimisation Business Manager / Programme Manager as well as supplementary information obtained/responses made during discussions and sample testing. We would like to express our gratitude 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.

At the time of the review both Divisional leads for the Mental Health & Learning Disabilities Division (MHLD) were on long-term sickness. The evidence was

provided to us by the Head of Planning and the Compliance & Workforce Coordinator.

Staff Survey Divisional Action Plans Reporting into the Workforce Improvement Group Meetings (WIG)

Workforce Improvement Group meetings commenced on the 26th September 2019 with further meetings taking place on the 29th November and 20th December 2019 respectively. We received the agenda papers for the three meetings however we did not receive minutes for 26th September or 29th November 2019 but did receive meeting notes for the 20th December 2019. The meeting scheduled for January 2020 was stood down.

No divisional action plans are evident on agenda papers for the 26th September or 20th December 2019 meetings. However, we did identify divisional action plans, including the three in our review, noted on the 29th November 2019 agenda.

Terms of reference have been provided which references but does not specifically refer to the Divisional action plans reporting into the WIG.

We were provided with draft Terms of Reference V0.1 [with footer details of Version 4.0 07/19]; in reviewing the principle duties and remit, we have extracted the following:

Draft Terms of Reference

3. Principal Duties and Remit

- *To establish and oversee the portfolio of programmes and projects that will deliver Workforce Improvements;*
- *To identify and oversee the delivery of major Workforce Optimisation programmes; and*
- *To support and challenge divisions and areas on delivery of the strategic action plan.*

We can find no specific reference in the draft Terms of Reference relating to monitoring the staff survey divisional action plans.

To review approval of the draft Terms of Reference, we were provided with evidence that the Terms of Reference was to be submitted to the Financial Recovery Group (FRG) for ratification at its September 2019 meeting. We reviewed the FRG minutes for the period 6th August to the 26th November 2019 inclusive and were unable to confirm that the Terms of Reference have been agreed.

In discussion with the Director of Workforce and OD, we recognise and note that the initial focus of the WIG meetings are on the delivery of savings and efficiencies.

Governance arrangements within the division to monitor the staff survey

We sought evidence that scrutiny and assurance was in place within the three divisions, where by the divisional staff survey action plans were discussed as

regular agenda items.

Estates & Facilities

Evidence was provided to us by way of the Estates and Facilities Divisional meetings. Agendas and minutes provided demonstrated the staff survey action plan being regularly discussed.

Mental Health & Learning Disabilities (MHLD)

MHLD were unable to provide any evidence, however we were informed that the NHS Staff Survey Action Plan will be on the agenda at their next meeting of the Divisional Directors Business Meeting on the 25th February 2020.

Secondary Care Ysbyty Gwynedd

No response was received.

Progress against the individual Divisional Staff Survey Action Plans

As there were no set standards for determining what was required for inclusion in the divisional action plans, evidence for all three divisions we reviewed provided varying degrees to support the progress made within the themes.

In reviewing the noted actions across the three plans, it has not been possible to definitively state that the progress reported, for some, address the actions due to limited specific/measurable actions.

Below are the three tables for each division we tested highlighting the theme, progress and evidence provided.

Estates and Facilities Division

Action to address Theme - Communication	Target date completion	Progress/Review	Status	Evidence Provided to Internal Audit
1.Effective communication between senior managers and staff	March 2019	Monthly Corporate/Divisional Local Team Brief Operational Meetings(Facilities/Operational Estates) Staff Side partnership/Communication Meetings Site Visits	Governance & Reporting structure	Final Governance Structure
			Listening Leads	Listening leads contacts, Pictorial listening leads display, email of dates regarding organised leads meeting (no minutes presented)
			Trade Union representative on Estates & Facilities Divisional Board	Minutes provided support attendance at the Estates & Facilities Divisional Meetings.
			Embedded and Reviewed	Minutes within the Estates & Facilities Divisional Meeting 28th August 2019 note the visits of the Executive Director Of Planning And Performance. Also evidenced within the Staff Achievements / Good News

				Stories – August / September 2019.
Theme – Learning & Development				
2.Work is valued by the organisation	March 2019	Annual BCUHB Staff Achievement Awards Seren Betsi Staff Awards CEO On the Spot Recognition Divisional Staff Achievement / Good News Stories Charity Sponsorship Recognition Long Service Awards PADR programme for all staff	Annual BCUHB Staff Achievement Awards	Evidenced within Staff Achievements / Good News Stories – July 2018
			Seren Betsi Star Awards	Staff Achievements / Good News Stories – June & July 2019.
			Staff celebration / Good News Stories	Evidenced through good news stories bulletins.
			Staff voluntary sponsorship	Staff Achievements / Good News Stories – Nov / Dec 2018.
			Staff development programme	Digital skills training programme that ensures all staff have the opportunity to develop their digital skills.
			Improvement PADRs & Mandatory Training	Staff Achievements / Good News Stories – October 2019. Estates & Facilities Divisional Meeting 28th August 2019 minuted "…noted that PADR

				compliance had decreased slightly…". Review of Workforce report notes September 2019 Mandatory training at 64% (60% April 2019); PADR 63.7% (46.1% April 2019).
Theme – Change in the organisation				
3. Change in the Organisation is well managed	March 2019	Compliance with the Organisational change Policy (OCP) Local consultations on service Change Listening Leads 3D Ambassadors Staff Side Partnership / Communication meetings Statutory and Mandatory Training Programme	Weekly Pay	Evidence of emails referencing the switch from weekly pay to monthly. W&OD Report for Estates & Facilities Divisional Meeting – Wednesday 22nd May 2019 evidences the Transfer of Weekly to Monthly Pay
			Review of Terms and Conditions – Operational Estates (East) IT / Digital Transformation – Staff App promotion.	Digital Skills Training Programme 2020-2022 Statutory and Mandatory Training Programme Evidence of Professional Development Programmes

		Professional Development Programmes Career Development Plans Workforce Plans Staff Coaching and Mentoring	Review of Employee Relations performance dashboard	Staff welfare - Long term sickness cases overview Meeting action tracker to ensure expected actions are progressed.

Ysbyty Gwynedd, Secondary Care

Action to address	Target date completion	Progress/Review	Evidence
Theme – Leadership/management approach			
1. Results of staff survey for YG (believed to relate to secondary care) shared with senior team for initial response to first results.	30/10/18	Discussion held, with subsequent focusing in on 5 greatest positive areas of difference with National results and 5 most negative.	No evidence provided
7. Communication and recognition. The feedback from the staff survey engagement event highlighted the need for the organisation as a whole to improve communication and engagement activities. The Ysbyty Gwynedd site has 8 staff ambassadors and 4 listening leads. There is an update event planned for January 2019. The opportunity for staff to become ambassadors or listening leads will be reiterated with a view to increasing the number further. The 'West's got talent' night was identified during the staff engagement event as a successful vehicle	30/08/19	Feedback across site and departments though directorate meetings, ward managers/matrons and Heads of Nursing meeting. Ysbyty Gwynedd site now has 9 staff engagement ambassadors. Best Christmas decorated ward competition has continued for a second year.	Example of 'you said, we did' from Emergency department. Example - Emergency department Improvement plan in place. Evidence provided of the latest Staff Engagement report 2019-20 17 departments entered the competition in 2019

for engagement. Similarly, the best decorated Christmas ward generated a competitive spirit and it has been proposed that similar competitions are scheduled across the year for notable diary dates. Work is already being progressed on a site clinical recognition award which would be built around the safety huddle; a penguin emblem would be adopted for the award.		Site Safety huddle held at 08:30am each weekday (9am at weekend). Staff are nominated by other team members for a 'penguin badge' as recognition of a specific action or going 'above and beyond' Example of certificate attached and since started over 150 staff have been recognised through nomination. The logo for the award was decided following a competition of designs submitted by staff (see attached). 14 Ysbyty Gwynedd staff have been nominated for staff achievement awards (see staff engagement report above for names and reasons). The division engaged with the Be Proud Pioneer programme with 6 ward teams participating. Initiatives included: <u>Ogwen Ward</u> - Baywatch: By changing the way staff respond to patients at night, and using sensor matts the ward have drastically reduced the number of falls over the past several months AND improved the levels of care staff feel able to give.	Evidence of Certificate and the badges provided also 14 Ysbyty Gwynedd staff have been nominated for staff achievement awards which can be seen within the staff engagement. Pictorial evidence was provided for some actions however we have not corroborated all of these points.

		Tryfan Ward - You Said, We did: 1. communication book and closed social media group established to support communication for all staff (Leadership & Stress) 2. Staffing review undertaken and vacancies filled (Leadership & Stress) 3. Proper lunch breaks ensured (Leadership & stress) 4. Handover taking too long – new ways of working being investigated (Leadership) Conwy ward – Staff Suggestion Boards: 5. What works well? What can we improve? How can we improve? 6. What can we all do to support our health and wellbeing? How can we engage staff to influence change and decisions on the ward? Tegid ward – 7. Implemented a You Said We Did Board.	

		8. Established a 'Thank You Thursday to recognise staff. 9. Holding Listening events. 10. Held fund raising events to raise money for a bladder scanner and ECG machine for the ward.	
Theme – Stress at work			
2. OD facilitated engagement event held at Ysbyty Gwynedd site.	10/12/18	Results collated within internal assessment paper on staff survey, which has helped inform actions.	No evidence received
4. Implementation of the Just Culture guide – NHS Improvement. The secondary care services at the Ysbyty Gwynedd site will look to adopt the NHS Improvement 'A just culture guide' as a tool to be used before formal management action is directed at an individual member of staff. This guide supports a conversation between managers about whether a staff member involved in a patient safety incident requires specific individual support or intervention to work safely. The guide highlights that action singling out an individual is rarely appropriate as most patient safety issues have deeper causes and require wider action. The tool has been supported within NHS England by trade union partners including the BMA, RCN, UNISION and Unite.	30/08/19	Rapid review and any make safe actions put into place immediately Serious incidents reviews as needed at which the review adopts the' just culture' approach to the session.	We requested evidence of agenda/minutes of reviews however none were provided.
Theme – General			

1. Car parking at the Ysbyty Gwynedd site. Difficulties with access to car parking at the Ysbyty Gwynedd site have been highlighted by a number of staff. Whilst access may not be a satisfaction factor, the absence of easy access is causing dissatisfaction. Discussions have commenced with an external company on support with understanding existing traffic flows, use made of public transport, signage and re-marking of existing car parks with a view to securing improvements.	There will be resource implications which are yet to determined or funded	A high level bid submitted as part of 2020-21 capital requirements for additional parking capacity on site. Operational estates plan to make minor improvements e.g. formalising areas of parking that have developed informally due to pressure (as safety allows).	A parking survey has been completed by external company

Mental Health & Learning Disability Division

Action to address	Target date completion	Evidence/Progress/Review
Theme – Management of Change		
1. Examine data further to establish areas to investigate in more detail. *Evidence must support 'expected outcome' for a better understanding of topics and identified areas to focus on so that staff are better*	March 2019	Evidence of a draft Wellness, work and us delivery plan 2019-2023 provided demonstrates that a Wellness, Work and You Project Group has been established to review data aligned to staff attendance, staff survey, outcome of SUI's and WOD investigations to establish themes. *Wellness work and you strategy* *Mental Health & Learning Disability Division (MHLD) – Service Delivery Plan 2019 – 2023* *Key aims of the strategy* • *To support staff as valued empowered individuals*

Action to address	Target date completion	Evidence/Progress/Review
informed of the change process		• *To challenge stigma around mental health and follow up the Time to Change Wales Pledge.* • *To signpost and encourage staff to engage with mental health support and develop a greater understanding of the impact of stress in the workplace.* • *Enable managers to be able to support staff effectively through clear guidance, training and information* • *Recognise and celebrate achievements of staff at all levels* • *Listen to staff suggestions, ideas and concerns, keep them informed* <u>Senior Leadership Master Class Programme:</u> Evidence has been provided by the way of a Senior Leadership Master Class programme that supports management of change. This programme has been developed for Band 8 and above and covers: • Leadership & Decision Making in Complexity • Designing Organisational Change that actually works • Leading in Complex Contexts • Asset-based Community Development • Human Rights – 'Diversity, Inclusion and Unconscious Bias' • Mental Toughness
3. Interview staff that have been through the 'OCP' process in the last two years to get live data and examples of good or poor practice.	March 2019	<u>OCP Consultation document for Tiers 3,4,5 & 6:</u> During recent years full consultation of the review and proposed substantive management structure for MHLD has been undertaken and completed. During this process all staff members affected met with their managers at varying times and were given the opportunity to meet with WOD colleagues if they wished. As evidence to support this a document entitled "Proposal – New Mental Health and Learning Disability Structure" has been provided.

Action to address	Target date completion	Evidence/Progress/Review
Evidence must support 'expected outcome' for a better understanding of current OCP issues ensuring that any proposed changes to methodology are informed by 'real' experiences		Consultation meetings were led by Heads of Operations and Service Delivery, Head of Workforce: Mental Health and Trade Union and Workforce and Organisation Developments were also invited to attend the Consultation meetings. Events were held on: • East: Tuesday 19th March 2019: Heddfan: VC Room - 14.00-17.00 • West: Wednesday 20th March: 2019: Hergest: VC Room - 13.00-16.00 • Central: Wednesday 27th March 2019: Ablett: VC Room - 14.00-17.00. • West: RSS: Thursday 28th March 2019: Bryn Tirion: Board Room - 09.00-12.00 • East : RSS: Friday 29th March 2019:Heddfan: Board Room - 9.00-12.00 • Central: RSS: Friday 29th March: Ablett: VC Room - 14.00-17.00 Following original consultation and engagement events the comments and feedback from staff were taken into consideration and the proposal was revised evidence of what feedback was captured has been provided. We have been informed that the Division will now undertake a survey (through Survey Monkey / Smart Survey) to review individual experiences. It is anticipated that will complete by the end of Q4 19/20.
Theme – Communications		
2. Establish what forms of communication staff want Evidence must support 'expected outcome' for a better use of new technology	March 2019	Key communication methods have been implemented to date including embedding of Listening Leads, Wellbeing Champions, and Engagement Ambassadors. Evidence was received for the Listening leads, Engagement ambassadors and Well-being champions. We have also been informed that a divisional quarterly meeting has taken place at director level on the 1st October 2019 with the next one scheduled for 13th February 2020, this has been introduced to hear feedback from the Listening Leads. We did not receive agenda or minutes for the meeting and can therefore not corroborate this took place.

Action to address	Target date completion	Evidence/Progress/Review
		In addition we were informed of actions that had been addressed from the 2017 Health Board Internal Communications Survey but have not corroborated this assertion. • Encouraging staff to download and use the BCUHB Staff App, which has a dedicated section for news from the MHLD Division • Introducing a Strategy & Service Redesign Newsletter, which is included as an agenda item in team and governance meetings. It is also emailed to MHLD Division staff and hard copies are made available • Making more print copies available of the Together for Mental Health in North Wales newsletter, which is sent to all MHLD wards and departments on a quarterly basis Provided was the MHLD Staff Engagement Survey – Pulse Check Report – April 2019 aimed at reviewing staffing trends and identify factors that may have enabling or inhibiting factors. Evidence was provided of the Be Proud Pioneer Teams programme which has been introduced implementing new initiatives for engagement within the MHLD teams. Initiatives range from: 11. Holding Listening events for staff. 12. Creating noticeboards to share BeProud news, share positive staff stories and highlight staff recognition. 13. The 'You've been Mugged' was implemented – this involves someone who has gone the extra mile being awarded a mug filled with goodies at the end of the week. 14. Staff have implemented 'niggle box' to voice issues as well as suggestions. Posters are displayed to show what changes are being implemented and prioritised as a result of the suggestions put forward by staff. The OD team have attended the Mental Health & Learning Disability Division Operational Accountability Meeting on the 18th February 2020 to discuss staff engagement. The first BeProud organisational report was discussed including the results for the division and how divisional scores compared against the organisations scores.

Action to address	Target date completion	Evidence/Progress/Review
5. Ensure the feedback from the 3D events is fed into the Quality Improvement and Governance Plan Evidence must support 'expected outcome' to ensure the feedback from the 3D events is fed into the Quality Improvement and Governance Plan so that staff are empowered to learn and share knowledge	March 2019	Evidence provided demonstrates that the Mental Health & Learning Disabilities Division (MH&LD) has 52 Engagement Ambassadors as well as 8 MH&LD Listening Leads. They have their own site within the Staff Engagement SharePoint site set up in order for them to be able to work and communicate collaboratively prior to and following Listening Lead sessions, assisting with their meeting preparation and feedback channels to staff. In November 2019 it was proposed within a quality and improvement proposal document that the Quality Improvement & Governance Plan be aligned with the Together for Mental Health Strategy. ***Quality and Improvement proposal document*** *Introduction 1.2* *To date, significant progress has been achieved in terms of aligning the T4MH Strategy and our Quality Improvement approach so that we undertake a whole system approach to service and quality improvement.* *Executive summary 2.5* *To test our thinking on a potential approach to QI, a workshop was held in October with staff members from across the Adult Mental Health teams. This workshop was led by an external organisation, Elliot Blanchard, who developed some common themes in looking at how to improve quality of services across the 'all age' mental health strategy.* *Executive summary 2.5* *The recent workshop allowed participants to think about ways of achieving sustainable improvement through the following areas:* • *Leadership & culture* • *Workforce (staff, volunteers, carers, families)* • *Pathways (that are joined up, person centred and evidence based)* • *Environment* • *Innovation and generation of improvement ideas*

Action to address	Target date completion	Evidence/Progress/Review
		Evidence of Wrexham based Psychiatric Intensive Care Unit staff who were named the Nursing Times' Team of the Year for their work to bring laughter and joy to people most seriously affected by mental ill health has also been provided.
Theme – Values		
1. Examine data further to establish areas to investigate in more detail *Evidence must support 'expected outcome' for a better understanding of topics and identified areas to focus on* **Our values** • Put Patients first • Work together • Value and respect each other • Learn and innovate • Communicate openly and honestly	March 2019	Value based interviews are implemented routinely to run alongside management interviews, for all new appointments. The Mental Health Strategy has been co-produced with people who have 'lived' experiences. Members of this group undertake a Value-Based Interview as part of the MHLD recruitment process. Evidence has been provided by way of a link to the value-based recruitment link and a value-based Interview spreadsheet <u>Introduction of I CAN Work pilot programme & I CAN Centres:</u> Other examples of evidence which identifies areas of focus is the I CAN Work pilot programme introduced in 2019. I CAN Work helps people with mild to moderate mental health problems find and remain in employment in order to support their recovery and improve their wellbeing. During 2019 I CAN Mental Health Urgent Care Centres at the three District General Hospitals were established to support people in crisis who attend Emergency Departments, but don't require medical treatment or admission to a mental health ward. <u>End of Life Suites:</u> In early 2019 a new care suite at Wrexham Maelor Hospital was developed to provide a peaceful setting for people with dementia to spend their final days. <u>Reduction in Assaults:</u> Evidence provided of the number of assaults by mental health patients on NHS staff in North Wales has halved in the last five years. Assaults on staff working in our Mental Health & Learning Disability services reduced by 50% between 2013-14 and 2017-18, with a 16% reduction achieved in the last year. <u>Annual Quality Statement (AQS) - 2019 – 2020 submission Pro Forma</u>

Action to address	Target date completion	Evidence/Progress/Review
		The reduction is a direct result of its investment in a team of specialist nurses who work proactively with frontline staff, carers and patients to improve standards of care. MHLD Leaders Collaborative Evidence of a collaborative event held on 16th October 2019 aimed to focus on the value of staff and service user time, examining how time, not money or other resources, connects everything, the TODAY I CAN model was identified as an enabler of change During the day. Evidence was provided of the Be Proud Pioneer Teams programme that has been introduced implementing new initiatives for engagement within the MHLD teams (initiatives are detailed in the communication theme).
4. Ensure staff are aware of 'TODAY I CAN' methodology and the Division's three year plan *Evidence must support 'expected outcome' for a better understanding of values*	April 2019	Developed by NHS mental health professionals, I CAN training provides an overview of common mental health problems as well as best practice guidance on how to listen, give helpful advice, and look after your own mental health and wellbeing. There has been a programme of 'TODAY I CAN' training events and forums rolled out across the MH & LD division, and to enhance staff aware of 'TODAY I CAN' methodology. We were advised that 330 delegates have attended TODAY I CAN Masterclasses an example of an agenda has been provided – we have not been provided with evidence to substantiate the number of delegates attending the classes. We were informed that TODAY I CAN Facilitators worked in collaboration with Workforce & Organisational Development Department and key members of the Wellness, Work and Us Project Group.
Theme – Visibility of Senior Staff / Executive Team		
1. Examine data further to establish areas to investigate in more detail	March 2019	Directors have regular meetings with the MHLD Listening Leads every quarter. The last meeting was on 1st October 2019 and the next meeting is scheduled for 13th February 2020 - we have not been able to evidence this with either agendas or minutes.

Action to address	Target date completion	Evidence/Progress/Review
Evidence must support 'expected outcome' for a better understanding of topics and identified areas to focus on		The Medical Director communicates via a newsletter on behalf of the Strategy & Service Redesign Groups (SSRD) across the Division – We have seen sight of the October and December 2019 newsletters but nothing further has been published at the time of this review. Evidence of a Hascas Ockenden recommendation highlights report 20th August 2019 submitted to the Hascas Ockenden records progress made by the division. This evidence correlates with the themes sampled within the review. A Be Proud Pioneer Teams programme has been developed, these teams have been supported by the senior management team in order to implement new initiatives for engagement within the teams (the initiatives can be seen in the communication theme).
6. Leadership Days with Divisional Directors and Triumvirates. Quarterly Planning days with wider staff *Evidence must support 'expected outcome' for enhanced communications*	October 2019	Evidence provided shows a Wrexham Leaders Collaborative – Wellbeing in Work Workshop was held on the 16th October 2019. Agenda for Quality and Workforce Group events on the 17th April and 6th September 2019 were provided.

Summary of Recommendations

The audit findings, recommendations are detailed in Appendix A together with the management action plan and implementation timetable.

A summary of these recommendations by priority is outlined below.

Priority	H	M	L	Total
Number of recommendations	**2**	**0**	**0**	**2**

Finding - ISS.1 – Workforce Improvement Group (WIG) (Operating effectiveness)	Risk
We were unable to confirm that the Terms of Reference for the Workforce Improvement Group (WIG) had been approved at the Financial Recovery Group (FRG) per the correspondence we have been provided. In addition we can find no reference in the Terms of Reference that relate to the scrutiny and review of divisional staff survey action plans per Minute SP19.52 of the Strategy, Partnership and Population Health Committee [4th July 2019]. We could find only one meeting [29th November 2019] where divisional updates were reported to the WIG.	Governance and accountability arrangements have not been formalised.
Recommendation	**Priority level**
The WIG Terms of Reference are reviewed, updated accordingly and submitted for approval to the group/meeting to which it reports assurance. The WIG meeting receives regular progress updates from all divisions on their staff survey action plans.	**High**
Management Response	**Responsible Officer/ Deadline**
WIG is being superseded by a structure of Strategic, Tactical and Operation workforce groups. The terms of Reference of the Integrated Operational Workforce Group (IOWG) has specific responsibility for Staff Engagement / Staff Survey Improvement as detailed below in the relevant sections extracted from the ToR: 2. Purpose	Associate Director of Workforce Performance & Improvement – 30/08/2020 (complete)

2.1 The Integrated Operational Workforce Group meetings will take place on a monthly basis within each area (East / Centre / West) the purpose of the meeting is to: • scrutinise and review divisional staff survey action plans, • drive improvements in workforce KPIs, specifically but not exclusively; and • Staff engagement scores as measured by local surveys and by National Staff Survey. 3.1 The Integrated Operational Workforce Group meetings principal duties are: • To oversee locality workforce KPIs, developing and enacting plans to ensure all are 'green' rated; and • To oversee effective local staff engagement plans resulting in highly engaged workforce as evidenced by improved staff engagement scores in local and national surveys. 11. Inputs Agenda – Standing Items: • Action Log (actions from previous meeting) • Updates from Sub-Groups • OD • Occupational Health & Safety • Workforce KPIs • Staff engagement scores as measured by local surveys and by National Staff Survey	

• Vacancy rates • Recruitment timescales • Sickness Absence rates • Mandatory Training compliance rates • PADR compliance rates • Levels of non-core usage (Agency / Bank / Locum / Overtime) • Any other Business • Date of Next Meeting IOWG agenda now includes regular staff survey action plans progress updates as a standing agenda item.	

Finding - ISS.2 –Divisional Action Plans scrutiny (Operating effectiveness)	**Risk**
With the exception of the Estates and Facilities Division, we were unable to identify Ysbyty Gwynedd or Mental Health and Learning Disabilities having a standing agenda item for their respective staff survey action plans.	Lack of local scrutiny and responding to staff survey findings.
Recommendation	**Priority level**

All Divisional Directors provide assurance to the WIG that respective staff survey action plans are standard agenda items within their senior management team meetings.	**High**
Management Response	**Responsible Officer/ Deadline**
Senior Divisional management are required attendees at the newly formed Integrated Operational Workforce Group (IOWG) chaired by the Head of HR / Divisional Director for each area. The terms of Reference of the Integrated Operational Workforce Group (IOWG) has specific responsibility for Staff Engagement / Staff Survey Improvement. IOWG agenda now includes regular staff survey action plans progress updates as a standing agenda item.	HoHR for each division – 30/10/2020
OD team leads have ensured there are local leads in West, Central, Estates & Facilities and Mental Health, with further work planned to develop the same process with a lead in the East. OD will ensure that Staff Survey Divisional leads are supported to enable regular reporting against their improvement plans through their local IOWG.	Head of OD – 31/07/2020 ongoing
HoHR will also support local divisional managers to ensure progress against improvement plans.	Head of OD – 31/07/2020 ongoing

Appendix B - Assurance opinion and action plan risk rating

Audit Assurance Ratings

 **Substantial assurance** - The Board can take **substantial assurance** that arrangements to secure governance, risk management and internal control, within those areas under review, are suitably designed and applied effectively. Few matters require attention and are compliance or advisory in nature with **low impact on residual risk** exposure.

 **Reasonable assurance** - The Board can take **reasonable assurance** that arrangements to secure governance, risk management and internal control, within those areas under review, are suitably designed and applied effectively. Some matters require management attention in control design or compliance with low to **moderate impact on residual risk** exposure until resolved.

 **Limited assurance -** The Board can take **limited assurance** that arrangements to secure governance, risk management and internal control, within those areas under review, are suitably designed and applied effectively. More significant matters require management attention with **moderate impact on residual risk** exposure until resolved.

 **No assurance** - The Board can take **no assurance** that arrangements in place to secure governance, risk management and internal control, within those areas under review, are suitably designed and applied effectively. Action is required to address the whole control framework in this area with **high impact on residual risk** exposure until resolved.

 **Assurance not applicable** is given to reviews and support provided to management which form part of the internal audit plan, to which the assurance definitions are **not appropriate** but which are relevant to the evidence base upon which the overall opinion is formed.

Prioritisation of Recommendations

In order to assist management in using our reports, we categorise our recommendations according to their level of priority as follows.

Priority Level	Explanation	Management action
High	Poor key control design OR widespread non-compliance with key controls. PLUS Significant risk to achievement of a system objective OR evidence present of material loss, error or misstatement.	Immediate*
Medium	Minor weakness in control design OR limited non-compliance with established controls. PLUS Some risk to achievement of a system objective.	Within One Month*
Low	Potential to enhance system design to improve efficiency or effectiveness of controls. These are generally issues of good practice for management consideration.	Within Three Months*

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

Betsi Cadwaladr University Health Board

Recruitment – Medical and Dental staff

Final Internal Audit Report

BCU 2019/20

September 2020

NHS Wales Shared Services Partnership

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Executive sign off:	Director of Workforce & OD
Distribution:	Workforce Information Systems Manager Head of Resourcing Associate Director Workforce Performance & Improvement Board Secretary Statutory Compliance, Governance and Policy Manager
Committee:	Audit Committee

Audit and Assurance Services conform with all Public Sector Internal Audit Standards as validated through the external quality assessment undertaken by the Institute of Internal Auditors.

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

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Audit reports are prepared by the staff of the NHS Wales Shared Services Partnership – 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.

1. Introduction and Background

The Health Board has implemented establishment control (EC) to ensure the recruitment to vacancies, changes in contracted hours/skill mix is undertaken in line with the funded establishment.

An effective establishment control process allows the Health Board to derive a number of benefits. These include: Having the right employees in the right positions at the right time; Finance reports to managers around costs will match workforce reports around sickness; Improved financial control around establishments, both staff in post & vacancies; Up to date vacancy reports become possible; Reduced workload in terms of correcting errors; Reduced risk of over and underpayments to staff; Answer any adhoc requests confidently and accurately (e.g. Freedom of Information requests).

On the 1st August 2019, the Health Board launched a fully electronic EC form, thus automating the approval process, prior to authorising the recruiting manager to formally advertise the post via the all-Wales TRAC system.

The TRAC system links NHS Jobs, the Electronic Staff Record and the Disclosure & Barring Service and can have a significant impact on reducing the time to hire, with all of the processing of the initial vacancy, through to the short-listing, recruitment and appointment phases being managed via the Trac system.

Following the introduction of EC within the Health Board, the additional control may adversely impact on the timely advertisement of vacancies in key areas such as medical and dental, where service continuity, through locum/agency cover, is needed to deliver safe, quality care.

2. Scope and Objectives

The scope of this review was limited solely to the recruitment of medical and dental staff where vacancies were advertised through TRAC, having prior EC approval.

The objective of the review was to identify the timescale between establishment control submission, approval and TRAC request to advertise and shortlist for the vacancy and if there are any delays in the process.

3. Associated Risks

The risks identified at the outset of this review were:

- Managers are not placing vacancies on Trac immediately following the EC approval process which are therefore not advertised in a timely manner.
- The overall EC approval process is delaying operational management advertising and filling vacancies.
- The Health Board incurs additional locum/agency costs.

OPINION AND KEY FINDINGS

4. Overall Assurance Opinion

We are required to provide an opinion as to the adequacy and effectiveness of the system of internal control under review. The opinion is based on the work

performed as set out in the scope and objectives within this report. An overall assurance rating is provided describing the effectiveness of the system of internal control in place to manage the identified risks associated with the objectives covered in this review.

The level of assurance given as to the effectiveness of the system of internal control in place to manage the risks associated with the Recruitment – Medical and Dental staff review is limited assurance.

RATING	INDICATOR	DEFINITION
Limited Assurance		The Board can take **limited assurance** that arrangements to secure governance, risk management and internal control, within those areas under review, are suitably designed and applied effectively. More significant matters require management attention with **moderate impact on residual risk** exposure until resolved.

The overall level of assurance that can be assigned to a review is dependent on the severity of the findings as applied against the specific review objectives and should therefore be considered in that context.

5. Assurance Summary

The summary of assurance given against the individual objectives is described in the table below:

Assurance Summary					
1	Data Quality (Establishment Control and TRAC)		✓		
2	Recruitment timeline		✓		

** The above ratings are not necessarily given equal weighting when generating the audit opinion.*

Design of Systems/Controls

The findings from the review have highlighted no issues that are classified as weakness in the system control/design for Recruitment – Medical and Dental staff.

Operation of System/Controls

The findings from the review have highlighted two issues that are classified as weakness in the operation of the designed system/control for Recruitment – Medical and Dental staff.

6. Summary of Audit Findings

The key findings are reported in the Management Action Plan.

This report is based upon the information provided to us at the start and during the review. We have relied solely on the documents, information and explanations provided, except where otherwise stated. We have not sought to or undertaken work to verify the accuracy of the information provided.

We are grateful to officers within Workforce & Organisational Development for their help and support with this review. In discussing our data requirements, it became apparent that the only unique identifier linking both data sets (EC and TRAC) was the EC reference (ECR). Our review period was the 1st August 2019 to 1st February 2020. The review has identified issues of data completeness which has impacted upon this review.

The Director of Workforce & OD has established a Medical Recruitment Panel and we were provided with a synopsis of its remit. Whilst we have not corroborated its operation in delivering its remit, we were advised of the following:

- Established to oversee all recruitment to medical posts with the aim of removing blocks from the current systems.
- Panel determines the most expedient route to recruit to each post, aiming to improve clinical and financial performance through reducing agency locum usage.
- Panel tracks progress in recruitment timescales ensuring that all posts progress in a timely manner and in accordance with agreed Key Performance Indicators (KPIs).
- Panel receives a tracker spreadsheet weekly summarising all known medical recruitment activity and highlighting any long waits.
- Senior Medical and Dental leaders present at the Panel to contact lead clinicians for posts that were currently "blocked" as awaiting clinician feedback.
- Panel ensures quality of adverts and job descriptions (e.g. making sure grade descriptions for doctors would mirror ESR definitions).
- Panel meetings held on a weekly basis, co-ordinated by Workforce.

Establishment Control (EC) data

Our review is based upon source data provided by the Workforce Systems Development Officer and focused solely on medical and dental staff.

The data extract totalled six hundred and one (601) records; refining this data to 'Recruitment only' requests amended the sample size to two hundred and thirty nine (239) records.

To identify the length of time taken between each step in the overall EC approval process, the following key date fields were provided within the data set:

- Finance Approval.
- Workforce Establishment Control Approval.
- Head of Service Approval.
- Divisional Management Team Approval.

- Divisional Review Team Approval.
- Executive Approval.
- Date the manager acknowledged they completed the 'action' i.e.: TRAC.
- Date the EC team acknowledged they completed the action i.e.: approved TRAC.

We have noted issues of data quality and completeness where some dates have not been recorded that has impacted on the analysis.

Using our data interrogation software, we note that the overall EC process takes on average 35.94 days.

It should however be noted that prior to the EC tracking system, the Health Board operated vacancy control (VC), where similar controls are likely to have been in place, but manual in nature and lacking details of the stage each submission was at.

There is no pre-EC evidence available that shows how long the process took prior to the EC system becoming live and therefore the EC average days should be seen in this context.

We reviewed the various approval stages to identify the duration from one control point to another. Table 1 below provides the shortest and longest time, by control point identified in our review.

Table 1: EC approval control stage

Approval control stage	Shortest duration to approve (days)	Longest duration to approve (days)
Requestor submission date to Finance approval date	1 day	98 days
Finance approval date to EC approval date	Same day	27 days
EC approval date to Head of Service approval date	Same day	46 days
Head of Service approval date to Divisional Management Team approval date	Same day	73 days
Divisional Management Team approval date to Divisional Review Team approval date	Same day	50 days
Divisional Review Team approval date to	Same day	20 days

Approval control stage	Shortest duration to approve (days)	Longest duration to approve (days)
Executive approval date		
Executive approval date to date manager acknowledged and actioned via TRAC	Same day	123 days
Time taken between original request date through to Executive approval date	1 day	106 days

Source: Data summary of EC data provided by Workforce & OD Department 11th February 2020.

The review of data has noted significant delays across the various control stages with both Finance and Divisional Management Team approval control stages noting greatest individual delay in the process.

The EC data records the current status of each application; we reviewed the data and noted the following (Table 2):

Table 2: EC stage

EC stage	Number of records	Percentage
Approval	47	20%
Cancelled	18	8%
Completed	84	35%
Declined	6	3%
Divisional Management	5	2%
Divisional Review	10	4%
Executive Review	3	1%
Finance	7	3%
Head of Service	5	2%
Requester	15	6%
Verification	39	16%

Source: Data summary of EC data provided by Workforce & OD Department 11th February 2020.

TRAC data

Our review is based upon source data provided by the Deputy Strategic Recruitment Manager and focused solely on medical and dental staff. We note that there are inherent steps within the recruitment of medical and dental staff,

e.g. Royal College input, which will add additional time for the recruitment process.

We were provided with two data sets; Candidate data set with one hundred and forty one (141) records and Vacancy data set with one hundred and seventy four (174) records.

In order to combine the two data sets into a recruitment pathway, we merged both data sets by 'Job reference' resulting in an amended sample size of ninety seven (97) records.

To identify the length of time taken between each step in the recruitment process, the following key fields were provided within the data set:

- Advertising start date.
- Closing date.
- Shortlisting date.
- Conditional offer date.
- Authorised start date.

We have noted issues of data completeness/data quality where some dates have not been recorded e.g. conditional offer date recorded but no shortlisting date recorded – this has impacted on full sample data analysis.

Using our data interrogation software, we identified TRAC recorded that the timescale between the conditional offer and authorised start date (all pre-employment checks have been completed) was an average of 45.92 days.

We reviewed the various recruitment stages to identify the duration from one point to another. Table 3 below provides the duration taken between the key stages in the process.

Table 3: TRAC recruitment stages

Recruitment stage	Shortest duration (days)	Longest duration (days)
Advertising start date to closing date	Same day	61 days
Closing date to shortlisting date	1 day	97 days
Shortlisting date to conditional offer date	3 days	145 days
Conditional offer date to authorised start date	4 days	106 days

Source: Data summary of TRAC data provided by Workforce & OD Department 13th February 2020.

The review has identified shortlisting and pre-employment checking periods taking the longest time to progress but recognise the additional engagements needed in the recruitment of all medical and dental staff.

EC and TRAC data

Using the EC reference (ECR) as the unique identifier, we merged both EC and TRAC datasets to identify the recruitment pathway from submission of EC request through to Authorised to Start Date (pre-employment check completion).

We identified a total sample of forty three (43) records which matched by ECR. However data quality was again problematic as the TRAC 'ECR Numbers' field often recorded 'Yes' as opposed to the actual number.

In reviewing the dates, thirty (30) records did not, at the time of our review, have authorised to start dates leaving a total sample for review of thirteen (13) records. Table 4 provides details of the thirteen records, by ECR number, both dates and duration of the pathway.

Table 4 –EC submission to pre-employment check complete

ECR number	EC submission date	Authorised to start date	Duration (days)
ECR2928	04/09/2019	07/02/2020	-156
ECR2505	20/08/2019	10/01/2020	-143
ECR2431	19/08/2019	06/01/2020	-140
ECR3265	12/09/2019	27/01/2020	-137
ECR3275	12/09/2019	10/01/2020	-120
ECR3275	16/09/2019	10/01/2020	-116
ECR2314	15/08/2019	03/12/2019	-110
ECR2036	08/08/2019	21/11/2019	-105
ECR2895	03/09/2019	03/12/2019	-91
ECR3624	25/09/2019	16/12/2019	-82
ECR3656	26/09/2019	02/12/2019	-67
ECR7955	12/12/2019	05/02/2020	-55
EC5547	25/10/2019	29/11/2019	-35

Source: Data merge of EC and TRAC data using ECR number as the unique identifier

The review of the data, albeit from a limited sample due to data quality, notes it takes an average of 104.38 days from EC request to completion of pre-employment checks.

7. Conclusion

Data quality and completion of set fields is poor; this needs addressing for the Health Board to have meaningful data.

The review has identified that the length of time taken from submission of an EC request to completion of pre-employment checks takes an average of 104 days; this does not take into account the period of notice a successful candidate will then need to give their existing employer. The ability of services/divisions to provide services is undermined by the lengthy recruitment process. This in turn could be detrimental in efforts to reduce locum/agency costs.

The overall EC approval process is essential to ensure the Health Board and its

services/divisions comply with the Standing Financial Instruction *13.3 Staff Appointments:*

> *13.3 Staff Appointments*
>
> *13.3.1 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.*

The process has six noted control steps which impact the recruitment process, on average, by over one month. In addition, three control steps are service/division specific – we consider this inefficient and adds unnecessary delay within the process.

The review of EC request stages has noted only 3% were declined – management may wish to review whether the system is over-controlled and could be streamlined whilst maintaining control.

The review of TRAC data notes the period between advert closing and shortlisting dates can add significant delay; it is unclear why closing date and shortlisting stage takes this amount of time as recruiting managers will know in advance the closing date and have adequate time to arrange to shortlist.

8. Summary of Recommendations

The audit findings, recommendations are detailed in Appendix A together with the management action plan and implementation timetable.

A summary of these recommendations by priority is outlined below.

Priority	H	M	L	Total
Number of recommendations	**2**	**0**	**0**	**2**

Finding - ISS.1 – Data quality EC & TRAC (Operating effectiveness)	Risk
Individuals are required to complete set fields to record the date certain steps were taken across both EC and TRAC. Further, both systems have one unique data field that connects both data sets. Our review identified: Date entry missing across both EC and TRAC systems; TRAC EC number not recorded, with 'Yes' noted in a large number of records; Some TRAC job reference details are not following the standard naming convention e.g. 'Urology Consultant- YG'.	Data quality and data use is compromised due to poor end-user completion.
Recommendation	**Priority level**
For both EC and TRAC, Workforce & OD stipulate: • the format for recording alphanumeric fields; • default the date recording, per date field, to the system date/time, thus removing issues of data quality and blank fields.	High
Management Response	**Responsible Officer/ Deadline**
Changes have been made to the EC Portal to ensure that a reference can be made between the two systems. Linking the two is now built into the process and a question amended on Trac for greater clarity (EC question on Trac to state please only add the alphanumeric EC reference). Additional guidance produced and available on the intranet also available direct in Trac. This additional Guidance is to help users understand how to complete Trac and EC Portal.	Workforce Information Systems Manager/ Head Of Resourcing (Complete)

Finding - ISS.2 – EC process review (Operating effectiveness)	Risk
The review of the EC process has identified six control steps designed to ensure due diligence over the recruitment of staff, in accordance with Standing Financial Instruction 13.3 - Staff Appointments. We noted that the EC process, based on data provided, takes on average 35.94 days. Three of the control steps are service/division specific which may include officers who have already approved/declined a request – This leads to duplication and unnecessary delay in the approval process.	Over-control within the EC process leads to delays in the recruitment of staff.
Recommendation	**Priority level**
The process for reviewing EC requests through the service/division are revisited. There may be an opportunity to remove steps so streamlining the EC approval process whilst maintaining robust internal control.	High
Management Response	**Responsible Officer/ Deadline**
An action plan has been developed to respond to all recommendations within this. A concurrent process of inputting Trac Vacancies at the point of the EC being raised is being deployed to reduce the overall burden for recruiting managers, from Resignation (including the overall EC Process) to Appointment. A full review of the end to end process has taken place thus removing unnecessary EC steps as appropriate. Inclusion of data within the Monthly Dashboard to highlight any specific delays.	Workforce Information Systems Manager/ Head Of Resourcing Action Plan with a series of deadlines is in place to address all recommendations. Medical Dental data is now included

Monitor and review KPIs in line with agreed EC Process. Dashboard currently shows that for M&D staff across BCU the time to hire (notice date to authorisation start date) has fallen consistently from 130 days in April to 90 days in June. (July is showing as less than 50 days but this may be an anomaly as there were relatively few starters that month).	on the WOD Monthly dashboard which highlights timeframes. Trac training cancelled due to COVID19. Refreshed dates will be arranged in collaboration with NWSSP

Appendix B - Assurance opinion and action plan risk rating

Audit Assurance Ratings

 **Substantial assurance** - The Board can take **substantial assurance** that arrangements to secure governance, risk management and internal control, within those areas under review, are suitably designed and applied effectively. Few matters require attention and are compliance or advisory in nature with **low impact on residual risk** exposure.

 **Reasonable assurance** - The Board can take **reasonable assurance** that arrangements to secure governance, risk management and internal control, within those areas under review, are suitably designed and applied effectively. Some matters require management attention in control design or compliance with low to **moderate impact on residual risk** exposure until resolved.

 **Limited assurance -** The Board can take **limited assurance** that arrangements to secure governance, risk management and internal control, within those areas under review, are suitably designed and applied effectively. More significant matters require management attention with **moderate impact on residual risk** exposure until resolved.

 **No assurance** - The Board can take **no assurance** that arrangements in place to secure governance, risk management and internal control, within those areas under review, are suitably designed and applied effectively. Action is required to address the whole control framework in this area with **high impact on residual risk** exposure until resolved.

 **Assurance not applicable** is given to reviews and support provided to management which form part of the internal audit plan, to which the assurance definitions are **not appropriate** but which are relevant to the evidence base upon which the overall opinion is formed.

Prioritisation of Recommendations

In order to assist management in using our reports, we categorise our recommendations according to their level of priority as follows.

Priority Level	Explanation	Management action
High	Poor key control design OR widespread non-compliance with key controls. PLUS Significant risk to achievement of a system objective OR evidence present of material loss, error or misstatement.	Immediate*
Medium	Minor weakness in control design OR limited non-compliance with established controls. PLUS Some risk to achievement of a system objective.	Within One Month*
Low	Potential to enhance system design to improve efficiency or effectiveness of controls. These are 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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Betsi Cadwaladr University Health Board

Quality Impact Assessment

Final Internal Audit Report

BCU 2019/20

November 2020

NHS Wales Shared Services Partnership

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Executive sign off:	Director of Finance
Distribution:	Head of Value and Savings Programme Acting Chief Executive Acting Board Secretary Statutory Compliance, Governance and Policy Manager
Committee:	Audit Committee

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1. Introduction and Background

The Ockenden report "*Review of the Governance Arrangements relating to the care of patients on Tawel Fan ward prior to its closure on 20th December 2013 and governance arrangements in Older People's Mental Health at Betsi Cadwaladr University Health Board (BCUHB) from December 2013 to the current time published in June 2018"* outlined fourteen findings with associated recommendations. One of which related to the Governance Arrangements of Quality Impact Assessments where it was highlighted that there was no evidence seen of strategic Board oversight.

Recommendation 2a) *the financial position of BCUHB is well known to be of significant concern. The Ockenden review was informed that 'Quality Impact Assessments' (where the clinical implication of financial savings plans are assessed by Executive members of the BCUHB Board) were 'still in the process of refinement' (as of spring 2017.) This therefore is likely to remain an issue that will require evidence of focussed Board attention going forward.*

2. Scope and Objectives

The objective of the review is to provide the Health Board with assurances that recommendation 2a of the Ockenden Report (June 2018) *'Review of the Governance Arrangements...'* whereby it seeks evidence that 'Quality Impact Assessments' are reviewed and the clinical implication of financial savings plans are assessed.

The scope of the review was limited to the governance arrangements in relation to Quality Impact Assessments (QIA) with a focus on:

- membership of Groups/Committees;
- attendance of Group/Committees; and
- evidence of escalation via Minutes.

3. Associated Risks

Risk associated with this review is that 'Quality Impact Assessments' are not monitored, reviewed or assessed with a disregard to the financial savings plans.

OPINION AND KEY FINDINGS

4. Overall Assurance Opinion

We are required to provide an opinion as to the adequacy and effectiveness of the system of internal control under review. The opinion is based on the work performed as set out in the scope and objectives within this report. An overall assurance rating is provided describing the effectiveness of the system of internal control in place to manage the identified risks associated with the objectives covered in this review.

The level of assurance given as to the effectiveness of the system of internal control in place to manage the risks associated with the Quality Impact Assessment review is limited assurance.

RATING	INDICATOR	DEFINITION
Limited Assurance		The Board can take **limited assurance** that arrangements to secure governance, risk management and internal control, within those areas under review, are suitably designed and applied effectively. More significant matters require management attention with **moderate impact on residual risk** exposure until resolved.

The overall level of assurance that can be assigned to a review is dependent on the severity of the findings as applied against the specific review objectives and should therefore be considered in that context.

5. Assurance Summary

The summary of assurance given against the individual objective is described in the table below (please refer to Appendix B for the assurance rating):

Assurance Summary					
1	Quality Impact Assessment		✓		

** The above ratings are not necessarily given equal weighting when generating the audit opinion.*

Design of Systems/Controls

The findings from the review have highlighted one issue that is classified as weakness in the system control/design for Quality Impact Assessment relating to the project initiation document standard operating procedure.

Operation of System/Controls

The findings from the review have highlighted two issues that are classified as weakness in the operation of the designed system/control for Quality Impact Assessment relating to the completion of Quality Impact Assessments and Improvement Groups ownership for projects.

6. Summary of Audit Findings

The key findings are reported in the Management Action Plan.

This report is based upon the information provided to us at the start and during the review. We have relied solely on the documents, information and explanations provided, except where otherwise stated. We have not sought to or undertaken work to verify the accuracy of the information provided.

The review identified that there is a clear governance structure in place, with Improvement Groups (twelve in total) chaired by an Executive Director.

We did encounter difficulties obtaining minutes and terms of reference from all the Improvement Groups. We were unable to match project information held by the Programme Management Office's (PMO) to individual Improvement

Groups. There was no apparent association between the Improvement Groups and Programme Management Office documentation.

The Improvement Groups provide updates to the Finance Recovery Group (FRG) as evidenced in minutes viewed. However we noted in reviewing minutes at the time of our review that these updates were not reports but verbal updates.

The FRG provides assurance to the Finance and Performance Committee (F&P). We evidenced the FRG Terms of Reference were approved by F&P on the 29th July 2019.

As no detailed reports were evident, we broadened the scope to ensure all live projects had undergone the appropriate approval process prior to initiating the project.

All Quality Impact Assessments (QIA) and Equality Impact Assessments (EQIA) are completed electronically and are integral within the Project Initiation Document (PID).

The Health Board Project Management Office (PMO) maintain two spreadsheets to manage the approval and progress of individual projects, these are:

- The Master Tracker; and
- BCU Director Approval Tracker.

Using the provided data, we reviewed 100% of the sample from the master tracker and cross referenced to the approval tracker to establish the approval stage of each project.

There are three levels of approval:

- Stage one: Project development stage where Divisional / Improvement Group formal approval is sought;
- Stage two: Executive Medical Director and Executive Director of Nursing approval of the QIA (the Director of Workforce and OD will review the EQIA); and
- Stage three: Chief Executive and Director of Finance approval, who have the Executive right to veto a project.

We verified projects that were live [in progress] had corresponding approval. We identified that the Health Board's PID process [September 2019] document contained incorrect job titles and did not definitively state whether stage two and three required both clinical Executives or just one to approve each stage.

We reviewed a total of four hundred and thirteen recorded projects as listed in the Master Tracker. Of those listed two hundred and eighteen copies of QIA/ EQIA/PID's were received. The review identified the following:

- Eighty five projects were stage two approved by the Executive Nursing Director and Executive Medical Director;
- Fifty were stage two approved by one Executive Director;
- Forty five were either awaiting stage two approval or impact assessment was showing as incomplete on the tracker;

- Twenty nine were not on the approval tracker;
- Five had been rejected by the Executive Nursing Director but approved by the Executive Medical Director (all these projects had a start date);
- One had been rejected by both the Executive Directors, there was no evidence of start date on this project;
- Three had no evidence of approval; and
- None appeared to have been approved by the Chief Executive and Director of Finance.

Of the one hundred and thirty three projects that were not fully authorised by both Clinical Executives - one hundred and thirty had been started.

Further information on the projects where we had PID's/EQIA's/QIA's noted the following:

- Two hundred and fifteen of the two hundred and eighteen had a project start of Jan 2020 or earlier;
- Three had no evidence of approval - of these two projects had started.

We also reviewed the approval stages of the one hundred and ninety five projects on the tracker where we did not receive a copy of EQIA/QIA/PID (None received for NWP coded projects), the review identified:

- Eighteen were stage two approved by both Executive Directors;
- Sixteen were stage two approved by one of the Executive Directors;
- Twenty four were either awaiting stage two approval or impact assessment showing as incomplete on the tracker;
- One hundred and thirty six were not on the approval tracker at all;
- One had been rejected by the Executive Nursing Director and awaiting response from the Executive Medical Director (the project had a recorded start date of Jan 2019).

Further information on the projects where we had no evidence of the PID's/EQIA's/QIA's are that:

- One hundred and twenty eight had a project starting January 2020 or earlier; and
- Sixty seven had no start date.

According to the approval step procedure, the e-Voting Stage three Executive veto, the Chief Executive and Director of Finance have the right to veto schemes if there is:

- *significant concern over the quality of care to patients; or*
- *if there will be an adverse impact on the effective running of the Health Board.*

This should be done via the e-voting process and within seven days from the request for approval.

It is unclear in the e-Voting process we were provided with as to whether a no response from the Chief Executive following the seven days is taken as approval, however we have been advised by the Interim Head of PMO that a 'positive' response is required.

7. Summary of Recommendations

The audit findings, recommendations are detailed in Appendix A together with the management action plan and implementation timetable.

A summary of these recommendations by priority is outlined below.

Priority	H	M	L	Total
Number of recommendations	**2**	**1**	**0**	**3**

Finding - ISS.1 - Improvement Groups and the Programme Management Office (Operating effectiveness)	Risk
We were unable to match project information held by the Programme Management Office's (PMO) to individual Improvement Groups for oversight of delivery. The Improvement Groups provide updates to the Finance Recovery Group (FRG) [per Minutes] however we were unable to identify any detailed assurance reports presented and note some were verbal updates.	Improvement Groups are not holding management to account or being held to account themselves in scrutinising and owning projects.
Recommendation	**Priority level**
All PMO projects are assigned to Improvement Groups for accountability, with subsequent reporting of progress to the Finance Recovery Group (FRG).	High
Management Response	**Responsible Officer/ Deadline**
A revised approach is required to quality improvement and savings as part of the Health Board's transformation strategy – • Draft proposals to be developed for review with incoming CEO • Revised approach to be agreed Detailed supporting procedures in place to ensure that all schemes are appropriately mapped for accountability within the new structure. Regular reporting of delivery will be presented to the Finance and Performance Committee.	Director of Finance (31/12/2020) CEO (31/01/2021) Head of PMO (14/02/2021)

Finding - ISS.2 – PID approval Standard Operating Procedure (Control design)	Risk
The PID approval process includes a step at stage three: *Chief Executive and Director of Finance approval, who have the Executive right to veto a project*: • *where there is significant concern over the quality of care to patients; or* • *if there will be an adverse impact on the effective running of the Health Board.* Noting we could find no evidence that the Chief Executive and Director of Finance had completed this section within our sample, it is unclear whether a lack of formal response from both is taken as approval, whilst noting on the flow chart they are required to approve once the two clinical Executive Directors have approved. We also noted that post titles may need review as they are not reflective of the Health Board structure e.g. Chief Nurse.	Formal approval of PID at Stage 3 is unclear.
Recommendation	**Priority level**
The Health Board review the current PID process with clarity over Stage 3 approval/veto. The review considers the role Improvement Groups in oversight, accountability and scrutinising delivery of projects.	Medium
Management Response	**Responsible Officer/ Deadline**
A full review of the PID process will be undertaken in light of the revised structure. Arrangements for accountability and scrutiny of projects will be clearly set out in the revised arrangements. The role of the stage 3 review will be explicitly addressed.	Head of PMO (31/01/2021)

Finding - ISS.3 – Quality Impact Assessments (Operating effectiveness)	Risk
The review of PIDs, where both clinical Executive Directors (Medical and Nursing & Midwifery) must approve the QIA in our sample of two hundred and eighteen that only eighty five had been signed by both. Of the one hundred and thirty three projects that were not fully authorised by both clinical Executives - one hundred and thirty had been started as there was a clear start date recorded on the PMO Tracker.	Projects are not subject to Quality Impact Assessment scrutiny before starting which may adversely affect the quality of care given to service users.
Recommendation	**Priority level**
All Quality Impact Assessments within each PID must be approved by both Executive Medical Director and Executive Director of Nursing & Midwifery prior to implementing.	High
Management Response	**Responsible Officer/ Deadline**
The requirement to conclude QIA review prior to implementation of schemes will be built into the revised PID process as described above	Head of PMO (31/01/2021)

Appendix B - Assurance opinion and action plan risk rating

Audit Assurance Ratings

 **Substantial assurance** - The Board can take **substantial assurance** that arrangements to secure governance, risk management and internal control, within those areas under review, are suitably designed and applied effectively. Few matters require attention and are compliance or advisory in nature with **low impact on residual risk** exposure.

 **Reasonable assurance** - The Board can take **reasonable assurance** that arrangements to secure governance, risk management and internal control, within those areas under review, are suitably designed and applied effectively. Some matters require management attention in control design or compliance with low to **moderate impact on residual risk** exposure until resolved.

 **Limited assurance -** The Board can take **limited assurance** that arrangements to secure governance, risk management and internal control, within those areas under review, are suitably designed and applied effectively. More significant matters require management attention with **moderate impact on residual risk** exposure until resolved.

 **No assurance** - The Board can take **no assurance** that arrangements in place to secure governance, risk management and internal control, within those areas under review, are suitably designed and applied effectively. Action is required to address the whole control framework in this area with **high impact on residual risk** exposure until resolved.

 **Assurance not applicable** is given to reviews and support provided to management which form part of the internal audit plan, to which the assurance definitions are **not appropriate** but which are relevant to the evidence base upon which the overall opinion is formed.

Prioritisation of Recommendations

In order to assist management in using our reports, we categorise our recommendations according to their level of priority as follows.

Priority Level	Explanation	Management action
High	Poor key control design OR widespread non-compliance with key controls. PLUS Significant risk to achievement of a system objective OR evidence present of material loss, error or misstatement.	Immediate*
Medium	Minor weakness in control design OR limited non-compliance with established controls. PLUS Some risk to achievement of a system objective.	Within One Month*
Low	Potential to enhance system design to improve efficiency or effectiveness of controls. These are generally issues of good practice for management consideration.	Within Three Months*

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

Cyfarfod a dyddiad: Meeting and date:	**17 December 2020**
Cyhoeddus neu Breifat: Public or Private:	All Audit Wales papers will be in the public agenda of the committee
Teitl yr Adroddiad Report Title:	• Audit Wales programme update • Structured Assessment report • Annual Audit Report • Review of Continuing Healthcare management arrangements • Welsh Community Care Information System
Cyfarwyddwr Cyfrifol: Responsible Director:	Dawn Sharp, on behalf of the executive team
Awdur yr Adroddiad Report Author:	Andrew Doughton and Amanda Hughes
Craffu blaenorol: Prior Scrutiny:	All final Wales Audit Office reports on Betsi Cadwaladr University Health have passed through a clearance process with the lead Executive Director.
Atodiadau Appendices:	

Argymhelliad / Recommendation:

The Audit Committee is requested to:

- Receive the programme update
- Receive and discuss the audit reports.

The Audit Committee may wish to cross-refer the report on the Welsh Community Care Information System to the Digital and Information Governance Committee.

Please tick one as appropriate (note the Chair of the meeting will review and may determine the document should be viewed under a different category)

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

Sefyllfa / Situation:

The documents for audit committee include an update on the delivery of the external audit programme at the Health Board, references to new national publications and novel practice work which is led and coordinated as part of the approach to collecting and sharing good practice.

Covid 19 has impacted the delivery of the performance audit programme and is under a process of regular review, with the latest position set out in the update.

Cefndir / Background:

Asesiad / Assessment & Analysis

Strategy Implications

Financial Implications
The Structured Assessment provides a high-level commentary on financial arrangements at the time of that review.

Risk Analysis
Any risks identified as part of a specific review should be used to inform the Health Board's risk management arrangements.

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Impact Assessment

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Audit Wales

Audit Committee Update – Betsi Cadwaladr University Health Board

Date issued: December 2020

Document reference: 2021A2020-21

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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Contents

Audit Committee Update

About this document

1 This document provides the Audit Committee with an update on current and planned Audit Wales work. Accounts and performance audit work are considered, and information is also provided on the Auditor General's wider programme of national value-for-money examinations and the work of our Good Practice Exchange (GPX).

Accounts audit update

2 **Exhibit 1** summarises the status of our key accounts audit work to be reported during 2020-21.

Exhibit 1 – Accounts audit work

Area of work	Current status
Audit of the 2019-20 Accountability Report and Financial Statements	Completed. Certified by the Auditor General on 2 July 2020 and laid by the Senedd on 3 July 2020.
Audit of the 2019-20 Funds Held on Trust Accounts	The audit work is complete and it is expected that the accounts will be approved at the Charity Committee on 8 December 2020 and the audit opinion will be certified by the Auditor General on the 9 December 2020.
Audit of the 2020-21 Accountability Report and Financial Statements	Audit planning is scheduled to start in December.

Performance audit update

3 The following tables set out the performance audit work included in our current and previous Audit Plans, summarising:

- completed work since the last Audit Committee update (**Exhibit 2**);
- work that is currently underway (**Exhibit 3**); and
- planned work not yet started or revised (**Exhibit 4**).

Exhibit 2 – Work completed

Area of work	Considered by Audit Committee
Review of interim director appointment arrangements	March 2020
The Refurbishment of Ysbyty Glan Clwyd	July 2020
Effectiveness of Counter-Fraud Arrangements	September 2020
Continuing Healthcare management arrangements	December 2020
Structured Assessment 2020	December 2020

Exhibit 3 – Work currently underway

Topic and relevant Executive Lead	Focus of the work	Current status and Audit Committee consideration
Review of Welsh Health Specialist	This work will focus on the governance and assurance arrangements of WHSSC.	Report being drafted

Topic and relevant Executive Lead	Focus of the work	Current status and Audit Committee consideration
Services Commissioning Committee	Fieldwork was well-progressed prior to the pandemic, but we revised the methodology for capturing views of health board Chairs and CEOs. Currently drafting the report.	March 2021
Orthopaedic services – follow up Executive Lead – Chief Operating Officer	This review will examine the progress made in response to our 2015 recommendations. The findings from this work will inform the recovery planning discussions that are starting to take place locally and help identify where there are opportunities to do things differently as the service looks to tackle the significant elective backlog challenges.	Report being drafted March 2021
Test, Track and Protect Executive Lead – Director of Public Health	In response to the Covid-19 pandemic, this work will take the form of an overview of the whole system governance arrangements for Test, Track and Protect, and of the Local Covid-19 Prevention and Response Plans for each part of Wales.	Report being drafted March 2021
A cross-cutting review focussed on North Wales partnerships Executive Lead: Chris Stockport	Care home placements represent a significant area of expenditure. Our work seeks to determine whether partners collaborating effectively to take account of demographic changes and other external pressures in the strategic commissioning of residential and nursing home care.	Scoping Timing dependent on impact of Covid. Fieldwork expected to be completed by May 2021.

Topic and relevant Executive Lead	Focus of the work	Current status and Audit Committee consideration
Review of Unscheduled Care Executive Lead Gill Harris	This work will examine different aspects of the unscheduled care system and will include analysis of national data sets to present a high-level picture of how the unscheduled care system is currently working. Once completed, we will use this data analysis to determine which aspects of the unscheduled care system to review in more detail.	Data analysis currently being completed Further work postponed to 2021 and replaced with work on Test, Track and Protect
Quality Governance Gill Harris	This work will allow us to undertake a more detailed examination of factors underpinning quality governance such as strategy, structures and processes, information flows, and reporting. This work follows our joint review of Cwm Taf Morgannwg UHB and as a result of findings of previous structured assessment work across Wales which has pointed to various challenges with quality governance arrangements.	May 2021

Exhibit 4 – Planned work not yet started or revised

Topic and relevant Executive Lead	Focus of the work	Current status and Audit Committee consideration
Ophthalmology services	In light of the demands cause by COVID-19, we are considering options to postpone or replace this work	In light of the demands cause by COVID-19, we are considering options to postpone or replace this work

Good Practice events and products

4 In addition to the audit work set out above, we continue to seek opportunities for finding and sharing good practice from all-Wales audit work through our forward planning, programme design and good practice research. All shared learning seminars listed in our original 2020-21 Annual Plan have been cancelled.

5 In response to the Covid-19 pandemic, we have established a **Covid-19 Learning Project** to support public sector efforts by sharing learning through the pandemic. This is not an audit project; it is intended to help prompt some thinking, and hopefully support the exchange of practice. We have produced a number of outputs as part of the project which are relevant to the NHS, the details of which are available here.

6 We are now in the process of developing a programme of webinars with an emphasis on practical knowledge transfer between peers and practitioners in relation to COVID learning. The most recent webinar - Mental health and wellbeing during COVID-19 - took place on December 1, 2020.

NHS-related national studies and related products

7 The Audit Committee may also be interested in the Auditor General's wider programme of national value for money studies, some of which focus on the NHS and pan-public-sector topics. These studies are typically funded through the Welsh Consolidated Fund and are presented to the Public Accounts Committee to support its scrutiny of public expenditure.

8 **Exhibit 5** provides information on the NHS-related or relevant national studies published in the last 12 months. It also includes all-Wales summaries of work undertaken locally in the NHS.

Exhibit 5 – NHS-related or relevant studies and all-Wales summary reports

Title	Publication Date
The National Fraud Initiative in Wales 2018-20	October 2020
Welsh Community Care Information System	October 2020

Title	Publication Date
Cracking the Code: Management of Clinical Coding across Wales	September 2020
10 Opportunities for Resettling and restarting the NHS Planned Care System	September 2020
‘Raising Our Game’ - Tackling Fraud in Wales	July 2020
Rough Sleeping in Wales – Everyone’s Problem; No One’s Responsibility	July 2020
NHS Wales Finances Data Tool - up to March 2020	July 2020
Findings from the Auditor General’s Sustainable Development Principle Examinations	May 2020

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Audit Wales

Structured Assessment 2020 – Betsi Cadwaladr University Health Board

Audit year: 2020

Date issued: October 2020

Document reference: 2039A2020-21

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Contents

Summary report

About this report

1 This report sets out the findings from the Auditor General's 2020 structured assessment work at Betsi Cadwaladr University Health Board (the Health Board). The work has been undertaken to help discharge the Auditor General's statutory requirement, under section 61 of the Public Audit (Wales) Act 2014, to be satisfied that NHS bodies have made proper arrangements to secure economy, efficiency and effectiveness in their use of resources.

2 This year's structured assessment work took place at a time when NHS bodies were responding to the unprecedented and ongoing challenges presented by the COVID-19 pandemic. On 13 March 2020, the Minister for Health, Social Services issued a framework of actions to help prepare the system for the expected surge in COVID-19 cases. The framework included the cessation of non-urgent planned activity and the relaxation of targets and monitoring arrangements across the health and care system. Emergency funding arrangements were also introduced to facilitate the wide range of actions needed to respond urgently to the COVID-19 pandemic.

3 Shorter planning cycles were agreed for 2020-21 supported by quarterly guidance setting out key considerations for the planning of the next phase of the pandemic, for maintaining delivery of essential services, and a movement towards the gradual reinstatement of routine services.

4 Our work[1] was designed in the context of the ongoing response to the pandemic to ensure a suitably pragmatic approach to help the Auditor General discharge his statutory responsibilities whilst minimising the impact on NHS bodies as they continue to respond to the next phase of the COVID-19 pandemic. The key focus of the work is on the corporate arrangements for ensuring that resources are used efficiently, effectively and economically. Auditors also paid attention to progress made to address previous recommendations[2] where these related to important aspects of organisational governance and financial management especially in the current circumstances.

5 The report groups our findings under three themes:

- governance arrangements;
- managing financial resources; and
- operational planning: to support the continued response to the pandemic balanced against the provision of other essential services.

[1] The conduct of our work was coordinated with Internal Audit's rapid governance review which includes further testing of key controls noted in this this report.

[2] Previous recommendations can be found in our 2019 report.

Key messages

6 The Health Board has maintained a good overall focus on governance, risk and quality during its response to the first phase of the pandemic. Whilst the Health Board's existing resilience plans didn't sufficiently meet the scale and complexity of the challenge posed by pandemic, the Board recognised these limitations early and took necessary action. This included introduction of command and control structures and workstreams, and a Cabinet which consisted of three independent and three executive board members to support decision making and oversight. Throughout this time we have seen improvement in partnership working and stronger stakeholder communications, particularly in relation to the response to the pandemic. The Board has taken steps to conduct its business with transparency through webcasting its meetings and our observations of Board and committee meetings show that they are generally conducted well. However, the Board will need to ensure it that its approach to scrutiny balances the challenges which are necessary with what is also needed to foster cohesive and collective leadership and direction amongst Board members.

7 The Health Board's senior management provided good leadership in response to the pandemic. However, given the challenging environment will continue, there is a need to ensure a resilient and cohesive executive team to effectively respond. The Health Board is continuing to review its governance arrangements with a focus on strengthening risk and quality assurance arrangements and is also maintaining its focus on quality and safety of services during the pandemic.

8 The overall financial position remains exceedingly challenging. In 2019-20, the Health Board did not meet its financial duties and had a £38.7 million year-end deficit despite slightly over-delivering against its £35 million savings target. For 2020-21 the Health Board originally forecast a £40 million deficit, but there are significant risks that could lead to further deterioration. These risks include non-delivery of savings and additional unfunded COVID-19 costs. The Health Board has continued to improve financial management arrangements and controls and has responded to most recommendations made as a result of recent externally commissioned financial reviews. Key financial controls set out in standing financial instructions, scheme of reservation and delegation and standing orders operated unchanged throughout the pandemic. But this meant that there was no realignment of financial authority to the command and control structure, and the Health Board should reflect on this should similar incident management arrangements be required in future. There are appropriate arrangements to monitor financial expenditure and financial compliance, however, for further reassurance, the Health Board is undertaking additional work led by a 'Financial Governance Cell' to review compliance during this period.

9 Short-term planning approaches are helping to respond to immediate and complex challenges created by the pandemic, but performance recovery will need a longer-term and more strategic approach. During the pandemic the organisation has used capacity demand modelling to inform its quarterly plans and taken steps to secure

sufficient workforce capacity to respond to a potential second COVID peak. It has introduced digitally enabled services is making some significant care pathway changes. The pandemic has demonstrated that the Health Board can deliver complex service change at pace.

10 Organisational performance recovery may require further major service change for some specialties. This needs to be grounded in a longer-term clinical strategy, which has yet to be produced. The Health Board is setting up a strategy group to take this work forward. Engagement of key strategic partners including the Community Health Council will be essential and there is opportunity for the Health Board to capitalise on the change management successes of the last 6 months.

Recommendations

11 We have made 3 recommendations which are set out in **Exhibit 1**. The Health Board's management response is summarised in **Appendix 1**.

12 In 2019 we made 7 recommendations in the structured assessment report of which most are still in the process of being addressed. The Health Board's Audit Committee received a detailed progress update on the 2019 recommendations in June and continues to track recommendations at each meeting. We will provide a further update on progress next year.

Exhibit 1: 2020 recommendations

Recommendations
Resilience/incident response planning R1 Undertake a rapid learning exercise on COVID-19 governance to inform and adapt resilience and emergency response plans, so they can be implemented should they be required over the coming months. This should include consideration of: • any need to temporarily adapt the Scheme of Reservation and Delegation to ensure financial and decision-making authority is aligned and • the risk management approach adopted as part of command and control and workstream arrangements.
Stakeholder engagement in clinical strategy and plan development R2 Ensure there is effective stakeholder engagement in the development of clinical strategy and any plans for significant service change.

Recommendations

Reporting progress against delivery of plans

R3 Ensure that impacts and outcomes achieved as a result of delivery of actions are appropriately articulated within quarterly plan and annual plan monitoring reports. This may require strengthening of underpinning business benefits analysis processes.

Detailed report

Governance arrangements

13 Our structured assessment work considered the Health Board's ability to maintain sound governance arrangements while having to respond rapidly to the unprecedented challenges presented by the pandemic.

14 We found that **the Health Board maintained a good overall focus on governance, risk and quality during its response to the first phase of the pandemic.**

Conducting business effectively

Revised governance and management arrangements have supported agile decision making and effective scrutiny but there is scope to improve emergency resilience planning.

15 COVID-19 has presented an unprecedented challenge to the health sector. The Health Board recognised early in February 2020 that its existing major emergency plan was not adequate for the challenge faced by COVID-19. While we did not consider the Health Board's previous emergency plan in depth, we noted that it contained several assumptions which didn't allow for the scale and complexity of the response required to COVID-19. For example, the plan assumed an outbreak could be managed broadly within existing management and operational arrangements and didn't sufficiently take account of the need for a significantly greater scale of response, adaptability and agility.

16 After recognising the weaknesses in its existing emergency plan, the Health Board responded effectively by rapidly developing alternative arrangements. On 12 March 2020, the Health Board initiated command and control structures following a Gold, Silver and Bronze (sub-regional) model. The Health Board also established a 'Cabinet' consisting of three independent members and three executive officers to oversee the response and enable timely decision-making and scrutiny. A further eleven workstreams were set up within the command structure to address specific but significant challenges. Throughout this time, we have seen improvement in partnership working and stronger stakeholder communications, particularly in relation to the response to the pandemic. In general, the workstreams were effective at coordinating the resources required to respond to the pandemic, including development of guidance, changes to estates, ensuring personal protective equipment and equipment, development of a testing and tracing service and creation of three field hospitals. However, there was a short delay in developing and strengthening the new arrangements at the beginning of the pandemic largely as a result of executive officers becoming ill or being required to shield or self-isolate. This demonstrated a weakness of continuity arrangements for a short timeframe.

17 By early April 2020 the Health Board had developed and agreed a COVID-19 strategy. This strategy appropriately helped to further shape and focus the work including the newly created workstreams to help coordinate the required action. At this point, the Health Board also introduced a Covid Command Group within the pandemic response structure. This group enabled the whole Executive Team to have oversight of the totality of the COVID-19 response. The group enabled separation of oversight of the pandemic response to the Executive Team's 'business as usual', allowing greater time and focus on specific COVID-19 issues.

18 The revisions to the Health Board's governance and management arrangements supported rapid decision-making while maintaining necessary scrutiny. The structure was clear and successfully helped the Health Board respond to urgent and significant challenges. The Health Board developed COVID-19 daily situation (sitrep) reporting which included hospital admission numbers/trends including acute bed occupancy, critical care bed occupancy, delayed transfer of care, workforce capacity and sickness absence. This reporting has now further developed to focus on early warning alarms including mortality statistics, emergency department activity, COVID-19 bed occupancy, and Test, Trace and Protect activity. The review of performance data during this period has, however, exposed a need for greater dedicated analytics support in future.

19 On 15 April 2020 the Board considered Welsh Government guidance on discharging Board committee responsibilities during COVID-19. In line with guidance, the Board approved temporary changes to its Standing Orders which included suspending its committees apart from the Audit Committee and the Quality and Safety Committee. The Health Board also reduced the breadth of agendas to focus on key risks and matters relating to COVID-19 and essential business. Revised standing orders appropriately detailed the alternative arrangements for those committees that had been 'stood down', identifying which committees would be responsible for considering key urgent items, making decisions and authorising expenditure.

20 At the same meeting in April 2020, the Board approved a revised approach to decision making. This required that, where possible, the full Board would retain decision making. If the full Board was not available, decision making operated with a quorum of three executives and three independent members that could be convened at speed to scrutinise and authorise decisions. 'Chair's Action' would be used as a last resort and would be recorded and ratified. During its pandemic response, the Health Board was required to use chair's action for a small number of decisions, for example in the approval of the field hospitals. We note that chair's actions were reported to the Board at its meetings on 14 May and 23 July 2020 in line with the Board approved 'Standard Operating Procedure on Chair's Action During COVID-19'. In the instance of the field hospitals, the action was scrutinised and signed by the vice-Chair to prevent any conflict of interest relating to the Chair's role in the temporary hospital group.

21 The Health Board also introduced decision logs into the command and control and workstreams to provide evidence and justification for decisions being taken. The

decision logs were routinely reported into the command and control structure and were taken to board briefing meetings. Despite initial variable quality of the logs, the Health Board improved the process through ongoing self-review combined with shared learning from North Wales Police and Military Liaison Officers.

22 At the introduction of emergency governance arrangements, reporting was streamlined allowing for verbal reports and shorter papers to fewer committees. But the Health Board's reporting and briefing arrangements evolved over time during the pandemic and increasingly became more time-consuming. The Cabinet received fortnightly update reports, there was also daily sitrep reporting and fortnightly board briefings for all board members, as well as regular Covid Command Group meetings for the Executive. As a result, additional Executive team capacity created by suspending committee business was increasingly consumed by a need to regularly update groups and members at briefings. There is opportunity to reflect on this as part of lessons learnt exercises.

The Board has taken steps to conduct its business with transparency although virtual Board meetings are driving a different scrutiny style which on occasions may not always be conducive to cohesive Board working

23 As the pandemic hit, the Health Board notified the public on its website that it is not possible to attend Board and committee meetings in person. To support transparency, the Health Board committed to publish the Board and committee meeting papers seven days in advance of meetings and meeting minutes three days following a meeting. The Board also intended to webcast its meetings from May 2020, but an unforeseen technical issue relating to licencing prevented live viewing of the May board meeting. All Board meetings from July onwards are being webcast but at present, there are no plans to webcast committee meetings.

24 Since March 2020, the Board has been meeting virtually. We noted that Board members have responded well to the changing demands on them through this challenging time. Our observations of meetings also indicate that these arrangements are generally working well and have evolved positively as the Board members got to grips with this new way of working.

25 The Health Board is enhancing the technology available to Board members to help with virtual meetings and has issued guidance on virtual meeting etiquette. In general, our observations indicate that Board and committee meetings are conducted properly and effectively. On some occasions, we noted that the nature of virtual Board meetings is resulting in very direct questioning by independent members during discussions, and a robust and challenging style of scrutiny. While this will sometimes be necessary at Board meetings, it will need to stay mindful of the impact this style can have on the relationships between the Executives and Independent Members and the ability of the Board to demonstrate collective leadership.

The Health Board's senior management provided good leadership in response to the pandemic but with challenging circumstances likely to continue, there will be a need to ensure a resilient and cohesive Executive Team.

26 The Executive Team and wider senior management response to the pandemic has generally been very positive. We found strong leadership within the temporary command and control arrangements and the majority of the workstreams which helped to respond effectively to number of challenges. However, the last six months has also been a stressful and stretching time for the Executive team. The Executive Team have had to work in very different ways, operating in new structures, in highly dynamic environments and with some excessive hours. The coming winter period may be just as challenging as the onset of the pandemic and there is a need to ensure the resilience and cohesiveness of the Executive Team to help meet these challenges.

Work is in progress to strengthen organisational structures, but there are also some concerns in specific areas such as the Mental Health division.

27 In our structured assessment report 2019, we highlighted the need to strengthen capacity at senior levels. This particularly focussed on building the required change/programme management capacity and capability and strengthening the secondary care structure. The Health Board is making progress, for example, it has agreed its structure for its acute services with substantive Managing Directors in post at all three sites. However, it has yet to fully address its continuing reliance on external interim management arrangements or set out required programme management arrangements. The Health Board recently sent a proposal to Welsh Government requesting support to enable the establishment of a strategic assistance programme and enhance its organisational development capacity. If successful, this should help strengthen the organisation's internal capacity and capability.

28 There has also been change at the top of the organisation. In January 2020, the substantive Chief Executive left the Health Board. An interim Chief Executive Officer was seconded from Welsh Government in February until late August 2020. A substantive replacement has recently been appointed who will take up the role in January 2021, with the Deputy Chief Executive Officer acting as interim until that date.

29 In July 2020 Audit Wales, alongside Healthcare Inspectorate Wales, formally highlighted concerns to the then interim Chief Executive relating to fragility of the leadership of the Mental Health division caused by long-standing vacancies and absences. The Health Board has indicated in its response that it is taking action to address required improvements in this area. The Health Board's Internal Audit Service is in the process of reviewing the governance arrangements of the mental

health division. Once the review is complete, we will consider their findings to determine if any additional action is required.

The Health Board has committed to reflect, learn and improve both usual governance arrangements and emergency arrangements.

30 The Health Board has a range of processes which demonstrate reflection and learning. For example, the Board and committees regularly review and refine their 'cycles of business' (agenda calendar) to ensure there is sufficient focus in the right areas. As part of routine arrangements and for several years, committees have also undertaken self-assessments which informs annual committee reports.

31 The Health Board is also receiving additional support from the Kings Fund to help strengthen the functioning of the Board and Executive Team and this work is ongoing. At the same time, there is ongoing work to further strengthen governance arrangements, focussing on risk and quality assurance, which we describe in the following subsection.

32 We are clear from interviews that there is a good understanding of lessons learnt from the initial COVID-19 response at an individual level. But there is a need to bring these reflections together. We understand that the Executive team will present a paper to the Board in the next few months which reflects on their response and identifies lessons for the future. This work is being supported by the Health Board's resilience team. **Recommendation 1** of this report is aimed at driving improvement through lessons learnt from the last six months and applying those lessons learnt into updated pandemic and resilience plans.

Systems of assurance

The Health Board developed specific arrangements for managing risks in relation to COVID-19 alongside continuing preparations to implement its new risk management strategy

33 The Health Board introduced specific arrangements for managing COVID-19 risks supported by additional training for those leading command and control and workstreams. For the duration of the initial response, the Health Board continued to refine and improve the COVID-19 risk management arrangements, led by the Governance and Risk workstream. Feedback from interviews indicated that at the time there was some variation and duplication of risk management between workstreams, command and control structures and 'business as usual' risk management. While we did not identify that this created significant issues, it is an area to reflect on as part of lessons learnt for future resilience and incident planning.

34 Over the last 12 months the Health Board has been in the process of a fundamental redesign of its risk management strategy. This was approved by the

Board on 23 July 2020. The risk strategy has been developed through staff and Board engagement and a key aim is to improve timely risk escalation between operational services and the Board. The strategy also aims to provide greater accountability for risk ownership and mitigation. The Health Board plans to launch the strategy in October 2020 and the progress of its implementation will be overseen by the Audit Committee. The development of the revised approach is largely positive, but its implementation will be challenging given the continued strain on health services as well as the 'virtual' nature of working for many staff.

The Health Board has maintained a focus on quality and safety and recognises the significant challenge of treating patients whose care has been delayed

35 The Health Board has maintained its focus on quality and safety of services both in relation to COVID-19 and for broader services. The Quality, Safety and Experience Committee continued to meet during the pandemic. While the committee had a reduced agenda, it focussed on quality in relation to COVID-19 and other high-risk areas. This included infection prevention, maintaining essential services during COVID-19, as well as considering patient groups that may be at risk because of reduced access to services. This is aligned to Welsh Government's four principles of direct and indirect harm related to COVID-19. The Board and Quality and Safety Committee is clearly aware of the need to balance the COVID-19 response and the need to prioritise essential services for those at most risk of health deterioration. The Health Board is risk-assessing and prioritising its waiting lists for those at greatest clinical risk. However, even with these processes, the mismatch between supply of services and the demand creates some difficult challenges. The Board and committees are regularly informed of the position of essential services and the extent of delays on the waiting list, but this is likely to take some time to resolve.

36 The Board is also focussed on staff wellbeing, including ensuring that working conditions are safe, that staff are provided with necessary wellbeing support and that high-risk staff groups are assessed. At its meeting in April 2020, the Board approved two new risks on Health and Safety and Personal Protective Equipment (PPE).The Quality, Safety and Experience Committee is overseeing these risks and the procedure for reporting and investigating for staff members who have tested COVID-19 positive. The Committee also recently received further assurance on Health and Safety matters in July 2020 relating to reporting to the Health and Safety Executive, staff testing levels and the application of the Welsh Government workforce risk assessment tool (discussed further in paragraph 65).

37 The Health Board has continued with some key operational quality assurance arrangements including mortality reviews and Putting Things Right processes. It is also undertaking work to assess serious incidents resulting from the pandemic. However, we note that both the ward accreditation process and the clinical audit programme were suspended during the COVID-19 outbreak.

38 The Health Board is progressing its Quality Improvement Strategy for 2020-2023 and strengthening quality assurance arrangements. This work includes a review against the five aims set out in the strategy and development of a corresponding action plan. During the early stages of the COVID-19 pandemic this work was paused, and the timeline is now being revised. However, proposals to strengthen quality and safety management and oversight are being taken forward. At present proposals include establishment of four groups focussing on patient safety, clinical effectiveness, patient experience and occupational health and safety which will directly report into the Quality Safety and Experience Committee.

The Health Board continues to track progress against recommendations.

39 In our structured assessment 2019 report, we recommended that the Health Board strengthen the sign off process as part of recommendation tracking. The Health Board has subsequently updated and strengthened its sign-off process to help improve the quality of updates against actions and provide better assurance when actions in response to recommendations are complete. It has provided training to the governance leads which has improved the consistency and quality of the updates provided on the audit recommendation tracker. The Health Board has also introduced a process to review the quality of information submitted within the recommendation updates. During the pandemic, the Audit Committee has continued to receive tracking reports on progress against key recommendations.

Managing financial resources

40 Our work considered the Health Board's financial performance, changes to financial controls during the pandemic and arrangements for monitoring and reporting financial performance. We found that, **reasonable financial arrangements were put in place to respond to COVID-19, but there are significant risks to achieving the Health Board's forecasted £40 million deficit**.

Achieving key financial objectives

The Health Board did not meet its financial duties in 2019-20

41 The Health Board did not meet its statutory financial duties for 2019-20 due to a £38.7 million deficit and an inability to prepare a financially balanced medium-term plan. The 2019-20 year-end financial position was slightly worse than the Health Board's planned £35 million deficit but significantly worse than the £25 million control total set by Welsh Government. This was despite the Health Board also exceeding its £35 million savings target by £0.5 million, with 70% of savings classed as recurrent. An element of the in-year cost growth was a result of additional secondary care agency costs and primary care prescribing drug price

increases. The Health Board achieved its capital resource limit and public sector payment policy targets and our audit of the Health Board's accounts resulted in an unqualified 'true and fair' audit opinion and a qualified regularity opinion on the Health Board's financial statements for the 2019-20 accounts.

42 For several years, the Health Board has been unable to balance its expenditure with its revenue allocation. This has resulted in a growing cumulative deficit. In June 2020, Welsh Government confirmed that it will write-off historic cumulative deficit for all NHS Wales organisations. However, this write-off is dependent on NHS Wales organisations delivering to their baseline plans in future, which is a recognised, long-standing issue for the Health Board. The Health Board is undertaking some additional work to better determine the drivers of its underlying deficit in response to recommendations made by PwC. As of August 2020, this work remains in progress.

There are significant financial risks to achieving the Health Board's planned deficit for 2020-21

43 The Board agreed the 2020-21 financial plan in April 2020. The plan included a forecast deficit of £40 million subject to delivery of savings of £45 million and containing any cost growth. This plan set out what was a realistic expectation of financial performance and spend forecasts. But the onset of the pandemic is likely to result in a deteriorating position. There are now several financial risks to the delivery of the agreed financial plan, including:

- the Health Board not receiving additional income to meet all direct and indirect COVID-19 related capital and revenue expenditure to date;
- any unfunded growth in COVID-19 spend over the autumn and winter;
- non-delivery of savings; and
- any additional expenditure required to restart and recover services.

44 For the first six months of the 2020-21 financial year, the programme management office responsible for coordinating savings during 2019-20 were redeployed. This was initially as part of the Health Board's pandemic response and subsequently supporting aspects of recovery and other urgent service requirements. The absence of the same degree of focus on savings compared to previous years has negatively impacted on the delivery of savings and subsequently reduced the savings potential for the year. As at August 2020, the Health Board has revised its year-end savings performance forecast to £14.2 million against its £45 million target. Of the £14.2 million, £7.6 million are identified and £6.6 million are in the 'pipeline'. This leaves a minimum unfunded cost pressure of £30.8 million.

45 Until August 2020, the Health Board was reporting an overall unchanged year-end financial forecast of £40 million deficit. Achievement of this was predicated on the assumption that Welsh Government will provide additional income for all direct and indirect costs related to COVID-19. This includes the assumption that non-delivery of savings against the agreed financial plan would be covered by Welsh

Government. At its meeting in August 2020, the Finance and Performance Committee decided to align their reporting with other health boards in Wales by not assuming that non-delivery of savings will be funded by Welsh Government. As such, the Health Board's reported forecast outturn position will deteriorate between its August and September reports to account for expected non-delivery of savings (currently around £30 million).

46 We have also noted that the Health Board is currently paying NHS England for services that it is not receiving. These services are commissioned under fixed 'block' contracts and services commissioned by Welsh Health Specialised Services. Until month three, the Health Board assessed that it has paid just over £35 million for services in England and that it has received just under £21 million in services. This has resulted in a non-recoverable expense of £14.5 million over those three months. Whilst this arrangement was required to sustain health services in England during the peak of the pandemic, continued expenditure represents a value for money issue if those arrangements extend into the medium-term. The Health Board is in discussion with Welsh Government and NHS bodies in England over this matter. The Health Board is seeking both to review the conditions of the block contract and to restart patient services for North Wales patients that travel to England for their care.

Financial controls

Building on work started in 2019, the Health Board has continued to improve financial management arrangements and controls

47 The Health Board is effectively responding to work started last year on financial management and controls. Over the last 12 months, there has been a strong focus on strengthening these areas at committee and management levels with the aim of meeting best practice, delivery of savings and financial recovery. To support this, the Health Board commissioned PwC both to review and support recovery. This work led to a range of required improvements on financial management arrangements and 'grip and control'. The resulting report made 32 recommendations focussed on financial planning, budget management and control, programme management office governance and savings. There were also 22 recommendations relating to grip and control of pay and non-pay procurement expenditure. In July 2020, the Health Board reported good progress against the PwC grip and control recommendations. The six outstanding financial management arrangements recommendations are more challenging to address as they relate to determining the drivers of the deficit, planning financially sustainable services, improving divisional financial information and strengthening the accountability framework.

48 The Health Board has a good track record in relation to budgetary delegation and its use of accountability agreements for 2020-21 are further strengthening arrangements. The Health Board maintained a strong approach on financial grip

and control throughout the last financial year, however this did not enable it to achieve a balanced budget. This suggests that financial control alone will not be enough to achieve financial recovery and that there is a need to reshape services to ensure they are more productive and financially sustainable.

49 Our statutory financial audit on the Health Board's 2019-20 financial accounts did not identify any significant material weakness in controls. Our financial audit team recognised the effectiveness and timeliness of the work of the Health Board's financial accounts team, both in preparing the financial statements and in responding to the audit, despite the pressures resulting from the pandemic.

Key financial controls have operated throughout the pandemic, and the Health Board is undertaking further work to provide assurance.

50 We have considered the budgetary arrangements in place at the Health Board during the early stages of the COVID-19 pandemic. Our work has identified clear itemised recording of capital and revenue expenditure related to COVID-19, use of business cases and decision logging and justification for procurement related expenditure. There were clear processes agreed by the Board in April 2020 which set out decision-making arrangements, as part of formal amendments to the governance arrangements. At an operational level, delegated authority limits continued to be enforced on the financial management system and the Health Board has undertaken tracking and analysis of COVID-19 spend. We haven't undertaken additional controls testing to assess the compliance or effectiveness of decision-making financial controls. However, the Health Board has initiated a 'Financial Governance Cell' to investigate compliance and conformance with process and policy between March to June 2020. This will include work by local counter-fraud services and a review by internal audit on financial governance during COVID-19. It is the intention of the Health Board to use this work to support its self-reflection and provide assurance on the effectiveness of and compliance with controls.

The Health Board could benefit by making changes to its Scheme of Reservation and Delegation if a command and control incident model is needed in future

51 The Health Board's Scheme of Reservation and Delegation (SORD), which provides delegated authority to officers remained unchanged during the pandemic. While this approach provided consistency for Executive Officers, it could have caused difficulty because those leading the command and control arrangements did not have formally delegated financial decision-making authority aligned to their remit. Our interviews did not identify any significant issues that prevented timely decision making, but the Health Board may benefit by reflecting on this arrangement as part of lessons learnt to inform future resilience planning.

Financial monitoring and reporting

There are appropriate arrangements to monitor financial expenditure against the plan and financial compliance

52 In April 2020, the Health Board altered its arrangements for financial oversight as part of its pandemic strategy. Under new arrangements, authorisation and scrutiny took place through fortnightly Cabinet meetings and formal Board meetings. Our work found that oversight of the Health Board's overall financial position and spend has been reasonable during this time, with interviews indicating that the revised governance arrangements supported timely decision making and scrutiny. While the Finance and Performance Committee stood down in March 2020, it resumed in June and now continues to review and scrutinise financial recovery and performance. This includes achievement against financial targets, revenue and capital expenditure, COVID-19 spend versus additional allocation, and variance to budget plan by division and savings performance.

53 The Audit Committee continues to appropriately oversee the work of counter fraud, internal audit and the post-payment verification team as well as receiving the assurance provided from the financial audit of the accounts. The financial conformance report to the Audit Committee also provides a good level of assurance on compliance against statutory or policy requirements including single tender and quote waivers, losses and special payments, aged debt and payroll.

Operational planning

54 Our work considered the Health Board's COVID-19 response planning including the development, resourcing and monitoring of quarterly operational plans. We have also considered the extent of required financial and performance recovery and the need for a strategic approach to meet these challenges.

55 We found that **The Health Board's quarterly operational plans are helping it to respond to a range of complex service risks, but there is a need for a strategy to recover services to help ensure they provide sustainable capacity and improvements in productivity.**

Developing the plan

The Health Board's quarterly planning process is improving, but plans need earlier scrutiny and greater explanation on risks to successful delivery

56 The Health Board is responding to the Welsh Government planning requirements but has found the short turn-around from the time that planning guidance is issued to the submission a challenge. The Health Board submitted both the quarter one

and quarter two operational plans to Welsh Government by their required deadlines. We noted though in relation to the quarter two operational plan, the Board received the draft plan on the 1 July, but this only left two days to make amendments prior to submission to Welsh Government on the 3 July 2020. This required some rapid changes and subsequent amendment prior to approval by the full Board on 23 July. But the changes that were made as a result of board member scrutiny resulted in improvements in the plan, particularly on the key actions required and accountability for delivery. The Health Board is addressing the timing challenge for future operational plans by scheduling additional board workshop meetings. This will provide more time to discuss and scrutinise the emerging quarter three operational plan before its submission to Welsh Government.

57 The Health Board's quarterly operational plans appropriately focus on the required flexibility of services in the short-term and are broadly in line with Welsh Government requirements. The Health Board has used data modelling of COVID-19 infection rates, service capacity and demand to help shape the quarter two operational plan and the key actions within it. The quarter two operational plan appropriately considers the 'four types of harm'. It includes, but is not limited to, high-level actions on:

- COVID-19 test, trace and protect;
- creating flexibility to shift capacity between Covid and non-Covid services;
- surge capacity should it be needed;
- prioritisation of essential services; and
- new digitally enabled service models particularly in primary care and outpatients.

58 However, it is difficult to determine from the quarter two operational plan what are the key risks to its effective delivery. Our review of the plan indicated that some of the actions within it are likely to be more challenging to deliver than others. Yet it is difficult to distil those higher risk areas, and this makes it more challenging to form a view on the likelihood of impactful delivery or those areas which are at a significant risk of non-delivery.

Elective waiting list performance has deteriorated, and to recover services the Health Board may need to be more ambitious in its clinical strategic approach, engaging stakeholders in the process

59 The Health Board's elective waiting lists have significantly deteriorated as a result of the pandemic and this is likely to continue into the winter period. The absence of an agreed clinical strategy has been a long-standing issue. A strategy is fundamental to the Health Board developing financially sustainable modern clinical services and recovering service performance. We made a recommendation in our 2019 structured assessment to strengthen clinical engagement and leadership as part of clinical strategy development and any associated service change programmes. We are aware that as part of the Health Board's pandemic response,

it had successfully brought together a range of clinical leads and developed and agreed over 35 new clinical pathway models. The Health Board is now developing a clinical strategy group as a means of ensuring clinical leadership and engagement to support development of a clinical strategy. We understand that this group will be building on work that was started last year on digitally enabled clinical services. In forming a clinical strategy there are clear opportunities to further progress digitally enabled services, but there may also be a need to adopt more significant changes to service models to boost surgical capacity and productivity.

60 Our work has indicated that the Health Board effectively engaged North Wales Police, local authorities, the university sector and the military in its early pandemic plans and response. However, it is not clear whether these stakeholders or the Community Health Council were given opportunity to effectively engage in quarterly operational plan development. Recovery of performance may require some significant changes to the shape of services to ensure they are productive and resilient. Strong stakeholder engagement in the development of a clinical strategy and subsequent operational plans will be helpful as a means to share an understanding on priorities, risks, actions and resourcing constraints (**Recommendation 2**).

Resources to deliver the plan

The Health Board has plans to adapt its bed capacity to meet forecasted surge demand

61 The Health Board approach seeks to prevent growth in COVID-19 cases in the community, provide enough capacity for patients testing positive in acute hospitals, provide essential services, and restart and recover other core services. This requires sufficient flexibility and capacity to respond to a surge in demand.

62 The Health Board has made demand forecasts based on best assumption for the impact of a second wave and increasing needs for unscheduled care services. Based on these assumptions it has forecast bed demand, at 92% occupancy, for non-COVID-19 emergency, COVID-19 emergency, essential services and additional planned work. Against the forecast of demand, the Health Board has assessed its bed capacity, including Acute and Community and field hospitals. The capacity available is enough to meet forecasted demand as set out in the quarter two operational plan.

63 The Health Board has identified the pace at which it can create sufficient surge capacity across all permanent and temporary (field hospital) facilities should this be needed. This indicates that 131 core acute and community beds can be mobilised within 24 hours, an additional 160 within a week, and the remaining surge capacity of 1,315 beds can be available after 7 days. At present, the Health Board is continuing the assumption that temporary field hospital accommodation may be required during the winter months and is ensuring this capacity can be flexed into

operation if required. The Health Board is also continuing to use the facilities at Spire Yale for diagnostics and essential surgery procedures.

The Health Board has responded well to its workforce challenges and risks

64 The Health Board undertook capacity modelling to understand requirements for its initial Covid-19 response and was proactive in securing additional workforce. This resulted in over 1700 staff and volunteers being recruited following a TV and social media campaign as well as deploying healthcare students and encouraging retired staff to return to practice. The Health Board has developed a new clinical deployment dashboard to support planning and decision-making in response to surge capacity requirements. This dashboard includes data on competencies and capacity of the workforce. The Health Board is maintaining a focus on capacity requirements and its ability to flex the workforce as required.

65 In relation to workforce protection and resilience, the Health Board recognised the risk to the workforce but also responded quickly as emerging information identified heightened risk for Black, Asian, and Minority Ethnicity staff. The Health Board had developed its own workforce risk assessment protocol and adopted the all-Wales risk assessment process, once this became available. This has resulted in over 800 risk assessments for Black, Asian, and Minority Ethnicity staff, representing an 80.6% assessment rate. The Health Board also introduced wellbeing hubs recognising the significant pressure and, in some instances, traumatic environment that staff have faced. We understand that these hubs have been well-utilised.

New digital approaches adopted over the last six months are helping to maintain and restart clinical services

66 The Health Board has deployed new technology to support new ways of working. This has included over 1,000 new mobiles and tablets to keep patients, families and the workforce connected when working in different environments. The Health Board also implemented infrastructure and systems for field hospitals, Covid-19 testing sites and the command and control sites while they were operating. IT systems have supported outpatient appointments management. This has included using systems to enable patient-initiated follow-ups (see on symptom), deployment of ‘attend anywhere’ clinical video appointment services and consultant connect professional advice line for primary care services and virtual visiting.

67 The informatics service has supported operational management and service planning through the creation of acute and community, care home, workforce and COVID-19 dashboards as well as forecasting models and reports. These digital approaches helped the response to the outbreak, and plans set out for quarter two continue to build on work already complete. Quarter two digital plans include further roll out of video consultations, e-prescribing, accelerating agile working and business intelligence.

The Health Board is prioritising the capacity that it has on patients that need it most.

68 The Health Board has developed new clinical risk assessment approaches to prioritise those requiring care most urgently on the waiting list. The approach is predicated on the ability to restart services while also being able to adapt service capacity between COVID-19 and non-COVID-19 activity. The Health Board is also allowing for contingency should there be a second COVID-19 peak alongside normal seasonal flu and wider winter pressures.

The Health Board developed change management arrangements necessary to respond to the pandemic

69 The Health Board has historically struggled to affect change with pace and impact. In last year's structured assessment, we made specific recommendations to the Health Board to strengthen its programme management structure, change programmes and programme management methodology.

70 During the pandemic the Health Board has achieved significant rapid change. It has mobilised the workforce, adapted some of its core estate, created three field hospitals, deployed new technology, developed COVID-19 testing and tracing services as well as creating new clinical pathway models. While this change has occurred as part of the pandemic response, it clearly demonstrates that the Health Board can effect rapid change through change management arrangements and resources.

71 The Health Board should reflect on the change management arrangements deployed during the early stages of the pandemic, and seek to build its future change management capacity, structure and methodology, with the aim of creating sufficient change capability to deliver its emerging clinical strategy. We have listed some core features of change management arrangements and our observations of the Health Board over the last 5 months (**Exhibit 2**).

Exhibit 2: attributes of organisational change management demonstrated since the onset of the pandemic

Attributes of change	What was evident between February and June 2020
Compelling organisational need and urgency	Clear urgency and priority given at a level that was required to respond to the outbreak.
Common understanding of the problem	Management considered the range of risks and issues, and set out a strategy to respond to them

Attributes of change	What was evident between February and June 2020
Leadership	Redeployment and change in management roles, with both leadership working from the top and middle/senior management working at a higher level and adopting more delegated authority
External engagement	Understanding that multi-partner response was required and working together to achieve it.
Programme structures and control	Command and control provided a programme governance framework, with workstreams taking shape as individual programmes of work.
Alignment of resources to support change	The enabling resources particularly finance, procurement, IT and workforce became integrated and supported the workstreams
Internal engagement	Staff communications through multiple channels, and proactive working with the Trade Unions. Clinical engagement and leadership were notable improvements during the period.
Programme monitoring and oversight	Command and Control Group and Cabinet provided programme management and programme oversight.
Post project/programme evaluation	A commitment to learn lessons from the last few months, but this remains an area to be progressed.

Monitoring delivery of the plan

Approaches to monitor and report on operational plan delivery have improved but more focus on the impact and outcomes is needed

72 There is regular oversight and scrutiny of progress of the operational plans. The Board, Finance and Performance committee, and the Strategy, Partnerships and Population Health Committee each reviewed progress of delivery of the quarter one operational plan in July and August 2020. In scrutinising progress against plans, Board and committee members take some assurance from reports and use

their existing knowledge of services to inform their questions, but also request further information on areas of limited progress.

73 The colour coded reporting approach developed for the quarter one operational plan enables a succinct visual analysis of overall progress against the commitments laid out in the plan and is an improvement against previous years' reporting approaches. However, the format also made it difficult to understand the detail on areas where progress is off-track, for example why an action is off-track and what is being done about it.

74 The Health Board is starting to address this for the quarter two operational plan progress reports which now contain basic narrative for actions that are off track. However, the narrative is of variable quality and could be further improved by focussing more on outcomes and impact to make it clear to the committee and the Board whether the delivery of actions is achieving the difference that was intended (**Recommendation 3**).

Appendix 1

Management response to audit recommendations

Recommendation	Management response	Completion date	Responsible officer
Resilience/incident response planning R1 Undertake a rapid learning exercise on COVID-19 governance to inform and adapt resilience and emergency response plans, so they can be implemented should they be required over the coming months. This should include consideration: • of any need to temporarily adapt the Scheme of Reservation and Delegation to ensure financial and decision-making authority is aligned and • of the risk management approach adopted as part of command and control and workstream arrangements.	A debriefing programme was implemented across the BCU command and control structures. The objectives of the debrief were: • To allow the Health Board to reflect on the identification of lessons learned and shared good practice from the incident; • To identify organisational experience relative to individual roles and responsibilities relating to the incident; • To identify key areas for development for the future; • To assist in the development or formation of guidelines or protocols for future incidents; and • To capture lessons learnt to feed into future response planning. Following this review, a report was prepared by Civil Contingencies Group (CCG) and finalised by Executive Team. The report sets out areas of good practice, together with recommendations for improvement. An executive led action plan was developed in response to ensure improved arrangements going forwards. The report and action plan was presented to the	September 2020 - Complete October 2020	Mark Wilkinson

Recommendation	Management response	Completion date	Responsible officer
	Strategy, Partnerships and Population Health Committee for approval. The action plan includes a full review of the existing COVID Command & Control structures led by COVID-19 Lead Director / Director of Planning and Performance. In addition, the decision-making protocol developed as part of the Command and Control Framework to be reviewed ensuring clarity at each level of the response. Led by Acting Board Secretary / Assistant Director of Information Governance & Risk. In addition to the debrief programme, a full review of the Health Board Major Emergency Plan has been undertaken along with revisions to Hospital Major Incident Plans to ensure that Covid considerations are included within key departmental action cards. Specific management arrangements have been developed for COVID-19 going forward, led by Director of Primary and Community Services. However, should a major incident be declared, command and control structures will be mobilised in line with outcomes of the above work.	November 2020	
Stakeholder engagement in clinical strategy and plan development R2 Ensure there is effective stakeholder engagement in the development of clinical strategy and any plans for significant service change.	During the first surge of Covid 19, the clinical strategy included a short cycle planning with a 'Once for North Wales' approach. The stakeholder engagement took place throughout, with the creation of pathways and the check and challenge approach at the Clinical Advisory Group (CAG). Further work is now ongoing to strengthen the CAG with further inclusion of stakeholders, such as Digital/Informatics. In addition to this work is now being undertaken to integrate the restart of essential services within the clinical strategy and to test the approach with CAG given its wider stakeholder presence. There is a standard	Complete	Arpan Guha

Recommendation	Management response	Completion date	Responsible officer
	operating procedure in place to ensure effective stakeholder engagement in the development of the clinical strategy and any plans for significant service change during our short cycle response. As BCUHB considers further development of the longer-term clinical strategy, it is envisaged that there will a development of a wide stakeholder engagement plan. This will involve agencies such as CHC, local authority, primary and secondary care, Universities, Welsh Government, as examples.	March 2021	
Reporting progress against delivery of plans R3 Ensure that outcomes achieved as a result of delivery of actions are appropriately articulated within quarterly plan and annual plan monitoring reports. This may require strengthening of underpinning business benefits analysis processes.	The plan for quarters 3 and 4 is stronger on outcomes at a programme level than previous quarterly plans. Our chosen outcomes tie back to Living Healthier Staying Well and national outcome frameworks. Performance trajectories are also being developed for this planning round. In respect of reporting against performance, through direct engagement with operational leads, we are strengthening the narratives required for actions that are off track. Furthermore, we are looking at triangulation with the performance measures outlined in the NHS Wales Delivery Framework and how plan outcomes are impacting upon these.	November 2020	Mark Wilkinson

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Rydym yn croesawu gohebiaeth a galwadau ffôn yn Gymraeg a Saesneg.

Archwilio Cymru
Audit Wales

Annual Audit Report 2020 – Betsi Cadwaladr University Health Board

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This document is also available in Welsh.

Contents

Summary report

About this report

1 This report summarises the findings from my 2020 audit work at Betsi Cadwaladr University Health Board undertaken to fulfil my responsibilities under the Public Audit (Wales) Act 2004. That Act requires me to:

- examine and certify the accounts submitted to me by the Health Board, and to lay them before the Senedd.
- satisfy myself that expenditure and income have been applied to the purposes intended and are in accordance with authorities; and
- satisfy myself that the Health Board has made proper arrangements for securing economy, efficiency and effectiveness in its use of resources.

2 I report my overall findings under the following headings:

- Audit of accounts
- Arrangements for securing economy, efficiency and effectiveness in the use of resources

3 This year's audit work took place at a time when public bodies were responding to the unprecedented and ongoing challenges presented by the COVID-19 pandemic. Given its impact, I re-shaped my planned work programmes by considering how to best assure the people of Wales that public funds are well managed. I considered the impact of the current crisis on both resilience and the future shape of public services and aimed to ensure my work did not hamper public bodies in tackling the crisis, whilst ensuring it continued to support both scrutiny and learning. All on-site audit work was suspended whilst we continued to work and engage remotely where possible through the use of technology. This inevitably had an impact on the delivery of some of my planned audit work but has also driven positive changes in our ways of working.

4 The delivery of my audit of accounts work was not without its challenges, not only in how and where we undertook the work, but also in taking account of new considerations for financial statements arising directly from the pandemic. The success in delivering to the amended timetable reflects a great collective effort by both my staff and the Health Board's officers to embrace and enable new ways of working and remain flexible to and considerate of the many issues arising.

5 At the onset of the pandemic I suspended the publication of some performance audit reports nearing completion, reflecting the capacity of audited bodies to support remaining fieldwork and contribute to the clearance of draft audit outputs. I have also adjusted the focus and approach of some other planned reviews to ensure their relevance in the context of the crisis. New streams of work have been introduced, such as my review of the Test, Trace and Protect programme, and my local audit teams have contributed to my wider COVID-19 learning work.

6 This report is a summary of the issues presented in more detailed reports to the Health Board this year (see **Appendix 1)**. I also include a summary of the status of planned work currently being re-scoped.

7 **Appendix 2** presents the latest estimate of the audit fee that I will need to charge to cover the costs of undertaking my work, compared to the original fee set out in the 2020 Audit Plan.

8 **Appendix 3** sets out the financial audit risks set out in my 2020 Audit Plan and how they were addressed through the audit.

9 The Chief Executive and the Director of Finance have agreed the factual accuracy of this report. We presented it to the Audit Committee on 17 December 2020. The Board will receive the report at a later Board meeting and every member will receive a copy. We strongly encourage the Health Board to arrange its wider publication. We will make the report available to the public on the Audit Wales website after the Board have considered it.

10 I would like to thank the Health Board's staff and members for their help and co-operation throughout my audit.

Key messages

Audit of accounts

11 I concluded that the Health Board's accounts were properly prepared and materially accurate, and my work did not identify any material weaknesses in the Health Board's internal controls (as relevant to my audit). I have therefore issued an unqualified opinion on their preparation. However, I placed an Emphasis of Matter paragraph in my report to draw attention to disclosures in the accounts relating to a Ministerial Direction to fund NHS clinician's pension tax liabilities in respect of the 2019-20 financial year. My opinion was not modified in respect of this matter.

12 The Health Board did not achieve financial balance for the three-year period ending 31 March 2020 and so I have issued a qualified opinion on the regularity of the financial transactions within the Health Board's accounts.

13 Alongside my audit opinion, I placed a substantive report on the Health Board's financial statements to highlight the failure to achieve financial balance and to have an approved three-year plan in place.

Arrangements for securing efficiency, effectiveness and economy in the use of resources

14 My programme of Performance Audit work has led me to draw the following conclusions:

- the Health Board maintained a good overall focus on governance, risk and quality during its response to the first phase of the pandemic
- reasonable financial arrangements were put in place to respond to COVID-19, and until the recent additional financial allocation announced in November, there were significant risks to the Health Board's financial position
- the Health Board's quarterly operational plans are helping it to respond to a range of complex service risks, but there is a need for a strategy to recover services to help ensure they provide sustainable capacity and improvements in productivity
- the Health Board demonstrates a commitment to counter-fraud, has suitable arrangements to support the prevention and detection of fraud and is able to respond appropriately where fraud occurs
- Overall, I found that the interim appointments were made in accordance with SFIs but that the daily rate paid to the Interim Recovery Director was above most of the benchmark comparators.
- the refurbishment of Ysbyty Glan Clwyd successfully removed the asbestos and created better facilities for patients, but there were several weaknesses in the governance and management of the project, which resulted in significant cost growth.
- I found that weaknesses in governance and oversight have led to inefficiencies, variation and tensions in the management of continuing healthcare, but the Health Board has been developing an ambitious plan for improvement.

15 These findings are considered further in the following sections.

Detailed report

Audit of accounts

16 This section of the report summarises the findings from my audit of the Health Board's financial statements for 2019-20. These statements are how the organisation shows its financial performance and sets out its net assets, net operating costs, recognised gains and losses, and cash flows. Preparing the statements is an essential element in demonstrating the appropriate stewardship of public money.

17 My 2020 Audit Plan set out the financial audit risks for the audit of the Health Board's 2019-20 financial statements. **Exhibit 4** in **Appendix 3** lists these risks and sets out how they were addressed as part of the audit.

18 My responsibilities in auditing the Health Board's financial statements are described in my Statement of Responsibilities publications, which are available on the Audit Wales website.

Accuracy and preparation of the 2019-20 financial statements

19 I concluded that the Health Board's accounts were properly prepared and materially accurate and issued an unqualified audit opinion on them. My work did not identify any material weaknesses in the Health Board's internal controls (as relevant to my audit), however, I placed an Emphasis of Matter paragraph in my report to draw attention to disclosures in the accounts relating to a Ministerial Direction to fund NHS clinician's pension tax liabilities in respect of the 2019-20 financial year.

20 We acknowledge the significant achievement of the Finance team in preparing the financial statements to a good standard, in the face of the challenges posed by the pandemic.

21 I must report issues arising from my work to those charged with governance before I issue my audit opinion on the accounts. My Financial Audit Engagement Lead reported these issues to the Health Board's Audit Committee on 29 June 2020. **Exhibit 1** summarises the key issues set out in that report.

Exhibit 1: issues identified in the Audit of Financial Statements Report

Issue	Auditors' comments
Uncorrected misstatements	There were no uncorrected misstatements
Corrected misstatements	There were several corrected misstatements which corrected classification errors or provided additional narrative disclosure
Other significant issues	The accounts were amended to include a contingent liability arising from a Ministerial Direction to fund NHS clinician's pension tax liabilities in respect of the 2019-20 financial year. My audit report includes an Emphasis of Matter in respect of this.

22 I also undertook a review of the Whole of Government Accounts return. I concluded that the counterparty consolidation information was consistent with the Health Board's financial position as at 31 March 2020 and the return was prepared in accordance with the Treasury's instructions.

23 My separate audit of the Charitable Funds financial statements is almost complete, and I anticipate that the accounts will be approved by the Charitable Funds Committee on 8 December 2020, following consideration of my report on the financial statements, and the audit opinion will be issued shortly afterwards.

Regularity of financial transactions

24 The Health Board did not achieve financial balance for the three-year period ending 31 March 2020 and had no other material financial transactions that were not in accordance with authorities not used for the purposes intended, so I have issued a qualified opinion on the regularity of the financial transactions within the Health Board's 2019-20 accounts.

25 The Health Board's financial transactions must be in accordance with authorities that govern them. The Health Board must have the powers to receive the income and incur the expenditure. Our work reviews these powers and tests that there are no material elements of income or expenditure which the Health Board does not have the powers to receive or incur.

26 Where a Health Board does not achieve financial balance, its expenditure exceeds its powers to spend and so I must qualify my regularity opinion. For the three-year

period ending 31 March 2020, the Health Board exceeded its cumulative revenue resource limit of £4,566 million by £118.813 million and therefore did not meet its financial duty.

27 I have the power to place a substantive report on the Health Board's accounts alongside my opinions where I want to highlight issues. Due to the Health Board's failure to meet its financial duties I issued a substantive report setting out the factual details: it failed its duty to achieve financial balance (as set out above) and it does not have an approved three-year plan in place and is operating under annual planning arrangements.

Arrangements for securing efficiency, effectiveness and economy in the use of resources

28 I have a statutory requirement to satisfy myself that the Health Board has proper arrangements in place to secure efficiency, effectiveness and economy in the use of resources. I have undertaken a range of performance audit work at the Health Board over the last 12 months to help me discharge that responsibility. This work has involved:

- undertaking a structured assessment of the Health Board's corporate arrangements for ensuring that resources are used efficiently, effectively and economically;
- reviewing the effectiveness of the Health Board's counter-fraud arrangements;
- examining arrangements for making Interim Senior Staff Appointments;
- reviewing the Refurbishment of Ysbyty Glan Clwyd project; and
- assessing the management arrangements that support delivery of Continuing Healthcare.

29 My conclusions based on this work are set out below.

Structured assessment

30 My structured assessment work was designed in the context of the ongoing response to the pandemic. I ensured a suitably pragmatic and relevant approach to help me discharge my statutory responsibilities, whilst minimising the impact on NHS bodies as they responded to the next phase of the COVID-19 pandemic. The key focus of the work was on the corporate arrangements for ensuring that resources are used efficiently, effectively and economically. Auditors also paid attention to progress made to address previous recommendations where these related to important aspects of organisational governance and financial management especially in the current circumstances.

31 The structured assessment grouped our findings under three themes:

- governance arrangements;
- managing financial resources; and
- operational planning: to support the continued response to the pandemic balanced against the provision of other essential services.

Governance arrangements

32 My work considered the Health Board's ability to maintain sound governance arrangements while having to respond rapidly to the unprecedented challenges presented by the pandemic. My work found **that in overall terms, the Health Board maintained a good overall focus on governance, risk and quality during its response to the first phase of the pandemic**.

33 The Health Board revised its governance and management arrangements in response to the significant challenges presented by Covid-19. The command and control and cabinet supported agile decision making and effective scrutiny. However, I found scope to improve emergency planning to strengthen resilience arrangements in the future. During the first wave of the pandemic, the Board took steps to conduct its business with transparency and demonstrated good leadership, but the pressures remain, and so there is a need to ensure the resilience of the senior management.

34 The Health Board developed specific arrangements for managing risks in relation to COVID-19 alongside continuing preparations to implement its new risk management strategy. My work also recognised some progress in strengthening organisational structures, particularly in acute services but at the same time there are also some concerns in specific areas such as the Mental Health division.

Managing financial resources

35 I considered the Health Board's financial performance, changes to financial controls during the pandemic and arrangements for monitoring and reporting financial performance. I found that **reasonable financial arrangements were put in place to respond to COVID-19, and until the recent additional financial allocation announced in November, there were significant risks to the Health Board's financial position**.

36 The Health Board has long-standing financial challenges and has continued to fail to meet its financial duties in 2019-20. Whilst the Health Board delivered slightly more savings than were planned, at just over £35 million, at the time of the audit there were significant financial risks to achieving the Health Board's planned deficit for 2020-21. These risks have since been reduced somewhat through Welsh Government financial allocation to support COVID-19 expenditure and additional funding to support performance improvement, announced in November.

37 Building on work started in 2019, the Health Board has continued to improve financial management arrangements and controls, progressing well with recommendations made by external financial consultants. My work also found that

key financial controls have operated throughout the pandemic, and the Health Board is undertaking further work to provide the Board with assurance.

Operational Planning

38 My work considered the Health Board's progress in developing and delivering quarterly operational plans to support the ongoing response to COVID-19 and to provide other essential services and functions in line with Welsh Government planning guidance. At the time of our work, the focus was on essential services with the aim of restoring normal and routine activities when it is safe and practicable to do so. **My work found that the Health Board's quarterly operational plans are helping it to respond to a range of complex service risks, but there is a need for a strategy to recover services to help ensure they provide sustainable capacity and improvements in productivity**.

39 Like other health bodies in Wales, the Health Board has adopted a shorter-term planning process to help respond to the rapidly changing environment as a result of COVID-19. My work has found that the quarterly planning process is improving, but plans need earlier scrutiny and greater explanation on risks to successful delivery. There also needs to be a stronger explanation of the impact and outcomes expected within the quarterly plans. This should help to ensure that progress monitoring can better assess the benefits achieved by delivery of those plans.

40 COVID-19 has exacerbated what was an already challenging position in respect of waiting times for elective treatment. To address this, the Health Board may need to be ambitious in the way it creates the necessary service capacity, engaging internal and external stakeholders in the process, to help shape a sustainable approach to recovery. The Health Board developed change management arrangements necessary to respond to the pandemic, adapted its capacity to meet the expected demand, responded well to its workforce challenges and risks, implemented the rainbow hospitals and progressed with some significant digital developments. The overall response to COVID-19 demonstrated that the Health Board can deliver complex change with pace and it should seek to build on the strengths of those arrangements for the future.

Effectiveness of counter-fraud arrangements

41 In June 2019, I published an overview for the Public Accounts Committee describing counter-fraud arrangements in the Welsh public sector. My team then undertook a more detailed examination across a range of Welsh public sector bodies to examine how effective counter-fraud arrangements are in practice and to make recommendations for improvement. In July 2020 I published Raising Our Game – Tackling Fraud in Wales setting out a summary of my findings and seven 'key themes' that all public bodies need to focus on in raising their game to tackle fraud more effectively.

42 Whilst this work was not included in the Health Board's audit plan, I also published an additional report setting out the Health Board's specific arrangements for preventing and detecting fraud. I found that The Health Board demonstrates a commitment to counter-fraud, has suitable arrangements to support the prevention and detection of fraud and is able to respond appropriately where fraud occurs.

Arrangements for Interim Senior Staff Appointments

43 My review examined the process followed by the Health Board in appointing five interim senior staff between February and October 2019, including the Interim Recovery Director. Overall, I found that the interim appointments were made in accordance with SFIs but that the daily rate paid to the Interim Recovery Director was above most of the benchmark comparators.

44 My review indicated that all the interim appointments were made using firms listed on approved framework agreements. This is consistent with the provisions set out in the Health Board's Standing Financial Instructions and Procurement Guidance for Staff. The Welsh Government agreed to contribute £350,000 towards the cost of the Interim Recovery Director, but played no part in the appointment itself, which was made by the Health Board before this funding had been confirmed. My work also found that whilst the Health Board asserts that competitive rates were negotiated for the appointment, I found that the £1,890 daily rate being paid by the Health Board for the Interim Recovery Director post is higher than most of the benchmark comparators that were used by officials during the appointment process.

The Refurbishment of Ysbyty Glan Clwyd

45 My report set out a factual account of the key matters contributing to the significant increase in the cost of the Ysbyty Glan Clwyd refurbishment project from that agreed in 2012. The refurbishment resulted in the successful removal of some 300,000 tonnes of contaminated waste from the site of a busy hospital. At the same time, the project has enhanced facilities that will provide patients and staff with a better experience and environment.

46 My review of the management of the programme of asbestos removal and refurbishment works at the hospital found weaknesses in the preparation of the business cases, deficiencies in the Health Board's governance and management of this project. The refurbishment was completed broadly on time in February 2019. Overall, there was an increase in project cost which resulted in the Welsh Government contributing £53.2 million and the Health Board contributing £7.2 million more than the £110.4 million funding originally awarded. Both the Health Board and the Welsh Government have taken action to strengthen their respective future approaches to managing and approving capital projects.

Continuing Healthcare arrangements

47 My work assessed the Health Board's management of Continuing Healthcare. I found that weaknesses in governance and oversight have led to inefficiencies, variation and tensions in the management of continuing healthcare, but the Health Board has been developing an ambitious plan for improvement.

48 In 2018, the Health Board altered the structure of its Continuing Healthcare team to help create local ownership for service delivery. The restructure created six sub-teams covering geographical areas (East, Central and West), specialist teams and also a corporate management team. However, while solving one issue, the new structure weakened the capacity for central coordination and management of continuing healthcare. These weaknesses have meant that services evolved in an unplanned way and led to some inefficiencies and occasional tensions between different teams. I also found opportunities to develop more consistent financial reporting, better utilise the IT systems and improve performance measurement and management.

49 More positively, since the autumn of 2019, the Health Board has been developing an ambitious improvement programme which should address many of the issues I identified in the review.

Appendix 1

Reports issued since my last annual audit report

Exhibit 2: reports issued since my last annual audit report

The following table lists the reports issued to the Health Board in 2020.

Report	Date
Financial audit reports	
Audit of Financial Statements Report	June 2020
Opinion on the Financial Statements	July 2020
Performance audit reports	
Structured Assessment 2020	October 2020
Effectiveness of counter-fraud arrangements	September 2020
Arrangements for Interim Senior Staff Appointments	March 2020
The Refurbishment of Ysbyty Glan Clwyd	July 2020
Continuing Healthcare arrangements	November 2020
Other	
2020 Audit Plan	March 2020

Exhibit 3: audit work still underway

There are a number of audits that are still underway at the Health Board. These are shown in the following table, with the estimated dates for completion of the work.

Report	Estimated completion date
Audit of the Charitable Funds Financial Statements Report	November 2020
Opinion on the Charitable Funds Financial Statements	December 2020
Orthopaedics	December 2020
Review of Welsh Health Specialised Services Committee	December 2020
Test, Trace and Protect	December 2020
Unscheduled care	Phase 1 – February 2021 Further work to be included as part of 2021 plan
Quality Governance arrangements	April 2021
Review of Ophthalmology (deferred with a view to replacement)	

Appendix 2

Audit fee

The 2020 Audit Plan set out the proposed audit fee of £407,921 (excluding VAT). My latest estimate of the actual fee, on the basis that some work remains in progress, is in keeping with the fee set out in the outline.

Appendix 3

Financial audit risks

Exhibit 4: financial audit risks

My 2020 Audit Plan set out the financial audit risks for the audit of the Health Board's 2019-20 financial statements. The table below lists these risks and sets out how they were addressed as part of the audit.

Audit risk	Proposed audit response	Work done and outcome
The risk of management override of controls is present in all entities. Due to the unpredictable way in which such override could occur, it is viewed as a significant risk [ISA 240.31-33].	My audit team will: • test the appropriateness of journal entries and other adjustments made in preparing the financial statements; • review accounting estimates for biases; and • evaluate the rationale for any significant transactions outside the normal course of business.	On a sample basis we tested both journal entries and accounting estimates and found no evidence of the management override of controls. We were satisfied that the accounts were free from material error.
There is a risk of material misstatement due to fraud in revenue recognition and as such is treated as a significant risk [ISA 240.26- 27].	My audit team will consider the completeness of miscellaneous income.	As part of our audit testing, we carried out work to provide assurance over the completeness of miscellaneous income, including third party verification. We were satisfied that it was materially stated.
The Board will once again fail to meet its first financial duty to break even over a three-year period. The position at month 10 shows a year-to-date deficit of £34.3 million and a forecast year-end deficit of £41 million. This, combined with the outturns	My audit team will focus its testing on areas of the financial statements which could potentially contain reporting bias.	We undertook a range of audit work to provide assurance over the risk of bias to ensure that the actual deficit position did not worsen from the forecasted position. This included:

Audit risk	Proposed audit response	Work done and outcome
for 2017-18 and 2018-19, predicts a three-year deficit of £121.1 million. As a result, I will be qualifying my regularity audit opinion and placing a substantive report on the financial statements highlighting the failure. The current financial pressures on the Board increase the risk that management judgements and estimates could be biased to ensure the forecast deficit does not worsen further.		• detailed sample testing of transactions either side of the year-end to ensure that they were recorded in the correct accounting period. This was focussed on the areas of greatest risk. • ensuring that accounting estimates were prepared on a reasonable basis and were supported by appropriate accounting judgements. We were satisfied that the accounts were free from material error. However, I qualified the regularity audit opinion.
On 18 December 2019 the First Minister issued a formal Ministerial Direction to the Permanent Secretary requiring her to implement a 'scheme pays' initiative in respect of the NHS pension tax arrangements for clinical staff.	We are considering the accounting treatment and audit implications of the direction (the first in Wales since 1999) in conjunction with the National Audit Office which is currently addressing the same issue in NHS England.	We satisfied ourselves that the contingent liability disclosure made in the accounts was appropriate. An Emphasis of Matter in respect of this matter was contained in the Audit report.
Introduction of IFRS 16 Leases in 2020-21 may pose implementation risks.	My team will undertake some early work to review preparedness for the introduction of IFRS 16 Leases.	As a result of the COVID-19 pandemic, the implementation of IFRS 16 was delayed into 2021-22. We will undertake this work next year.

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Continuing Healthcare arrangements – Betsi Cadwaladr University Health Board

Audit year: 2019-20

Date issued: November 2020

Document reference: 2016A2020-21

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

Contents

Summary report

Background

1 Continuing NHS Healthcare (CHC) is a package of care provided by the NHS for those individuals with primary health needs[1]. Health boards are responsible for ensuring that CHC is provided to eligible adults and Continuing Care is provided for eligible children and young people[2].

2 The Welsh Government provides guidance and advice for Health Boards on CHC. The National Framework for Continuing NHS Healthcare (The National Framework) sets out a mandatory process for the NHS, working together with local authority partners, to assess health needs, decide on eligibility and provide appropriate care. Several resources have also been developed to support the delivery of the National Framework, for example a Decision Support Tool which supports the CHC assessment process.

3 The National Framework sets out its expectations of Local Health Boards in managing CHC, as shown in **Exhibit 1**.

Exhibit 1: Organisational Expectations for CHC

Local Health Boards are responsible for:

- ensuring consistency in the application of the National Framework for CHC;
- promoting awareness of CHC;
- implementing and maintaining good practice, ensuring quality standards are met and sustained;
- providing necessary training and development opportunities for practitioners; identifying and acting on issues arising in the provision of CHC;
- informing commissioning arrangements, both on a strategic and individual basis;
- ensuring best practice in assessment and record keeping; and
- provision of strategic leadership and organisational and workforce development, and ensuring local systems operate effectively and deliver improved performance.

(The National Framework for Continuing NHS Healthcare)

4 In 2019-20, Betsi Cadwaladr University Health Board (the Health Board) spent £106.2 million on CHC. This was an increase of around 8% compared to the previous year. CHC costs per head of population in the Health Board were the

[1] CHC is different from 'Funded Nursing Care' provided for people in nursing homes that require nursing support but are not considered to be eligible for CHC

[2] For the purposes of this review the use of the term CHC refers to both Continuing Healthcare for adults and Continuing Care for children and young people.

second highest of any health board in Wales in 2018-19 and CHC expenditure continues to create significant financial pressures for the Health Board.

5 This review assessed the Health Board's management arrangements for CHC at the corporate and operational level and included an examination of financial management and performance management arrangements and supporting information systems. The quality of the Multi-Disciplinary Team (MDT) decision making process and the NHS CHC panels i.e. whether decisions reached are appropriate sat outside of the scope of our review.

6 Our review was undertaken during January and February 2020 and therefore took place ahead of the declaration of the COVID-19 pandemic. We acknowledge that the Health Board has made several short-term changes to its CHC processes in response in line with Welsh Government guidance. This included implementation of a new Discharge to Recover and Assess process. The Discharge to Recover and Assess process means that patients that may be eligible for CHC have their care fully funded by the Health Board due to normal CHC assessments and processes being suspended. At the time of writing the Health Board was awaiting a national decision on when the usual CHC process should resume. We anticipate that this review can provide helpful reflections and valuable learning for the Health Board as it starts to reinstate normal CHC processes.

7 Audit Wales has also recently undertaken reviews of Social Services Budgetary and Cost Pressures at Denbighshire County Council and Conwy County Borough Council.[3] These reviews looked at how the Councils commission and administer residential and nursing home care placements and so may provide further context on some of the issues raised in this report. In addition, we are intending to undertake a further review of residential and nursing home commissioning during 2020-21 which will involve the Health Board and all six north Wales councils.

Key messages

8 Overall, our work has found that weaknesses in governance and oversight have led to inefficiencies, variation and tensions in the management of CHC. But the Health Board has been developing an ambitious plan for improvement.

9 Prior to 2018 the Health Board managed CHC through a single health board-wide team. However, it was recognised that this structure did not adequately foster ownership of the CHC processes by operational staff, particularly in relation to budgetary management. Therefore, in 2018 the Health Board altered the structure of its CHC team, creating six sub-teams covering geographical areas, specialities and corporate aspects of CHC management. However, while solving one issue, the new structure weakened the capacity for central coordination and management of continuing healthcare. These weaknesses have meant that the management of

[3] Both 'Social Services Budgetary and Cost Pressures' reviews are due to be published to the Audit Wales website in October 2020.

CHC since 2018 evolved in an unplanned way and has led to some inefficiencies and occasional tensions between different CHC teams.

10 We also found that the Health Board's wider corporate arrangements are not yet effectively supporting the devolved CHC teams. There are opportunities to develop more consistent financial reporting, better utilise the IT systems and improve performance measurement and management. Staff raised significant concerns around weaknesses in the fee setting for care homes which has been causing tensions between partners, care homes and patients and their families. The Health Board has recently agreed to increase the fees paid to care homes to address this issue.

11 Lastly, we found varying performance across the CHC area teams and mental health division.[4] However, we did identify that since the autumn of 2019, the Health Board has been developing an ambitious improvement programme. This improvement programme, if it can be given sufficient momentum, should help to address many of the issues identified in this report.

12 Recommendations arising from this audit are detailed in **Exhibit 2**. The Health Board's management response to these recommendations are summarised in **Appendix 1**.

Recommendations

Exhibit 2: recommendations

The table below sets out the eight recommendations from our review.

Recommendations
The Health Board should develop a range of relevant and accessible governance documents for its management of CHC
R1 Building on the new national Framework (when published) and supporting tools, the Health Board should develop a set of key guidance documents to ensure consistent management of CHC across its teams. In addition, the Health Board should develop standard operating procedures that guide team members in the use of certain CHC tools such as the checklist.

[4] We do not comment on the quality of contracted and commissioned CHC services which sat outside the scope of this review.

Recommendations

The Health Board should introduce a consistent and accessible training programme for CHC team members and those that engage with CHC

R2 Following development of new guidance detailed in **R1** the Health Board should develop a consistent and accessible training programme for CHC team members and those that routinely engage with CHC (ie members of the MDT). In developing the programme, the Health Board could usefully engage with key partners such as local authorities and providers.

The Health Board should increase consistency of its CHC team structures and ensure roles are clearly articulated and understood

R3 The Health Board's work to drive consistency in the structure of its operational CHC area / divisional teams and divisions should include work to ensure job descriptions reflect the roles required. These should be clearly articulated and understood by existing and new CHC area/divisional team members.

The Health Board should introduce a formalised escalation procedure to resolve CHC disputes between its teams

R4 The Health Board should formalise and implement escalation arrangements for CHC disputes at pace. There should be a clear procedure which is widely understood by relevant staff and can be used to quickly resolve internal disputes, for example, which team should take the budgetary responsibility for specific CHC patients.

The Health Board should seek to invest and develop its CHC contracting and commissioning team

R5 The Health Board's role as a contractor and commissioner of CHC is underdeveloped which causes inefficiencies and tensions amongst its staff and its providers. The Health Board should resume the work it began in 2019 to develop a CHC contracting and commissioning team with the capacity and capability to plan and deliver CHC more effectively and efficiently.

The Health Board should have consistent reports across its CHC teams to enable the identification of good practice and learning opportunities

R6 The finance team provides a range of different reports for each operational CHC area team and division which produces different insights on performance and expenditure. This makes it difficult to identify areas of good practice or

Recommendations

learning opportunities between teams. Quality metrics for CHC are also underdeveloped. With central co-ordination and oversight, Operational CHC teams and divisions should work together to explore and agree on a set of quality, financial and performance metrics to manage CHC effectively and consistently across the Health Board.

The Health Board should ensure its CHC teams use the BroadCare IT system effectively and consistently

R7 The BroadCare IT system for managing CHC patients is not yet operating effectively at the Health Board due to weaknesses in its implementation, lack of training and lack of administrative support. In order to maximise the value of the system in managing CHC, the Health Board should:

- address the backlog of incomplete records through additional short-term capacity;
- ensure the system is set-up correctly for the Health Board, with system terminology matching that of the CHC process;
- ensure CHC teams are sufficiently trained on the use of the system; and
- ensure the corporate finance team use the system effectively.

The Health Board should formalise leadership within the corporate CHC team

R8 While the Health Board took steps to strengthen leadership within its corporate CHC team during 2019, arrangements are currently temporary. The Health Board should seek to develop longer-term leadership to ensure improvement and robust central oversight of its CHC management.

Exhibit source: Audit Wales

Detailed report

Weaknesses in the governance and oversight of CHC has led to inefficiencies, variation and tensions in its management, but the Health Board has been developing an ambitious plan for improvement

While the restructuring of CHC teams in 2018 had some benefit, the lack of central co-ordination and management impacted the CHC teams' ability to operate effectively

CHC restructuring in 2018 created improved divisional ownership for continuing healthcare

13 In 2018, the Health Board altered the structure of its CHC team, creating six sub-teams covering both corporate and operational aspects of CHC management. Prior to this, the Health Board managed CHC through a single team, which was hosted by one of its three geographical 'areas'. However, this structure caused concerns that operational CHC staff did not take ownership over the process, particularly in terms of the budget. This was leading to significant cost growth.

14 The CHC teams are currently structured as follows:

- three operational 'area' teams covering the geographic areas of east, central and west north Wales with responsibility for both general and elderly mental health CHC patients;
- a mental health operational team which covers all of North Wales;
- a children's services operational team which covers all of North Wales; and
- a corporate team, which covers aspects such as training and retrospective claim reviews.

15 Those we spoke to as part of our fieldwork were generally of the view that devolving the management of CHC to more local teams has been positive. For example, there is a consensus of views that the operational team staff take greater ownership over the CHC process and budget under the new structure. Operational teams also have the benefit of having a greater understanding of the services available within their area and can make effective use of locally developed relationships between partners, such as local authorities and care homes.

Limited central coordination has allowed unnecessary variation in processes and duplication of effort

16 From the point of restructure in 2018, the Health Board intended that the corporate CHC team would have a vital role in establishing robust arrangements that enables effective management of CHC across the Health Board. The corporate CHC

team's responsibilities include developing and monitoring the use of Health Board guidance, providing necessary training materials and courses; overseeing and managing the appeals process and managing retrospective claims for CHC.

17 Despite these intentions, the corporate team is small, and its capacity has recently been further strained due to staff secondments, long-term sickness absence and ongoing vacancies. Its lack of capacity has limited its ability to support and co-ordinate the operational teams. The team has been focussing on managing retrospective reviews and on identifying learning themes from appeals and complaints, which led to the recent development of a new appeals process.

18 The Health Board recognises that there are several areas where CHC processes and management should be strengthened. For example, use of the CHC checklist[5] is inconsistent which can have a direct consequence for patients. This includes variation in the period for which teams will fund care between a patient's positive checklist result (ie care is required) and the point at which the Decision Support Tool and CHC panel formally agrees a CHC package. Standard operating procedures could helpfully provide guidance in this way.

19 We are aware that some operational teams have taken steps to strengthen their own governance, such as the mental health CHC team strengthening controls by developing its operational framework. While such steps may lead to more effective working for individual teams, the absence of governance across teams is a cause for concern. This may allow undesirable variability and practice across the organisation (**Recommendation 1**).

Operational teams have developed in an ad hoc way and now vary in terms of size, seniority and experience, reflecting differing levels of investment across areas

20 Each of the operational CHC teams were small following changes to the CHC structure in 2018. Since that time each division has taken steps to increase the size and alter the structures of their teams.

21 While some teams were able to secure investment from within their divisions quickly and with relative ease, others have taken a more gradual approach and utilised temporary funding such as Invest to Save Fund and the Integrated Care Fund. This has resulted in notable differences between operational CHC teams, for example:

- teams have significantly varied numbers of substantive and temporary roles including managers, care facilitators and nurse reviewers;
- some teams have developed structures wherein the members specialise in different types of CHC patients where others have not; and

[5] In addition to the National Framework and the Decision Support Tools that Health Boards are required to use, the Welsh Government also recommends the use of the CHC checklist

- the mental health team has developed a Right Care and Assurance Programme (RCAP) function to manage high-cost care cases within their cohort of patients.

There was no central coordination of these changes and as a result the individual team structures have evolved independently of one another.

22 The Health Board has traditionally recruited CHC staff by attracting candidates with a nursing background. However, some of those we spoke to explained that the expectations of CHC staff are more specific. For example, staff should also be able to demonstrate higher levels of resilience and be skilled at managing difficult conversations. In addition, following the structural changes in 2018 there was no formal evaluation of job descriptions to reflect the differences of working in localised teams. Several of those we spoke to told us that their roles had altered significantly but that their job descriptions had not been updated to reflect the changes. Given the complexity and sensitivity surrounding the CHC process, there is a risk that current arrangements require staff to undertake roles and discharge responsibilities that go beyond the expectations formally set out by the Health Board.

23 As part of the Health Board's developing improvement plans for CHC (discussed further in **paragraphs 71-75**), it intends to develop workforce plans and re-evaluate the operational structure of its CHC teams. At the time of our fieldwork the Health Board was conducting workshops to develop a model team structure for CHC, utilising service demand and productivity benchmarks. This work is important in supporting decision-makers to ensure appropriate capacity, capability and consistency of the Health Board's CHC teams (**Recommendation** 3).

24 The resilience and stability of the Health Board's CHC teams is a further key concern. The rates of sickness absence and turnover within the Health Board's CHC teams are comparatively high which impacts on the capacity and resilience of teams. For one of the area operational teams the longest serving member of the team had been in post for two years. This is a further risk for the Health Board in ensuring it can ensure its ability to discharge its responsibilities in respect of CHC over the long-term. Increasing the stability and resilience of its CHC area teams and divisions should be a key consideration of the Health Board's work to develop CHC workforce plans.

The Health Board's CHC training is not yet fit for purpose

25 The national framework for CHC requires partners to provide access to appropriate training for staff involved in CHC. Following the publication of the National Framework in 2014, the Health Board was engaged in a regional CHC training and education group with local authority representatives, but this is no longer in operation. Subsequently, the corporate team developed a training package for CHC team members. However, capacity constraints and workload pressures have limited access to this training. As a result, different operational teams have developed their own training and induction programmes, which include a mixture of shadowing, observing and practicing with anonymised packages and mock panels.

The length of time teams provide for new recruits to train varies from a few days to three months. This inevitably makes it challenging to drive consistency and effectiveness in the management of CHC across the Health Board.

26 In addition, patients can be referred for CHC from a range of professional staff and various environments. There is currently no general training on CHC available for staff that are outside of CHC teams, such as ward nurses, although there is an information leaflet on the role of the Care Co-ordinator. CHC staff members we spoke to feel that there is a long-standing confusion across the Health Board regarding the role of CHC, particularly in terms of how it fits into the wider picture of patient flow, discharge planning and reablement. Inability to access training presents a missed opportunity to more fully inform and educate members of staff who, while sitting outside the direct CHC teams, impact on the CHC process through their involvement with patients (**Recommendation** 2).

27 While there is currently no training strategy for CHC, at the time of our fieldwork the Health Board had an ambition to develop such a strategy and was considering how to progress this work. For example, it may work with its partner local authorities to reinstate a joint training group following the publication of the new national Framework. The publication of the new Framework has been delayed as a result of the pandemic. In light of changes created by the COVID-19 pandemic there is now an even greater opportunity for the Health Board to reflect on any changes it saw as beneficial and implement a formal and accessible training programme that supports the Health Board in improving its CHC processes.

While there is good engagement between the corporate and operational teams, there are examples of significant tensions between operational CHC teams

28 Those we spoke to told us of how the relationship between the corporate and operational CHC teams work well. Although limited by its capacity, the corporate CHC team attempts to make itself available to support the operational teams with ad hoc queries and to provide learning points such as from retrospective reviews, appeals and Welsh Government guidance.

29 However, we heard examples of significant tensions between operational teams that can lead to internal disputes. These are mainly caused by a disagreement over which operational team should take primary ownership and financial responsibility for an eligible CHC patient. The differing budgets and organisational structures for each team, along with separate CHC panels has caused disagreements over which team/s should fund patients either with multiple needs, ie mental health and physical health, high-cost or complex needs.

30 Internal disputes have in the past become significant and protracted. While staff we spoke to were confident that this does not impact on quality of care, it causes significant frustration between staff. The corporate CHC team is often aware of the ongoing issues, however they do not have the power to arbitrate disputes, as they must be resolved between divisions (which hold the specific budgets for each team). The absence of policies such as pathways for specific care needs means

there is little to guide staff in the event of a dispute. At the time of our fieldwork the Health Board were developing a set of principles for dispute resolution. To add to this, the Health Board should develop a formal escalation process that staff can access and apply to reduce tensions and delays in the management of CHC (**Recommendation 4**).

Wider arrangements to support effective continuing healthcare management are underdeveloped

Multidisciplinary team decision making processes are starting to strengthen with the aim of improving the quality of their recommendations

31 A fundamental part of the CHC process is the work of the multidisciplinary team. The multidisciplinary team can draw on members from several professional disciplines such as doctors, nurses, therapists and social workers. The multidisciplinary team assesses the eligibility of a patient for CHC, develops a care package to meet the needs identified and presents a recommendation to the CHC panel to approve or challenge the recommendation. The multidisciplinary teams are led by care co-ordinators who coordinate the whole process of assessment for longer-term care, including gathering evidence to inform the decision on CHC eligibility.

32 It is crucial that multidisciplinary teams have the capacity and capability to undertake these roles effectively to ensure eligible patients can receive the right care in the right place and at the right time. Multidisciplinary team recommendations can be challenged and rejected by the CHC panel if they are judged to be incomplete or at odds with the National Framework. The National Framework states, 'Only in exceptional circumstances and for clearly articulated reasons should the LHB not accept the multidisciplinary team's expert advice on CHC eligibility'. Although there is a mechanism to appeal such judgements and to submit retrospective claims, this can cause distress for the patient and family and is costly and time-consuming for the Health Board. Therefore, the focus should be on getting the right decision made first time. Members of staff from the Health Board told us that a significant number of CHC applications submitted by multidisciplinary teams are regularly challenged or rejected by CHC panels. This suggests there may be room for improvement in the quality of multidisciplinary team recommendations to the CHC panel as well as potentially the application of the CHC eligibility criteria by the panel.

33 The Health Board has increasingly recognised that it must provide greater support to its multidisciplinary team to ensure that they fully understand the CHC process, which, in turn will ensure greater quality of applications received by the CHC panel. Some operational teams have acted by placing one of the CHC team members to act as an expert to guide multidisciplinary team discussions, helping them to navigate the national Framework and other legal frameworks. The Health Board

has a CHC improvement group (see **paragraph 71**) which, at the time of fieldwork, was evaluating this approach with a view to implementing it more broadly across each operational area team.

34 We also found that some divisional CHC operational teams are seeking to better engage with staff that are likely to be called upon as care co-ordinators by inviting them to observe multidisciplinary team discussions and CHC panel decisions. Those we spoke to said these steps were improving the quality of CHC applications while also managing the expectations of patients and families more effectively and appropriately than before. However, as detailed earlier in this report there are capacity restraints within the CHC teams which limits the availability of staff to provide support.

There is scope to improve partnership working between the Health Board and local authorities in the management of CHC

35 The National Framework for CHC makes clear the expectation that Health Boards and Local Authorities work effectively in partnership for specific elements of managing CHC, such as appointing jointly funded care packages, dealing with formal disputes and commissioning for residential and nursing homes. Effective management of CHC is, in many cases, dependent on effective communication between the Health Board and Local Authority, for example where a patient requires a housing adaptation before they can be discharged from hospital.

36 As described in **paragraph 7**, as part of our wider audit work programme, we have recently undertaken a review of social services financial pressures in Denbighshire County Council and Conwy County Borough Council. Both reviews indicate some weaknesses in partnership working which can cause delays in managing a patients' care and tensions between partners, providers and patients, including lack of communication regarding:

- the outcome of CHC panel decisions;
- changes to the nursing home rates previously agreed between partners; and
- the next steps for patients who, following review, are found to no longer be eligible for CHC packages.

These examples are largely a result of poor or slow communication between partners. We are aware that the urgent issues caused by the COVID-19 pandemic resulted in partners engaging in proactive and rapid communication to ensure patients had appropriate and timely access to CHC. The Health Board should build on this work with partners to reflect on how they can improve communication arrangements in the long-term. Again, this is an area where consistent guidance and accessible training (as referenced in **Recommendations 1 and 2**) could prove beneficial.

Commissioning and finance support for CHC teams is under-developed

37 The National Framework advises Health Boards to adopt an integrated approach of working with local authorities to commission CHC services to 'exercise maximum influence over the development of provision.' The Health Board does not currently commission services through a planned, collective approach, relying instead on spot purchasing. Spot purchasing refers to the practice of buying to meet an immediate need. The practice of spot purchasing means that the Health Board is engaged in a resource intensive practice which does not guarantee best value for money. The Health Board has, however, recently sought the support of the National Collaborative Commissioning Unit (NCCU) to identify ways to support it in terms of commissioning, planning and working with providers. In addition, the Health Board is in the process of developing a commissioning team and business support hub, which it intends will be able to further progress its commissioning capacity and experience.

38 In June 2019 the Health Board utilised Invest to Save funding to recruit a Head of Commissioning based within the corporate CHC team. The intention was to subsequently establish a commissioning team. However, due to pressures with the Health Board's management of CHC previously discussed in this report such as teams needing ad hoc support and advice, the appointed Head of Commissioning was asked to undertake an interim management role for the corporate team. This represents a poor use of resources as the Health Board are not using their resources as planned to make improvements but are instead having to focus on managing operational issues in a reactive way. The Health Board should resume plans to develop a skilled and dedicated commissioning capacity and capability (**Recommendation 5**).

39 There is a dedicated finance resource to support the Health Boards management of CHC, however, its capacity has been stretched since the expansion to six CHC teams in 2018. Operational CHC teams indicate that in general they receive good support from the finance team. The finance team collates CHC activity and cost data into weekly, monthly and quarterly reports but has developed different reporting content for different teams focussing on different aspects of financial performance and improvement. This results in lost opportunities that would arise from consistent reporting approaches across teams, for example:

- benchmarking and performance can be shared to support learning; and
- a smaller number of standardised reports would make better use of finance team capacity. This in turn could enable finance staff to better support service development.

The Health Board should therefore have consistent reports across its CHC teams to enable the identification of good practice and learning opportunities (**Recommendation 6**).

The process of fee setting for CHC is a cause of tension

40 In addition to support from the finance team, the operational CHC teams also receive support from a contract management function. This has helped set agreed standards of service, monitoring agreements and escalating procedures with local authorities and care homes. Not all nursing homes are signed up to the agreement and in these instances, the contracting team will have a funding letter in its place.

41 Several staff we interviewed also raised concerns about the process of fee setting with care providers. While there's been a focus on CHC savings by the Health Board, there is a growing discontent amongst care home and domiciliary care providers with the current arrangement for setting fees. This is due to factors such as:

- the income from the Health Board for care homes hasn't increased with the rate of inflation for several years;
- rates for CHC, albeit often requiring intensive care services, being lower than the rates of Funded Nursing Care which are paid by the Local Authority. This has the potential to impact on the quality and sustainability of services; and
- some care homes have raised fees for some elements of their service, commonly referred to as 'top-up fees' which have not been agreed with the Health Board.

42 These issues have caused significant tension between the Health Board, some CHC providers and their patients and families which also sometimes inappropriately draws in ward staff to help manage this issue on a case by case basis.

43 At the time of fieldwork, we were aware that the Health Board had increased engagement with partners to agree a way forward which provides a clear and fair fee setting arrangement that all partners can sign up to and uphold. The Health Board has recently taken significant steps to address this issue. In response to pressures caused by the first phase of the pandemic, the Health Board agreed uplifts to care home fees. In 2020-21 the Health Board's broader financial planning also included long-term uplifts to care home fees.

The IT system for CHC is not yet being utilised effectively, leading to a reliance on less resilient systems

44 The Health Board uses an IT system called BroadCare to manage CHC. The system acts as a database which holds information on the patients in the CHC process. The BroadCare system was introduced at the Health Board in 2018. However, there were some weaknesses in the way the system was implemented within the Health Board which continue to affect its utility.

45 The BroadCare system was originally developed for NHS England and is widely used by NHS Trusts in England. There were therefore some features of BroadCare that were not well-suited to the Health Board due to differences between working practices and CHC processes between NHS England and NHS Wales. There was

limited recognition of these issues when the system was originally implemented, and the support to implement the system within the Health Board, including opportunities for training staff was not sufficient, being limited to a one-day training package and access to a test system for three months. The Health Board attempted to adopt a train the trainer approach, involving developing two super users of BroadCare within each operational team. However, this had limited success as those we spoke to said there was a lack of capacity for people to learn through using the system. As a result, many staff have developed their own approaches to using the system, which has created inconsistencies.

46 The purpose of implementing BroadCare was to provide a single file repository and reporting system. Prior to BroadCare, information regarding CHC activity and spend was stored on Microsoft Excel spreadsheets. However, while the BroadCare system had been in place for over two years at the time of our review, data relating to activity and cost continues to be managed through Microsoft Excel spreadsheets. This is due to incomplete records within BroadCare which undermines the reliability and usability of the system for accurate reporting and payments. The contracting team has had issues due to patient records within the BroadCare IT system being incomplete which has caused delays in payments being made to providers.

47 Those we spoke to attributed the gaps in information within the BroadCare system to factors such as:

- some staff do not fully understand how to use the system;
- the system is not intuitive or compatible with their working practices; or
- lack of administrative capacity to complete current and past records.

48 There is a need to both correct and cleanse the historic data and ensure effective use of the system by staff so that the issues relating to data quality do not recur. The CHC Operational Group and Improvement Group are aware of and exploring ways to address these issues in order to maximise the use of BroadCare across its CHC function. As part of this process, the Health Board is also exploring ways to integrate BroadCare with other Health Board data systems. The Health Board should seek to address these issues urgently to improve the robustness of its patient records for CHC (**Recommendation 7**).

CHC performance is variable, and information on quality is insufficient, however, the Health Board is developing an ambitious improvement programme

Performance management and measures are limited and the Board does not regularly oversee CHC performance, but the Health Board is exploring opportunities for richer data

49 There are mechanisms for monitoring and reporting on CHC at local, operational levels. The various teams of CHC have their own mechanisms to monitor and

report their performance. Some information is also reported to various groups and sub-committees of the Board through different performance reports. Performance measures for CHC at the Health Board have mainly focussed on:

- Activity: number of cases, number of out of area placements, number of reviews, those overdue and breaches;
- Cost: per package, movement since last period and changes to annual forecasted spend against budget (including efficiencies); and
- Risks: including cases under dispute or not yet reviewed by panel.

50 The national CHC Framework states that at Board level, each Board should receive information, including relevant escalated actions relating to CHC and that performance reports should be shared with any local partnership board with local authorities. Our review has found that CHC does not currently feature strongly within the routine performance monitoring by the Board.

51 The Health Board has started to develop its performance monitoring of CHC to provide richer data that can drive improvement. For example, the corporate CHC team is looking at good practice English CHC key performance indicators to help strengthen its performance measurement and management information.

52 In addition, the BroadCare IT system has the functionality to provide business intelligence reports. At the time of our fieldwork the Health Board's performance team was starting to develop a dashboard which draws on activity, spend and quality data from BroadCare, though this will be dependent on BroadCare having reliable and complete records. The Health Board recognises that its information regarding patient experience remains absent, and that such qualitative information is a challenge to capture and present.

CHC spending continues to increase year-on-year

53 As **Exhibit 3** shows, spending on CHC increased each year since 2016-17. This level of growth is unlikely to be sustainable in the long-term.

Exhibit 3: annual Health Board spend on CHC

The below exhibit shows the annual Health Board spend on CHC between 2016-17 and 2019-20.

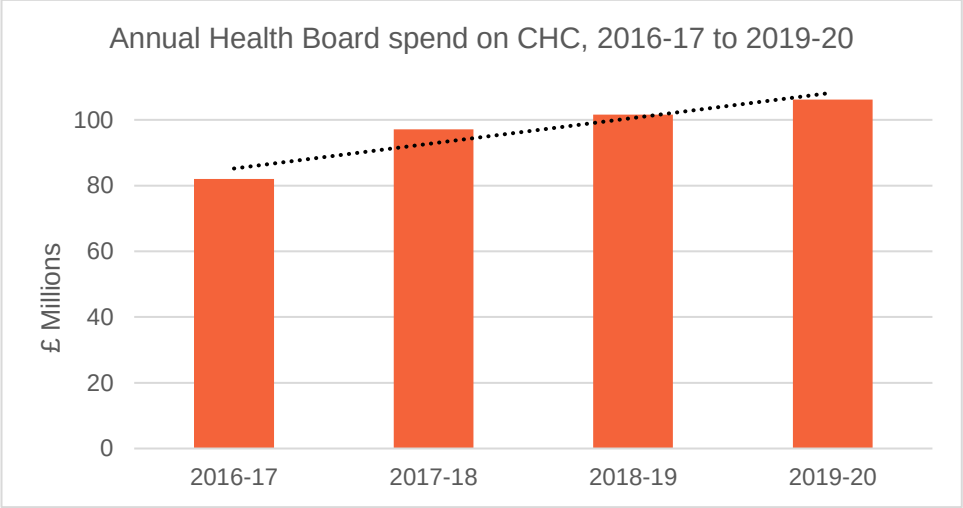

Exhibit source: Health Board data

54 An NHS benchmarking network exercise compared the spend and activity of CHC for each Health Board in Wales between 2016-17 and 2018-19. The benchmarking exercise suggested that the Health Board has the highest number of patients per 100,000 of population in 2018-19, calculated at 389. It is worth noting that some staff we spoke to felt that the benchmarking exercise was not meaningful due to perceived differences in the way Health Boards measure and record activity for CHC.

55 CHC teams have been required to deliver against savings targets to address the increasing spend of the function. Given the organisational structure for CHC, operational teams have their own savings targets, and performance and movement in expenditure varies significantly between operational area teams from one financial year to another, shown in **Exhibit 4**. The Health Board recognises that there is a benefit in reporting savings in a collective way and is now identifying common themes that areas can compare and learn from one another.

Exhibit 4: operational area movement in expenditure, 2017-2020

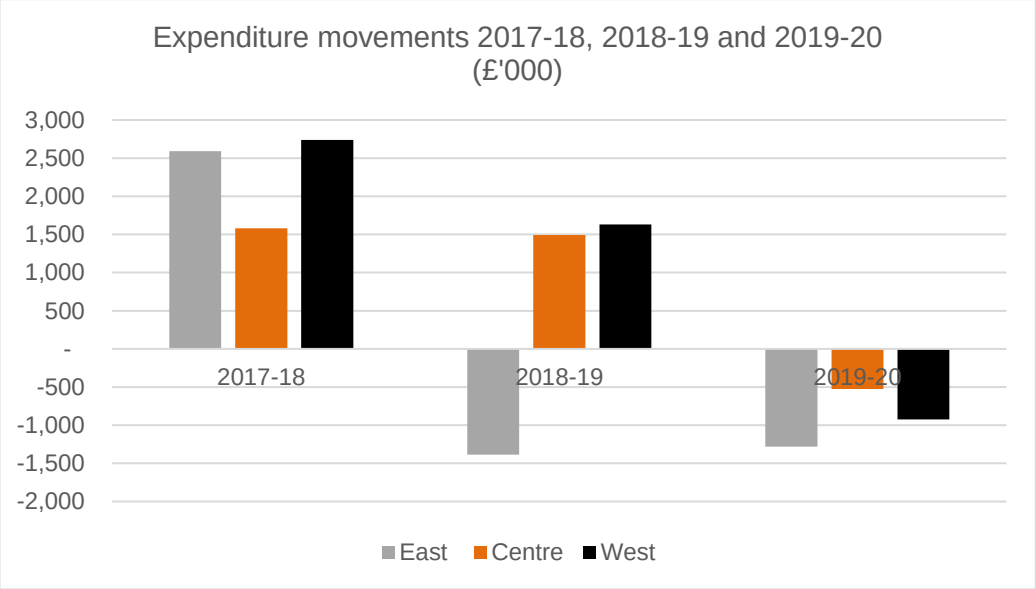

Exhibit source: Health Board data

56 Although CHC teams have individual savings targets, those savings are not subsequently available for the CHC teams to invest in the service, but rather are counted as savings within their broader respective divisions. This could be a barrier in terms of incentivising teams to make savings and pursue improvements, particularly if their divisions are not on board with the improvement agenda for CHC.

The Health Board regularly has overdue CHC reviews due to stretched capacity and external factors but has been making good progress with retrospective reviews

57 The National Framework sets specific performance expectations in terms of timeliness within the CHC process. For example, the time between a CHC assessment and agreeing a care package should be no longer than eight-weeks, or two days for a fast-track patient; and the time between first receiving CHC care and having a review of your care needs should be no longer than three months and annually thereafter.

58 While most of the Health Board's CHC work is completed in accordance with the expectations of the National Framework, it regularly sees breaches for a minority of cases. For example, since the introduction of the checklist there has been some instances of delays in CHC team members following up on the findings of the checklist which has led to patients waiting ten weeks which is beyond the eight-week limit.

59 We also heard examples of funding packages that had been agreed but not formally sent through to the CHC finance team, meaning providers had not been

paid for weeks, or even months following the placement of a patient within a care home. Given the lack of central co-ordination it is difficult for the Health Board to manage and mitigate this issue.

60 The Health Board regularly has a small number of overdue reviews. Overdue reviews can be protracted due to factors such as lack of capacity within CHC teams, difficulties in the patient's care such as movements in and out of hospital, and access to social workers.

61 During the pandemic the Health Board was required to suspend its usual arrangements for reviewing patients in receipt of CHC, although it did undertake light-touch safe and well checks. These checks, which were done remotely, provided assurance that patients were still receiving the right care.

62 Under a previous arrangement each Health Boards retrospective reviews were managed through a national project hosted in Powys. When this project came to an end in March 2019 each Health Board took back responsibility for retrospective claims in their area. The Health Board re-inherited 41 retrospective claims at that time. The Health Board has since made good progress with retrospective claims which can take a significant amount of time to progress due to the need for peer review, independent review or legal advice. At the time of fieldwork, the Health Board was anticipating having completed its investigations into all retrospective claims by the end of 2020.

Quality assurance arrangements are insufficient

63 The national framework states that the Health Board has a responsibility to monitor the quality of services provided through CHC in the context of provider performance as it would for all service contracts. It details that this includes making clear arrangements within purchasing and contracting processes on respective responsibilities.

64 The Pre-Placement Agreement (PPA) for nursing homes includes the providers' responsibilities regarding quality assurance, which includes the submission of a quarterly self-assessment survey of nursing homes which require providers to report against a set of indicators including falls and any submissions to Care Inspectorate Wales. The information from the survey is provided to the Health Board's contract management team and is discussed in quality meetings between contract management and operational teams. The information from the survey is also used to inform a rolling annual inspection programme. Inspections are undertaken between contracting representatives, practice development nurses and sometimes social service staff. These inspections look at a range of information including the care homes' insurance and training of staff.

65 However, not all the care homes contracted by the Health Board have signed up to the PPA and it is unclear whether the arrangements outlined above apply equally to those not signed up. While these arrangements partially cover care homes, the Health Board does not currently have established quality assurance arrangements for domiciliary care. The Health Board does not receive assurance on what domiciliary care providers are delivering and is currently unable to monitor them. At

the time of fieldwork, the Health Board was working on developing data drawn from and within the Health Board and from external sources such as Care Inspectorate Wales and partner Local Authorities. While this will support the Health Board to monitor providers to an extent it can only provide a limited level of assurance about the quality of care services provide for the its patients. The Health Board should work to develop quality metrics for CHC to support performance monitoring and reporting (**Recommendation 6**).

66 Since the start of the pandemic, there have been some changes to CHC quality assurance arrangements for CHC. This includes introduction of an escalation and support tool and a formal system for daily contact between care home providers, the Health Board and local authorities to rapidly identify issues and offer support. The Executive Director of Primary and Community Care's portfolio for CHC has also recently strengthened with clearer responsibility for quality assurance and oversight. As part of this, the Health Board is currently developing underpinning governance arrangements with operational groups and reporting lines.

There are greater opportunities to invest CHC expenditure in reablement to promote patient independence

67 The National Framework (for CHC) is supportive of the Welsh Government's wider aims of prevention and promoting independence. It states that 'CHC should not necessarily be viewed as a permanent arrangement. Care provision should be needs-led and designed to maximise ability and independence' (CHC guidance). There is an expectation that partners should work together to ensure that there is sufficient access to services which promote and support independent living and prevent needs from deteriorating. It is therefore vital that partners have a good and comprehensive range of core services to provide for needs of the current and future population.

68 However, many of those we spoke to at the Health Board felt several patients are in receipt of CHC because a core service provision is not available to them due to issues such as lack of funding or workforce shortages. Gaps in core services impact negatively on the ability and/or independence of some patients and makes their needs greater, and potentially needing CHC. One example cited frequently was a lack of access to district nurses. District nursing can provide substantial support to patients to enable them to stay healthy in their communities. In addition, gaps in services for children mean that children with primary health needs must go 'out of area' to receive the care they need, which negatively impacts the patient and incurs substantial costs to the Health Board.

69 Strengthening access to core services has the potential to prevent escalated health needs. This has benefits in terms of patient care and experience and produces efficiencies as there is less demand for more intensive CHC services. As part of the community transformation programme, area teams have been working to develop a wider range of core services which can support people to maximise their independence. This has on occasion included the block purchasing of discharge to assess beds in care homes. The Health Board recognises that there is scope for

greater investment into core services which will deliver longer term benefits for patients as well as the health and care system

The Health Board is developing an ambitious improvement programme for its CHC arrangements but needs to ensure there is a sustainable approach to the leadership of this important function

70 In September 2019, the Health Board appointed an Assistant Director for Primary and Community Services on a fixed-term contract to oversee CHC improvement. This appointment was made to strengthen leadership and oversight of CHC and we have noted a positive direction of travel since the appointment, albeit that we expect the additional capacity will be required over a number of years. The Health Board should formalise the leadership within the corporate CHC team to maintain long-term improvement and oversight (**Recommendation 8**).

71 The Health Board also introduced a CHC improvement group during 2019. The group is chaired by the Assistant Director for Primary and Community services and meets monthly. The aim of the group is to drive continuous improvement and support longer-term transformation, though its focus is also on achieving financial savings targets. Attendance at the CHC improvement group is variable although the membership has evolved to include a broader range of key representatives including finance and local authority representatives.

72 During our fieldwork, some of those we spoke to suggested that the improvement group is currently too financially focussed and a need for greater emphasis on quality and safety of services. Our observation and review of previous meetings' minutes showed an increasing improvement in the balance of the agenda.

73 In addition to the Improvement Group there is a CHC Operational Group which also meets monthly. Its purpose is to gather key members of staff to discuss broad issues including learning from past cases and appeals, discussing any common problems such as IT systems and discussing performance including financial performance. Some of those we spoke to indicated that the operational group was helpful in bringing teams together to think collectively, however the membership of the group could be more inclusive because some staff do not always hear the outcomes from meetings. This issue could be addressed by revisiting the membership of the group or ensuring a better information cascade from the discussions and decisions at that meeting.

74 At the time of our fieldwork, the Health Board was developing an ambitious plan for improving its management of CHC, overseen and driven by its CHC improvement and operational groups. This included the development of two business cases for CHC which combine to cover three key elements, namely:

- increased grip and control; this will see the Health Board identifying and applying a consistent approach across the Health Board in the management of CHC. This will include developing standard operating procedures.

- development of a business support unit; this team would be responsible for procurement, contracting and performance monitoring. This hub will manage relationships with providers in a more planned and proactive way.
- development of a complex case team: this additional team will manage CHC on behalf of complex and high-cost patients. This will provide a single, experienced panel to manage the cohort of complex patients which occasionally causes tensions between area teams and operational divisions.

75 It is worth noting that during the pandemic, the Health Board implemented a command structure to enable rapid and effective decision making for urgent matters related to COVID-19. This included a care home cell, with members comprised form a range of key partners including local authorities. We understand that this arrangement was unique and has been commended as good practice by Welsh Government. In relation to the points above, the Health Board has indicated that it has made good progress in relation to establishing its business support function with the creation of a virtual management team and improved partnership working to support contracting of care home services. We are aware that the Health Board is still committed to plans in the other two areas, but that progress has been delayed due to the pandemic and the delayed publication of the new National Framework.

Appendix 1

Action plan

Our recommendations are set out below to improve the operational management arrangements which support the administration of continuing healthcare. We have not made any recommendations relating to the post-COVID-19 environment. The Health Board should compete this table and ensure that recommendations are logged on the corporate recommendation tracking system, to enable audit committee to monitor progress.

Para	Recommendation	Intended outcome/ benefit	Agreed	Responsible officer and actions	Completion date
18	**The Health Board should develop a range of relevant and accessible governance documents for its management of CHC** R1 Building on the new national Framework (when published) and supporting tools, the Health Board should develop a set of key guidance documents to ensure consistent management of CHC across its teams. In addition, the Health Board should develop standard operating procedures that guide team members in the use of certain CHC tools such as the checklist.	Staff have access to necessary and relevant local guidance	Yes	**Head of CHC Commissioning** A set of key local guidance documents will be finalised by November 2020 and a work programme will be signed off. Key documents will be completed by March 2021 with full completion by June 2021. All the documents will be available on the Health Board Intranet site and where appropriate on the dedicated pages of the Health Boards' website. Documentation will be	June 2021

Para	Recommendation	Intended outcome/ benefit	Agreed	Responsible officer and actions	Completion date
				reviewed and refreshed when the new national CHC Framework is published.	
25	**The Health Board should introduce a consistent and accessible training programme for CHC team members and those that engage with CHC** R2 Following development of new guidance detailed in R1 the Health Board should develop a consistent and accessible training programme for CHC team members and those that routinely engage with CHC (ie members of the MDT). In developing the programme, the Health Board could usefully engage with key partners such as local authorities and providers.	Staff that feel informed and educated about the CHC process and how to apply it effectively	Yes	**Head of CHC Commissioning** A tiered training programme will be designed by 31 March 2021. This will provide the foundations for a rolling training programme reflecting competency levels required for different roles associated the CHC process on a 1-4 tier system. The design of the programme will be discussed with partners including those representing providers. Level 1 will be a core on-line training for all CHC active staff. Level 2 will include additional CHC support for key CHC	March 2021

Para	Recommendation	Intended outcome/ benefit	Agreed	Responsible officer and actions	Completion date
				staff such as CHC coordinators. Level 3 will be a focused programme of training for clinical staff in CHC teams including an in-team induction programme and corporate supported training events. Level 4 will be focused on sharing learning between CHC staff from corporate and area teams, including case reflection and themed learning integrated into practice such as learning from appeals and retrospective cases.	
22	**The Health Board should increase consistency of its CHC teams and ensure roles are clearly articulated and understood** R3 The Health Board's current work to drive consistency in the structure of its CHC teams should include work to ensure job descriptions reflect the roles required. These should be	Operational teams with the right capacity and seniority to work effectively.	Yes	The CHC corporate team will lead the design of core structures for operational teams at Area and divisional level. This will include standardised job descriptions and structures on teams can work towards locally as	March 2021

Para	Recommendation	Intended outcome/ benefit	Agreed	Responsible officer and actions	Completion date
	clearly articulated and understood by current and new CHC team members.			opportunities allow within employment law.	
29	**The Health Board should introduce a formalised escalation procedure to resolve CHC disputes between its teams** R4 The Health Board should formalise and implement escalation arrangements for CHC disputes at pace. There should be a clear procedure which is widely understood by relevant staff and can be used to quickly resolve internal disputes, for example, which team should take the budgetary responsibility for specific CHC patients.	Reduced tensions between teams as staff can resolve disputes quickly and easily through an agreed escalation process.	Yes	**Head of CHC Commissioning in partnership with Area / MHLD Directors of Finance** The Health Board will develop an internal disputes process mirroring the three stages in the PPA agreement used with external providers. This will be health board wide covering Area teams and the MHLD division.	April 2021

Para	Recommendation	Intended outcome/ benefit	Agreed	Responsible officer and actions	Completion date
39	**The Health Board should seek to invest and develop its CHC contracting and commissioning team** R5 The Health Board's role as a contractor and commissioner of CHC is underdeveloped which causes inefficiencies and tensions amongst its staff and its providers. The Health Board should resume the work it began in 2019 to develop a CHC contracting and commissioning team with the capacity and capability to plan and deliver CHC more effectively and efficiently.	A dedicated contracting and commissioning resource to undertake planned commissioning of CHC care that is efficient and effective.	Yes	**Associate Director of HealthCare Contracting and Finance** The Health Board accepts the need for the development of a new 'Commissioning Unit' with the responsibility for the strategic commissioning and performance management of all CHC and ICP placements. The HB has agreed in principle to adopt a 'Business Hub' model that will build on these principles, work has commenced to develop an outline business case.	April 2021
40	**The Health Board should have consistent reports across its CHC teams to enable the identification of good practice and learning opportunities** R6 The finance team provides a range of different reports for each operational CHC area team and division which produces different insights on performance and expenditure. This makes it difficult	Oversight of performance across a range of metrics for various CHC teams that informs ongoing management and the Health Board's wider improvement plans.	Yes	**Head of CHC commissioning** CHC quality and performance tools are in development to support CHC delivery. They build on the learning during pandemic and the changes implemented in pathways of care. Quality metrics will be explicit in the revised PPA which providers will be	March 2021

Para	Recommendation	Intended outcome/ benefit	Agreed	Responsible officer and actions	Completion date
	to identify areas of good practice or learning opportunities between teams. Quality metrics for CHC are also underdeveloped. With central co-ordination and oversight, Operational CHC teams and divisions should work together to explore and agree on a set of quality, financial and performance metrics to manage CHC effectively and consistently across the Health Board.			required to sign as a core component of the contractual arrangements. **Chief Finance Lead for CHC in partnership with Head of CHC Commissioning** Finance Metrics – with the full adoption of the BroadCare system, the opportunity is recognised to improve reporting efficiency and agree a standardised set of Financial metrics reports. Work on this through the Health Boards CHC Operational Group has already commenced and any requests for non-standard reports to support the different Operational requirements will be evaluated by that Group to see if they should be adopted and add value to all Divisions.	February 2021

Para	Recommendation	Intended outcome/ benefit	Agreed	Responsible officer and actions	Completion date
48	**The Health Board should make arrangements to ensure its CHC teams use the BroadCare IT system effectively and consistently** R7 The BroadCare IT system for managing CHC patients is not yet operating effectively at the Health Board due to weaknesses in its implementation, lack of training and lack of administrative support. In order to maximise the value of the system in managing CHC, the Health Board should: • address the identified backlog of incomplete records through additional short-term capacity; • ensure the system is set-up correctly for the Health Board, with system terminology matching that of the CHC process • ensure CHC teams are sufficiently trained on the use of the system. • Ensure the corporate finance team use the system effectively.	A reliable patient record system for CHC that staff can use to inform its plans, performance monitoring and decisions	Yes	**Chief Finance Lead for CHC in partnership with Head of CHC Commissioning supported by the Senior Systems analyst Informatics.** The Health Board accepts this recommendation and is implementing a BroadCare optimisation programme. The optimisation programme will ensure: a) Consistent case management documentation, a peer support programme and improved data quality in CHC operational teams. b) Financial reconciliation and transfer to BroadCare software case management for authorisation and payment of care packages.	February 2021

Para	Recommendation	Intended outcome/ benefit	Agreed	Responsible officer and actions	Completion date
69	**The Health Board should formalise leadership within the corporate CHC team** R8 While the Health Board strengthened leadership within its corporate CHC team during 2019, arrangements are currently ad hoc and temporary. The Health Board should seek to develop longer-term leadership to ensure improvement and robust central oversight of its CHC management.	Strengthened long-term oversight and management	Yes	**Assistant Director for Primary and Community Services.** A transition plan has been agreed to consolidate the corporate CHC leadership team. This team will now oversee CHC and the care home sector reporting into a substantive Assistant Director of Primary and Community services from 1 January 2021.	January 2021

Exhibit source: Audit Wales

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Archwilio Cymru
Audit Wales

Welsh Community Care Information System

Report of the Auditor General for Wales

October 2020

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Mae'r ddogfen hon hefyd ar gael yn Gymraeg.

Contents

4 Key messages

1 The Welsh Community Care Information System (WCCIS) is intended to enable health and social care staff to deliver more efficient and effective services using a single system and a shared electronic record. WCCIS is being developed for use across a wide range of adult and children's services, moving from a position of multiple systems at different stages of development or paper records. The Welsh Government has always intended that all 22 local authorities and seven health boards should implement WCCIS through a contract signed in March 2015.

2 The programme of work to implement and roll out WCCIS and realise its benefits is complex and ambitious. It requires various organisations to collaborate at a national, regional and local level, working within different accountability frameworks. Together they need to agree priorities and manage risks and inter-dependencies as part of wider policy development across the health and social care system. We have examined the latest position. **Appendix 1** describes our audit approach and methods.

Implementation and roll-out of WCCIS are taking much longer and proving more costly than expected. Despite efforts to accelerate the process, the prospects for full take-up and benefits realisation remain uncertain. Some important issues around the functionality of the system, data standards and benefits reporting are still to be fully resolved.

3 The Welsh Government recognises that an IT system alone will not deliver the changes to health and social care it wants to see. However, WCCIS is the key digital enabler. Through the WCCIS contract, local authorities and health boards can agree 'deployment orders' with the supplier without needing their own procurement process. The contracting framework has needed to evolve since 2015 to encourage delivery by the supplier and take-up by organisations.

4 There was an initial estimation that all local authorities and health boards could be using the system by the end of 2018, although the timescales were not binding. It was anticipated that the detailed plans would be completed in negotiation with the supplier and participating organisations.

5 As at 31 August 2020, 19 organisations were using WCCIS or had signed deployment orders, with four in active negotiation and six yet to commit. Of the 19 organisations, 13 local authorities and two health boards had gone live. However, 'live' can mean different things. Differences in how organisations are choosing to deploy WCCIS currently limit opportunities for integrated working and raise other value for money issues.

6 Key aspects of the expected functionality have been significantly delayed. This includes certain enhancements to the original contractual requirements. The current estimate is that the remaining updates will be delivered on a phased basis through to the end of 2021. Areas where work is still needed include Welsh-language requirements, mobile functionality and interfaces with other NHS Wales systems. The National Programme Team has also needed to address concerns about system performance.

7 Implementing and rolling out the system is proving more costly than expected and with additional investment needed to support related service transformation. To date, just over £30 million has been spent or committed to March 2022 by the Welsh Government and NHS Wales Informatics Service (NWIS). Further capital costs are possible, although these may fall to deploying organisations.

8 We have been unable to arrive at a reliable overall estimate of local implementation costs met from organisations' own budgets, although it is apparent that these run into several millions of pounds. Once organisations have gone live, they also pay ongoing service charges, although in most cases WCCIS has replaced predecessor systems and their associated costs. The National Programme Team has emphasised that accountability for detailed local costs, risk and benefits rests with the local organisations.

9 Through the national programme management arrangements, action has been taken at various points to review and try to accelerate delivery. However, some key issues have taken a long time to resolve or have still not been fully resolved. Recent changes to programme governance structures are intended to support a more co-ordinated national approach, including acceleration of national data standards which are key to realising some of the benefits of WCCIS. The work on data standards is at different stages across different service areas. We understand that the use of WCCIS to support the COVID-19 response has highlighted the importance of this work and showed that this is possible given enough focus.

10 Responsibility for implementing WCCIS is widespread and includes organisations that are not party to the contract. The Welsh Government can require health boards to use the system. It has not yet chosen to do so and is currently relying on accelerating take-up through additional funding. The Welsh Government has provided some financial support to local authorities but does not have similar powers to require them to use the system.

11 The arrangements for reporting the benefits from WCCIS roll-out have been the subject of discussion and review from the outset. Work is still ongoing to develop a suitable reporting framework.

The potential benefits of a shared electronic record across health and social care are clear to see; even more so given some of the challenges presented by the COVID-19 pandemic. However, the Welsh Government's ambitious vision for WCCIS is still a long way from being realised. It now needs to work with the various organisations involved to take stock of expectations for the remainder of the contract term and the resources and wider commitment needed to support progress.

Adrian Crompton
Auditor General for Wales

Key facts

Roll-out to 31 August 2020

	Health boards	Local authorities
Live	2	13
Deployment order signed – not yet live	2	2
No deployment order signed	3	7

Click here to access our interactive data tool which provides further detail on the roll-out position across all 29 organisations.

Central support costs to March 2022: actual/committed

£30.16 million

£8.41 million

capital costs for software development, licences, hardware and network infrastructure

£8.62 million

national programme management support

£13.13 million

support for health boards and local authorities for implementation and roll-out and related service transformation

[Excludes local implementation costs and service charges met from organisations' own budgets and wider opportunity costs associated with the overall governance arrangements for WCCIS implementation and roll-out.]

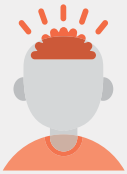
Potential service area coverage (with examples)

Social care services for adults, children and families

- Safeguarding and adult protection
- Fostering and adoption

Social care financial services

- Direct payments
- Financial assessments
- Foster care payments



Child and Adolescent Mental Health Services (CAMHS)

- Early intervention and prevention
- Learning disability service

Child community services

- School nursing
- Flying Start and Families First health visiting

Adult and older mental health

- Psychology
- Prescribed medication support
- Acquired brain injuries

Community (other)

- District nursing
- Physiotherapy
- Adult weight management

4 Recommendations

While there are important issues still to be resolved – including on outstanding functionality, data standards and benefits reporting – we are not making specific recommendations in these areas. They are all the subject of ongoing work through the national programme management arrangements. However, the recommendations that we have made are relevant from an overall programme delivery perspective. Also, some of the broader recommendations in our January 2018 report on informatics systems in NHS Wales remain relevant to WCCIS implementation.

Recommendations

R1 We recommend that, before committing any further central funding, the Welsh Government works with the WCCIS National Programme Team, health boards, local authorities and the supplier to:

- produce an updated business case that takes account of local, regional and national costs and sets out expectations for further roll-out of the system, its use over the remainder of the contract term, the development of national data standards and planning for any successor arrangements;
- ensure the organisations involved have the necessary capacity to support implementation and are giving enough priority to the programme against a clearly agreed plan; and
- pull together a clear national picture on feedback from front-line users about the performance and general functionality of the system.

Recommendations

R2 We recommend that the Welsh Government works with the National Programme Team to consider:

- how the WCCIS contract might have been strengthened to support and incentivise delivery and manage risk; and
- how relevant lessons can be applied to any successor contracting arrangements and wider public procurement.

Strategy and contracting

01

Contracting for the use of WCCIS across Wales is a key part of the Welsh Government's plans for integrated health and social care

WCCIS is the key digital enabler to support the Welsh Government's plans for integrated health and social care

1.1 For the Welsh Government, a common electronic health and social care record is key to its ambition of integrated and person-centred health and social care services. In **A Healthier Wales**[1], the Welsh Government committed to accelerate roll-out across local authorities and health boards.

1.2 Recently, the Welsh Government has sought to clarify what the 'Once for Wales' approach for digital systems that it set out in 2015[2] means in practice. It has confirmed that this approach allows for some all-Wales 'national systems' and for different 'interoperable' systems using the same standards. Reinforced by the experience of responding to the COVID-19 pandemic, the Welsh Government still considers that a national approach to information sharing between health and social care is an appropriate model to enable the co-ordination of care within the community.

1.3 The Welsh Government recognises that an IT system alone will not deliver the changes to health and social care it wants to see. Among other things, the Transformation Fund[3] and the Integrated Care Fund[4] are aimed at supporting integrated working across health and social care.

1 Welsh Government, **A Healthier Wales: our Plan for Health and Social Care**, June 2018.

2 Welsh Government, **Informed Health and Care – A Digital Health and Social Care Strategy for Wales**, December 2015.

3 Running between 2018-2021, the Transformation Fund is targeted to priority projects and new models of health and social care, with the aim of speeding up their development and demonstrating their value.

4 See Auditor General for Wales, **Integrated Care Fund**, July 2019 for further information.

Under a 'Master Services Agreement', local authorities and health boards can agree 'deployment orders' with the supplier – CareWorks – without needing their own procurement process

1.4 The WCCIS contract was awarded to the supplier, CareWorks, in December 2014 and signed in March 2015. CareWorks were predominantly experienced in providing social care software solutions. The company had previously provided social care systems for a consortium of eight local authorities in Wales.

1.5 Bridgend County Borough Council led the procurement because, at that time, it needed to replace its social care information system and had previously acted as lead authority in a consortium of eight local authorities. A 'Joint Procurement Board' with wider local government and NHS Wales representation supported the procurement process.

1.6 CareWorks intended initially to use two sub-contractors. One of the sub-contractors would help develop the required health board functionality. Between contract award and contract signing, CareWorks' offer changed and no longer involved that sub-contractor – Advanced[5]. We have been unable to confirm whether those responsible for the contracting process considered the impact of this change on CareWorks' ability to deliver the required health functionality, some of which remains outstanding. Advanced told us that it withdrew as it felt that the system requirements could not be delivered within the timeframe and cost envelope proposed at the time. In late 2019, Advanced acquired CareWorks resulting in changes to CareWorks' management arrangements for WCCIS.

1.7 The contractual model operates as a 'call off contract', including a 'Master Services Agreement' (MSA) and separate 'deployment orders' (**Box 1**). Including opportunities for extension, the contract runs to March 2027. The National Programme Team believes that there are grounds to extend individual deployment orders beyond 12 years, so that early adopters can continue to use WCCIS until 2030. This would help to align end dates and facilitate future collaborative procurement.

1.8 CareWorks offered an overall financial discount amounting to 11.5% of the pricing in its original bid if the costs for licences and ICT infrastructure were paid up-front rather than as organisations implemented the system. This option was preferred, with the Welsh Government funding the up-front costs.

5 The other subcontractor remained involved to provide data storage and infrastructure support.

1.9 Nevertheless, the contractual framework exposes the Welsh Government to some value-for-money risks. The return the Welsh Government gets on its investment in software development, hardware and licences depends on the pace of roll-out and the use organisations make of the available functionality. Bridgend County Borough Council was the only organisation required to sign a deployment order. The call-off nature of the contractual framework also exposed CareWorks to certain financial risks.

Box 1: The contractual framework for WCCIS (as agreed originally)

Master Services Agreement (MSA)

- Bridgend County Borough Council entered into the MSA with CareWorks
- The MSA sets out the overarching terms and conditions under which local organisations implement WCCIS
- For example, it sets out the 'Statement of Requirements' (SoR), CareWorks' technical solution to the SoR, governance arrangements, dispute resolution mechanisms, change control processes, service levels and service charges

Deployment orders

1 x for the central hardware, all-Wales licences and 'sunk development costs'[6] incurred by CareWorks, with these costs being met by the Welsh Government

[Up to] 29 x agreed between CareWorks and individual local authorities and health boards[7] – including common elements but able to be tailored to meet local requirements

Original contract timescales

- Minimum of eight years, from March 2015, for the MSA
- Option to extend the MSA for four years, until March 2027 (on a 1+1+1+1 basis)
- Local deployment orders may run beyond March 2027 but must end by March 2030
- Local deployment orders worked on an 8+1+1+1+1 year basis initially, but have since been amended

6 Before entering into the contract, at its own risk CareWorks enhanced its existing CareDirector product to meet some of the requirements, at a cost of £2.2 million.

7 While the focus has been local authority and health board settings, the contractual framework allows for Velindre NHS Trust and the Welsh Ambulance Services NHS Trust to agree deployment orders. The National Programme Team has engaged with both organisations to help them understand the potential benefits of implementing WCCIS.

The contracting framework has needed to evolve to encourage delivery by CareWorks, take-up by organisations and to correct some organisations' service charges

1.10 Under the contract the full functionality was expected to have been delivered before the end of 2015. The contract did not provide for any 'liquidated damages'[8] should CareWorks not deliver the full functionality on time, or additional payments should it meet contractual deadlines. However, the fixed-term nature of the contract provides some incentive for CareWorks, given that its revenue is based on take-up. There are also provisions in individual deployment orders for 'delay payments' in certain circumstances.

1.11 The financial model in the MSA set out the service charges each organisation was expected to pay CareWorks over the initial eight-year term of their deployment order. The total service charges amounted to just over £29 million across the 22 local authorities and seven health boards. However, the actual costs would increase over time to reflect inflation. If organisations choose to extend their deployment orders, the financial model provides for a reduced rate[9].

1.12 The service charges took account of the comparative size of each organisation and the cost to CareWorks of providing support for local implementation. The charges were fixed, regardless of how widely organisations might choose to deploy the system across their services or how much of the expected functionality was available when they signed deployment orders.

1.13 The service charges also included contributions towards £0.50 million for outstanding software development to deliver the statement of requirements functionality. These costs were additional to the development costs already paid by the Welsh Government. However, the Welsh Government has now agreed to fund these software development costs apart from £0.02 million already paid by deploying organisations up to September 2019. The service charges have been adjusted accordingly. The Welsh Government is also funding some additional development for enhanced functionality beyond the statement of requirements.

8 A liquidated damages clause is a common way of dealing with a possible breach under a commercial contract. The sum that must be paid must be fixed in advance (a reasonable estimation of the particular loss) and written into the contract.

9 One-year extension = 10% discount; two-year extension = 15%; three-year extension = 25%; four-year extension = 35%.

1.14 In November 2019, the National Programme Team and Careworks agreed a contract variation to support CareWorks to maintain development capability and accelerate the remaining software development. These changes mean that CareWorks will now receive some payments earlier than anticipated when it delivers outstanding functionality to an agreed set of payment milestones.

1.15 Other contractual changes have affected the way the deployment orders and service charges are working in practice across different organisations. Initially, the contract term was effective from the date a deployment order was signed. This was the case solely for Bridgend County Borough Council, who were the first deploying organisation. However, there was a concern this would discourage other organisations from signing orders because they were keen to avoid the contract running down before the system was ready. Meanwhile CareWorks was having to carry out preparatory work with no firm commitment from organisations.

1.16 Following a renegotiation during the first year of the MSA, the contract only becomes effective when the contracting organisation is satisfied the system has been operating in a stable manner for 30 days – 'stable operations'. The assumption was that it would take around six months after signing deployment orders to reach stable operations[10]. Therefore, the overall contract length was reduced from eight years to 7.5 years. Organisations were still liable for the full eight years' worth of service charges identified in the MSA but paid over a 7.5 year period instead.

1.17 An error in the financial model in the MSA, discovered after the contract term had been changed to 7.5 years, meant the service charges for seven organisations[11] did not cover the full term, falling short by up to three months' worth of payments. CareWorks offered the choice of continuing with a shorter contract term or making up the difference over the full contract term. Each of the seven organisations opted for a shorter initial contract term. The National Programme Team has explained that this option was deemed more cost effective should a contract extension be sought after the initial contract term given the discounted rates for the extensions (**paragraph 1.11**).

10 In practice, implementation work to reach stable operations has generally taken longer than six months.

11 Isle of Anglesey County Council, Vale of Glamorgan Council, Powys County Council, Powys Teaching Health Board, Merthyr Tydfil County Borough Council, Gwynedd Council, Ceredigion County Council.

1.18 All local authorities that have deployed the system to date are liable for service charges at the rates set out originally in the MSA. However, in June 2017 the WCCIS Leadership Board agreed a revised financial model for the five health boards that had not already signed deployment orders[12]. The revised model was based on a phased implementation[13] rather than a 'big-bang' approach. CareWorks had also agreed to an overall reduction in service charges under this model due to changes in planned implementation timescales and not all the expected functionality for health boards being available.

1.19 Organisations signing deployment orders can commission additional functionality beyond that provided for in the original contract. For example, Newport City Council commissioned an interface to its corporate finance system. The Council met the development costs, but the same functionality is now available to other organisations. Any other organisation taking up this functionality would not have to pay development costs but would pay additional service charges.

12 Powys Teaching Health Board and Betsi Cadwaladr University Health Board had already signed deployment orders by this point.

13 Once stable operations have been reached for the first phase of implementation, any subsequent phases must be completed within 24 months. The health board would be liable for service charges if any longer delay was due to local decisions.

Roll-out and costs

02

Implementing and rolling out WCCIS is taking much longer and proving more costly than expected, with the prospects for full take-up still uncertain

Roll-out has been much slower than initially expected, with some organisations still to commit and different choices being made about how much use to make of the system

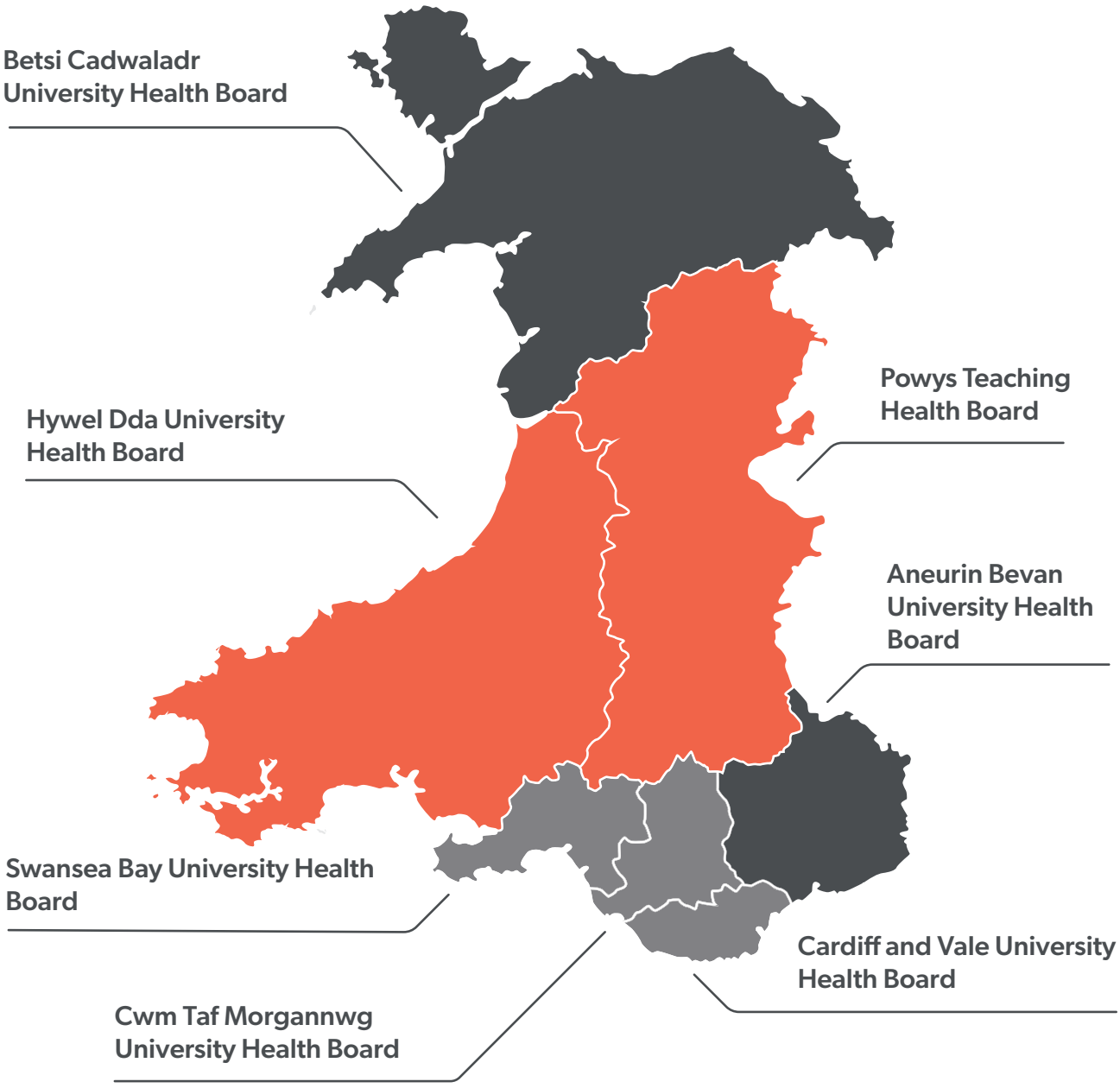
As at 31 August 2020, 19 organisations were using WCCIS or had signed deployment orders, with four in active negotiation and six yet to commit

2.1 The initial March 2015 full business case estimated that successful implementation for the whole of Wales could take up to four years to achieve. Estimated dates, that were also reflected in the contractual documents, suggested that all 29 organisations could be using the system by December 2018. Of these, 11 organisations were identified for potential go-live in 2015-16 and nine in 2016-17. These timescales were not binding. It was anticipated that the detailed development and implementation plans would be completed in negotiation with the supplier and participating organisations.

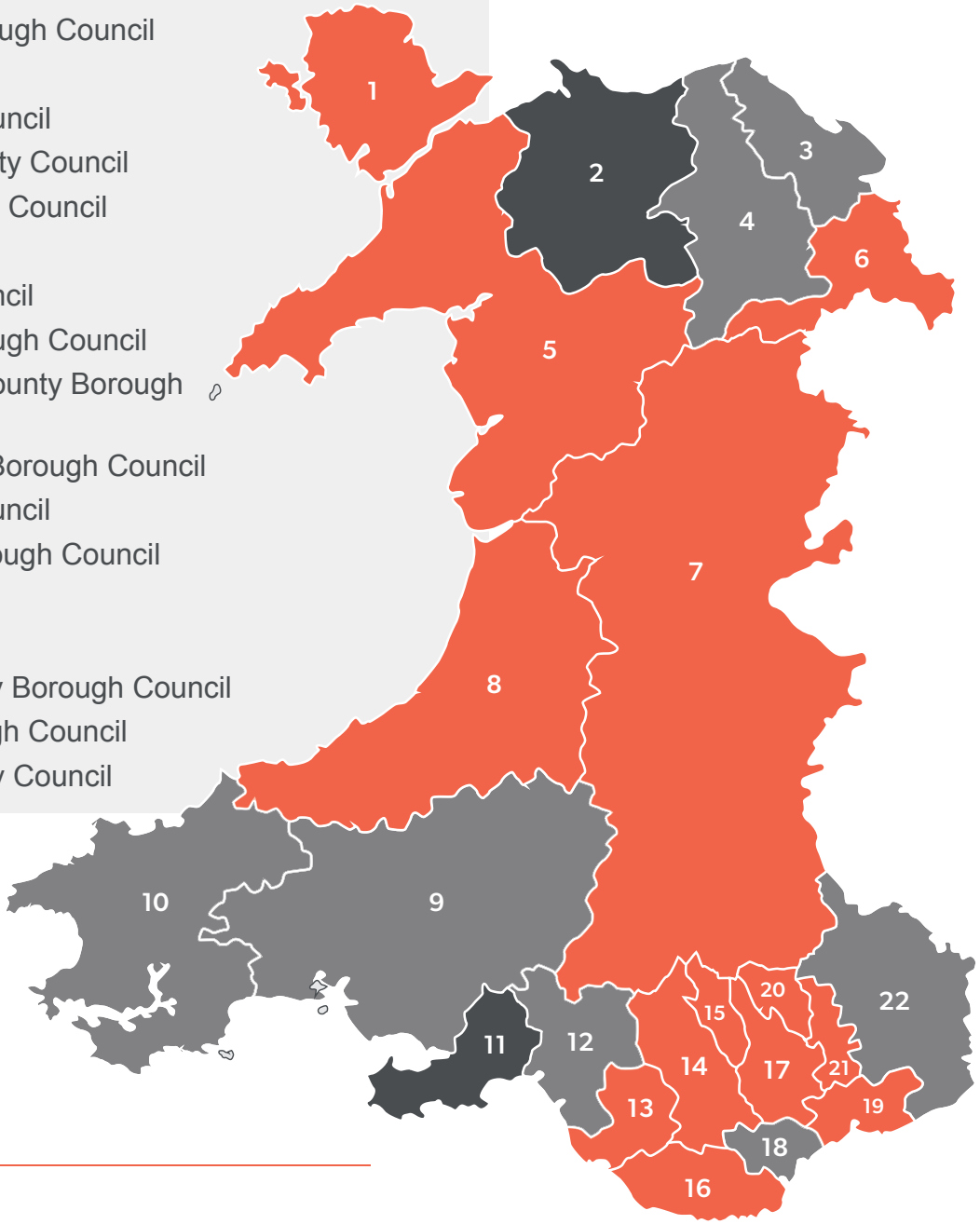
2.2 As at 31 August 2020, 13 local authorities and two health boards – Hywel Dda University Health Board and Powys Teaching Health Board – had gone live and were using WCCIS in some way (**Figure 1**). The business case recommended that WCCIS should be rolled-out on a regional basis and configured to support regional ways of working, reflecting wider policy developments. This approach to roll-out has not happened in practice.

Figure 1: Implementation status of local authorities and health boards as at 31 August 2020

- Live
- Deployment order signed but not yet live
- No deployment order signed



1 Isle of Anglesey County Council
2 Conwy County Borough Council
3 Flintshire County Council
4 Denbighshire County Council
5 Gwynedd Council
6 Wrexham County Borough Council
7 Powys County Council
8 Ceredigion County Council
9 Carmarthenshire County Council
10 Pembrokeshire County Council
11 Swansea Council
12 Neath Port Talbot Council
13 Bridgend County Borough Council
14 Rhondda Cynon Taf County Borough Council
15 Merthyr Tydfil County Borough Council
16 Vale of Glamorgan Council
17 Caerphilly County Borough Council
18 Cardiff Council
19 Newport City Council
20 Blaenau Gwent County Borough Council
21 Torfaen County Borough Council
22 Monmouthshire County Council



- Live
- Deployment order signed but not yet live
- No deployment order signed

Click here to access our interactive data tool which provides further detail on the roll-out position across all 29 organisations.

Source: National Programme Team

2.3 Two more local authorities have signed deployment orders. Of the remaining seven local authorities, three are in active dialogue with the supplier and four are not currently pursuing WCCIS take-up.

2.4 Of the remaining five health boards, two have signed deployment orders. Aneurin Bevan University Health Board signed a deployment order in March 2018 with the intention of full implementation by January 2021. The first phase of implementation in mental health services was scheduled for June 2019. In February 2019, CareWorks advised the health board that it would not be able to meet this date. Currently, the timescale for the health board implementing any aspect of WCCIS remains uncertain. In April 2020, the health board wrote to CareWorks with a claim for 'delay payments' under the contract terms. The health board continues to be engaged with the supplier to work through the issues to help inform a correction plan.

2.5 After signing a deployment order in March 2016, Betsi Cadwaladr University Health Board had an initial go-live date of April 2017 for a phased implementation commencing with mental health services. The date was not met, and the health board then discussed with CareWorks an initial small-scale implementation in its community nursing and mental health teams. The health board has informed us that it will be reviewing the potential for the WCCIS implementation, along with other priority programmes, as it returns to business as usual post COVID-19.

2.6 Swansea Bay University Health Board is in dialogue with CareWorks to work towards a deployment order. Two other health boards are not currently working towards signing a deployment order. Cardiff and Vale University Health Board's view is that even when all the agreed functionality is available, the current version of WCCIS would not meet its requirements, offering less and proving significantly more costly compared to its existing arrangements. Cwm Taf Morgannwg University Health Board is not in active dialogue with CareWorks but intends to implement WCCIS in mental health services first, once the relevant functionality is available.

2.7 Even with the benefit of hindsight, the estimated implementation timescales set out in the full business case appear to us to have been unrealistic. The timescales do not appear to have taken full account of the work required to implement the system and manage the necessary business change processes, whether at a national or local level.

2.8 CareWorks' capacity to support implementation has also been a concern through much of the period to date. As noted in **paragraph 1.6**, CareWorks intended originally to work with a subcontractor to help develop the required health board functionality. In addition, the original contractual framework did little to encourage organisations to support implementation or to incentivise delivery by CareWorks (**paragraph 1.10)**.

2.9 For most of the organisations (11 of 15) that have gone live, go-live dates agreed in deployment orders were missed. For local authorities, the average delay was four months with a range between one month and 26 months. For the two health boards, the delays were one month and five months.

Differences in how organisations are choosing to deploy WCCIS currently limit opportunities for integrated working and raise other value for money issues

2.10 'Live' can mean different things as organisations can choose which elements of the available functionality they use and how widely they deploy the system. For health boards, the variability has arisen as they have tailored deployment orders to meet their individual needs:

a Powys Teaching Health Board's deployment order is based on the organisation going live with all the available health functionality. Currently, it is using most of the available functionality. As at August 2020, the health board had 1,083 users of the system.

b Hywel Dda University Health Board's deployment order covers just the community nursing element of the system. As at August 2020, its 113 users were using the system to deliver community nursing services in Ceredigion[14]. The health board is looking to extend coverage for community services in Pembrokeshire and Carmarthenshire and at how it might use WCCIS in certain therapies services.

c As noted in **paragraph 2.4,** Aneurin Bevan University Health Board has agreed a phased approach to implementing WCCIS.

14 Ceredigion County Council is the only one of the three local authorities in the Hywel Dda region to have signed a deployment order. The Council went live with the system in August 2016.

2.11 All local authority deployment orders allow for coverage across a wide range of adult and children's social care services. For some services, such as disabled and frail older people and safeguarding children, all 13 live local authorities are using WCCIS in some way, but still with differences in the detail of their deployment. There is more of a pick and mix approach in other areas. Only one live local authority is using functionality around special education needs, with the same true for adoption. The National Programme Team's view is that there was always going to be some variation to reflect local needs and that this flexibility has encouraged take-up, with the opportunity to make more use of the system as a deployment order progresses.

2.12 The full business case did not articulate any specific expectations about how much use organisations would make of the system across different services. However, the current picture means that even where the system is live, it is not yet being used to its full potential. This, in turn, raises questions about the overall value for money of the expenditure to date. Some organisations' service charge costs are slightly lower than the costs they were incurring using previous systems. Nevertheless, the contractual framework means that all are essentially paying service charges for functionality that they are not currently using, albeit to different degrees.

2.13 The overall deployment picture and the different approaches to implementation mean that it is currently difficult to realise some of the information sharing and integrated working benefits that the system was expected to support. As part of wider work to identify data and information requirements around COVID-19 for community-based services, WCCIS has been used to help identify vulnerable persons to assist with the delivery of care packages. WCCIS is also being used to support rehabilitation care in the community for people who are recovering from coronavirus. The use of WCCIS to support the COVID-19 response has highlighted the need to address issues around national data standards. It has also shown that this is possible given enough focus.

Key aspects of the expected functionality have been significantly delayed and the National Programme Team has also needed to address concerns about system performance

2.14 As noted in **paragraph 1.10**, some early WCCIS documentation suggests that CareWorks was initially expected to have delivered all agreed functionality by October 2015. As at August 2020, key aspects of the originally agreed functionality were still to be fully delivered, notably the mobile application, the interfaces needed to enable WCCIS to integrate effectively with other NHS Wales IT systems and Welsh-language requirements (**Box 2**). In some of these areas the original contractual requirements have been added to and work is still needed to deliver these 'enhancements'.

Box 2: Key areas where functionality is still to be fully delivered, as at August 2020

Integration – The contract requires CareWorks to develop interfaces between WCCIS and several other NHS Wales systems/services, for example, to access diagnostic results, send to and receive information from GPs or receive hospital to community referrals. Developing these interfaces requires collaboration between the NHS Wales Informatics Service, CareWorks and health boards. Some of the required interfaces were identified in the original Statement of Requirements, while others were agreed in 2019 as enhancements to the 2015 contract.

Of the 16 interfaces now agreed, two are currently live and a further seven interfaces are ready to go into testing. The remaining seven are now scheduled for phased delivery through to the end of 2021.

Mobile application – Under the original contract requirements, WCCIS must be capable of working on a mobile platform via wireless and 3/4G so that it can be accessed by NHS and local authority staff working in the community. A version of the mobile application based on the original requirements is now scheduled to be piloted before the end of 2020. The pilot has been delayed in part due to the impact of COVID-19 and the capacity of local organisations to support this work. Enhanced functionality has also been agreed and is due to go into testing shortly, for example to include appointments management.

Welsh language –CareWorks must deliver a system compliant with the Welsh Language Act 1993 and Welsh Language (Wales) Measure 2011 which together govern the use of the Welsh language in the delivery of public services. Some key aspects of the functionality expected to meet Welsh-language requirements set out in the original contract are not yet available. For example, the system does not currently provide for structured data collection in Welsh.

2.15 It has been clear to the National Programme Team since implementation in Bridgend County Borough Council in 2016, that the system lacked some of the contractually agreed functionality. A November 2017 Gateway review found that the National Programme Team and CareWorks had different views about whether the issues identified were part of, or enhancements to, the original contractual requirements. In mid-2018, the National Programme Team began work to identify a definitive list of the functionality that remained outstanding.

2.16 By March 2019, CareWorks and the National Programme Team had identified that 157 of the 1,500 items set out in the Statement of Requirements had not been delivered. In addition, CareWorks' service desk was not operating as required, the system was not supporting performance reporting as expected, and updates to fix longstanding problems that live organisations were experiencing were failing testing[15]. Under the Master Services Agreement, the National Programme Team issued CareWorks with a contractual non-conformance notice and sought to remedy the situation.

2.17 After a further six months of dialogue, in November 2019 the National Programme Team and CareWorks agreed a timeline, or roadmap, for delivering the outstanding and enhanced functionality over four updates through to September 2020. Accelerated payments tied to delivery milestones and funded by the Welsh Government were also agreed (**paragraph 1.14**).

2.18 Partly as a result of the COVID-19 pandemic, the go-live date of the first of four planned updates to the system was delayed until mid-July. This impacted on the timetable for later updates, which include key aspects such as the enhanced mobile functionality. However, the continuing impact of the pandemic put the plan to complete all four updates by January 2021 at significant risk of delay. The current estimate is that the updates will be delivered on a phased basis through to the end of 2021.

2.19 In addition, arrangements have needed to be confirmed for longer-term operational support for the system platform. It has been known since 2018 that WCCIS is based on a version of a Microsoft platform that will not be supported after July 2021. The National Programme Team has since been discussing with CareWorks how to resolve the issue.

15 For example, some areas of the system cannot be audited, and an individual might have multiple active records running on the system. One of the original aims of WCCIS was to improve patient safety by having a single record. While the different records can be accessed, this currently involves workarounds.

2.20 Under the 'do minimum' option, WCCIS moves to an updated platform that is supported by Microsoft and with CareWorks required to meet the associated costs under the contract terms. Recently, another option emerged of moving to a newer version of the system hosted on the Cloud[16]. In July 2020, the National Programme Team considered the two options. For a variety of reasons, the National Programme Team considered that it was not now practical to move to the Cloud-based version within the required timescales.

2.21 Before the end of 2020-21, the National Programme Team expects to complete a detailed appraisal of the costs, benefits and risks of moving to the Cloud-based version of WCCIS. It intends to consider this in the context of longer-term decisions around the possible extension, or otherwise, of the contractual period and wider Welsh Government digital strategy.

2.22 There have been some significant performance issues with the system over the past year. These have included some complete outages among nine 'severity level 1' incidents[17] and with additional strain on the system during the COVID-19 response. We have heard from the front-line about the impact of system-performance issues on the ability of staff to do their job effectively. Concerns due to system performance issues, including risks to staff and service users, have also been raised in some local reporting by Care Inspectorate Wales and Healthcare Inspectorate Wales.

2.23 The National Programme Team has agreed a performance improvement plan with CareWorks, which has included the installation of additional technical capacity, coupled with recent software improvements. The National Programme Team reports this has resulted in significantly improved performance with ongoing monitoring of the situation.

16 Currently, WCCIS is centrally hosted on physical hardware in the NWIS data centre.

17 Severity level 1 incidents are the most serious type of system performance issue and defined as causing significant business impact and preventing a normal service being provided.

Implementing and rolling out WCCIS is proving more costly than expected and with additional investment needed to support related service transformation

Overall, just over £30 million has been spent or committed to March 2022 by the Welsh Government and NHS Wales Informatics Service (NWIS)

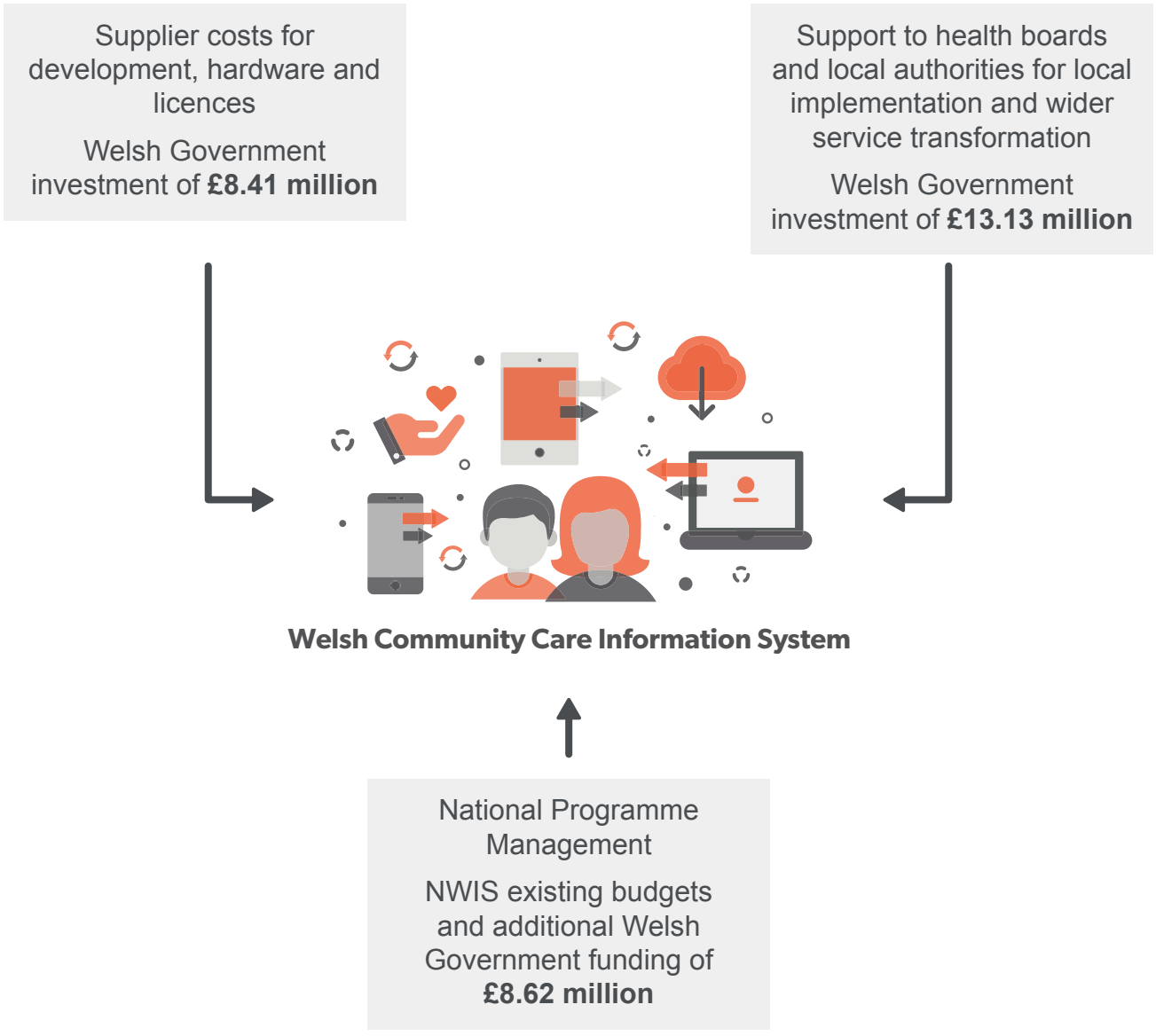
2.24 Where possible, we set out to compare the estimated costs of developing and rolling-out WCCIS with initial estimates in the full business case. Overall, central costs can be broken down into three main areas: Welsh Government capital investment; Welsh Government and NHS Wales Informatics Service (NWIS) spending on national programme support; and Welsh Government funding to support local organisations' costs. Exactly how this local funding is being spent across different activities is not clear. However, the National Programme Team has emphasised to us that its purpose extends beyond the scope of the initial business case.

2.25 We recognise that some of the central expenditure to support local WCCIS implementation would otherwise have been incurred to develop or replace other systems on an organisation-by-organisation basis. Also, some of that expenditure is supporting wider service transformation relating to the implementation of WCCIS or contributing to ongoing service charges. The business case accounted separately for ongoing service charges, which it assumed would be met in full by local organisations.

2.26 **Figure 2** provides a high-level overview of the £30.16 million known to have been spent by the Welsh Government and NWIS supporting WCCIS implementation and roll-out to date or committed through to the end of March 2022. While we are unable to provide a complete like-for-like comparison, the full business case allowed for central Welsh Government costs and NWIS programme support of £16.75 million up to the end of March 2022 and £20.18 million over a full 13-year term.

2.27 **Paragraphs 2.28 to 2.52** in the remainder of this part of our report provide further details about Welsh Government and NWIS expenditure and about additional expenditure by local organisations. In addition to the costs identified, there are opportunity costs associated with staff time that is being committed by various organisations to the overall governance arrangements for WCCIS implementation and roll-out.

Figure 2: Welsh Government and NWIS spend on WCCIS implementation and roll-out and related service transformation, to March 2022 (actual and committed)



Source: National Programme Team and Audit Wales analysis

Welsh Government capital funding of £8.4 million is currently within full business case estimates but with further capital costs possible that may fall to deploying organisations

2.28 The full business case identified a £9.89 million Welsh Government capital funding requirement (**Figure 3**), almost all of which was profiled in the period to the end of March 2021. Local authorities and health boards were expected to identify any local capital funding requirements as part of their local planning. As at December 2019, the Welsh Government had approved £8.41 million of capital grant funding up to March 2022. Should a future decision be made to move to the newer Cloud-based version of the system (**paragraphs 2.20 to 2.21**), additional funding will be required under its own business case.

Figure 3: Welsh Government capital grant funding for WCCIS implementation, up to March 2022 (£ millions)

	Full business case estimate to March 2027	Total grant funding (actual and committed to March 2022)
All-Wales licences	3.94	3.28
Software development	3.60	3.00
Central hardware[1]	2.26	2.10
Network infrastructure[2]	0.09	0.03
Total	**9.89**	**8.41**

Notes

1 Business case estimate included an estimated £0.94 million for a hardware refresh in 2020-21.

2 The National Programme Team has told us that, while it was originally allocated £0.09 million for network infrastructure, it will not draw down more than the £0.03 million already spent. The remaining £0.06 million has been subsumed within the commitment shown for central hardware.

Source: WCCIS full business case and National Programme Team reports

2.29 In March 2015, the Welsh Government approved an initial £6.58 million of capital funding for licences, software development and central hardware costs. This figure excluded provision for a planned refresh of the central hardware. It also excluded network infrastructure costs of £0.09 million which were covered by the Welsh Government in a separate approval. Meanwhile, the negotiated cost of the licences required was lower than expected in the business case and some additional software development was built initially into the service charges for local organisations (**paragraph 1.13**).

2.30 In December 2019, the Welsh Government approved additional capital grant funding of £1.80 million from its Digital Priorities Investment Fund[18]. This included a further £1 million provision for the planned central hardware refresh and £0.80 million for software development. The software development funding covers most of the costs that were initially built into local service charges and some additional enhancements that were not within the original scope of the business case and contract[19].

2.31 The £0.80 million figure agreed for software development was an estimate. The latest figure following commercial negotiation is £1.12 million. Deploying organisations will need to decide on the affordability and value for money of the remaining enhancements not covered by the Welsh Government funding.

2.32 In addition, the National Programme Team is currently negotiating with the supplier to finalise costs to refresh the central hardware during 2020-21. The National Programme Team is anticipating this cost may exceed the £1 million covered by the Welsh Government funding. Organisations that have signed deployment orders are liable to pay a share of any additional costs.

18 Announced in September 2019, the £50 million Digital Priorities Investment Fund is focused on transforming digital services for patients, the public and professionals, investment in data and intelligent information, modernising devices and moving to Cloud services, and cyber-security and resilience.

19 Organisations paying service charges had already contributed £0.02 million to the software development costs, and around £0.30 million of the committed Welsh Government funding is for software enhancements that were not included in the original contract.

At £8.6 million, expected national programme support costs to the end of March 2022 are around £1.7 million higher than estimated in the full business case for the same period

2.33 The full business case estimated a £10.28 million requirement for national programme support over a 13-year period to the end of 2026-27 (**Figure 4**). Within that, it estimated a £6.89 million requirement to the end of March 2022 made up of:

- £1.77 million to cover existing NWIS staff who were supporting WCCIS implementation; and
- £5.12 million for additional dedicated National Programme Team support.

Figure 4: Actual or planned expenditure on National Programme Team support to March 2022 (£ millions)

	Full business case estimate to March 2022	Full business case estimate to March 2027	Actual/committed expenditure to March 2022
NWIS (existing budgets)	1.77	2.17	3.32
Welsh Government funding (additional)	5.12	8.11	5.30
Total	**6.89**	**10.28**	**8.62**

Note: The full business case also included estimated costs associated with NWIS 'hosting' the ICT hardware for WCCIS. This was estimated at £0.59 million over 13 years. Deploying organisations had contributed £0.06 million to the end of 2019-20 with NWIS also reporting that it had absorbed costs of at least £0.05 million. We have not accounted for these costs in our overall analysis.

Source: WCCIS full business case and National Programme Team reports

2.34 Until March 2019, support costs were largely covered by a combination of NWIS's existing budgets and £1.5 million of Welsh Government funding from the Integrated Care Fund. In June 2019, responding to a request from the Welsh Government, the Senior Responsible Owners for the WCCIS programme provided an estimate of the overall costs incurred and the additional National Programme Team resources required through to March 2022 to help increase the pace of implementation in health boards and complete roll-out.

2.35 The Welsh Government agreed to provide an additional £3.80 million of support through the Digital Priorities Investment Fund. The funding is increasing capacity and capability in several areas. Among other things, these include a national service desk, system testing, training to ensure patient safety, standardisation of system content and work to develop interfaces with other NHS systems (**paragraph 2.14**).

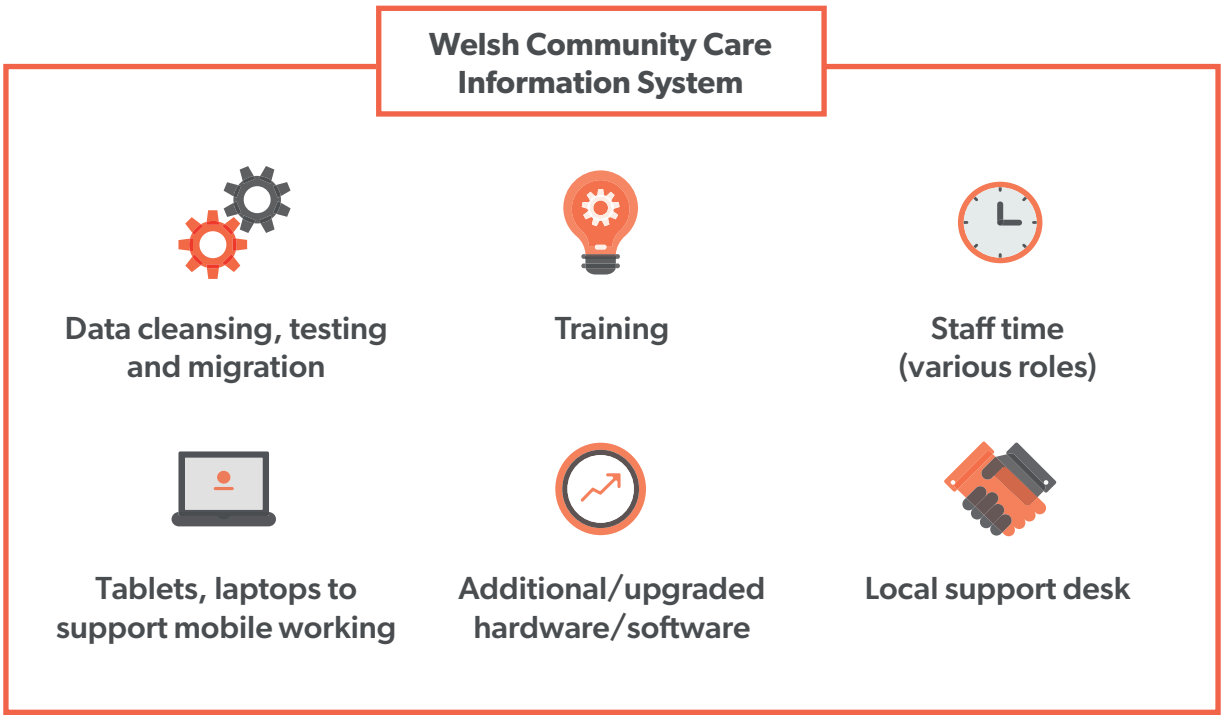
2.36 During the latter stages of our work, the National Programme Team changed its estimate of the amount of NWIS resources that had already been spent or were thought to be needed to support national programme management over the full 13 years of the programme. Its original estimate of £9.48 million, which informed the bid for additional Welsh Government funding on top of this figure, has reduced to £6.64 million. The National Programme Team advised us that the forward looking element of its original estimate was speculative and some over-estimation of past spend had occurred when preparing the original figures.

2.37 Together with the Welsh Government's funding, the £8.62 million cost of national programme support now estimated through to the end of March 2022 compares with the full business case estimate of £6.89 million. The National Programme Team has advised us that part of the reason for the increase is that the business case did not account for wage inflation for NWIS posts. The National Programme Team is still working through the support requirements and funding arrangements beyond March 2022.

The Welsh Government has so far committed just over £13 million to support local implementation and roll-out and related service transformation

2.38 The full business case acknowledged that organisations would incur additional local costs when implementing WCCIS. **Figure 5** describes some of the costs that might be incurred.

Figure 5: Examples of costs to support local implementation of WCCIS



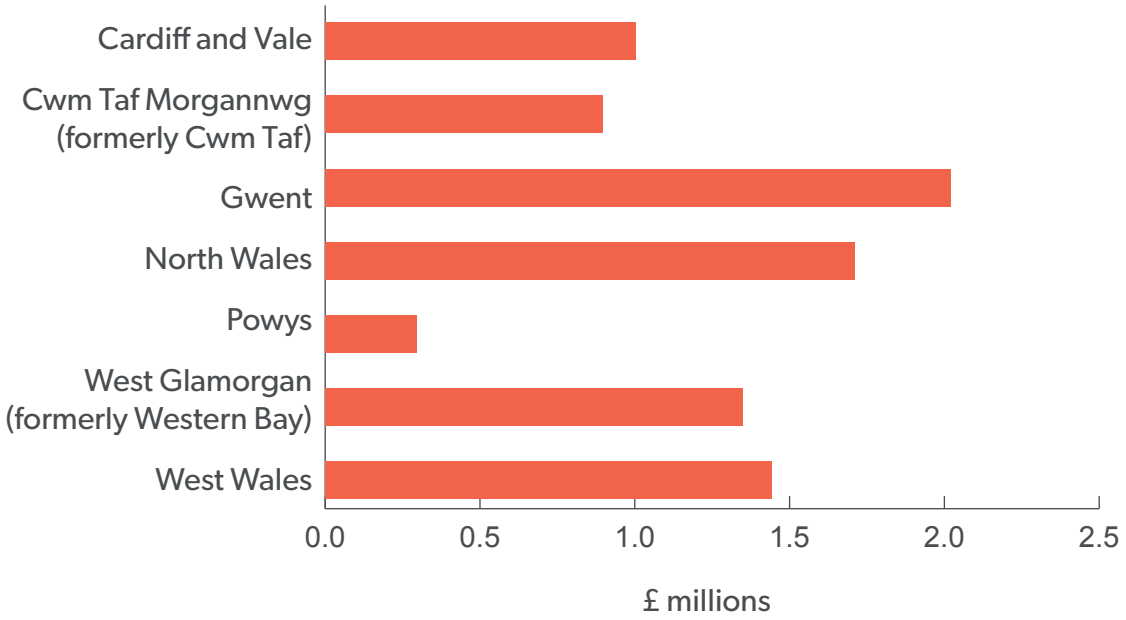
Source: Audit Wales

2.39 The full business case estimated that these costs would total £2.58 million and assumed that organisations would find these resources from their existing budgets. While there are additional costs being met from local budgets, by the end of 2021-22, local authorities and health boards will have received Welsh Government funding of £13.13 million to support implementation and roll-out. As noted in **paragraph 2.24**, the National Programme Team has emphasised to us that the activity that this funding supports extends beyond the scope of the original business case, including wider service transformation work related to WCCIS.

2.40 Much of this funding has come from the Integrated Care Fund (**Figure 6**). This funding is distributed through Regional Partnership Boards (RPBs)[20] and will continue through to the end of 2020-21. Overall, the Integrated Care Fund support will total £8.72 million.

20 RPBs consist of health boards, local authorities and the third sector. They work together to improve the wellbeing of the population and how health and care services are delivered.

Figure 6: Regional distribution of the Integrated Care Fund to support WCCIS implementation and related service transformation, April 2016 to March 2021



Notes: Cwm Taf Morgannwg Regional Partnership Board was previously the Cwm Taf Regional Partnership Board. It incorporated the Bridgend County Borough Council area on 1 April 2019 which had previously been part of the Western Bay Regional Partnership Board. The Western Bay Regional Partnership Board is now called the West Glamorgan Regional Partnership Board.

Source: Welsh Government

2.41 Initially, RPBs received a formula-based allocation. The National Programme Team considers that around £4.50 million of this funding between 2016-17 and 2018-19 was used predominantly to support planning work around local WCCIS implementation.

2.42 Since the start of 2019-20, funds have been allocated on a 'proposal' basis and with more of a focus on related service transformation. Some regions requested an increase on their previous allocations. This created a £0.21 million Integrated Care Fund shortfall for the two years 2019-2021. The difference was met by the Welsh Government Transformation Fund in 2019-20 and is being met from Welsh Government central reserves in 2020-21.

2.43 In 2018-19, the Welsh Government provided £0.05 million to Conwy County Borough Council on top of the Integrated Care Fund allocation distributed through the North Wales Regional Partnership Board. This came from a separate Welsh Government social services budget and covered additional training, staffing, software and technical support. The Council signed a deployment order in April 2019 and is currently in the implementation phase.

2.44 The full business case also identified that local authorities and health boards might have existing revenue budgets for IT systems that WCCIS would be replacing. However, some local authorities had developed 'in house' systems rather than contracting with external providers.

2.45 The National Programme Team requested a further £0.20 million from the Welsh Government between 2019-20 and 2021-22 to support Neath Port Talbot Council to implement WCCIS and £0.30 million to support Monmouthshire County Council[21]. Despite the funding request being agreed by the Welsh Government, Neath Port Talbot Council decided not to commission WCCIS and did not take the funding offered by the Welsh Government. There was a request for this funding to be released to support WCCIS implementation across the wider West Glamorgan region, but the Welsh Government turned this down. Monmouthshire County Council has not yet signed a deployment order and is still in dialogue with CareWorks. There is currently no agreed go-live date.

2.46 The Welsh Government is also providing £4.06 million from the Digital Priorities Investment Fund direct to health boards to accelerate implementation between 2019-20 and 2021-22[22]. This funding will address:

- financial challenges in some health boards where community health services are largely still operating paper-based systems and there are no revenue budgets for IT systems; and
- embedding of new ways of working for health professionals.

21 The National Programme Team also requested additional funding between 2019-20 and 2021-22 to support Flintshire County Council (£0.04 million) and Conwy County Borough Council (£0.46 million). The Welsh Government turned down this bid as the councils were already paying for existing systems.

22 This is funding to local bodies, in additional to the National Programme Team support from the same fund (**paragraph 2.35**).

We have been unable to arrive at a reliable overall estimate of local implementation costs met from organisations' own budgets, although it is apparent that these run into several millions of pounds

2.47 The National Programme Team has not collated information about overall local implementation costs, including contributions from local budgets. There has not been any specific guidance about how these costs, and any savings compared with previous systems or by not having to go through separate procurement processes, should be considered as part of local business case development. The National Programme Team has noted that it has provided ad hoc advice and supported knowledge sharing about local business case development. It has also emphasised that accountability for detailed local costs, risk and benefits rests with the local organisations.

2.48 We asked local authorities and health boards that have gone live or signed deployment orders if they could provide figures on local implementation costs met from their own budgets. Some were unable to do so.

2.49 Even where figures were reported, organisations had used different approaches or were unable to distinguish WCCIS specific costs from wider project work. It was difficult therefore to identify a valid overall estimate. However, examples included Betsi Cadwaladr and Aneurin Bevan university health boards which reported quite different figures of £0.41 million and £3.16 million up to the end of March 2020[23]. As noted in **paragraphs 2.4 to 2.5**, neither of the two health boards has yet gone live despite signing deployment orders.

2.50 Some organisations that are yet to sign deployment orders also provided forward-looking estimates. Cardiff and Vale University Health Board for example had estimated that implementation would cost £3.9 million, including work to develop functionality equivalent to its current arrangements. Ongoing maintenance costs would also be significantly more expensive.

2.51 To the end of June 2020, those organisations that have progressed with implementation to the point of paying service charges had paid a total of £2.56 million to CareWorks. The overall extent to which this is new expenditure compared with the cost of previous systems is not clear. However, some organisations are realising modest savings compared with the cost of previous systems (**paragraph 2.12)**. The roll-out position means that CareWorks' income from service charges has been substantially lower than expected at the outset.

23 The figures provided by Betsi Cadwaladr University Health Board include costs of staff directly employed to support implementation but exclude the value of staff time for others who still assisted. Similarly, Aneurin Bevan University Health Board has noted that its estimate does not account in full for all the staff time that has been committed.

2.52 There are other ongoing costs for organisations that have gone live, but that may also have been incurred previously supporting predecessor systems. The full business case included a £6.64 million estimate for financial resources required to fund ongoing local WCCIS support costs over a 13-year period.

Programme management

03

While action has been taken at various points to review and try to accelerate programme delivery, some key issues have taken a long time to resolve or have still not been fully resolved

The programme was slow to respond to issues identified by a November 2017 Gateway Review, including delays filling two important National Programme Team roles

3.1 As noted in **paragraph 2.7**, in our view some of the early estimations around the pace of roll-out were simply unrealistic. However, in a programme of this nature it is also inevitable that there will be a need to respond to issues as they arise and to keep delivery arrangements under review.

3.2 In November 2017, the programme's Senior Responsible Owners commissioned a 'Gateway Review' that looked at the prospects for successful delivery. For the purpose of the review, successful delivery was narrowly defined as delivering the technical platform within the available Welsh Government capital funding and its use as a stable live system by an [unspecified] critical mass of local authorities and health boards.

3.3 The review gave the programme an 'amber' rating. The review found that there were some significant issues facing the programme but that these issues were being addressed and, at the time, appeared resolvable.

3.4 Parts 1 and 2 of this report have already described various actions taken before and since the Gateway Review, including contractual changes and decisions around additional funding and implementation support. Nevertheless, many of the issues that have been identified during the life of the programme have taken a long time to resolve or have still not been fully resolved.

3.5 The National Programme Team considers that eight of the Gateway Review's nine recommendations are now complete, although most actions in response extended beyond the anticipated deadline of late spring 2018. Because it took about a year for the Welsh Government to agree funding, there were delays filling two new posts to support implementation. The Gateway Review found that programme staff were over-stretched and identified a 'significant weakness' in communication between the National Programme Team and other organisations. In December 2018, a new Programme Director took up post to oversee the governance and activity of the programme. From June 2019, a Communications Lead began working on a consultancy basis.

3.6 Work is ongoing to develop a Benefits Framework (**paragraph 3.18**) and despite the National Programme Team viewing the original recommendation as complete, further work is needed on the roadmap for the outstanding functionality (**paragraph 2.18**). Establishing revised governance arrangements has also taken longer than expected.

Recent changes to programme governance structures are intended to support a more co-ordinated national approach, including acceleration of national data standards which are key to realising some of the benefits of WCCIS

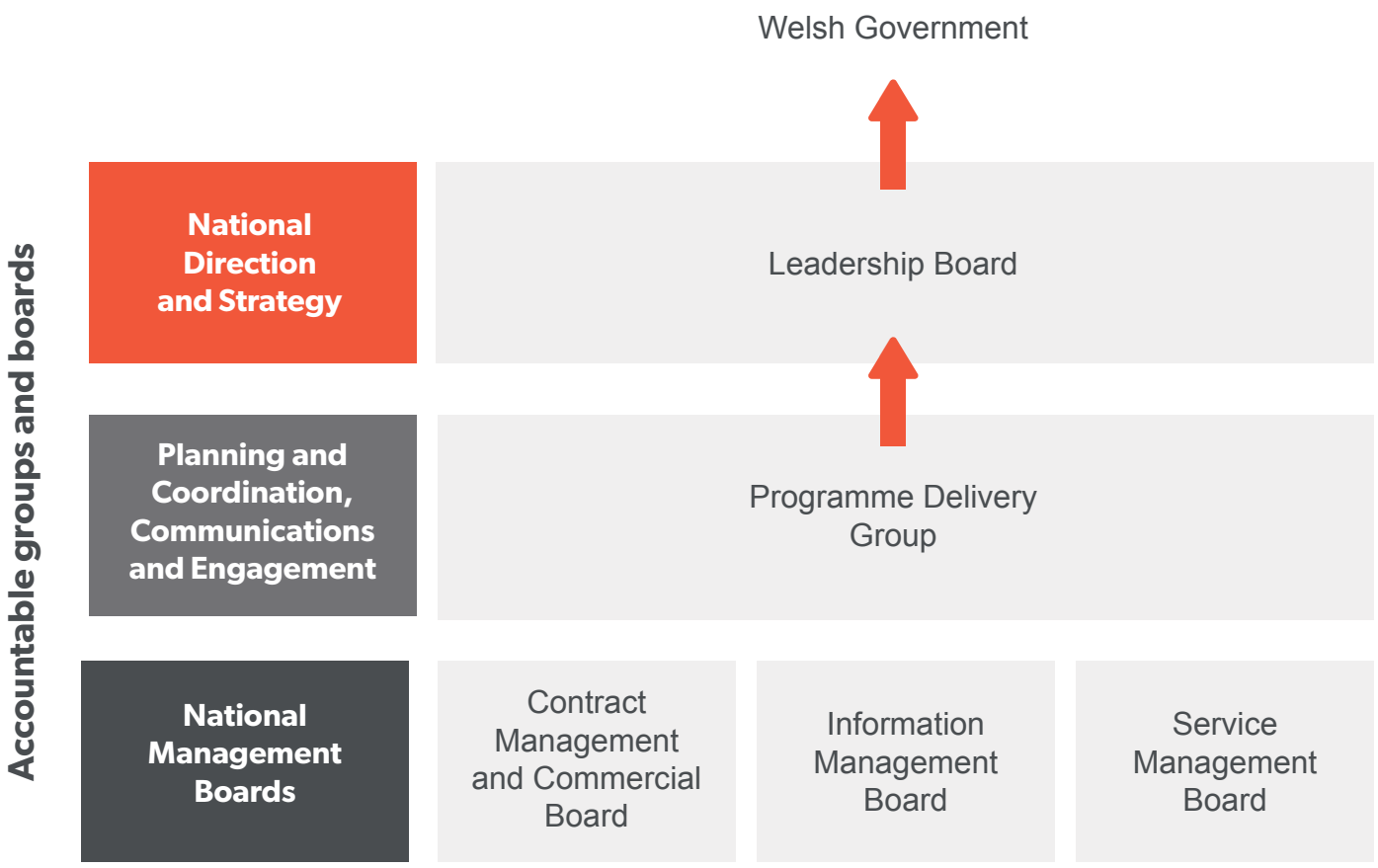
3.7 Following revisions to decision-making and escalation structures in May 2019, in September 2019, the WCCIS Leadership Board refreshed its Terms of Reference to try to clarify where it exercises decision-making authority. Under the current Terms of Reference, the Leadership Board has 'overall responsibility for ensuring the delivery of the digital capability to support service transformation and supporting and encouraging its implementation across Wales'.

3.8 Responsibility for implementing WCCIS is widespread and includes the health boards and local authorities as well as the Regional Partnership Boards. The Welsh Government can require health boards to use the system but has not yet chosen to do so. It is currently relying on accelerating take-up through the additional funding that it is providing (**paragraph 2.46**). Although it has also provided some financial support to local authorities, the Welsh Government does not have similar powers to require them to use the system.

3.9 In providing additional funding from the Digital Priorities Investment Fund, the Welsh Government made clear that it expected the National Programme Team to do several things by February 2020, including to develop a detailed delivery plan and timetable. None of the deadlines were met. In March 2020, the Welsh Government told the National Programme Team that continued funding is contingent on the required actions being undertaken or alternative arrangements being agreed. The required actions have since been discharged.

3.10 **Figure 7** sets out the current high-level programme governance arrangements as agreed from January 2020. In addition to the new National Programme Team roles described above, these structures have evolved over the life of the programme, with new groups set up recently to try to address some of the remaining areas of concern. The governance arrangements now include a revised Programme Delivery Group with regional representation to oversee and co-ordinate activities that require or would benefit from a national and strategic approach. At the time of our fieldwork it was too early to judge the impact of these revised arrangements, although the National Programme Team considers that they have proved invaluable through the COVID-19 response.

Figure 7: High-level governance structure for the WCCIS Programme, from January 2020



Note: **Appendix 2** provides further details about roles and responsibilities and other parts of the governance structures, including three further 'national assurance and advisory groups'.

Source: National Programme Team

3.11 A key aim is to accelerate national data standards as the basis for a national reporting framework in children's services, mental health, community nursing, social care and therapies[24]. Practitioners use electronic forms to assess the needs of patients. Individual organisations have developed their own forms, based on the information they want to report on and their own data definitions. The additional Welsh Government funding confirmed in December 2019 means that the National Programme Team is now able to support clinical informaticians to work in four of these five areas. However:

a work across the five areas is at different stages of development. Achieving consensus about the content of national forms is not straightforward, particularly as it requires a degree of consensus about working practices. For example, it took about three years to develop a standardised all-Wales nutrition risk assessment for use in adult in-patient settings. The Welsh Government has had an ambition to develop a core dataset for mental health since 2012[25]. This is now scheduled for delivery by the end of 2022.

b for any forms developed to be national, organisations not using WCCIS would also have to agree to use the forms, either as paper-based forms or changing their existing IT systems.

c it is not clear how the use of these forms could be mandated for use by local authorities.

3.12 A new Information Management Board will support the development of the national data standards and will also aim to address the long-standing issues around Welsh-language requirements and the development of an integrated record (**paragraphs 2.15 to 2.17**). An Integrated Record Group will link in with the Board, with its terms of reference to be agreed in September 2020.

Work is still ongoing to develop a framework for reporting on the benefits realised from WCCIS implementation

3.13 The potential benefits of WCCIS implementation can be immediate – for example implementation is seeing some community-based health records move onto an electronic system – and longer term, supporting wider service transformation. In articulating some of the potential benefits (**Figure 8**), the full business case set out the need for a 'benefits strategy', with roles clearly assigned. It made clear that responsibility for collecting evidence about benefits rested with local organisations. The suggested focus for the Leadership Board, set out in its terms of reference, was on collating that evidence and promoting the main messages.

24 Therapies include services such as podiatry, physiotherapy, occupational therapy, dietetics, speech and language therapy and art therapy.

25 Welsh Government, **Together for Mental Health Delivery Plan**, October 2012.

Figure 8: Potential benefits of WCCIS implementation

Source: Audit Wales based on WCCIS full business case

3.14 The arrangements for reporting the benefits from WCCIS implementation have been the subject of discussion and review from the outset (**Figure 9**). Despite some early developments, the November 2017 Gateway Review still called for a benefits realisation plan. It also highlighted the need to distinguish between the direct immediate business benefits from the technology itself and those from wider business change. The review recommended giving priority to collecting evidence of wider business change being achieved by roll-out of the system. Work is still ongoing to develop a suitable reporting framework.

Figure 9: Timeline of benefits reporting framework developments

3.15 Until March 2019, Regional Partnership Boards were not required to report on the specific outcomes being achieved with the funding they received for WCCIS implementation from the Integrated Care Fund (**paragraphs 2.40 to 2.42**). From April 2019, funding has been allocated on a 'proposal' basis with a focus on benefits realisation, although the reporting arrangements do not align with the intended outcomes outlined in the full business case for WCCIS implementation.

3.16 During our work, we asked local authorities and health boards for any evidence of local or regional benefits realisation. We received limited feedback. The National Programme Team shared with us evidence compiled by Bridgend County Borough Council which reflected on lessons learnt. In summer 2019, Powys Teaching Health Board surveyed its users although the response rate was low and the feedback mixed. Powys County Council has recently surveyed users' perceptions of the performance of the system, in its adults and children's social services departments. At the time of writing, we had not seen the full set of survey results.

3.17 We were not provided with any evidence at this stage that WCCIS is being used to progress wider service transformation benefits. Mainly, this is because the system has not yet been rolled out more fully. As noted in **paragraph 2.10**, even where the system has been implemented, there are differences in the way it is being used. Some of the issues around functionality (**paragraph 2.14)** and standardisation (**paragraph 2.35**) are also acting as barriers to integrated working.

3.18 In January 2020, the National Programme Team came together with regional representatives to discuss work to date on approaches to benefits management and reporting. Initiatives in this area were reported by the National Programme Team to be very variable between regions and local organisations.

3.19 The National Programme Team is now seeking to work effectively with regional WCCIS groups to develop a benefits framework that can support and inform local and regional developments and provide more detailed and structured national reporting. The national WCCIS Business Change Group is seen as a key forum to support this work. A task and finish group will be responsible for developing a national benefits framework that links effectively with, and supports, local and regional approaches.

3.20 The Welsh Government's recent approval of grant support from the Digital Priorities and Investment Fund comes with specific evaluation requirements. The Welsh Government is expecting the National Programme Team to produce a comprehensive annual report on the progress of the programme, starting with the period to the end of March 2020. That first report had been due by the end of April 2020, but completion has been delayed by the impact of COVID-19.

Appendices

1 Audit approach and methods

2 Implementing WCCIS: roles and responsibilities

1 Audit approach and methods

Audit approach

We examined whether key partners have put in place the appropriate arrangements to implement WCCIS and deliver its anticipated benefits.

We focussed on whether the functional requirements and intended benefits are being delivered within anticipated costs and timescales. We also considered the contractual model and the way in which the development and implementation of the system is being funded. We have not looked in detail at the arrangements that individual organisations have put in place to support local implementation or at the regional programmes of work that are intended to support wider service transformation related to WCCIS.

We confirmed the scope of our work to the Welsh Government and the WCCIS Leadership Board in October 2019 and gathered and reviewed most of our evidence between November 2019 and February 2020.

We provided feedback about our emerging findings to the Welsh Government and WCCIS Leadership Board members in February 2020.

In advance of publication, we invited comments on our draft report, or relevant extracts, from the Welsh Government, the WCCIS Leadership Board, the WCCIS supplier – CareWorks, and other named organisations. Our report reflects the position of the programme and the evidence available to us as at the end of August 2020.

Audit methods

Document review

We reviewed a wide range of WCCIS-related documents including contractual documents, business cases, papers supporting the National Programme governance arrangements, Ministerial briefings and a 2017 Gateway Review report.

For wider context, we also considered relevant issues covered in other reports relating to information systems in NHS Wales, including:

- Auditor General for Wales, **Informatics systems in NHS Wales**, January 2018
- National Assembly for Wales Public Accounts Committee, **Informatics systems in NHS Wales**, October 2018
- Channel 3 Consulting (for the Welsh Government), **Digital Architecture Review – Final Report**, March 2019
- Local Partnerships, **Welsh Government Review: Future Structure and Governance for Health Informatics in Wales**, March 2019

Interviews

We interviewed officers from across the Welsh Government, NHS Wales and local government and met with the NHS Assistant Directors of Informatics group. We had discussions with the chairs of WCCIS regional partnership groups and with regional co-ordinators, where regional structures exist.

We also met with CareWorks, the contracted supplier for WCCIS, and with its new parent company Advanced.

Analysing costs and benefits

We analysed several different sources of data to get an overall picture of expenditure on WCCIS implementation.

We also collected information from the 22 local authorities and seven health boards about expenditure on WCCIS and arrangements for measuring and reporting on the benefits of the system.

Visits

We visited Powys Teaching Health Board and Bridgend County Borough Council to meet with staff who use WCCIS.

2 Implementing WCCIS: roles and responsibilities

Figure 10 provides an overview of some of the key roles and responsibilities of those leading and managing the programme. **Figure 11** summarises the current governance arrangement for the WCCIS programme at a national level. Aspects of both the roles and responsibilities and the governance arrangements have evolved over time to address some of the challenges that have been faced.

The National Programme Team has emphasised to us that the role of the WCCIS National Programme is to ensure delivery of digital capability that can support local and regional service transformation and to support and encourage its implementation.

While it has an overall co-ordinating role, the National Programme does not have direct authority or accountability for all aspects of the complex landscape and the mix of stakeholders. Regional Partnership Boards have a role to align and support local organisations' take-up of the system as part of the wider aims of regional transformation strategy and plans. Local organisations have their own individual lines of accountability for their investment in local implementation.

In addition to the high-level structures described here, a range of other groups have been established at a national and a regional level to support WCCIS implementation and benefits realisation. These include a Business Change Group that reports to the Programme Delivery Group and oversees the work of a task and finish group established in February 2020 to develop a national benefits framework.

The core membership of the WCCIS Leadership Board includes the SROs, Director of NWIS, the WCCIS Programme Director and an Association of Directors of Social Services (ADSS) Cymru representative. The full board also includes Welsh Government policy leads, chairs of the three national boards, the WCCIS Communication and Engagement Lead and a senior representative of CareWorks, as required. Membership of other groups varies, but they draw in a wide range of representatives for specific organisations/sectors and professional groups.

Figure 10: Key roles and responsibilities in the WCCIS programme

Role	Responsibilities
Senior Responsible Owners (SROs)	Joint chairs of the Leadership Board. One is the Chief Executive of Powys Teaching Health Board and the other is Director of Social Services for Caerphilly County Borough Council. The role of the SROs is to ensure that work is governed effectively and delivers the programme objectives.
WCCIS Programme Director	Accountable to the SROs and chairs the Programme Delivery Group. Has a lead role in building and maintaining stakeholder relationships, engaging with Regional Partnership Boards, regional WCCIS boards, and other groups as required.
WCCIS Programme Manager	Day to day co-ordination, management and reporting on the programme.
WCCIS Communications and Engagement Lead	Responsible for national communication and engagement strategy and planning.
NWIS support	NWIS hosts the dedicated national programme, including the WCCIS Programme Director and Communications and Engagement Lead. NWIS staff provide additional operational support to the programme and NWIS manages the data centres that house the CareWorks hardware.

Figure 11: Key governance groups in the WCCIS programme

National direction and strategy	Leadership Board	Oversees the alignment of WCCIS with Welsh Government health and social care policy and strategy. Directly accountable to the Welsh Government via the joint SROs.
Planning and co-ordination, communications and engagement	Programme Delivery Group	National planning and co-ordination. Accountable to the Leadership Board. Responsible for co-ordinating the work of the three national boards across the seven regions.
National Management Boards	Contract Management and Commercial Board	Responsible for delivery of the contractual requirements. Provides commercial expertise and guidance to other groups.
	Information Management Board	Works with other national initiatives to develop and assure national information and data standards, and reporting requirements, across community health and social care services.
	Service Management Board	Ensuring WCCIS is operated in line with the Master Services Agreement and All-Wales Deployment Order.
National assurance and advisory groups	Practice/ Business Assurance Panel	Advisory group on integrated health and social care services. Provides assurance that programme plans and activities are consistently benefits led.
	Information Governance Advisory Panel	Providing advice, guidance and ensuring appropriate and timely consultation as required.
	Change Advisory Group	Approving, declining or deferring any request for change across all organisations using WCCIS.

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Board/Committee report template

Cyfarfod a dyddiad: Meeting and date:	**17th December 2020 Audit Committee**
Cyhoeddus neu Breifat: Public or Private:	Public
Teitl yr Adroddiad Report Title:	Update on Financial Governance during COVID
Cyfarwyddwr Cyfrifol: Responsible Director:	Sue Hill, Acting Executive Director of Finance
Awdur yr Adroddiad Report Author:	Nigel McCann, Chief Finance Officer, Chair of Financial Governance Cell
Craffu blaenorol: Prior Scrutiny:	Sue Hill, Acting Executive Director of Finance
Atodiadau Appendices:	APPENDIX A – Completed Governance Self-Assessment Checklist APPENDIX B – Work plan

Argymhelliad / Recommendation:

The Committee is asked to:

a) Note the level of collaborative work undertaken through the Financial Governance Cell to date.

b) Note the planned next steps, through the establishment of a Financial Improvement Group.

Please tick as appropriate

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

Sefyllfa / Situation:

This paper summarises the work of the Financial Governance Cell working in partnership with Internal Audit, Audit Wales and Shared Services (NWSSP), also building on work undertaken across NHS Wales through the Directors of Finance, in the context of a fast emerging pandemic response.

The Acting Executive Director of Finance presented an interim Briefing Paper to the Committee in August 2020 highlighting performance against the Welsh Government COVID-19 Guidance.

Cefndir / Background:

The Welsh Government issued Guidance to Chief Executives on the 30 March 2020 specifically in relation to Financial Governance and Decision-Making during the COVID-19 (CV19) emergency period and response.

On the 3 April 2020, the Acting Executive Director of Finance shared the Welsh Government Guidance with all Directors and Divisions, clearly setting out the Financial Governance arrangements and controls that were being put in place across the Health Board.

The Acting Executive Director of Finance established the Financial Governance Cell, working in partnership with Internal Audit and Audit Wales, Payroll, Procurement and Workforce to review these arrangements.

Asesiad / Assessment & Analysis

1. Strategy Implications

The August August Committee was provided with a self-assessment against the key Principles of Financial Governance set out in the Welsh Government Guidance of the 30th March 2020.

2. Options considered

This is a Briefing Paper to provide the Committee with an overview of the work of the Financial Governance Cell and the next steps.

3. Financial Governance Summary

The following table summarises the key timelines, actions and controls put in place;

Financial Decision Making Guidance Received from Welsh Government.	30th March
BCU Director of Finance Letter to all Directors and Budget Holders setting out the Financial Governance arrangements and controls.	3rd April
BCU Director of Finance discussion document, recommending the creating of a Financial Governance Cell	14th April
BCU Director of Finance agreement with NHS Wales Shared Services Partnership Internal Audit to work on the Governance Cell in a consultancy capacity	9th May
BCU Director of Finance agreement with Welsh Audit Office to work alongside the Financial Governance Cell in an advisory capacity	11th May
First Meeting of the BCU Finance Governance Cell	13th May
KPMG commissioned by Welsh Government to undertake a formal review of the Field Hospitals; request for information received from KPMG	27th May
Financial Governance update to the Finance & Performance Committee	2nd June
All Wales Directors of Finance proposal for an All-Wales Audit approach	3rd June
Update to the Audit Committee on progress against the WG Guidance	27th August
Governance Cell & Internal Audit Advisory Report - COVID 19 Financial Governance Cell Discretionary Capital	August
Audit Report - Governance Arrangements during the Covid-19 Pandemic	16th Oct
All-Wales Directors of Finance CV19 Governance findings and themes	16th Oct
Governance Cell & Internal Audit Completion of the Controlled Self-Assessment	October
Update to the Finance & Performance Committee on the Self-Assessment and Action Plan	29th Oct
Closing Meeting of the Governance Cell, moving into Financial Improvement Group	27th Nov
Update Briefing Paper to the Audit Committee, including the next steps	17th Dec

4. Risk Analysis

The COVID-19 specific Finance Risk (ID 3152) is logged and continues to be monitored in light of the recent receipt of an additional £83million of Funding from Welsh Government:

5. Legal and Compliance

Not Applicable.

6. Impact Assessment & Recommendations

This briefing paper has summarised the Financial Governance actions put in place by the Acting Executive Director of Finance since April 2020.

The Committee is asked to:

a) **Note the positive actions and controls that were put in place in advance of and during the CV19 Response, and the level of work undertaken to date through the Finance Governance Cell and the Controlled Self-Assessment.**

b) **Note the Action Plan and next steps.**

APPENDIX B : DRAFT ACTION / WORK PLAN

ID	Theme	Action Narrative	Lead Exec	Supported By	Timescale
1	Emergency Control Structures & Arrangements	Controls and Emergency Plans need to be reviewed to ensure they are robust enough to deal with the additional requirements identified through the recent, current experience of responding to a pandemic.	Director of Planning & Performance	Finance	31/12/20
2	Emergency Control Structures & Arrangements	Board to formally agree an Emergency SORD and any necessary changes to SO's and SFI's	Company Secretary	Finance	31/12/20
3	Emergency Control Structures & Arrangements	Consider and the need for centralised control over certain aspects, for example; PPE Stock, Asset Tracking, Ad-Hoc Pay Arrangements.	Director of Finance	WOD / Procurement	31/3/21
4	Business Continuity & Procedures	All Departments to review, refresh (or develop) BCP's and Desktop Procedures / SOP's, reflective of the increased move towards flexible, agile and home working.	Director of Finance	ICT	31/12/20
5	Retrospective Review	Review of significant investments / CV19 expenditure to identify the additional benefit / outcome that this investment delivered and future use (where relevant).	Director of Finance	Planning & Performance	31/3/21
6	Skills, Capacity & Capability	Critical review of skills, capacity and tools for dynamic modelling, planning and prioritising.	Director Primary & Community Care	ICT; Planning & Performance	31/12/20
7	Field Hospitals	Formally review the DoF Recommendations.	Director of Finance	Planning & Performance	31/12/20
8	Collaboration	Review how to maximise joint working, both internally across Departments and externally	Chief Executive		31/3/21

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

Betsi Cadwaladr University Health Board

COVID-19 Financial Governance self-assessment

Internal Audit

BCU 2020/21

December 2020

NHS Wales Shared Services Partnership

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Introduction and Background

On the 30th March 2020 the Director General Health & Social Services/NHS Wales Chief Executive wrote to all NHS Wales Chief Executives concerning 'COVID-19 Decision Making and Financial Guidance'. The letter included specific guidance titled 'COVID-19 Financial Guidance to NHS Wales' Organisations' that had eleven key headings:

- Financial Governance.
- Core Financial Systems & Processes.
- Counter Fraud.
- Revenue & Capital Allocations and Cash.
- Ring-fenced Allocations (excluding DEL/AME Non Cash Depreciation).
- Cost Reimbursement – Revenue Costs.
- Financial Reporting & Monitoring.
- Capital.
- Purchase of enhanced discharge support services / Partnership arrangements.
- Cross-Border Flows.
- Primary Care Contractors.

On the 3rd April 2020, the Executive Director of Finance wrote out to Directors and senior officers outlining the key messages that needed to be adhered to during the COVID-19 pandemic, these included:

- Ensuring adherence to 'Managing Welsh Public Money'.
- Compliance with Standing Financial Instructions and Standing Orders for all investment and expenditure.
- Issue of additional financial guidance and policy where services develop further.

Associated Risks

- Financial guidance issued by Welsh Government and Director of Finance is not adhered to.
- Poor decision making with non-compliance with Standing Orders and Standing Financial Instructions.
- Value for money is not achieved.

Self-assessment Checklist

Following the request to prepare a self-assessment checklist this document was prepared, a number of key documents and sources were reviewed and a list of expected controls was collated. The resulting table is detailed below:

Table 1 – Self assessment checklist

Strategic Governance			
Areas for consideration	**Findings**	**Evidence**	**Supporting guidance**
1. Board meetings a) Have agendas been reviewed to ensure meetings are focused on key risks both in relation to the Covid crisis and those identified in the Corporate Risk register. b) To enable meetings to function as required and informed decisions to be made are papers as submitted being streamlined? c) Are meetings being held virtually where possible, is the technology in place to support this, with all Members able to contribute when desired? d) Have arrangements been made to exclude the public from Board meetings in compliance with The Health Protection (Coronavirus Restrictions) (Wales) Regulations 2020?	In addition to the Command and Control structure, the Health Board implemented a range of temporary measures to facilitate new ways of working including: • Streamlining the Board and Committee structure including the suspension of Committees of the Board, excepting the Audit and Quality, Safety and Experience Committees; • Introduction of virtual meetings with the available telephone and video conferencing facilities and changes to the public's access to meetings and records; and • Created a Cabinet, where the Board considered and approved its Terms of Reference, which detailed its purpose "..to be responsible for oversight of key high-level strategic matters relating to the Health Board's response to the health emergency presented by the Covid-19 pandemic. This will involve consideration of the outputs of	***Governance Arrangements during the Covid-19 Pandemic*** Advisory Review Final Report 2020/21 Betsi Cadwaladr University Health Board Audit and Assurance Services	Letter to Board Secretaries from the Director of Mental Health, Vulnerable Groups and NHS Governance, 26th March 2020: *Advice/Proposals from NHS Board Secretaries/Directors of Corporate Governance on Covid-19* Welsh Government Guidance Note: *Discharging Board Committee Responsibilities during COVID-19 response phase* Standing Orders

Strategic Governance			
Areas for consideration	Findings	Evidence	Supporting guidance
e) Have quoracy requirements been reviewed?	Gold Command and other levels within the Command Structure as necessary - providing scrutiny, challenge and seeking assurance - and also decision-making on those matters requiring escalation to the full Board." • The Health Board moved quickly to ensure that Board and Committee meetings could continue to be held virtually in order to comply with social distancing and other Welsh Government guidance, with Executive Directors and Independent Members showing a great deal of flexibility. Members of the public were unable to observe Board meetings until the Board meeting of the 21st May 2020, intended for live streaming via Webex and Youtube, but despite two successful dry runs, the live stream failed due to technical issues. Subsequently the Board has successfully streamed live on Youtube on the 23rd July 2020. • The Board, Audit Committee and Quality, Safety and Experience Committee (QSE) continued to operate, with all other		
2. Committee meetings (see Board meetings) a) Have Committees been reviewed and streamlined or delayed where appropriate? b) How is assurance and issues for escalation being addressed due to possible suspension in Committees' meeting/reduced focus on key issues? c) Have quoracy requirements been reviewed and mandatory attendance by relevant Executives determined and formally approved by the Board?		***Governance Arrangements during the Covid-19 Pandemic*** Advisory Review Final Report 2020/21 Betsi Cadwaladr University Health Board Audit and Assurance Services	Welsh Government Guidance Note: *Discharging Board Committee Responsibilities during COVID-19 response phase*

Strategic Governance			
Areas for consideration	Findings	Evidence	Supporting guidance
	Committees stood down. This was formalised through the Board meeting of the 15th April 2020 and detailed within the 'Maintaining Good Governance COVID-19' paper.		
3. Executive roles and responsibilities – Scheme of Reservation and Delegation (SoRD) a) Has the SoRD been updated to reflect changes to enable delivery of COVID-19 whilst also maintaining business as usual services? Where were these changes approved? b) Is there a specific SoRD for the HECC and Field Hospitals (where relevant) that has been formally approved by the Board? c) Confirm that changes made to delegated limits, authorised signatories are subject to	a) The SORD was not updated however the Standing Orders were amended for administrative purposes. **b) No there was no specific SORD or full Terms of Reference for the HECC or its Sub-Structures.**	***Governance Arrangements during the Covid-19 Pandemic*** Advisory Review Final Report 2020/21 Betsi Cadwaladr University Health Board Audit and Assurance Services	Welsh Government Guidance Note: *Discharging Board Committee Responsibilities during COVID-19 response phase* Letter from Director General Health and Social Services/NHS Wales Chief Executive 30th March 2020 *COVID-19 – Decision Making* that included *Financial Guidance and COVID-19 - Financial Guidance to NHS Wales' organisations* Standing Orders

Strategic Governance			
Areas for consideration	Findings	Evidence	Supporting guidance
review, and where appropriate reversal, once COVID-19 arrangements are stood down and decommissioning is complete.	c) Whilst the change made to the SO's was only for administrative purposes, The Audit Committee meeting on the 28th July 2020 received a paper 'Resetting Governance' to formally reset the temporary governance arrangements and associated Standing Order amendments.		
4. Emergency powers and decision making a) Does the SoRD capture any revised decision-making processes including emergency powers? b) Is there a documented reporting process in place that formally records decisions taken that are formally reported to the Board?	**a) There was no dedicated SORD or full Terms of Reference for the HECC.** b) HECC and all its sub-structures were required to maintain formal Decision Logs.	***Governance Arrangements during the Covid-19 Pandemic*** Advisory Review Final Report 2020/21 Betsi Cadwaladr University Health Board Audit and Assurance Services	Welsh Government Guidance Note: *Discharging Board Committee Responsibilities during COVID-19 response phase* Standing Orders

Strategic Governance			
Areas for consideration	Findings	Evidence	Supporting guidance
5. Changes to Governance arrangements a) Are arrangements in place to keep revised structures under review as the situation changes? b) What steps are being taken to ensure conflicts of interest in decision making are not encountered between Operational and HECC management structures? c) Have key controls been identified in the event of reduced staff numbers in key areas to reduce the risk of fraud e.g. segregation of duties.	a) Yes, further evidenced by the recent appointment of the "Associate Director COVID" reporting to the Executive Director of Primary Care & Community. b) All Decisions were formally logged. c) Under the Workforce SRO Group, 3 Workforce Hubs were established and a Redeployment Process and central log was created and maintained.	***Governance Arrangements during the Covid-19 Pandemic*** Advisory Review Final Report 2020/21 Betsi Cadwaladr University Health Board Audit and Assurance Services	Standing Orders Letter from Director General Health and Social Services/NHS Wales Chief Executive 30th March 2020 *COVID-19 – Decision Making* that included *Financial Guidance and COVID-19 - Financial Guidance to NHS Wales' organisations*

Risk Management			
Areas for consideration	Findings	Evidence	Supporting guidance
6. Risk Management a) Are risk management arrangements appropriately factored in the COVID-19 management and operational structure? b) Do all decisions taken have a documented risk assessment? c) Is there a COVID-19 risk register and what scrutiny is in place to oversee the risks and ensure control measures are effective? d) Step up and step down arrangements/plans for potential second/third spikes in cases are identified and known?	a) Risk Management arrangements remained extant throughout, **although the Guidance on Decision Making for Command did not provide the full criteria for risk rating.** b) Decision Logs recorded Risks. c) A specific CV19 Risk Register was established and reported to Cabinet and all Work streams reported Risks into HECC. d) Managed through the HECC, Executive Team and through the Executive Director of Primary Care and Community.	***Governance Arrangements during the Covid-19 Pandemic*** Advisory Review Final Report 2020/21 Betsi Cadwaladr University Health Board Audit and Assurance Services	Letter from Director General Health and Social Services/NHS Wales Chief Executive 30th March 2020 *COVID-19 – Decision Making* that included *Financial Guidance and COVID-19 - Financial Guidance to NHS Wales' organisations* Risk Management Strategy and Policy

Financial Governance			
Areas for consideration	Findings	Evidence	Supporting guidance
7. Standing Financial Instructions (SFIs) a) Have any changes been made to the SFI's? i. If yes, what were the changes and have they been formally approved by the Board?	a) No changes were made to the SFI's.	***Governance Arrangements during the Covid-19 Pandemic*** Advisory Review Final Report 2020/21 Betsi Cadwaladr University Health Board Audit and Assurance Services	Standing Financial Instructions Letter from Director General Health and Social Services/NHS Wales Chief Executive 30th March 2020 *COVID-19 – Decision Making* that included *Financial Guidance and COVID-19 - Financial Guidance to NHS Wales' organisations* HFMA Covid-19 Briefing March 2020 *"Covid-19 financial governance considerations"*
8. Annual Accounts a) Has the accounts timetable been updated to reflect new deadlines issued by Welsh Government? b) Have the revised reporting requirements been received,	a) Yes the timetable was updated, however we successfully delivered the Accounts in line with the original timetable. b) Yes.	***Governance Arrangements during the Covid-19 Pandemic*** Advisory Review Final Report 2020/21	

Financial Governance			
Areas for consideration	Findings	Evidence	Supporting guidance
communicated effectively and being worked to? c) Have any changes to year-end processes been made? If so, where have these been formally agreed?	c) Accounts were delivered within the normal timetable and complied with Welsh Government Guidance, with no significant issues raised by Audit Wales.	Betsi Cadwaladr University Health Board Audit and Assurance Services	
9. Authorised Signatories/Approval Hierarchy in E-Financials/Delegated limits a) Are additional authorised signatories required to ensure 'contingency'/ cover arrangements for when staff are absent or operating remotely - Have any changes been made and subject to formal approval and recorded? b) Are electronic signatures (for bank account signatories) held securely and are processes in place to maintain an audit trail of usage?	**a) No changes were made to the SORD's** b) Yes, Bank Account signatories and controls are all managed via Financial Services.	***Governance Arrangements during the Covid-19 Pandemic*** Advisory Review Final Report 2020/21 Betsi Cadwaladr University Health Board Audit and Assurance Services	Letter from Director General Health and Social Services/NHS Wales Chief Executive 30th March 2020 *COVID-19 – Decision Making* that included *Financial Guidance and COVID-19 - Financial Guidance to NHS Wales' organisations* Letter from Executive Director of Finance 3rd April 2020, *COVID-19; Financial Governance and Decision Making*

Financial Governance			
Areas for consideration	Findings	Evidence	Supporting guidance
c) Where appropriate has the Divisional SoRD been updated and formally approved by the Board Secretary? d) Have any changes been made to the E-Financials Hierarchy? If so, what are they and have they been formally approved the lead Director/Director of Finance? e) Review of changes in financial controls e.g. delegated limits, signatories, to ensure appropriate mitigations/reporting of changes and documenting formal approval by the Board.	c) No formal Changes were made, although **one Division did make administrative changes to their SORD.** d) The key changes were the addition of CV19 specific cost centres, which was led by Finance. e) No Changes were made.		
10. Systems and processes (Standing Financial Instructions a) Are processes in place to update/develop procedures to support system changes/new systems?	a) Yes, Business Systems is managed as a single Team within the overall Finance Department.	***Governance Arrangements during the Covid-19 Pandemic*** Advisory Review Final Report 2020/21	Letter from Director General Health and Social Services/NHS Wales Chief Executive 30th March 2020 *COVID-19 – Decision Making* that included *Financial Guidance and COVID-19 - Financial Guidance to*

Financial Governance			
Areas for consideration	Findings	Evidence	Supporting guidance
b) Are procedure notes and operational procedures available for all staff in relation to key systems and processes. c) In addition are details around revised arrangements available to view in conjunction with the main procedures to which the changes pertain. d) A Financial Governance document has been issued in relation to the Field Hospitals and all related expenditure. e) Have significant investments, for example an extra 1,000 beds, been asset-tracked and will they be able to be re-deployed on de-commissioning, with clear financial benefits visible in both revenue and capital plans for 2021/22? f) Is there a Finance Directorate Business Continuity and Disaster Recovery Plan in place,	b) **NO – these are currently being developed** c) **NO – these are currently being developed** d) Yes, via the Temporary Hospital Capacity Silver Group e) **In part yes, but some assets (such as these beds) are not owned by the Health Board and as such do not sit on the HB Asset Register.** **The HB may wish to consider its wider strategy for Asset Tracking.** f) Yes	Betsi Cadwaladr University Health Board Audit and Assurance Services KPMG Review of Field Hospitals	*NHS Wales' organisations* Letter from Executive Director of Finance 3rd April 2020, *COVID-19; Financial Governance and Decision Making* Field Hospital financial governance framework Manual for Accounts 2019/20 HFMA Covid-19 Briefing March 2020 *"Covid-19 financial governance considerations"*

Financial Governance			
Areas for consideration	Findings	Evidence	Supporting guidance
in accordance with Health Board Policy? i. Has it been communicated to all staff who are aware of its existence and where to obtain a copy? ii. When was it last updated, tested and lessons learnt? iii. The plan records both recovery and continuity arrangements for all core financial systems, financial systems, monitoring, reporting and continued service delivery across the broad services the Finance Directorate are accountable for. g) Do all proposed/actual service delivery solutions in response to COVID-19, e.g. field hospitals, testing centres, have appropriate NHS Indemnity arrangements and documented advice from Welsh Risk Pool?	Yes. Updated March 2020. Yes, and was updated to include NWSSP managed services such as Payroll and Procurement. g) NWSSP issued an updated Indemnity Paper.	NHS Wales Shared Service Partnership Document	

Financial Governance			
Areas for consideration	Findings	Evidence	Supporting guidance
h) Procedures, and rules for key systems are available and accessible to all appropriate staff (both hard copy and electronically) to support staff required to undertake roles outside of their normal duties. i) In light of pressures on key stock items e.g PPE/single use items to ensure all items are available at the right times to deliver patient care: i. What documented stock check procedures are in place for products in high demand? ii. Have additional, more frequent, stock checks been introduced? iii. Is distribution of stock effective to limit reduce the risk of no stock available for patients/staff?	h) **NO – these are currently being developed.** i) A detailed PPE Stock Policy / SOP was put in place, initially through the Finance SRO and then later managed by the Executive Director of Nursing & Midwifery through a Daily PPE Steering Group and PPE SRO Group. Stock counts were coordinated though Finance and taken daily, 7 days a week by all Divisions (including Mental Health). Where necessary, PPE Stock was moved between Divisions / Sites to ensure that adequate stocks were available.	***Governance Arrangements during the Covid-19 Pandemic*** Advisory Review Final Report 2020/21 Betsi Cadwaladr University Health Board Audit and Assurance Services	

Financial Governance			
Areas for consideration	Findings	Evidence	Supporting guidance
j) **NHS organisations/Primary Care/Care Home/Local Authorities** – If stock/items are moved, what records have been kept of where these items have/are /being sent to ensure that they are appropriately accounted for and are not lost or wasted? k) **Losses and Special Payments** – Have the requirements set out in the Manual for Accounts and Finance Procedure F06 been followed for any items/services that meet the criteria for recording as loss/special payment?	j) Stock counts were coordinated though Finance and taken daily, 7 days a week by all Divisions (including Mental Health). Where necessary, PPE Stock was moved between Divisions / Sites to ensure that adequate stocks were available. k) There have been no Health Board losses or write offs relating to CV19 recorded, however had there been a need then the Policy would have been followed.	***Governance Arrangements during the Covid-19 Pandemic*** Advisory Review Final Report 2020/21 Betsi Cadwaladr University Health Board Audit and Assurance Services	
11. COVID-19 Expenditure a) Has the Health Board continued to ensure its core Financial Systems (Oracle and ESR) is used for all expenditure; pay,	**General point regarding Value & Impact.** a) Yes, the Health Board continued to use all existing systems and controls to manage CV19 income and expenditure.	***Governance Arrangements during the Covid-19 Pandemic***	Letter from Director General Health and Social Services/NHS Wales Chief Executive 30th March 2020 *COVID-19 – Decision Making* that included *Financial Guidance*

Financial Governance			
Areas for consideration	Findings	Evidence	Supporting guidance
non-pay, revenue, capital and charitable funds? Where Estates and Pharmacy systems are used to generate commitment orders and payments, do these continue to meet the prompt payment code and Standing Financial Instructions? b) Have all revenue and capital expenditure business investments been expressly approved by Welsh Government? Details must include: i. nature of the additional cost; ii. timeframe; and iii. why it cannot be met from the HB's existing allocation	b) All Revenue costs were processed and approved within the relevant Divisions SORD's and where the Governance Cell identified costs that did not fully meet the CV19 criteria they were recharged back to the appropriate Divisional revenue Budget. **Whilst WG did not enforce the Capital Guidance, 2 capital schemes samples, we believe should have been reported formally to HECC Command and to The Board**	Advisory Review Final Report 2020/21 Betsi Cadwaladr University Health Board Audit and Assurance Services Advisory Review Second Draft Briefing Note: COVID-19 Discretionary Capital Expenditure	*and COVID-19 - Financial Guidance to NHS Wales' organisations* Letter from Executive Director of Finance 3rd April 2020, *COVID-19; Financial Governance and Decision Making* HFMA Covid-19 Briefing March 2020 *"Covid-19 financial governance considerations"*

Financial Governance			
Areas for consideration	Findings	Evidence	Supporting guidance
c) The Health Board has developed a process that clearly collects all COVID-19 financial information that includes all details supporting all decisions taken. d) The Health Board has developed a robust reporting process to record the reduction in planned care, resources freed up from this reduction and how it is being used to support COVID-19 expenditure. e) The Executive Director of Finance letter of the 3rd April 2020 details the control process template documentation required to be followed within the Health Board for recording <u>all</u> Capital investment-decisions and <u>all</u> Revenue investment-decisions. i. Are all capital and revenue specific COVID-19 expenditure supported by a capital/revenue fund	c) Yes, CV19 spend formally reviewed and reported to the Board and Welsh Government. d) "Savings" from the reduction in planned care form part of the formal monthly Monitoring Return report to Welsh Government. e) All revenue expenditure was managed through the Divisional SORD and Oracle approval hierarchies however Not ALL revenue items were supported by a "Request Form" as an operational de-minims level was put in place, however all spend was approved by an authorised manager. **See previous comment (11-b) re the reporting of Capital Expend tire decisions to HECC Command and the Health Board**	***Governance Arrangements during the Covid-19 Pandemic*** Advisory Review Final Report 2020/21 Betsi Cadwaladr University Health Board Audit and Assurance Services Advisory Review Second Draft Briefing Note: COVID-19 Discretionary Capital Expenditure	

Financial Governance			
Areas for consideration	Findings	Evidence	Supporting guidance
request form? Have all sections been completed in full and all authorisation sections complete in accordance with the SoRD? ii. In raising the required Oracle requisition, has the funding request form been attached to the requisition? iii. For Pharmacy/Estates systems COVID-19 specific expenditure, all Capital and Revenue request forms are included with the requisition? f) If quotation/ tender arrangements need to be waived, are processes in place to document this? i. Have any Single Quotation/Tender Actions been completed for COVID-19 expenditure and formally approved and reported on in line with SFI's?	f) **Retrospectively a number of expenditure items should have been supported by a STW, and as such are reported in the Conformance Report.** **The Tender & Quotes approach needs to be reviewed heading into 20/21.**	***Governance Arrangements during the Covid-19 Pandemic*** Advisory Review Final Report 2020/21 Betsi Cadwaladr University Health Board Audit and Assurance Services	

Financial Governance			
Areas for consideration	Findings	Evidence	Supporting guidance
g) Have any changes/streamlining of process been made to adding a new supplier for procurement purposes? i. What due diligence and supplier checks have/are being made? h) Prepayments i. The Health Board has robust processes in place to ensure any prepayment is compliant with Standing Financial Instruction 14.4 - Prepayments? ii. Has the Health Board identified any goods/services, prior to COVID-19, were scheduled to be delivered but due to restrictions have not been carried out e.g. planned maintenance/servicing of equipment?	g) All new Suppliers are created using NWSSP Process and checks. h) No specific payments in advance were made.	***Governance Arrangements during the Covid-19 Pandemic*** Advisory Review Final Report 2020/21 Betsi Cadwaladr University Health Board Audit and Assurance Services	

Financial Governance			
Areas for consideration	Findings	Evidence	Supporting guidance
iii. What steps are being/will be taken to ensure the Health Board is not paying for services it has not received? i) Recruitment – Have all posts been subject to the Establishment Control process approval and supported by a completed Revenue Fund Request form? j) Recruitment – Have all pre-employment checks, references etc been sought prior to confirming a start date due to the pressures on service delivery? k) Recruitment – Have any non-Agenda for Change rates/Incentives been made to attract staff? Have these been formally approved by the Remuneration and Terms of Service Committee?	i) All recruitment activities are approved through the Establishment Control and TRAC process. j) Audit were not able to very all pre-employment checks were undertaken by NWSSP k) **A Non-A4C change to Overtime payments for Band 8 and Band 9 staff was implemented, although it is not clear that this decision was escalated to HECC Command or the Health Board for ratification.**	***Governance Arrangements during the Covid-19 Pandemic*** Advisory Review Final Report 2020/21 Betsi Cadwaladr University Health Board Audit and Assurance Services	

Financial Governance			
Areas for consideration	Findings	Evidence	Supporting guidance
12. Payments to Agency, Locum and Substantive staff a) What approval process is in place to ensure agency/locum payments, enhanced rates and use of non-contract agency(ies) is appropriately approved prior to engagement? Is this adequately recorded in the SoRD? b) What process is in place to formally approve any overtime and other enhancements for senior managers, other officers involved with COVID-19, ensuring value for money and service needs at all times?	a) Agency spend was approved through the normal route with any "above cap" rates requiring Director approval. Agency Spend is formally reported to the Health Board and Welsh Government every month. b) **See 11.k) – the Policy was not explicitly clear who it applied to and who should approve claims; the evidence sample identified varying levels of approval.** **The Overtime Form lacked any narrative section for the individual to document exactly what CV19 related duties they were undertaking during these overtime hours as such the sample reviewed could only identify the number of hours and the value paid and the approver.**	***Governance Arrangements during the Covid-19 Pandemic*** Advisory Review Final Report 2020/21 Betsi Cadwaladr University Health Board Audit and Assurance Services	Letter from Director General Health and Social Services/NHS Wales Chief Executive 30th March 2020 *COVID-19 – Decision Making* that included *Financial Guidance and COVID-19 - Financial Guidance to NHS Wales' organisations* Letter from Executive Director of Finance 3rd April 2020, *COVID-19; Financial Governance and Decision Making*

Financial Governance			
Areas for consideration	Findings	Evidence	Supporting guidance
13. Financial reporting The Health Board is complying with the revised reporting arrangements set by Welsh Government, including, amongst others the following: i. Baseline position pre COVID-19 (per previous financial plan). ii. Year to date and forecast outturn iii. Risks. iv. Alocation and Income assumptions. v. Cashflow and capital assumptions. vi. Additional COVID-19 expenditure incurred. vii. Planned expenditure or investments not incurred due to COVID-19.	Financial Reporting internally within the Divisions and to the Health Board and its Committees includes a full suite and range of CV19 related reports and analysis. Reporting to the Welsh Government is fully prepared in line with the Mentoring Return and the additional CV19 Tables.	***Governance Arrangements during the Covid-19 Pandemic*** Advisory Review Final Report 2020/21 Betsi Cadwaladr University Health Board Audit and Assurance Services	Letter from Director General Health and Social Services/NHS Wales Chief Executive 30th March 2020 *COVID-19 – Decision Making* that included *Financial Guidance and COVID-19 - Financial Guidance to NHS Wales' organisations* Letter from Executive Director of Finance 3rd April 2020, *COVID-19; Financial Governance and Decision Making* HFMA Covid-19 Briefing March 2020 *"Covid-19 financial governance considerations"*

Financial Governance			
Areas for consideration	Findings	Evidence	Supporting guidance
14. 2020/21 budget and month end processes a) Is a 2020/21 budget in place to support financial reporting? b) Do the financial reports clearly identify the implications of COVID-19 against the Board approved budget? Has this been reported on regularly? c) Are there any proposed changes to month end processes? d) Have cashflow forecasting and reporting processes been reviewed?	a) The 20/21 Budget was approved at the Board on the 1th April 2020. b) Monthly reports clearly spate out all CV19 costs and income and risk assumptions. c) During the Pandemic, Monthly reporting has remained at Day 4 with a Day 5 positon reported to Welsh Government. d) Cash Flow is reviewed and reported monthly.	***Governance Arrangements during the Covid-19 Pandemic*** Advisory Review Final Report 2020/21 Betsi Cadwaladr University Health Board Audit and Assurance Services	Letter from Director General Health and Social Services/NHS Wales Chief Executive 30th March 2020 *COVID-19 – Decision Making* that included *Financial Guidance and COVID-19 - Financial Guidance to NHS Wales' organisations* Standing Orders Standing Financial Instructions HFMA Covid-19 Briefing March 2020 *"Covid-19 financial governance considerations"*
15. Savings a) Are arrangements in place to report the 2019/20 position?	a) Savings Performance continues to be reported monthly to Divisions the Board and its Committees and to Welsh Government.	***Governance Arrangements during the Covid-19 Pandemic***	Letter from Director General Health and Social Services/NHS Wales Chief Executive 30th March 2020 *COVID-19 – Decision Making* that included *Financial Guidance*

Financial Governance			
Areas for consideration	Findings	Evidence	Supporting guidance
b) What savings/service redesign programmes will/will not be maintained/ceased in 2020/21? c) What progress to date has been made in identifying savings already achieved and reported on, remaining conscious of the need to maintain financial prudence? d) What steps are in place to re-start the savings programmes once the normal position returns? e) The Health Board has a clear assessment of the forecast outturn on non-delivery of planned savings?	b) All schemes continue to be pursued, although it is recognise that Workforce Schemes may be delayed as staff are required to focus on supporting the CV19 response. c) Savings continue to be tracked through Finance and reported to the Board, Committee and Welsh Government d) Specific Savings "re-start" processes discussed at Executive Team and the Board and its Committees. e) Savings continue to be tracked through Finance and reported to the Board, Committee and Welsh Government	Advisory Review Final Report 2020/21 Betsi Cadwaladr University Health Board Audit and Assurance Services	*and COVID-19 - Financial Guidance to NHS Wales' organisations* Standing Orders Standing Financial Instructions

Financial Governance			
Areas for consideration	Findings	Evidence	Supporting guidance
16. Capital a) Is the Health Board cognisant of Welsh Government's requirements in respect of: i. Where additional capital funding is required above approved Capital Resource Limits (CRLs) and Capital Expenditure Limits (CELs). ii. Depreciation funding requirements above baseline. b) Is the Health Board/Committee being kept aware of all capital projects and progress during this time? c) Are systems and processes in place to capture specific IT expenditure relating to COVID-19?	**See capital comment in Section 11b & e** a) Yes, capital is managed through CPMT and all allocations and expenditure are managed through the CRL. b) Capital reporting is included in the Board Finance Report and in the Welsh Government Monitoring Return. c) All IT spend is managed via the IT Department.	***Governance Arrangements during the Covid-19 Pandemic*** Advisory Review Final Report 2020/21 Betsi Cadwaladr University Health Board Audit and Assurance Services	Letter from Director General Health and Social Services/NHS Wales Chief Executive 30th March 2020 *COVID-19 – Decision Making* that included *Financial Guidance and COVID-19 - Financial Guidance to NHS Wales' organisations* Standing Orders Standing Financial Instructions HFMA Covid-19 Briefing March 2020 *"Covid-19 financial governance considerations"*

Financial Governance			
Areas for consideration	Findings	Evidence	Supporting guidance
17. Partnership arrangements/Enhanced Discharge support services a) Where the Health Board has purchased additional capacity, has this been in accordance with the Standing Financial Instructions and revenue purchase guidelines? What additional capacity has been purchased locally? b) Use of the Integrated Care Fund has been revisited, re-aligned where necessary to focus on emerging pressures from COVID-19.	a) Additional capacity has been secured (eg Spire), through the agreed Contracts Team and process. b) ICF funds (Revenue and capital) have been re-allocated to support CV19, with the full approval of the NWRPB and Welsh Government ICF Team.	***Governance Arrangements during the Covid-19 Pandemic*** Advisory Review Final Report 2020/21 Betsi Cadwaladr University Health Board Audit and Assurance Services North Wales Regional Partnership Board	Letter from Director General Health and Social Services/NHS Wales Chief Executive 30th March 2020 *COVID-19 – Decision Making* that included *Financial Guidance and COVID-19 - Financial Guidance to NHS Wales' organisations*

Financial Governance			
Areas for consideration	Findings	Evidence	Supporting guidance
18. Cross-Border Flows and Long Term Agreements a) What block contracts have been agreed during this period and have the implications of these been assessed and reported on? Are they the right contracts? b) Have the Standing Financial Instructions/delegated limits been complied with in agreeing and signing the contracts? c) What are the financial consequences/risk to the Health Board in agreeing block contracts and has the Health Board been made aware of this? d) What arrangements are in place to monitor the contracts? e) Has the all-Wales approach endorsed by Welsh Government for long-term agreements been shared with the Health Board with any financial risk of the approach identified?	a) All existing contracts have been retained. and rolled over from 2019/20 b) Yes. c) The ongoing cost of these contracts and the financial risk, is reported to the Board and its Committees. d) Contracts are monitored monthly through the Finance Contracting team. e) Yes, all payments and contracts re in line with the National Guidance and Policy, with the financial risk reported to the Board and its Committees.	***Governance Arrangements during the Covid-19 Pandemic*** Advisory Review Final Report 2020/21 Betsi Cadwaladr University Health Board Audit and Assurance Services	Letter from Director General Health and Social Services/NHS Wales Chief Executive 30th March 2020 *COVID-19 – Decision Making* that included *Financial Guidance and COVID-19 - Financial Guidance to NHS Wales' organisations* Standing Orders Standing Financial Instructions

Financial Governance			
Areas for consideration	Findings	Evidence	Supporting guidance
19. Primary Care Contractors a) How are additional costs for COVID-19 being captured, scrutinised by the Health Board and re-imbursement sought from Welsh Government? b) Has further guidance been received by the Health Board from Welsh Government Policy Leads that have a financial consequence/risk for the Health Board and is being complied with?	a) GMS Contractors are required to make formal claims for CV19 financial support on an agreed Claim Form, approved by the relevant Area Director in line with the SORD. All CV19 spend (including GMS and GDS) is reported to Welsh Government via the Monitoring return Tables, a specific CV19 Table has been established. b) Welsh Government Guidance received in relation to the use of Cluster Funds and in relation to the payment of GMS / GDS and Optometrists – all Guidance has been and is being followed.	***Governance Arrangements during the Covid-19 Pandemic*** Advisory Review Final Report 2020/21 Betsi Cadwaladr University Health Board Audit and Assurance Services	Letter from Director General Health and Social Services/NHS Wales Chief Executive 30th March 2020 *COVID-19 – Decision Making* that included *Financial Guidance and COVID-19 - Financial Guidance to NHS Wales' organisations* Standing Orders Standing Financial Instructions

Financial Governance			
Areas for consideration	Findings	Evidence	Supporting guidance
20. Decommissioning of Temporary sites/services a) The Health Board has a documented process detailing expected controls that when the time comes, it vacates all property/services used as part of COVID-19 in a structured manner, ensuring value for money. b) All items are tracked and traceable when re-distributed/ongoing services e.g. oxygen/heat/light/water are terminated etc.	a) Field Hospital contracts include Decommissioning arrangements. **See asset tracker comment above; 10e).**	KPMG Review of Field Hospitals	Letter from Director General Health and Social Services/NHS Wales Chief Executive 30th March 2020 *COVID-19 – Decision Making* that included *Financial Guidance and COVID-19 - Financial Guidance to NHS Wales' organisations* Standing Orders Standing Financial Instructions

Counter Fraud			
Areas for consideration	Findings	Evidence	Supporting guidance
21. Counter Fraud (LCFS) a) Have Counter Fraud been regularly contacted for advice and guidance? Are they adequately resourced? b) Are Counter Fraud contactable during this period of lockdown and have their contact details been widely circulated? c) Has there been a reduction in the number of fraud referrals and if so, is action required to re-enforce the fraud awareness message? d) How have Counter Fraud LCFS' discharged their responsibilities during the period of heightened risk? e) Is there a Fraud Risk Assessment that has been updated and reported on due to the impact of COVID-19?	a) Counter Fraud has been regularly contacted for advice and guidance during lockdown and are adequately resourced. b) LCFS has been contactable during lockdown and their contact details have been widely circulated. c) There has been a reduction in the number of referrals. Action has been taken to re-enforce the Counter Fraud message. d) LCFS has discharged its responsibilities during the period of heightened risk by working agilely using all of the tools and techniques which would be used in times of usual operation. e) Security alerts are circulated by the UK Cabinet Office, COVID 19 Fraud Response Team / NHS Counter Fraud Authority and NHS CFS Wales.	***Governance Arrangements during the Covid-19 Pandemic*** Advisory Review Final Report 2020/21 Betsi Cadwaladr University Health Board Audit and Assurance Services LCFS Performance Statistics for Welsh Government. LCFS Newsletter and payslip message circulated to all staff.	Letter from Director General Health and Social Services/NHS Wales Chief Executive 30th March 2020 *COVID-19 – Decision Making* that included *Financial Guidance and COVID-19 - Financial Guidance to NHS Wales' organisations* Letter from Executive Director of Finance 3rd April 2020, *COVID-19; Financial Governance and Decision Making*

Charitable Funds			
Areas for consideration	Findings	Evidence	Supporting guidance
22. Charitable Funds The Charitable Funds Committee has allocated financial support from funds to support the impact of COVID-19 on both staff and service users. *COVID-19 Staff Support Fund, 8T53 £50,000* a) What reporting arrangements and delegated authority is in place to ensure expenditure is appropriate and in line with the terms stipulated by the Committee – This allocation is overseen by Mental Health Services & HECC. *COVID-19 Response Charitable Funding needs under £100 (£2,000 each to Ysbyty Glan Clwyd; Gwynedd & Wrexham Maelor)*	a) Guidance "*COVID-19 Voluntary Support Plas"* was shared across the Organisation.	***Governance Arrangements during the Covid-19 Pandemic*** Advisory Review Final Report 2020/21 Betsi Cadwaladr University Health Board Audit and Assurance Services	Letter from Executive Director of Finance 3rd April 2020, *COVID-19; Financial Governance and Decision Making* BCUHB'S COVID-19 Voluntary Support Plan

Charitable Funds			
Areas for consideration	Findings	Evidence	Supporting guidance
a) All items of expenditure from this allocation are supported by proof of purchase and a formal request that is approved by a Band 8a or above? b) Where a Band 8a is self-approving, and has ticked the 'Self-authorisation' box, all expenditure is subject to independent scrutiny? *COVID-19 Response Charitable Funding needs over £101 - £4,999* a) A Funding Request Form (for items £101 to £4,999) must be submitted by a Band 8a and approved by the HECC Gold Command? *COVID-19 Response Charitable Funding needs over £5,000* a) An Application Form (For items £5,000 and over) must be completed by a Band 8a and approved by the HECC Gold Command and then the Charitable Funds Committee.	**b) Self-Authorisation of expenditure or petty cash claims is not recommended** All Charitable Funds expenditure is recorded centrally within Finance and is reported to the Charitable Funds Committee formally.	***Governance Arrangements during the Covid-19 Pandemic*** Advisory Review Final Report 2020/21 Betsi Cadwaladr University Health Board Audit and Assurance Services	

Charitable Funds			
Areas for consideration	Findings	Evidence	Supporting guidance
Donations and receipt of income a) Are existing internal controls for the receipting of donations/income being complied with? b) What additional controls have been applied to recognise the increase public support during COVID-19? c) Has the Charity provided detailed guidance to all staff on who may be approached to accept donations? *Registering Gifts and Hospitality* a) Whilst being mindful that the public want to show their appreciation for all NHS Wales staff at this time, have all staff been reminded of their obligation to record any gifts/hospitality they receive?	a) All gifts and hospitality are formally recorded. The Awyr Las Team maintained a record of all donations and offers of support, working alongside the WorkForec staffing Hubs in relation to managing volunteers.	***Governance Arrangements during the Covid-19 Pandemic*** Advisory Review Final Report 2020/21 Betsi Cadwaladr University Health Board Audit and Assurance Services	

Information Governance			
Areas for consideration	Findings	Evidence	Supporting guidance
23. Information Governance a) Have robust measures and controls been established by the Information Governance department to mitigate issues and risks arising from the Covid-19 crisis?	a) Robust measures remained in place throughout the CV19 crisis with outstanding areas of work now being worked back into BAU. Senior Information Risk Owner (SIRO) was also the HECC Silver Commander There is focus on CV19 information governance risks, with a specific document on the Health Board's website developed to provide guidance (COVID-19 NHS Wales Information Governance Joint Statement).	***Governance Arrangements during the Covid-19 Pandemic*** Advisory Review Final Report 2020/21 Betsi Cadwaladr University Health Board Audit and Assurance Services	National Information Governance Managers' Group (IGMAG) NHS Wales Operational Security Service Management Board (OSSMB)
b) Are operational systems and assurance processes being maintained for the management of cyber risks?	b) Operational processes for cyber security have not changed during the pandemic. Encryption and other security measures maintained with the increased numbers of laptops (etc) issued. Existing security arrangements have continued, eg ,monitoring mail for viruses / malware etc.		

Cyfarfod a dyddiad: Meeting and date:	Audit Committee
Cyhoeddus neu Breifat: Public or Private:	Public
Teitl yr Adroddiad Report Title:	Charitable Funds Annual Report and Financial Statements 2019/20
Cyfarwyddwr Cyfrifol: Responsible Director:	Sue Hill, Acting Executive Director of Finance
Awdur yr Adroddiad Report Author:	Rebecca Hughes, Charity Accountant
Craffu blaenorol: Prior Scrutiny:	Charitable Funds Committee
Atodiadau Appendices:	Appendix 1: Annual Report and Financial Statements

Argymhelliad / Recommendation:

The Charitable Funds Annual Report and Accounts are brought for information.

Please tick one as appropriate (note the Chair of the meeting will review and may determine the document should be viewed under a different category)

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

Sefyllfa / Situation:

The attached Annual Report and Financial Statements (Appendix 1), which have been subject to audit, provide the formally reported position for the charity for 2019/20. They were approved by the Charitable Funds Committee on the 8th December 2020 and signed by the Auditor General on the 9th December 2020.

Cefndir / Background:

The Charitable Funds Accounts have been prepared in accordance with the timetable set by the Charity Commission and in line with Charities SORP. The accounts were prepared and submitted to Audit Wales at the end of September 2020, with the audit taking place throughout October and November. The submission of the accounts was delayed this year due to COVID-19.

The Charitable Funds Committee has delegated authority to approve the final accounts. The Board (as Charitable Trustees) will formally receive the accounts at a meeting to be arranged in early 2021. The deadline for submission to the Charity Commission is the 31st January 2021. The accounts will not be submitted to Welsh Government.

Asesiad / Assessment:

Strategy Implications

Aligned to the Awyr Las Charity Strategy.

Options considered

Not applicable – information on the financial position of the charity.

Financial Implications

Statement of Financial Activities

The Statement of Financial Activities (SoFA) summaries the charity's income and expenditure for the year. Income for the year totalled £2.6m; expenditure was £2.5m, with a loss on investments of £0.3m, giving a net decrease in funds of £0.2m (increase in funds of £0.2m in 2018/19).

Incoming Resources

Total income of £2.6m shows an increase of 30% year on year (£2.0m in 2018/19). Of this, £0.5m relates to an increase in legacies and £0.1m from higher fundraising income.

Legacies in particular are a volatile and unpredictable source of income that can vary greatly from year to year. Part of the charity's strategy over the long term is to increase the legacy income it receives.

Expenditure

Expenditure of £2.5m was 14% higher year on year (£2.2m in 2018/19). 'Note 7. Analysis of expenditure on raising funds' and 'Note 8. Analysis of charitable activity' provides the breakdown of expenditure between the running costs of the charity, fundraising costs and grants made.

The primary reason for the increase in expenditure is an increase in grants awarded of 29% (£2.2m in 2019/20 compared to £1.7m in 2018/19). The analysis of this over the different grant categories is shown below.

Type of Grant	2019/20 £000	2018/19 £000	Movement £000
Grants for NHS Capital expenditure	507	159	348
Staff education and welfare	611	521	90
Patient education and welfare	1,011	962	49
Medical research	82	102	(20)
Total	**2,211**	**1,744**	**(467)**

The largest increase has been in grants for NHS Capital. Capital grants in 2019/20 included an Electromagnetic Navigation Bronchoscopy (ENB) costing £0.1m, additional equipment for the YGC Hybrid Theatre (£0.1m) and an Ambulatory ECG Monitoring System (£0.05m). There were no significant capital schemes funded by the charity in 2018/19.

Movement in Investments

Many of the donations and legacies that the charity receives cannot be spent immediately, as they need to be accumulated to fund the most appropriate purchases. These donations are therefore invested in order to generate income and protect their value in real terms. During 2019/20, losses on these investments totalled £0.3m compared to a gain of £0.4m in 2018/19. The COVID-19 pandemic resulted in a significant fall in the stock market in February and March 2020, which led to a loss of £0.9m in the portfolio over the two months, outweighing the gains seen earlier in the year. All of this loss has been recovered in 2020/21.

Balance Sheet

The funds of the charity at the end of the year totalled £7.6m, comprising £3.8m of unrestricted funds and £3.8m of restricted funds. Restricted funds are those that have a legal restriction placed on them, such as legacies. These funds are further split into general funds and designated (earmarked) funds, which are identified to specific areas and/or services.

Fixed Assets
During 2017/18 a piece of land located in Porthmadog was donated to the charity. The land was valued by the District Valuer and was brought onto the charity's balance sheet at £0.1m. The charity is currently still holding this land, although there are parties interested in purchasing it.

The year-end balance held in investments was £7.7m, which is a decrease of £0.3m from 2018/19.

Current Assets
Debtors, as analysed in 'Note 16. Analysis of current debtors' have increased by 54% to £0.5m (£0.3m in 2018/19). This is due to an increase in accrued income for legacies, where we have been confirmed as a beneficiary in a Will and probate has been granted, but the distribution of the estate had not been completed.

Cash balances of £0.9m are the same as at the end of 2018/19. Cash held at the end of the year is higher than would usually be held, but is required to pay creditors that fall due at the start of the new financial year.

Liabilities
Creditors, as can be seen in 'Note 18. Analysis of liabilities', amounted to £1.6m which is a 4% increase year on year (£1.5m in 2018/19). This is due to an increase in accruals for grants owed to NHS bodies, which are the funding commitments made by the charity.

Other Notes

Other key items included in the financial statements are as follows.

Related Party Transactions (Note 2)
This note identifies the transactions made with the Health Board. As the Health Board and Charitable Funds accounts are produced under different accounting regulations, there is a timing difference as to when a grant that has been awarded by the charity is recognised. Therefore, this note contains two disclosures; one that mirrors that in the Health Board accounts and one that agrees to the expenditure reported through the charity accounts.

This note also includes details on Board members' interests where appropriate.

Post Balance Sheet Events (Note 22)
Due to the time delay between the balance sheet date and the date of signing the accounts, plus the materiality of the investments to the charity, a post balance sheet event is always recorded showing the movement in the value of the investments over this time.

This year, a note on COVID-19 has also been included.

Risk Analysis
Not applicable

Legal And Compliance
Not applicable.

Impact Assessment
Not applicable.

ANNUAL REPORT & ACCOUNTS

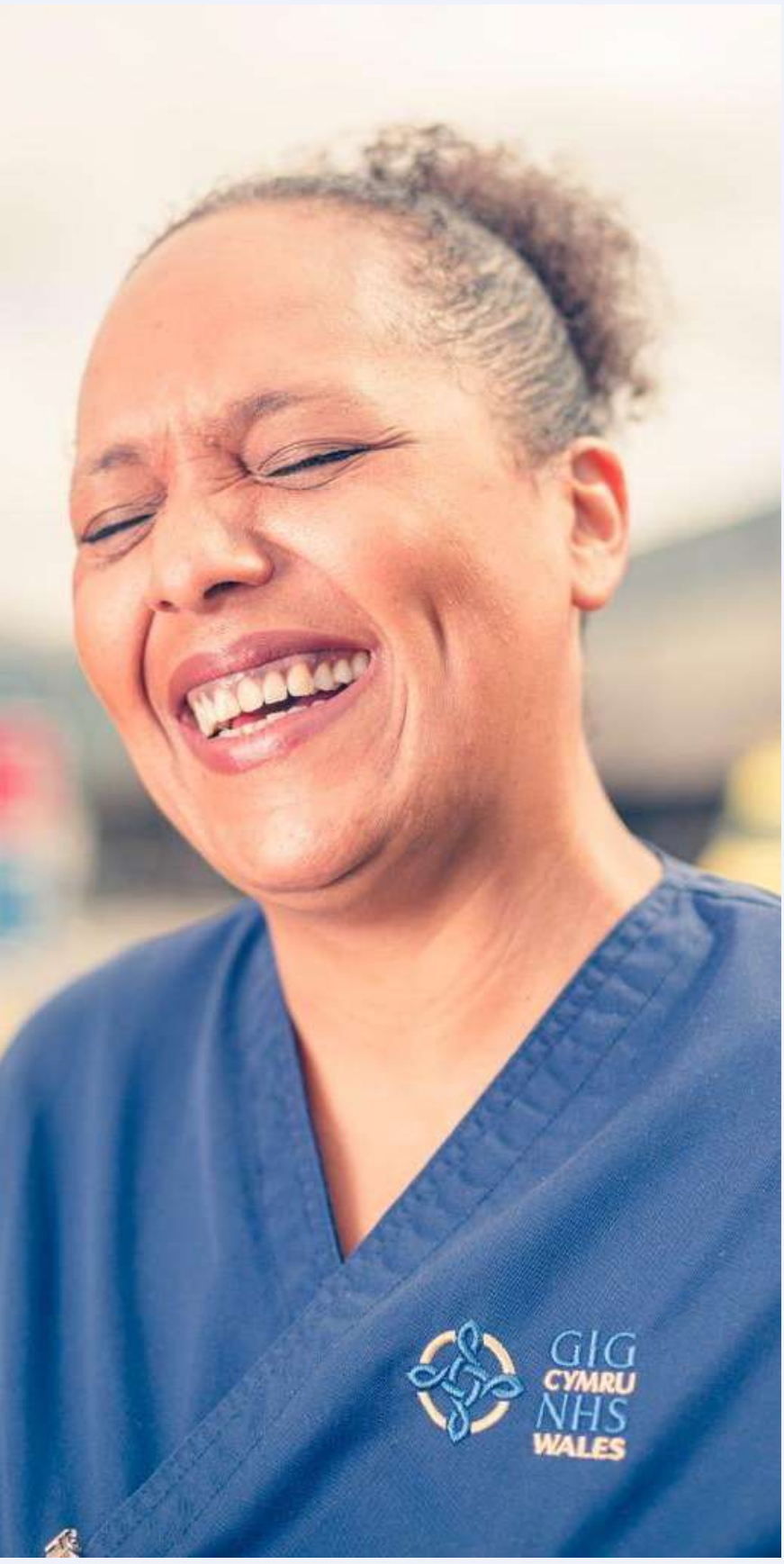
2019/20

AWYR LAS / BLUE SKY IS THE WORKING TITLE OF BETSI CADWALADR UNIVERSITY HEALTH BOARD CHARITY & OTHER RELATED CHARITIES
REGISTERED CHARITY NUMBER 1138976

Awyr Las
Blue Sky

Elusen GIG Gogledd Cymru
The North Wales NHS Charity

CONTENTS



WELCOME FROM THE HONORARY PRESIDENT

I am pleased to present the Awyr Las Annual Report & Accounts for 2019/20.

Annual reports are usually written from a clear vantage point of retrospection – imbued with the knowledge and certainty of how decisions made within a given time-frame have shaped the fortunes of the subsequent period.

Following the cataclysmic events that occurred at the tail-end of this financial year, the Charity finds itself reporting from a perspective that is shrouded in uncertainty. The onset of a global pandemic in December 2019 presented the Charity with a set of challenges that were completely alien. The response to these required rapid adaptation, and the Charity was forced to frequently reappraise its position and priorities at a moment's notice.

There is no denying that COVID-19 has had a profound impact on the NHS in Wales and the communities it serves. At the time of writing, the pandemic remains a looming spectre; there is little in our day-to-day lives that remains untouched by the shadow COVID-19 has cast.

It is difficult therefore to reflect on the year that has passed without doing so through the prism of this wretched virus.

That said, please join me in celebrating some of the Charity's achievements from 2019/20. It is also a chance to reflect on the bold and definite decisions taken at the height of the pandemic that have enabled the Charity to mobilise in the face of the crisis and move forward with a tentative optimism.

The year saw the Charity building upon partnerships with other NHS charities in Wales, solidifying relationships that would be called upon during the pandemic.

The successful "Hearts & Minds" small grant scheme trialled last year was scaled up. Again, it offered staff across Betsi Cadwaladr university Health Board (BCUHB) the opportunity to quickly access modest amounts of funding that would help them make small changes on their wards that would result in big differences for their patients.

Building on the success of Hearts & Minds, the Awyr Las Support Team worked with colleagues from both Mental Health and Workforce & Organisational Development to launch two themed small grant schemes; the "I CAN" Mental Health small grant scheme, and the Staff Experience small grant scheme.

Over 140 applications were submitted across all three grant schemes, confirming the appetite among NHS staff to innovate and use charitable funding to enhance the experience of their patients and colleagues.

In total, the Charity awarded over £2.1m of funding this year, an increase of 20% compared to the year ending 31st March 2019 (£2,211,000 vs £1,838,000).

Towards the end of the financial year, Awyr Las took up its important role in helping staff contend with the pandemic.

At the beginning of March 2020, as COVID-19 took root around the globe, the Awyr Las Support Team began working with a local family on a pre-emptive fundraising campaign to help Ysbyty Gwynedd's Intensive Care Unit prepare for the likely impact of the pandemic in North Wales.

The campaign - which raised over £6,000 in twelve weeks - provided an ideal stepping off point, from which the Charity's formal COVID-19 Response Appeal was launched later that month.

By 31st March 2020, the COVID-19 Response Appeal had raised almost £4,000, primarily from donations given by local individuals. The Board also agreed to allocate £65k of existing funds to the appeal.

At this point, I would like to take a moment to extend my heartfelt thanks to the communities of North Wales. I and everyone involved with the Charity have been humbled by the community's response to the pandemic. The outpouring of generosity from every part of North Wales (and beyond) was truly overwhelming. You truly have been the Blue Sky for NHS staff and patients affected by COVID-19.

Diolch yn fawr.

As well as the physical and emotional toll that the pandemic has taken, COVID-19 has, seemingly irreversibly, changed the fundraising landscape. Its effects will continue to be felt in this regard for a long time, and as the Charity moves into the new financial year, there is a high level of uncertainty around the future of fundraising.

Mass participation challenge events and community gatherings, the bread and butter of fundraising, are on hold for the foreseeable future.

In spite of this, our network of supporters has been incredibly resourceful. They have shown a great deal of innovation, with individuals taking their fundraising online, or adapting events so that they can continue to raise money whilst remaining socially distant.

We are all incredibly grateful for this support.

Yet we are mindful that this surge in support for Awyr Las and other NHS Charities has created a buffer that has, to date, shielded the Charity from the full extent of the impact that COVID-19 has had on the wider sector. The true impact of the pandemic on the Charity's ability to fundraise in the future remains to be seen.

To counter this, the Charity's 2021 – 2026 strategy will have a focus on making fundraising for the Charity easy and safe in the context of COVID-19, with significant attention paid to how the Charity can do more to offer donors and supporters meaningful, fulfilling experiences using digital and remote channels.

Similarly, we will work to ensure that we are able to communicate effectively about the impact of donations. In the absence of being able to visit hospital sites and see the fruits of their labour in action, we will develop alternative methods for donors to be able to see the impact of their support.

The onset of the pandemic has seen the Charity revise its processes radically. Early on, it became possible for staff to claim refunds online for unforeseen expenditure – for example, essential items for vulnerable patients – with many being reimbursed the same day, thanks to dedicated support from the Charity's accountants.

Requests for larger sums of money were being turned around within five days, and decisions on some of the largest scale projects were often able to be made "out of committee".

This agile approach to grant making is something that the Charity wishes to expand upon in the new financial year.

The Awyr Las Support Team, working remotely, has shown remarkable commitment in often difficult circumstances.

The board have also played their part in helping develop a response to unprecedented need which is swift, flexible and straightforward.

As we continue to navigate this uncharted territory together, may we continue to hold our National Health Service and Awyr Las close to our hearts and enable them both to flourish in the face of adversity, so that so that everyone in North Wales can lead healthy, happy lives.

Barry Jones

RT HON LORD BARRY JONES P.C.
HONORARY PRESIDENT OF AWYR LAS

ABOUT THE CHARITY

Awyr Las is the NHS Charity for North Wales, the area served by Betsi Cadwaladr University Health Board (BCUHB). Put simply, the Charity exists to help the NHS do more.

It does this by funding cutting-edge equipment and brand-new facilities; specialist and additional staff training, world-class research and innovation projects, special projects and additional services; complementary therapies, and extra patient comforts.

All of which go beyond what the NHS can provide on its own, and – when combined - ensure people in North Wales can benefit from better NHS services when they need them the most.

The Charity funds projects in hospitals and in the community.

Since 2010, the Charity has funded over £27m of projects to improve healthcare across North Wales, making a genuine difference to the lives of patients, families, and NHS staff.

The Charity does not replace the core funding that the NHS receives from the government.

This means that the money given and raised by the public genuinely improves the care that is available to people in North Wales. Your money funds things that would not otherwise be possible.

Awyr Las (Blue Sky) is the working name of the Charity. Its official name is Betsi Cadwaladr University Health Board Charity and other related Charities. It is a Registered Charity (number 1138976). It was constituted under a trust deed on the 23rd of September 2010.

The Charity's registration incorporates a linked Charity, the North Wales Cancer Appeal (NWCA). A very active subsidiary, NWCA volunteers work alongside NHS staff in the North Wales Cancer Treatment Centre and raise additional funds for priority projects that benefit patients and families affected by cancer.

The Charity has a sole Corporate Trustee, the Betsi Cadwaladr University Health Board (BCUHB). Whilst BCUHB Members undertake responsibility for the administration of the Charity's funds as part of their tenure of the Board, they do not hold trustee status as individuals.

Designated Funds

Within Awyr Las, there are over 400 designated funds. Almost every BCUHB ward, service, department and project across North Wales is represented within these funds. These funds are attached to the ward, service or department that they are aligned with. Designated funds can only be used to fund projects within that healthcare area. To this end, each fund has at least one Fund Advisor. These individuals have a special role, in that they act as guardians for their designated fund. It is their responsibility to uphold the fund's objectives and ensure that expenditure is only authorised when it is in furtherance of the goals that their fund was set up to achieve.

When donors give money to a designated fund, it goes directly and promptly to that ward or department, ready for NHS staff to use towards projects and priorities decided at the ward level.

Non-Designated Funds

Those few wards and departments that do not have a fund can receive support from the Awyr Las Support Team to establish one, or they can request funding from the Charity's non-designated fund.

When donors give to the Charity without expressing a preference as to where the money should go, the donation is assigned to the Charity's non-designated fund. Though in the minority, these donations are incredibly important. This is because they enable staff without a fund of their own, or without sufficient monies in their fund, to still draw on funding from the Charity. In some circumstances, non-designated donations are funnelled towards a priority fund; a pertinent example being the newly established COVID-19 Response Fund.

Fundamentally, donations from the public help dedicated NHS staff in hospitals and in communities across North Wales to offer an enhanced healthcare service, offering patients and their families the very best care and treatment available.

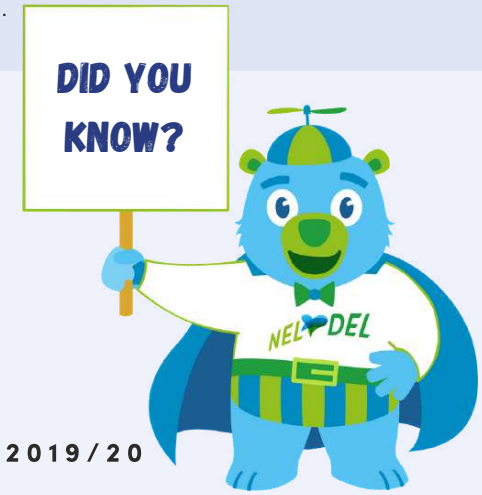
Levels of funding

Projects costing less than £5,000 can be authorised by a Fund Advisor, thus enabling NHS staff to gain prompt access to funding.

Because of this, staff can quickly implement their ideas, meaning the tangible positive differences they wish to achieve for their patients or colleagues can be realised almost immediately.

There is a formal application and scrutiny process for applications that request £5,000 or more. The process is designed to be accessible, whilst ensuring projects receive rigorous scrutiny to ensure they are robust, innovative, and realistically able meet the objectives set out by the applicant.

Derived from the geography of North Wales, the Awyr Las heart motif is symbolic of the Charity's duty to enhance healthcare for everyone in the region.



MISSION, PURPOSE & STRATEGY

The Charity has a mission to enhance Betsi Cadwaladr University Health Board's ability to improve the health and wellbeing of people across North Wales and deliver excellent care.

Mission

In other words, the Charity's mission is to help the Health Board to do more for its patients.

Purpose

There are two main reasons why the Charity exists. Both purposes are equally important and each has a significant bearing on the treatment and care that patients receive.

These are to ensure that:

- BCUHB's strategic priorities for improving healthcare can be met, and;
- Those who want to give back to specific healthcare services can do so in a way that supports local priorities.

NHS charities are not new – they, like the NHS itself, have been in existence since 1948.

NHS charities have always had an important role to play in achieving the above, but as we are living longer, many of us with complex health conditions and diseases, there is an increasing need for the additional support that the Charity can provide in pursuit of excellent healthcare.

The impact of COVID-19 and the associated challenges it presents throws the part the Charity must play into sharp relief.

Traditionally, the Charity has had a focus on secondary care, particularly cancer services. The 2016 - 2021 strategy highlights two pressing issues which the Health Board in conjunction with the Charity must address.

1. Around 90% of the care people receive is from primary care and community services. With predicted rises in cases of dementia and other mental health issues, cancer, diabetes and heart conditions there will be ever increasing demands on these services.

2. Health inequalities mean that those living in the least deprived areas of North Wales are likely to live 13 years longer in better health than those living in the most deprived areas.

COVID-19 compounds these two issues; we already know that the pandemic has disproportionately affected some sections of our community, such as Black, Asian and Minority Ethnic people. There is also the emerging concept of "long-COVID", which will present challenges and place demands on both Primary and Secondary Care.

The challenge for the Charity is to continue to provide the support for wards and departments in secondary care settings whilst simultaneously securing the support needed to address the two pressing issues outlined above.

The Awyr Las Support Team

The Charity's Support Team is made up of finance, fundraising and administrative support staff. It is in place to make sure that the Charity can carry out its mission effectively.

The Support Team's responsibilities

The responsibilities of the Charity Support Team are varied. it is in place to:

- Effectively manage the Charity's financial accounts, investment portfolio and grant programmes
- Support the Charity's Fund Advisors, the gatekeepers for the Charity's designated funds, with guidance and practical assistance
- Provide a great experience for the fundraisers that generously choose to organise events and activities in aid of the Charity by giving support, advice and encouragement
- Raise the Charity's profile in hospitals and the community, so more people can become inspired to donate, fundraise or act as ambassadors
- Communicate well with supporters and the wider community, from direct communication with fundraisers to broad messaging via social media
- Maximise the value of donations to the Charity by reclaiming Gift Aid
- Add value to the work of the Health Board and the Charity by supporting independent charities, for example, the Leagues of Friends who provide additional direct charitable support to BCUHB

Vision

"A North Wales Health Service which promotes equality for all with an emphasis on staying well and active."

Values

The Charity shares the same set of values as the Health Board. These are:

- Put patients first
- Work together
- Value and respect each other
- Learn and innovate
- Communicate openly and honestly

The Awyr Las Support Team and the Board, along with the circa 17,000 staff that make up BCUHB - who are the embodiment of Awyr Las – are responsible for making sure everything the Charity does reflects these values.

- In addition to the above, the work of the Charity is informed by three guiding principles: Patients are at the heart of Awyr Las
- NHS staff are the lifeblood of Awyr Las
- Be true to those who support Awyr Las

Goals

The principal goals for the Charity are to help create transformational change for the most vulnerable across the region and to support impactful change for patients and their families at a local level.

Transformational Change

The Charity prioritises programmes that contribute to improved health and wellbeing for the most vulnerable people in North Wales. Awyr Las provides support for all patients, but in order to make transformational change happen, a greater emphasis is placed upon:

- Older people
- Children
- Mental health services

Impactful Change

To bring about impactful change, the Charity Support Team works alongside NHS staff, patients and their carers to identify local priorities, so that donations to the Charity are directed towards the key projects that will make a difference at the local level.

Looking ahead

A new Awyr Las strategy is in development. This plan will cover the period 2021 – 2026, and build on the Charity's 2016-2021 strategy.

The impact of COVID-19, and its anticipated medium to long term effects on the community, the NHS, and the Third Sector, will shape the formation of this plan.

The strategy will align to BCUHB's priorities as set out in the "Living Healthier, Staying Well" plan, which was developed after the current Awyr Las strategy. These priorities are:

- Setting up lifestyle services that help people make the right choices and keep well
- Tackling health inequalities and promoting equality
- Making the most of our partnership working
- Strengthening our protection and prevention services
- Concentrating on health in the early years

THE YEAR AT A GLANCE

5,757 Total number of donations given to Awyr Las

Value of average donation to the Charity **£233**

51% Proportion of total income from Donations & Fundraising

Proportion of total income from Legacy Gifts **45%**

41% Proportion of donations towards Cancer Care

Proportion of donations to non-General Funds **99%**

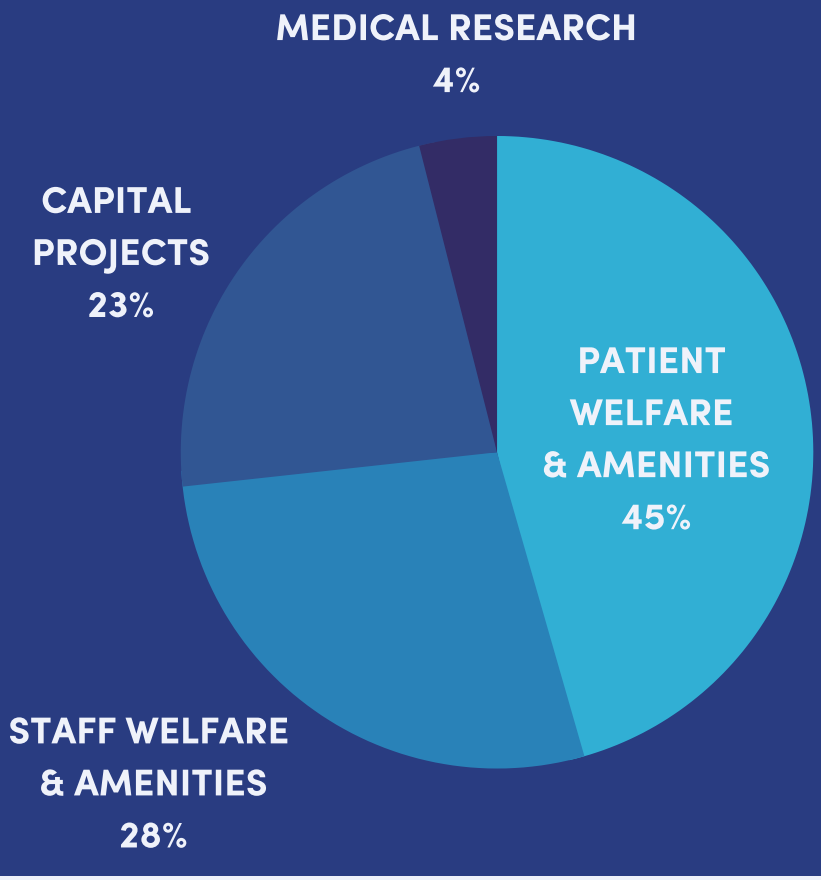
£2,631,000

INCOME 2019/20

+30% COMPARED TO PREVIOUS YEAR

INCOME IN 2018/19: £2,023,000

DISTRIBUTION OF EXPENDITURE



MEDICAL RESEARCH
£82,000

CAPITAL PROJECTS
£507,000

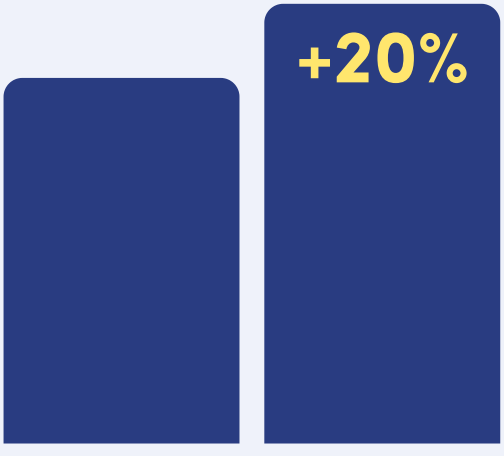
STAFF WELFARE
£611,000

PATIENT WELFARE
£1,011,000

£2,211,000

Total expenditure on charitable activity

This represents an increase of 20% compared to the financial year ending 31st March 2019 (£1,838,000)



NOTABLE EVENTS

During the year, the Charity organised and participated in several successful fundraising events, including the annual NHS Big Tea.

Velocity 2 Zip Wire

In June, 80 BCUHB colleagues took part in a mass sponsored Zip Wire challenge as part of the Zip World Rocks festival, organised by the Love Hope Strength Foundation in partnership with ZipWorld. The 80 daredevils raised almost £30,000 for 30 different Awyr Las funds.

Cake Competition

This year, 14 people took part in the annual cake decorating competition.

The winner was Sonia King, a Radiotherapy Radiographer at North Wales Cancer Treatment Centre.

The competition again proved valuable in increasing the Charity's online audience.

The Awyr Las Facebook page gained 210 likes and achieved an average post reach of 2,203 during the period that the competition was live.

SMALL GRANTS

The successful "Hearts & Minds" small grant scheme trialled last year was scaled up in 2019/20.

Hearts & Minds

A total of 52 applications were submitted to the Hearts & Minds small grants scheme, illustrating the significant demand that exists among NHS staff for ready access to modest amounts of funding.

After the evaluation process, 10 projects received a total of £6,695 in funding. A further £20k has been alocated for future awards.

The Awyr Las Support Team worked alongside colleagues in Mental Health and Workforce & Organisational Development to trial the Hearts & Minds model as a method to commission themed projects using their funds.

I CAN

A total of 37 applications for a small grant were received under the I CAN scheme.

Staff Experience

In total, 54 applications for a small grant were received under the Staff Experience scheme; £24k has been allocated to fund a selection of these projects.

FUNDING CASE STUDY

Electromagnetic Navigation Bronchoscopy (ENB) uses GPS like technology to create a 3D map of the lungs.

State of the art technology will help early detection of lung cancer

New technology capable of detecting lung cancer in its early stages is now available for patients across North Wales, thanks to funding of £130,000 from Awyr Las.

It is a minimally invasive procedure that allows doctors to diagnose and prepare to treat cancerous lesions using a single procedure, as quickly as possible.The procedure will be carried out at Glan Clwyd Hospital by the Lung Cancer team, which includes Dr Robin Poyner, Dr Daniel Menzies, Dr Sakkarai Ambalavanan and Dr Abou Haggar.

Glan Clwyd Hospital is the first district general hospital in Wales, and only second in the UK to use the Illumisite Navigation system by Medtronic.

Dr Daniel Menzies, Consultant in Respiratory Medicine, said:

"Up until now it has been difficult to get an early diagnosis, sometimes because of the location of the cancer in the patient's chest. With this new piece of equipment, it can detect lung cancer in its early stages, sometimes before other symptoms have become evident.

"This means there is potential for earlier treatment and a good outcome for the patient."

One patient who has already benefited from this new technology is Ann Bedford, from Holyhead, who was offered this procedure during a trial last year.

The 74-year-old was first diagnosed with lung cancer three years ago in her left lung, and last year discovered the cancer had returned.

She said: "When I was first diagnosed with lung cancer I had to undergo surgery and chemotherapy.

"Last year I went back into hospital after I became unwell and following some tests I was referred to Glan Clwyd Hospital where I was offered this new procedure.

"This diagnosed the second cancer in my right lung so much quicker and the procedure was much less invasive – the staff were fantastic and explained the process very clearly to me.

The technology, worth £130,000, has been funded by the generous donations of patients and the community through NHS' North Wales charity, Awyr Las.

Dr Robin Poyner, Consultant in Respiratory Medicine, said he and the team were extremely grateful for the donation that has allowed them to purchase this life-saving equipment.

He said: "We are very grateful to Awyr Las for their support in purchasing the ENB equipment we need to further enhance our service.

"By introducing this new service it will also bring waiting times down for CT guided lung biopsies and reduce the number of CT scan follow ups, which will be hugely beneficial for our patients.

"Most patients who have ENB treatment can go home on the same day so this is a major advancement in technology for us, and will lead to a significant improvement in cancer care in North Wales."

Kirsty Thomson, Head of Fundraising for Betsi Cadwaladr University Health Board, added:

“This is an excellent example of how donations to our healthcare services are helping NHS staff to lead the way in providing new and innovative treatment.

"This equipment was funded thanks to hundreds of generous donations from local people that wanted to give back to say thank you, or that chose to give to help ensure patients here in North Wales can receive the very best care.

“We are all hugely grateful to the fundraisers that have made this possible.”

Mike Pidding from Medtronic also wished to thank the charity for their support in purchasing the equipment.

He added:

"We would like to thank the charity for kindly purchasing the system and to the consultants for their dedication and passion to set up and offer this service to the patients of North Wales.

“Without the charity and donations this would not have been possible.”

KEY DETAILS

FUND
North Wales Cancer Treatment Centre

COST
£130,000

LOCATION
Ysbyty Glan Clwyd

CATEGORY
Patient Welfare

THEME
Cancer Care

THE ROBINS VOLUNTEER SCHEME

The Robins volunteer scheme is part-funded through donations to Awyr Las. The support given by volunteers in hospitals and the community makes a huge difference for patients.

Always close at hand

The Robins Volunteer Scheme again made a significant contribution to BCUHB during 2019/20.

There were a total of 239 active Robins across North Wales during this period.

The volunteers provided support across the three acute sites, and in 15 community hospitals.

Collectively, the Robins volunteers gifted 21,013 hours to the Health Board during this financial year. Using the National Living Wage, the monetary value of this support is equivalent to £183,233.

Recognition

Joyce Tudor (who volunteers in Ysbyty Maelor Wrexham) and Andy Fewings (who volunteers in Ysbyty Gwynedd) both won the Seren Betsi award this year, in August and September respectively.

COVID-19 RESPONSE APPEAL

On 15th March, the Charity launched its COVID-19 Response Appeal. Over the next 16 days, the JustGiving campaign received over £8,000, an average of £500 per day.

Supporting our staff

To ensure support was available for staff immediately, £65,000 was transferred from the Staff Development Fund into the COVID-19 Staff Support Fund (£50,000) and the COVID-19 Response Fund (£15,000).

Fast Track requests

During the early stages of the pandemic, the support available was concentrated on grants for NHS staff to spend quickly on enhancing the wellbeing of their patients, and safeguarding their own emotional and physical health, and that of their colleagues.

In 2019/20, £6,000 was committed to support staff dealing directly with the impact of the coronavirus crisis.

Our future with COVID-19

As we moved into the 2020/21 financial year, the Charity's focus shifted to rebuilding and resilience, with work underway to ensure our NHS staff are equipped to deal with subsequent waves and the long-term impact of COVID-19.

GOVERNANCE

Many of the donations the Charity receives cannot be spent immediately, as they need to be accumulated to be able to fund the most appropriate purchases that improve patient care.

The Charity's investments

Because of this, Awyr Las invests these donations in order to generate income and protect their value in real terms. The Charity's Investment Managers are currently Rothschild Wealth Management Limited.

Ethical investment framework

The Trustee has adopted an ethical framework for investments, with underlying principles supporting an ethical component of the overall investment strategy.

Investment strategy

This has given direction to the Investment Managers to develop a suitable investment strategy.

The investment strategy is consistent with these ethical principles, whilst affording sufficient flexibility to provide the best balance of risk and reward for the Charity.

The portfolio is managed in accordance with this agreed strategy, which can be found overleaf.

Investment strategy

It is recommended that there is negative exclusion of investment in companies manufacturing and distributing:

- Alcoholic products
- Tobacco products
- Any products which may be considered in conflict with the Health Board's activities

Investment in companies which have a poor record in human rights and child exploitation and/or which derive their profits from countries with poor human rights records should not be permitted.

In addition, investment in companies that demonstrate compliance with the principles of the Equality Act 2010 should be supported.

Investment performance is monitored by the Charitable Funds Committee at its quarterly meetings.

The Committee receives reports from the investment managers explaining the portfolio's performance, the level of risk seen and expectations for the future.

Trustee Recruitment, Appointment and Induction

The Board Members of the Health Board make up the corporate trustee.

The Chair and Independent Members of the Health Board are appointed by the Minister for Health and Social Services of the Welsh Government, with the Executive Directors being appointed in accordance with Health Board policy.

New members of the Board are provided with appropriate induction and training on behalf of the Executive Director of Finance.

Orientation documentation provided for new members includes the previous year's Annual Reports and Financial Statements, copies of the Charity's Governing Documents, and r elevant Charity Commission publications.

Charity staff

The Charity does not directly employ any staff. The day-to-day management of the charity is delegated to the Executive Director of Finance. Members of the Awyr Las Support Team are employed by the Health Board and then recharged to the charity in accordance with the proportion of their time that has been spent on charity work.

The Health Board Senior Manager responsible for the administration of the charity is Sue Hill, Executive Director of Finance. The Charity Accountant is Rebecca Hughes, and the Head of Fundraising is Kirsty Thomson.

Key Management Personnel Remuneration

The trustees have concluded that the Corporate Trustee through the Charitable Funds Committee comprises the key management personnel of the Charity as they are in control of directing the Charity.

The Charity does not make any payments for remuneration nor to reimburse expenses to the Charity trustees for their work undertaken as trustee. Trustees are required to disclose all relevant interests, register them with the Health Board and withdraw from decisions where a conflict of interest arises.

All related party transactions are disclosed in note 2 to the accounts.

The Charity's advisors

Bankers

NatWest Bank, 5 Queen St, Rhyl, Denbighshire, LL18 1RS

Investment advisors

Rothschild Wealth Management,
New Court, St Swithin's Lane,
London, EC4N 8AL

Registered auditors

Wales Audit Office,
24 Cathedral Road, Cardiff, CF11 9LJ

CHARITABLE FUNDS COMMITTEE

Operational responsibility for the administration of the charity is delegated to a Charitable Funds Committee (CFC). The CFC is a committee of the full Health Board.

Purpose

The purpose of Betsi Cadwaladr University Health Board's Charitable Funds Committee is to make and monitor arrangements for the control and management of the Health Board's Charitable Funds, held within the BCUHB charity, Awyr Las.

All voting members of the Health Board can act as corporate trustees of the charity.

The committee meets quarterly.

Membership

Members: Up to four Independent Members, including the Chair and Vice Chair of the committee, plus three Executive Members

Chair: An Independent Member

Vice Chair: Another Independent Member

Executive Members: Executive Director of Finance (Lead Director), Executive Director of Strategy, Executive Director #Nursing and Midwifery

BCUHB BOARD MEMBERSHIP 2019/20

MR MARK POLIN - CHAIR

MRS MARIAN WYN JONES - VICE CHAIR (TO 30/11/19)
Area of expertise / representation role: Community, Primary Care, Mental Health

MRS LUCY REID - INDEPENDENT MEMBER, VICE CHAIR (WEF 03/12/19)
Area of expertise / representation role: Community, Primary Care, Mental Health

MRS LYN MEADOWS - INDEPENDENT MEMBER
Area of expertise / representation role: Community
Member of Charitable Funds Committee (to 22/12/19)

CLLLR CHERYL CARLISLE - INDEPENDENT MEMBER
Area of expertise / representation role: Community

CLLLR MEDWYN HUGHES - INDEPENDENT MEMBER
Area of expertise / representation role: Local Authority

PROF NICHOLA CALLOW - INDEPENDENT MEMBER (WEF 05/06/19)
Area of expertise / representation role: University

MS HELEN WILKINSON - INDEPENDENT MEMBER
Area of expertise / representation role: Third Sector
Member of Charitable Funds Committee

MRS JACKIE HUGHES - INDEPENDENT MEMBER
Area of expertise / representation role: Trade Union
Chair of Charitable Funds Committee

MR JOHN CUNLIFFE - INDEPENDENT MEMBER
Area of expertise / representation role: Community

MR EIFION JONES - INDEPENDENT MEMBER (WEF 05/08/19)
Area of expertise / representation role: Community

MR GARY DOHERTY - CHIEF EXECUTIVE (TO 07/02/20)

MR SIMON DEAN - INTERIM CHIEF EXECUTIVE (WEF 10/02/20)

MR RUSSELL FAVAGER - EXECUTIVE DIRECTOR OF FINANCE (TO 28/04/19)
Lead Executive for Charitable Funds Committee (to 28/04/19)

MS SUE HILL - ACTING EXECUTIVE DIRECTOR OF FINANCE (WEF 29/04/20)
Lead Executive for Charitable Funds Committee (wef 29/04/19)

MISS TERESA OWEN - EXECUTIVE DIRECTOR OF PUBLIC HEALTH

MRS SUE GREEN - EXECUTIVE DIRECTOR OF WORKFORCE & ORGANISATIONAL DEVELOPMENT

BCUHB BOARD MEMBERSHIP 2019/20 (CONT.)

MR MARK WILKINSON - EXECUTIVE DIRECTOR PLANNING AND PERFORMANCE
Member of Charitable Funds Committee

DR EVAN MOORE - EXECUTIVE MEDICAL DIRECTOR (TO 31/07/19)

DR DAVID FEARNLEY - EXECUTIVE MEDICAL DIRECTOR (WEF 01/08/19)
Member of Charitable Funds Committee (wef 04/09 /19)

DR CHRIS STOCKPORT - EXECUTIVE DIRECTOR PRIMARY AND COMMUNITY SERVICES

MRS GILL HARRIS - EXECUTIVE DIRECTOR NURSING & MIDWIFERY / DEPUTY CHIEF EXECUTIVE (WEF 01/07/19)
Member of Charitable Funds Committee (to 03/09/19)

MRS DEBORAH CARTER - ACTING EXECUTIVE DIRECTOR NURSING AND MIDWIFERY (01/04/19 - 31/08/19)
Member of Charitable Funds Committee

MR ADRIAN THOMAS - EXECUTIVE DIRECTOR THERAPIES & HEALTH SCIENCES

MRS GRACE LEWIS-PARRY - BOARD SECRETARY (TO 31/08/19)

MS DAWN SHARP - ACTING BOARD SECRETARY (WEF 01/09/19)

MRS LIZ JONES - ACTING BOARD SECRETARY (18/12/19 - 05/02/20)

MRS JUSTINE PARRY - ACTING BOARD SECRETARY (06/02/20 - 27/04/20)

ASSOCIATE BOARD MEMBERS

MR ANDY ROACH - DIRECTOR OF MENTAL HEALTH AND LEARNING DISABILITIES

MRS LESLEY SINGLETON - ACTING DIRECTOR OF MENTAL HEALTH AND LEARNING DISABILITIES (WEF 06/11/19)

MRS MORWENA EDWARDS - ASSOCIATE MEMBER
Area of expertise / representation role: Director of Social Services, Gwynedd

MR FFRANCON WILLIAMS - ASSOCIATE MEMBER
Area of expertise / representation role: Chair - Stakeholder Reference Group

MR GARETH EVANS - ASSOCIATE MEMBER
Area of expertise / representation role: Chair - Healthcare Professionals Forum

PERFORMANCE

The Charity's overall objective is to provide additional support to benefit staff and patients within Betsi Cadwaladr University Health Board in accordance with the wishes of donors.

Connecting with staff

In order to achieve this objective, the Charity Support Team prioritises activities that raise awareness among staff, helping them to learn about fundraising, the funds available to them. The team also has a focus on demystifying the mechanisms for accessing funding, along with supporting staff to become empowered to innovate and draw down funding (or, where no funding exists, to proactively generate the necessary income) to help them implement their ideas.

Evaluating requests for funding

To ensure that the Charity's money is well spent and meets with its objectives, all applications for grants over £5,000 require approval from the Charitable Funds Committee, which is a Committee of the full Health Board.

The Charitable Funds Advisory Group (CFAG) was established at the start of 2016 to provide further scrutiny of applications. Because of COVID-19, the CFAG has been stood down.

Given the uncertainty over the coming months, the CFAG will remain inactive until January 2021. High levels of scrutiny remain in place via the Charitable Funds Committee.

Evaluating applications for funding

Applicants are required to provide details on the outcomes of their project and how they will be measured. They are also required to demonstrate that they have evaluated the risks and considered mitigation. All requests for funding must demonstrate how their proposal helps to address health inequalities.

Charity Support Team

To help meet the Charity's objectives, the Awyr Las Support Team is transitioning from working geographically to working thematically.

In practice, this guarantees that East, West and Central still have a dedicated point of contact, but that individual members of the team can undertake projects that are more defined and closely aligned with their skills and experience.

Broadly, the specialisms within the team are:

- Community Fundraising & Corporate Sponsorship
- Nurturing Internal Relationships & Partnership with Independent Charities
- Digital & Data

The aim of this evolution is to enable the team to work more efficiently and be more effective within the current capacity. The Charity did not receive any official fundraising-related complaints in the past year.

The Charity Support Team continues to streamline its processes and develop relationships with other teams within BCUHB to ensure it can provide the highest possible level of donor care.

The Awyr Las Support Team has not uncovered any failure to comply with Fundraising Regulation by staff or Awyr Las volunteers in 2019/20.

GRANT MAKING

Awyr Las makes grants from both its restricted and unrestricted funds. These funds are further split into non-designated (general) funds and designated (earmarked) funds.

Non-designated funds

These funds are given to the Charity with no preference expressed by the donor. They are used to fund things that are either needed across the region, or in areas/services that do not have their own fund. The Finance Director - Operational Finance acts as the Fund Advisor on non-designated funds and so can authorise expenditure up to £5,000.

Non-designated funds have been decreasing in value significantly over recent years.

This is an ongoing challenge for the Charity as it limits the things that can be funded where there is no suitable designated fund.

Designated funds

Within Awyr Las, most donations sit in one of the 400+ designated funds which are aligned to specific wards and departments.

Every fund has at least one Fund Advisor, who is the authorised signatory on the fund for purchases up to £5,000.

Fund Advisors receive monthly statements outlining the income and expenditure on the fund. For all expenditure over £5,000, a scheme of delegation is in place whereby additional approvals are required from the senior team for that area in the Health Board and the Charitable Funds Committee. This ensures that applications are fully reviewed and assessed alongside the objectives of the Charity.

Public benefit

In planning activities for the year and when considering applications for grant funding, the trustees always consider the Charity Commission's guidance on public benefit.

FINANCIAL SUMMARY

The following figures are taken from the full accounts approved on 30th of November 2020, which carry an unqualified audit report.

The accounts should be viewed in full if more details are required. This part of the Trustee's annual report comments on key features of those accounts.

The full accounts have also been logged with the Charity Commission.

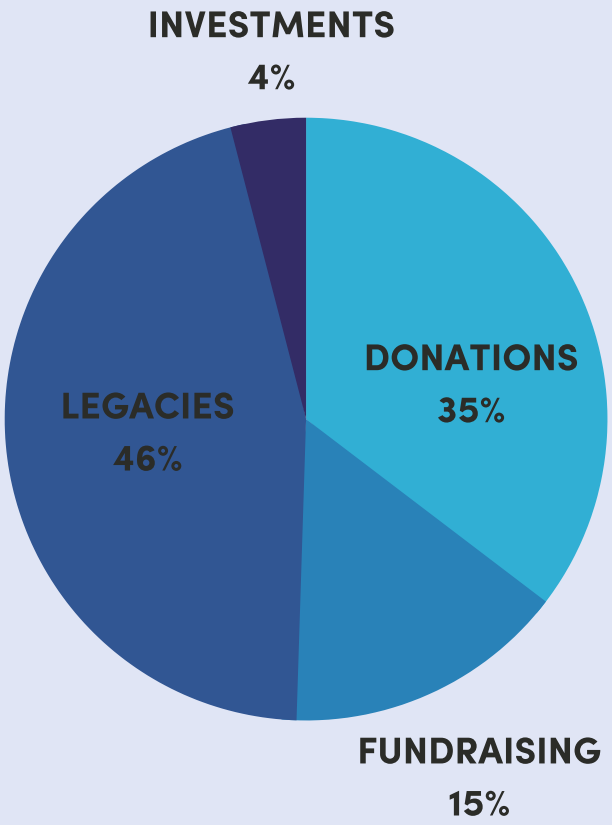
Almost all the Charity's income comes from the voluntary efforts of NHS staff and the general public. This year, donations generated £929,000 - 35% of the Charity's total income.

Fundraising accounted for 15% of the Charity's total income (£411,000).

Legacy gifts formed 46% of the Charity's income (£1,194,000).

Investment of funds not immediately required by the Charity has generated £97,000 in returns, equating to 4% of Awyr Las' total income.

INCOME 2019/20



TOTAL: £2,631,000

Financial health

The assets and liabilities of Awyr Las as at 31st March 2020 are shown overleaf, compared with the position at 31st March 2019.

Further details can be seen in the financial statements section.

BALANCE SHEET AS AT 31 MARCH 2020

	Note	Unrestricted funds £000	Restricted income funds £000	Total 31 March 2020 £000	Total 31 March 2019 £000
Fixed assets:					
Tangible assets	14	135	0	**135**	135
Investments	15	3,756	3,917	**7,673**	7,962
Total fixed assets		**3,891**	**3,917**	**7,808**	**8,097**
Current assets:					
Debtors	16	270	273	**543**	352
Cash & Cash Equivalents	17	440	444	**884**	910
Total current assets		**710**	**717**	**1,427**	**1,262**
Liabilities:					
Creditors: Amounts falling due within one year	18	-746	-751	**-1,497**	-1,473
Net current assets / (liabilities)		**-36**	**-34**	**-70**	**-211**
Total assets less current liabilities		**3,855**	**3,883**	**7,738**	**7,886**
Creditors: Amounts falling due after more than one year	18	-42	-42	**-84**	-48
Total net assets / (liabilities)		**3,813**	**3,841**	**7,654**	**7,838**
The funds of the charity:					
Restricted income funds	21	0	3,841	**3,841**	3,434
Unrestricted income funds	21	3,813	0	**3,813**	4,404
Total funds		**3,813**	**3,841**	**7,654**	**7,838**

RISK ANALYSIS

As part of the Charitable Funds Committee meetings that take place at least four times a year, the trustees consider the major risks facing Awyr Las.

Managing risk

The main risks to the charity are reviewed by the Committee on an annual basis, every March. The Charity's Risk Register was most recently reviewed on 10th March 2020.

The Committee has identified steps to mitigate the identified risks. Eight "High" or "Moderate" risks have been identified. Arrangements have been put in place to mitigate those risks. There are currently no red ("Extreme") rated risks.

As we move into the new Financial Year, the Risk Register will be reviewed again to evaluate how COVID-19 is likely to affect the risks already identified, and whether it will pose any new risks that need to be incorporated into the register moving forward.

An individual Risk Analysis is completed for all Awyr Las events and activities, and for new processes and ways of working introduced by members of the Awyr Las Support Team.

Risk 1: Fundraising

There is a risk of non-compliance with fundraising regulations.

This could be due to:

- Involvement with third parties
- Not being aware of all the fundraising taking place in the Charity's name
- Lack of resources meaning basic processes are not in place
- New regulations which the Charity is not aware of

The impact of this could be damage to the Charity's reputation and potential investigation/fine by the Fundraising Regulator.

Controls in place

The Joint Working Protocol, which has established the need for signed Joint Working Agreements (JWA) for all relationships with third parties in order to clearly set out the terms and expectations of the relationship. The Charity Support Team maintains a log of fundraising that is taking place in the Charity's name. The Fundraising Support team is working towards set targets for ensuring basic processes are in place. The Charity Strategy provides the direction for the Charity and is crucial for informing what its priorities are and where fundraising efforts should be directed. The Charity is a member of NHS Charities Together which provides updates on new legislation and regulations that may impact the Charity.

Further action to achieve target risk score

Establish a marketing materials and stewardship plan to be reviewed by the BCUHB Data Protection Officer to provide assurance that the new legislation is being met. All new or different engagement projects must be check by a Fundraising Regulator representative to ensure all activity complies with GDPR and Fundraising Regulation.

Ensure that all new third-party relationships have a signed Joint Working Agreement (or Memorandum of Understanding if more appropriate).

Continue to establish and maintain good communication links with staff, the public and donors so that everyone is aware of the need to seek approval from the Charity for any fundraising being undertaken in its name.

Risk 2: Fund Advisors

There is a risk that the Charity's Fund Advisors are unaware of their role and responsibilities.

This could be due to:

- Lack of training
- Lack of understanding of a Charity and the appropriate rules and regulations.

The impact of this could be that the Charity's funds are not spent or not spent in accordance with its objectives.

Controls in place

A Fund Advisor Handbook was developed and issued to all Fund Advisors, to provide guidance and support in discharging their responsibilities.

Fund Advisor training days are held at various dates throughout the year.

An Accountability Agreement for all Fund Advisors was established to ensure that roles and responsibilities are understood and accepted.

The Handbook includes a requirement for all Fund Advisors to undertake an Annual Review of their fund and prepare an expenditure plan.

A review of dormant funds is undertaken every year. Funds that are not being utilised and do not have future expenditure plans in place are referred to divisional management teams.

Further action to achieve target risk score

A new online Accountability Agreement system is being established for 2020/21 Accountability Agreements and budget plans.

The Fundraising Team needs to undertake further work to engage with Fund Advisors of the lesser active funds to help establish expenditure plans.

Fund Advisors need to be aware that funds should be used, and they need to be clear and transparent about their plans.

Training sessions for Fund Advisors set up for 2020/21.

Risk 3: Appeals

There is a risk that the charity is unable to identify a potential major Appeal.

This could be due to:

- Lack of detailed information about the priorities for charitable support.
- The geography of BCUHB making it difficult to identify one appeal for the whole Health Board.

The impact of this could be that the charity does not undertake a major appeal and loses out on potential income.

Controls in place

The Charity Support Team reviews the unfunded requests submitted to voluntary organisations and those on the capital register.

The Annual Review section in the Accountability Agreement requires Fund Advisors to formally document their priorities and identify any future fundraising that may be required.

Initial engagement with the Planning Team has taken place to help align the priorities of the charity with those of the Health Board.

Discussions of the Health Board as Trustee have identified four key priority areas (Mental Health, Older People, Younger People and Cancer Care) as key strategic priorities for the Charity. Projects aligned to these areas will be a focus for the Charity over the next year.

Further action to achieve target risk score

Campaign leads are now in place and Business Plans are being developed.

Risk 4: Staff Engagement

There is a risk that staff are disengaged, or unaware of the charity.

This could be due to:

- Lack of training. The size of the Health Board making it difficult to communicate messages.
- Negative media impacting on their opinion of the charity.
- Difficulty with placing orders.

The impact of this could be that staff do not positively promote the Charity with patients and potential donors and it loses out on potential income.

Controls in place

The introduction of the Charitable Funds Advisory Group has allowed NHS staff to become involved in decision making on charitable expenditure. The Fund Advisor Handbook highlights to Fund Advisors that they have a key role to play in promoting the benefits of the charity. This is reinforced through the Fund Advisor training days. An action plan for staff engagement, including working with Workforce & Organisational Development and the Communications team has been developed as part of the Communication Strategy. The use of social media has been increased and used to promote good news stories about the charity, as well as responding to any negative media coverage. A process for ordering items not available on Oracle has been agreed with Procurement, to ensure that staff can order the items that they want, whilst still complying with Procurement procedures and maintaining an audit trail.

Further action to achieve target risk score

A network of Charity Champions at ward, department or locality level is being established to aid the promotion of the Charity and the work that it is doing.

Staff communications will be issued around the Charity's Annual Report to help inform staff of the work that the charity does and how they can become involved.

A Staff Lottery, due to be launched in 2020/21, aims to assist with staff engagement and communicating key messages more effectively.

Risk 5: Investments

There is a risk that the investment portfolio falls significantly in value.

This could be due to:

- Changes in the markets or economy.
- Poor performance from the investment managers.

The impact of this could be that a severe impairment to the Charity's ability to support future projects.

Controls in place

The Charity's investment portfolio is monitored on a monthly basis by the Charity Support Team and on a quarterly basis by the Charitable Funds Committee.

The investment policy is reviewed by the Committee on an annual basis, in conjunction with the Investment Managers, to ensure it remains relevant to the Charity's long-term strategy.

The Investment Managers attend Committee meetings on an annual basis, but are available to answer any issues raised throughout the year.

Further action to achieve target risk score

Monitoring of investments and the portfolio performance needs to be a continual process. The investment policy needs to be reviewed considering the income and capital needs of the charity for the short to medium term.

Risk 6: Financial

There is a risk that the charity does not have sufficient reserves to support the projects it wishes to.

This could be due to:

- Reduction in the income to the charity.
- Approval of expenditure above the level of resources available.

The impact of this could be that a severe impairment to the Charity's ability to support future projects.

Controls in place

Funds available are monitored through the Reserves Policy, which is updated and reviewed by the Committee on an annual basis.

The level of reserves is monitored against the target and reported to the Committee on a quarterly basis.

Individual funds are checked to ensure
there is enough monies available before any expenditure is approved from them.

Available General Funds are monitored closely and reported to the Committee on a quarterly basis.

Further action to achieve target risk score

Further work needs to be done to establish income plans in order to develop new and different income streams.

A Staff Lottery is being launched in 2020/21 with the intention of increasing undesignated income to help fund small and medium sized applications for funding from priority services, which don't traditionally receive charitable funding.

Risk 7: Use of Technology

There is a risk that the charity is not using technology as effectively as possible.

This could be due to:

- Lack of resources meaning the basics are not in place.
- Lack of expertise.

The impact of this could be a lack of engagement with donors.

Controls in place

The Charity's internet site is being redeveloped. Much of this is now live, although there are some sections that require further development.

The Communications Strategy includes specific actions around social media to engage widely with the population of North Wales.

New ways of donating, via text giving, Facebook and debit/credit card have been introduced to maximise the use of technology in this area.

Further action to achieve target risk score

Further developments to the internet site are required to allow the charity to significantly improve its engagement with donors, volunteers and staff, whilst providing a platform for the promotion of events and social media streams.

A member of the Awyr Las Fundraising Section will be responsible for Data and Digital from March 2020. Having a dedicated point person for digital and data projects will enable the team to improve use of existing resources and trial new technology.

Risk 8: Reputation

There is a risk that the Charity's reputation is damaged.

This could be due to:

- Adverse publicity in the media.
- Disagreement with a funding decision among donors/supporters/the public.

The impact of this could be a reduction in the income that the charity receives.

Controls in place

The Charity's Fund Advisors make decisions on how funds should be spent, involving NHS staff in decision making.

The use of the Charity's social media platforms has increased and is used to promote good news stories about the charity, as well as responding to negative media coverage.

There is an external audit and sign off for the Charity's accounts and annual report by Wales Audit Office.

Regular reporting of any complaints received to the Charitable Funds Committee, so that they can be monitored, and assurance given that actions have been taken to address them.

Further action to achieve target risk score

Regular updates on grant making need to be maintained on the Charity's internet site and social media to continue to improve engagement with staff, donors and the public.

Consideration needs to be made of the public and donor view in all funding decisions, to ensure that grants awarded would pass the 'Tabloid Test', as recommended by NHC Charities Together.

Improvements are being made to the funding application form to ensure that it allows applicants to clearly identify the impact that the grant will have for patients. This will help to support funding decisions.

RESERVES POLICY

Reserves that are part of a Charity's unrestricted funds which are freely available to spend on any of the Charity's purposes.

The reserves policy explains why a charity is holding a particular amount of reserves and should consider the Charity's financial circumstances and other relevant factors.

To establish the Charity's target level of reserves, several factors were considered:

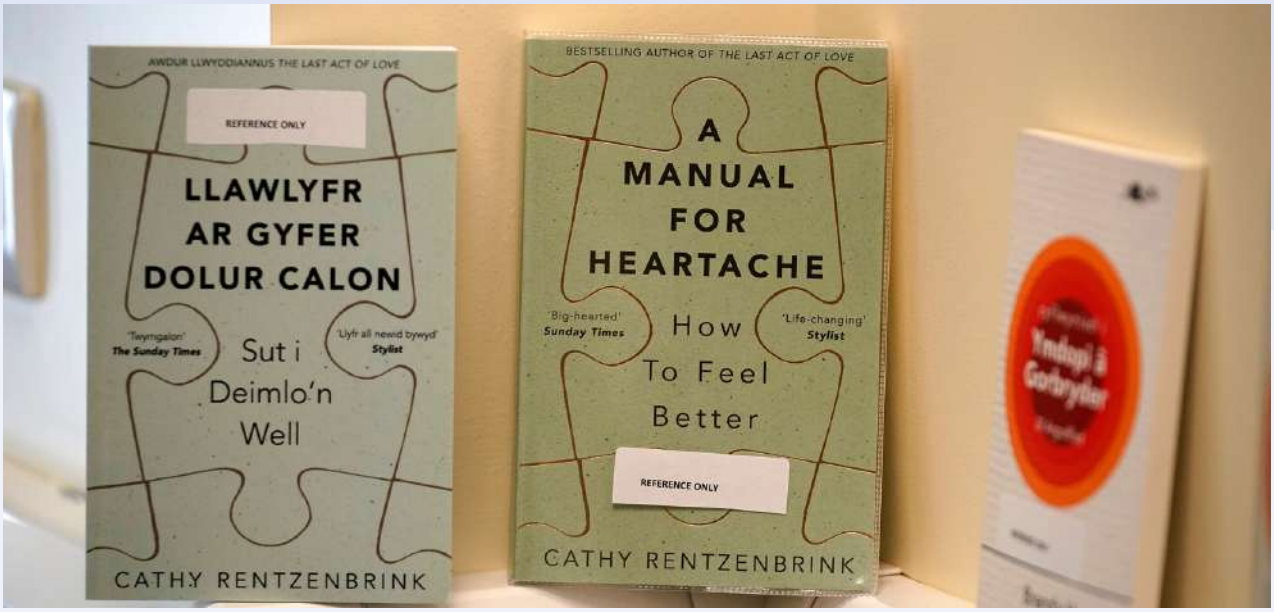
- Anticipated levels of income and expenditure for the current and future years
- Anticipated levels of expenditure for the current and future years
- Future needs and opportunities, commitments and risks

This includes looking at future plans, projects or other spending needs that cannot be met from the income of a single year's budget.

Taking these into account, this is the Charity's reserves policy for 2019/20.

The reserves policy has the objective of ensuring that the Charity has sufficient funds available to maintain liquidity, cover unforeseen risks and provide for future opportunities.

The Charity relies heavily on income from donations, fundraising and legacies.



These are unpredictable sources that can vary year to year.

Therefore the Charity needs sufficient reserves to be able to continue its activities in the event of fluctuations in its income.

The Charity has a target level of reserves of £2,811,000.

This is based on the following calculation, with average figures taken from the last three years of audited accounts:

- One year's administration costs (support costs, fundraising costs and investment management costs)
- 25% of the value of investments held
- 25% of the grant funded activity expenditure.

The target level of reserves will be reassessed on an annual basis. The Board will review the actual reserves held against the target throughout the year, to ensure that sufficient funds are held within the charity, whilst also continuing to utilise funds within a reasonable period of receipt.

BETSI CADWALADR UNIVERSITY HEALTH BOARD CHARITY & OTHER RELATED CHARITIES

ACCOUNTS FOR THE YEAR ENDED 31 MARCH 2020

Foreword

The accounts (financial statements) have been prepared in accordance with the Statement of Recommended Practice: Accounting and Reporting by Charities preparing their accounts in accordance with the Financial Reporting Standard applicable in the UK and Republic of Ireland (FRS 102) issued on 16 July 2014 and the Charities Act 2011 and UK Generally Accepted Practice as it applies from 1 January 2015.

Statutory Background

The Betsi Cadwaladr University Local Health Board is the corporate trustee of the charity under paragraph 16c of Schedule 2 of the NHS and Community Care Act 1990.

The Trustees have been appointed under s11 of the NHS and Community Care Act 1990.

Awyr Las, the working name of the Betsi Cadwaladr University Health Board Charity and other related Charities, is a registered charity and is constituted under a trust deed dated 23rd September 2010.

Within the charity group registration there are two subsidiary charities:

- Betsi Cadwaladr University Health Board Charity
- The North Wales Cancer Appeal

Main purpose of the Funds held on Trust

The main purpose of the Charity is to apply income for any charitable purposes relating to the National Health Service wholly or mainly for the services provided by the Betsi Cadwaladr University Local Health Board.

STATEMENT OF FINANCIAL ACTIVITIES FOR THE YEAR ENDED 31 MARCH 2020

	Note	Unrestricted funds £000	Restricted income funds £000	Total funds 2019-20 £000
Incoming resources from generated funds:				
Donations and legacies	3	896	1,277	**2,123**
Other trading activities	5	324	87	**411**
Investments	6	57	40	**97**
Total incoming resources		**1,277**	**1,354**	**2,631**
Expenditure on:				
Raising funds	7	171	122	**318**
Charitable activities	8	1,257	714	**1,838**
Total expenditure		**1,428**	**836**	**2,156**
Net gains / (losses) on investments	15	-135	-189	**-324**
Net income / (expenditure)		**-286**	**102**	**-184**
Transfer between funds	20	-305	305	**0**
Net movement in funds		**-591**	**407**	**-184**
Reconciliation of funds				
Total funds brought forward	21	4,404	3,434	**7,838**
Total funds carried forward		**3,813**	**3,841**	**7,654**

STATEMENT OF FINANCIAL ACTIVITIES FOR THE YEAR ENDED 31 MARCH 2019

	Note	Unrestricted funds £000	Restricted income funds £000	Total funds 2019-20 £000
Incoming resources from generated funds:				
Donations and legacies	3	911	733	**1,644**
Other trading activities	5	247	59	**306**
Investments	6	43	30	**73**
Total incoming resources		**1,201**	**822**	**2,023**
Expenditure on:				
Raising funds	7	196	122	**318**
Charitable activities	8	1,124	714	**1,838**
Total expenditure		**1,320**	**836**	**2,156**
Net gains / (losses) on investments	15	229	145	**374**
Net income / (expenditure)		**110**	**131**	**241**
Transfer between funds	20	-21	21	**0**
Net movement in funds		**89**	**152**	**241**
Reconciliation of funds				
Total funds brought forward	21	4,315	3,282	**7,597**
Total funds carried forward		**4,404**	**3,434**	**7,838**

BALANCE SHEET AS AT 31 MARCH 2020

	Note	Unrestricted funds £000	Restricted income funds £000	Total 31 March 2020 £000	Total 31 March 2019 £000
Fixed assets:					
Tangible assets	14	135	0	**135**	135
Investments	15	3,756	3,917	**7,673**	7,962
Total fixed assets		**3,891**	**3,917**	**7,808**	**8,097**
Current assets:					
Debtors	16	270	273	**543**	352
Cash & Cash Equivalents	17	440	444	**884**	910
Total current assets		**710**	**717**	**1,427**	**1,262**
Liabilities:					
Creditors: Amounts falling due within one year	18	-746	-751	**-1,497**	-1,473
Net current assets / (liabilities)		**-36**	**-34**	**-70**	**-211**
Total assets less current liabilities		**3,855**	**3,883**	**7,738**	**7,886**
Creditors: Amounts falling due after more than one year	18	-42	-42	**-84**	-48
Total net assets / (liabilities)		**3,813**	**3,841**	**7,654**	**7,838**
The funds of the charity:					
Restricted income funds	21	0	3,841	**3,841**	3,434
Unrestricted income funds	21	3,813	0	**3,813**	4,404
Total funds		**3,813**	**3,841**	**7,654**	**7,838**

The notes on pages 52 to 74 form part of these accounts.

Signed: . . . . . .

Name: . . . . . **(Chair of Trustees) 8th December 2020**

STATEMENT OF CASH FLOWS FOR THE YEAR ENDING 31 MARCH 2020

	Note	**Total funds 2019-20 £000**	Total funds 2018-19 £000
Cash flows from operating activities:			
Net cash provided by (used in) operating activities	19	**-88**	**-23**
Cash flows from investing activities:			
Dividend, interest and rents from investments	6	97	73
Proceeds from the sale of investments	15	1,528	1,429
Purchase of investments	15	-1,378	-1,408
(Increase) / decrease in cash awaiting investment	15	-185	-37
Net cash provided by (used in) investing activities		**62**	**57**
Change in cash and cash equivalents in the reporting period		**-26**	**34**
Cash and cash equivalents at the beginning of the reporting period	17	910	876
Cash and cash equivalents at the end of the reporting period	17	**884**	**910**

NOTE ON THE ACCOUNTS

1 ACCOUNTING POLICIES

(a) Basis of preparation

The financial statements have been prepared under the historic cost convention, with the exception of investments which are included at fair value.

The accounts (financial statements) have been prepared in accordance with the Statement of Recommended Practice: Accounting and Reporting by Charities preparing their accounts in accordance with the Financial Reporting Standard applicable in the UK and Republic of Ireland (FRS 102) issued on 16 July 2014 and the Charities Act 2011 and UK Generally Accepted Practice as it applies from 1 January 2015.

The accounts (financial statements) have been prepared to give a 'true and fair' view and have departed from the Charities (Accounts and Reports) Regulations 2008 only to the extent required to provide a 'true and fair view'. This departure has involved following Accounting and Reporting by Charities preparing their accounts in accordance with the Financial Reporting Standard applicable in the UK and Republic of Ireland (FRS 102) issued on 16 July 2014.

The Trustees consider that there are no material uncertainties about the Charity's ability to continue as a going concern. There are no material uncertainties affecting the current year's accounts.

In future years, the key risks to the Charity are a fall in income from donations or investment income but the trustees have arrangements in place to mitigate those risks (see the risk management and reserves sections of the annual report for more information).

The Charity meets the definition of a public benefit entity under FRS 102.

NOTE ON THE ACCOUNTS

1 ACCOUNTING POLICIES (CONTINUED)

(b) Funds structure

Where there is a legal restriction on the purpose to which a fund may be put, the fund is classified either as:

- A restricted fund, or;
- An endowment fund.

Restricted funds are those where the donor has provided for the donation to be spent in furtherance of a specified charitable purpose. The Charity's restricted funds tend to result from appeals or legacies for specified purposes.

Endowment funds arise when the donor has expressly provided that the gift is to be invested and only the income of the fund may be spent. These funds are subanalysed between those where the Trustees have the discretion to spend the capital (expendable endowment) and those where there is no discretion to expend the capital (permanent endowment). The charity has no permanent or expendable endowment funds.

Those funds which are neither endowment nor restricted income funds, are unrestricted income funds which are subanalysed between designated (earmarked) funds where the Trustees have set aside amounts to be used for specific purposes or which reflect the non-binding wishes of donors and unrestricted funds which are at the Trustees' discretion, including the general fund which represents the charity's reserves. The major funds held in each of these categories are disclosed in note 21.

NOTE ON THE ACCOUNTS

1 ACCOUNTING POLICIES (CONTINUED)

(c) Incoming resources

Income consists of donations, legacies, income from charitable activities and investment income.

Donations are accounted for when received by the charity. All other income is recognised once the charity has entitlement to the resources, it is probable (more likely than not) that the resources will be received and the monetary value of incoming resources can be measured with sufficient reliability.

Where there are terms or conditions attached to incoming resources, particularly grants, then these terms or conditions must be met before the income is recognised as the entitlement condition will not be satisfied until that point. Where terms or conditions have not been met or uncertainty exists as to whether they can be met then the relevant income is not recognised in the year and deferred and shown on the balance sheet as deferred income.

(d) Incoming resources from legacies

Legacies are accounted for as incoming resources either upon receipt or where the receipt of the legacy is probable, whichever falls sooner.

Receipt is probable when:

- Confirmation has been received from the representatives of the estate(s) that probate has been granted
- The executors have established that there are sufficient assets in the estate to pay the legacy, and;
- All conditions attached to the legacy have been fulfilled or are within the charity's control.

If there is uncertainty as to the amount of the legacy and it cannot be reliably estimated then the legacy is shown as a contingent asset until all of the conditions for income recognition are met.

NOTE ON THE ACCOUNTS

1 ACCOUNTING POLICIES (CONTINUED)

(e) Resources expended and irrecoverable VAT

All expenditure is accounted for on an accruals basis and has been classified under headings that aggregate all costs related to each category of expense shown in the Statement of Financial Activities. Expenditure is recognised when the following criteria are met:

- There is a present legal or constructive obligation resulting from a past event.
- It is more likely than not that a transfer of benefits (usually a cash payment) will be required in settlement.
- The amount of the obligation can be measured or estimated reliably.

Irrecoverable VAT is charged against the category of resources expended for which it was incurred.

(f) Recognition of expenditure and associated liabilities as a result of grants

Grants payable are payments made to linked, related party or third party NHS bodies and non NHS bodies, in furtherance of the charitable objectives of the funds held on trust, primarily relief of those who are sick.

Grant payments are recognised as expenditure when the conditions for their payment have been met or where there is a constructive obligation to make a payment.

A constructive obligation arises when:

- We have communicated our intention to award a grant to a recipient who then has a reasonable expectation that they will receive a grant.
- We have made a public announcement about a commitment which is specific enough for the recipient to have a reasonable expectation that they will receive a grant.
- There is an established pattern of practice which indicates to the recipient that we will honour our commitment.

NOTE ON THE ACCOUNTS

1 ACCOUNTING POLICIES (CONTINUED)

(f) Recognition of expenditure and associated liabilities as a result of grants (continued)

The Trustees have control over the amount and timing of grant payments and consequently where approval has been given by the trustees and any of the above criteria have been met then a liability is recognised.

Grants are not usually awarded with conditions attached. However, when they are those conditions have to be met before the liability is recognised.

Where an intention has not been communicated, then no expenditure is recognised but an appropriate designation is made in the appropriate fund. If a grant has been offered but there is uncertainty as to whether it will be accepted or whether conditions will be met then no liability is recognised but a contingent liability is disclosed.

(g) Allocation of support costs

Support costs are those costs which do not relate directly to a single activity. These include staff costs, costs of administration, internal and external audit costs. Support costs have been apportioned between fundraising costs and charitable activities on an appropriate basis. The analysis of support costs and the bases of apportionment applied are shown in note 11.

(h) Fundraising costs

The costs of generating funds are those costs attributable to generating income for the charity, other than those costs incurred in undertaking charitable activities or the costs incurred in undertaking trading activities in furtherance of the charity's objects. The costs of generating funds represent fundraising costs together with investment management fees. Fundraising costs include expenses for fundraising activities and a fee paid to a related party, the Health Board, under a fundraising agreement. The fee is used to pay the salaries and overhead costs of the Health Boards' fundraising office.

NOTE ON THE ACCOUNTS

1 ACCOUNTING POLICIES (CONTINUED)

(i) Charitable activities

Costs of charitable activities comprise all costs incurred in the pursuit of the charitable objects of the charity. These costs, where not wholly attributable, are apportioned between the categories of charitable expenditure in addition to the direct costs. The total costs of each category of charitable expenditure include an apportionment of support costs as shown in note 8.

(j) Tangible assets

Tangible fixed assets are stated at cost less accumulated depreciation and accumulated impairment losses. Cost includes the original purchase price (or value of the asset on a full replacement cost basis if donated), costs directly attributable to bringing the asset to its working condition for its intended use, dismantling and restoration costs. Tangible fixed assets are capitalised if they are capable of being used for more than one year and have a cost equal to or greater than £5,000.

Land is stated at open market value. Valuations are carried out professionally at five-yearly intervals with an impairment review undertaken in all other years. No depreciation is applied to land.

Tangible fixed assets are derecognised on disposal or when no future economic benefits are expected. On disposal, the difference between the net disposal proceeds and the carrying amount is recognised in the Statement of Financial Activities (SoFA).

(k) Investments

Investments are a form of basic financial instrument. Fixed asset investments are initially recognised at their transaction value and are subsequently measured at their fair value (market value) at the balance sheet date. The Statement of Financial Activities includes the net gains and losses arising on revaluation and disposals throughout the year.

NOTE ON THE ACCOUNTS

1 ACCOUNTING POLICIES (CONTINUED)

(k) Investments (continued)

The main form of financial risk faced by the charity is that of volatility in equity markets and other investment markets due to wider economic conditions, the attitude of investors to investment risk and changes in sentiment concerning equities and within particular sectors. Further information on the charity's investments can be found in note 15.

(l) Debtors

Debtors are amounts owed to the charity. They are measured on the basis of their recoverable amount.

(m) Cash and cash equivalents

Cash at bank and in hand is held to meet the day to day running costs of the charity as they fall due. Cash equivalents are short term, highly liquid investments, usually in notice interest bearing savings accounts.

(n) Creditors

Creditors are amounts owed by the charity. They are measured at the amount that the charity expects to have to pay to settle the debt.

Amounts which are owed in more than a year are shown as long term creditors.

(o) Realised gains and losses

All gains and losses are taken to the Statement of Financial Activities as they arise. Realised gains and losses on investments are calculated as the difference between sales proceeds and opening carrying value (purchase date if later). Unrealised gains and losses are calculated as the difference between the closing and opening carrying values, adjusted for purchases and sales.

NOTE ON THE ACCOUNTS

2 RELATED PARTY TRANSACTIONS

During the year none of the Trustee's Representatives or members of the key management staff or their close relatives have undertaken any material transactions with the Betsi Cadwaladr University Health Board Charitable Funds.

Board Members (and other senior staff) take decisions both on Charity and Exchequer matters but endeavour to keep the interests of each discrete and do not seek to benefit personally from such decisions. Declarations of personal interest have been made in both capacities and are available to be inspected by the public.

The Charity has made grant payments for revenue and capital to the Betsi Cadwaladr University Health Board. Such payments are for specific items which are in furtherance of the Charity's objectives. The Betsi Cadwaladr University Health Board prepares its accounts in accordance with the Government Financial Reporting Manual (FReM) and International Finanical Reporting Standards (IFRS), whereas the Charity prepares its accounts in accordance with FRS 102. The Charity therefore recognises a constructive obligation when it awards a grant, whereas the Health Board recognises it when the grant is received. This creates a timing issue as the Charity recognises expenditure before the Health Board does.

In its accounts and under FRS 102, the Charity recognises that it has made grant payments to the Betsi Cadwaladr University Health Board totalling £2.11 million (2018-19: £1.74 million). Under the FReM and IFRS, grant payments to the Betsi Cadwaladr University Health Board totalled £2.18 million (2018-19: £2.11 million). The audited accounts of the Betsi Cadwaladr University Health Board are included in their annual report and are available from their website.

NOTE ON THE ACCOUNTS

2 RELATED PARTY TRANSACTIONS (CONTINUED)

HEALTH BOARD MEMBER NAME	DETAILS OF POSITIONS HELD DURING THE FINANCIAL YEAR	DETAILS OF INTEREST DECLARED
DIRECTORS / EXECUTIVE DIRECTORS		
Mr S Dean	Interim Chief Executive	Seconded civil servant employed by Welsh Government.
INDEPENDENT BOARD MEMBERS		
Mr M Polin OBE QPM	Chair	Spouse is employed by the Health Board.
Mrs M W Jones	Independent Member and Vice Chair	Chair of Council, Bangor University. Vice Chair of Arts Council Wales.
Mrs L Reid	Independent Member and Vice Chair (01.12.19 - 31.03.20)	Committee Chair for the Primary Care Appeals Service of NHS Resolution.
Cllr C Carlisle	Independent Member	County Councillor, Conwy Council.
Mr J Cuncliffe	Independent Member	Member of the Joint Audit Committee, North Wales Police and Crime Commissioner. Spouse is employed by the Health Board.
Prof N Callow	Independent Member (University Representative)	Dean of the College of Human Sciences at Bangor University
Mrs J F Hughes	Independent Member (Trades Union Representative)	Two children are employed by the Health Board and one works voluntarily within the Health Board. Chair of the Welsh Council of the Society and College of Radiographers.
Cllr R Medwyn Hughes	Independent Member (Local Authority Representative)	County Councillor, Gwynedd Council.
Mr H E Jones	Independent Member	Member of Gwynedd County Council Standards Committee.
ASSOCIATE BOARD MEMBERS		
Mrs M Edwards	Associate Board Member - Director of Social Services	Corporate Director and Statutory Director of Social Services at Gwynedd Council.
Mr G Evans	Associate Board Member - Chair, Healthcare Professionals Forum	Spouse is employed by the Health Board.

NOTE ON THE ACCOUNTS

2 RELATED PARTY TRANSACTIONS (CONTINUED)

Material transactions between the Charity and related parties disclosed during 2019-20 were as follows:

	Expenditure with related party £000	Amounts owed to related party £000	Income from related party £000	Amounts owed by related party £000
Bangor University	7	(1)	0	0
Conwy County Borough Council	2	0	0	0
North Wales Police	1	0	0	0
Arts Council of Wales	0	0	30	8
Welsh Government	0	0	1	1

NOTE ON THE ACCOUNTS

3 INCOME FROM DONATIONS AND LEGACIES

	Unrestricted funds £000	Restricted income funds £000	Total 2019-20 £000	Total 2018-19 £000
Donations	896	33	**929**	969
Legacies	0	1,194	**1,194**	675
	896	**1,227**	**2,123**	**1,644**

4 ROLE OF VOLUNTEERS

Like all charities, the Betsi Cadwaladr University Health Board Charity is reliant on a team of volunteers for our smooth running. Our volunteers perform two roles:

- **Fund advisors**

Within the Charity there are 397 designated funds which are aligned with specific areas and/or services. Every fund has at least one fund advisor, who acts as the authorised signatory on the fund for purchases up to £5,000 and receives monthly statements as to the income and expenditure on the fund. Fund advisors are responsible for ensuring that the expenditure they authorise from their funds is appropriate and fits in with the objects of the fund and the Charity. They are also responsible for ensuring that their designated fund is never in a deficit position.

- **Fundraisers**

A number of volunteers actively support the Charity by running events such as coffee mornings, sponsored walks and sports tournaments, as well as supporting events directly organised by the charity.

In accordance with the SORP, due to the absence of any reliable measurement basis, the contribution of these volunteers is not recognised in the accounts.

NOTE ON THE ACCOUNTS

5 OTHER TRADING ACTIVITIES

Income from other trading activities arises from fundraising events that are organised by the charity, or by volunteers in aid of the charity. These include events such as coffee mornings, cake bakes, sporting challenges and sponsored walks.

6 GROSS INVESTMENT INCOME

	Unrestricted funds £000	**Restricted income funds £000**	**Total 2019-20 £000**	Total 2018-19 £000
Fixed asset equity and similar investments	56	40	**96**	72
Short term investments, deposits and cash on deposit	1	0	**1**	1
	57	**40**	**97**	**73**

7 ANALYSIS OF EXPENDITURE ON RAISING FUNDS

	Unrestricted funds £000	**Restricted income funds £000**	**Total 2019-20 £000**	Total 2018-19 £000
Fundraising office	104	75	**179**	214
Fundraising events	32	6	**38**	41
Investment management	29	21	**50**	47
Support costs	6	7	**13**	16
	171	**109**	**280**	**318**

NOTE ON THE ACCOUNTS

8 ANALYSIS OF EXPENDITURE ON CHARITABLE ACTIVITY

	Grant funded activity £000	Support costs £000	Total 2019-20 £000	Total 2018-19 £000
Grants for NHS Capital expenditure	476	31	**507**	192
Staff education and welfare	581	30	**611**	545
Patient education and welfare	975	36	**1,011**	995
Medical research	78	4	**82**	106
	2,110	**101**	**2,211**	**1,838**

9 ANALYSIS OF GRANTS

The charity does not make grants to individuals. All grants are made to the Health Board to provide for the care of NHS patients in furtherance of our charitable aims. The total cost of making grants, including support costs, is disclosed on the face of the Statement of Financial Activities and the actual funds spent on each category of charitable activity, is disclosed in Note 8.

The Trustees operate a scheme of delegation for the charitable funds, under which fund advisors manage the day to day disbursements on their projects, in accordance with the directions set out by the Trustees in the Charity Standing Financial Instructions. Funds managed under the scheme of delegation represent ongoing activities and it is not possible to segment these activities into discrete individual grant awards. The Trustees do make grant awards based on invited applications from the Health Board.

NOTE ON THE ACCOUNTS

10 MOVEMENTS IN FUNDING COMMITMENTS

	Current liabilities £000	Non-current liabilities £000	Total 31 March 2020 £000	Total 31 March 2019 £000
Opening balance at 1 April (see Note 18)	871	48	**919**	1,437
Increase / (decrease) in liabilities	406	36	**442**	-518
Closing balance at 31 March (see Note 18)	**1,277**	**84**	**1,316**	**919**

As described in notes 8 and 9, the charity awards a number of grants in the year. Many grants are awarded and paid out in the same financial year. However, some grants, especially those relating to research and development or for funding specific posts, are multi-year grants paid over a longer period.

11 ALLOCATION OF SUPPORT COSTS

Governance costs are those support costs which relate to the strategic and day to day management of a charity.

Support and overhead costs are allocated between fundraising activities and charitable activities based on the proportion of expenditure incurred against them both during the year. These support and overhead costs are then further allocated to unrestricted and restricted funds based on the balance held in these funds.

NOTE ON THE ACCOUNTS

11 ALLOCATION OF SUPPORT COSTS (CONTINUED)

	Raising funds £000	Charitable activities £000	Total 2019-20 £000	Total 2018-19 £000
Governance				
External audit	1	9	**10**	10
Finance and administration	6	44	**50**	48
Total governance	**7**	**53**	**60**	**58**
Finance and administration	5	41	**46**	48
Other costs	1	7	**8**	4
	13	**101**	**114**	**110**

	Unrestricted funds £000	Restricted income funds £000	Total funds 2019-20 £000	Total funds 2018-19 £000
Raising funds	6	7	**13**	16
Charitable activities	50	51	**101**	94
	56	**58**	**114**	**110**

12 TRUSTEES' REMUNERATION, BENEFITS AND EXPENSES

The charity does not make any payments for remuneration nor to reimburse expenses to the charity trustees for their work undertaken as trustees.

13 AUDITORS REMUNERATION

The auditors remuneration of £10,250 (2018-19: £10,250) related solely to the audit of the statutory annual report and accounts.

NOTE ON THE ACCOUNTS

14 TANGIBLE FIXED ASSETS

	Freehold land 2019-20 £000	Freehold land 2018-19 £000
Cost and valuation		
Balance brought forward	**135**	135
Additions	**0**	0
Disposals	**0**	0
Balance at 31st March	**135**	**135**
Depreciation and impairments		
Balance brought forward	**0**	0
Disposals	**0**	0
Impairments	**0**	0
Balance at 31st March	**0**	**0**
Net book value at 1st April	135	135
Net book value at 31st March	**135**	**135**

During 2017-18, a piece of land located in Porthmadog was donated to the charity, for the benefit of the Madog Community & Hospital fund. The land was independently and professionally valued at open market value by the District Valuer in March 2018. There has been no impairment to the land in 2019-20. The charity intends to dispose of the land on the open market.

NOTE ON THE ACCOUNTS

15 FIXED ASSET INVESTMENTS

	Total 2019-20 £000	Total 2019-20 £000
Market value brought forward	**7,962**	7,572
Add: additions to investments at cost	**1,378**	1,408
Less disposals at carrying value	**-1,528**	-1,414
Increase / (decrease) in cash awaiting investment	**185**	22
Add net gain / (loss) on revaluation	**-324**	374
Market value as at 31st March	**7,673**	**7,962**

All investments are carried at their fair value.

All of the Charity's investments are held within a portfolio managed by Rothschild Wealth Management Limited. The key objective of the portfolio is to preserve and grow the investments' value in real terms, in order to continue to support charitable distributions over the long term. In order to meet this objective, the Trustees have agreed on a 'balanced' approach for the investment strategy. A 'balanced' portfolio is intended to achieve steady growth over the long term through a diversified approach to investment. Attention is paid to avoiding the worst of the downside and capturing some, but not all, of the upside of financial market returns. Capital preservation in real terms over a long time horizon is the primary objective, and some volatility is acceptable in order to achieve this.

In line with this investment strategy, at the 31st March 2020 the portfolio had a 66% allocation to return assets. Return assets are expected to drive long-term performance but are also likely to be volatile over shorter periods. In addition, the portfolio held a 34% allocation to diversifying assets. These assets are included to provide real diversification and protection in difficult market conditions. Overall, the portfolios remain relatively defensively positioned. This approach provides protection on the downside, but allows the addition of return assets opportunistically, taking advantage of attractive prices particularly during market turbulence.

15 FIXED ASSET INVESTMENTS (CONTINUED)

During the last two months of the year, the COVID-19 pandemic resulted in a significant fall in the stock market, which led to a loss of £0.9m in the portfolio, outweighing gains made earlier in the year. The diversifying assets held in the portfolio meant that the loss suffered was not as severe as that seen by the stock market as a whole.

The environment for investors remains challenging and fraught with risks. In managing our portfolios, Rothschild Wealth Management Limited assess these risks and the potential impact they will have on the portfolio on an on-going basis. They also adjust investments to make the most of opportunities and to protect against risks as they see them. Risks promote uncertainty and make markets unpredictable over short periods. A solid allocation to diversifying assets and portfolio protection has therefore been maintained, resulting in risk within the portfolio being considerably lower than the broader equity markets.

16 ANALYSIS OF CURRENT DEBTORS

Debtors under 1 year	**Total 31 March 2020 £000**	Total 31 March 2019 £000
Accrued income	**537**	340
Prepayments	**2**	1
Other debtors	**4**	11
	543	**352**

NOTE ON THE ACCOUNTS

17 ANALYSIS OF CASH AND CASH EQUIVALENTS

	Total 31 March 2020 £000	Total 31 March 2019 £000
Cash in hand	**884**	910
	884	**910**

No cash or cash equivalents or current asset investments were held in non-cash investments or outside of the UK.

18 ANALYSIS OF LIABILITIES

	Total 31 March 2020 £000	Total 31 March 2019 £000
Creditors under 1 year		
Trade creditors	**42**	120
Creditors owed to BCU	**144**	401
Accruals for grants owed to NHS bodies	**1,277**	871
Other accruals	**34**	81
	1,497	**1,473**
Creditors over 1 year		
Accruals for grants owed to NHS bodies	**84**	48
	84	**48**
Total creditors	**1,581**	**1,521**

NOTE ON THE ACCOUNTS

19 RECONCILIATION OF NET INCOME / EXPENDITURE TO NET CASH FLOW FROM OPERATING ACTIVITIES

	Total 31 March 2020 £000	Total 31 March 2019 £000
Net income / (expenditure) (per Statement of Financial Activities)	**-184**	241
Adjustment for:		
(Gains) / losses on investments	**324**	-374
Dividends, interest and rents from investments	**-97**	-73
Donated fixed assets	**0**	0
(Increase) / decrease in debtors	**-191**	489
Increase / (decrease) in creditors	**60**	-306
Net cash provided by (used in) operating activities	**-88**	**-23**

20 TRANSFER BETWEEN FUNDS

There have been the following transfers between material designated funds:

- £305,381 was transferred from General Funds (unrestricted) to various restricted funds to reimburse net overall charity costs, less income from interest and investment gain/loss. This is included in Other Funds in Note 21.b., offset by the transfers in totalling £65,000 that are noted below.

- £65,000 was transferred out of the Staff Development Fund moved to the COVID-19 Staff Support Fund (£50,000) and the COVID-19 Response Fund (£15,000) to help support staff during the COVID-19 pandemic.

NOTE ON THE ACCOUNTS

21 ANALYSIS OF FUNDS

A. ANALYSIS OF RESTRICTED FUND MOVEMENTS

	Balance 1 April 2019 £000	Income £000	Expenditure £000	Transfers £000	Gains and (losses) £000	Balance 31 March 2020 £000
General Fund, YG	534	8	-19	34	-20	537
BCU Legacies Fund	250	120	0	0	0	370
North Wales Cancer Appeal	284	95	-27	28	-17	363
General Fund, YGC	280	12	-11	20	-12	289
Wrexham Medical Institute	274	3	-10	17	-10	274
Cancer Fund, YGC	0	538	-322	60	-45	231
General Fund, Llandudno	202	3	-7	12	-7	203
Cardiology Fund, YMW	224	2	-54	15	-8	179
Leukaemia/Allied Blood Disease, YMW	167	1	-6	10	-6	166
General Fund, YMW	160	8	-6	11	-7	166
Pathology Leukaemia/Haematology, YGC	114	1	-8	7	-4	110
Other Funds	945	563	-593	91	-53	953
	3,434	**1,354**	**-1,063**	**305**	**-189**	**3,841**

The objects of each of the restricted funds are to benefit the patients of the area, department or service stated in the funds' name, in accordance with the Charity's overall objectives. There is one fund listed above that is not aligned to a specific area:

- The BCU Legacies fund holds the accruals for legacies where probate has been granted, but we have not yet received the cash. This fund is used to protect the designated funds from fluctuations in the final legacy received. When the legacy is received it will be credited to the designated fund specified in the Will and the accrual will be reversed out from the BCU Legacies fund.

The Trustees have set an opening or closing balance of £100,000 or above as the threshold for the separate reporting of material designated funds. In the interests of accountability and transparency a complete breakdown of all such funds is available upon written request.

NOTE ON THE ACCOUNTS

21 ANALYSIS OF FUNDS (CONTINUED)

B. ANALYSIS OF UNRESTRICTED AND MATERIAL DESIGNATED FUND MOVEMENTS

	Balance 1 April 2019 £000	Income £000	Expenditure £000	Transfers £000	Gains and (losses) £000	Balance 31 March 2020 £000
Cancer Fund, YGC	615	97	-13	6	0	705
Alaw Ward, YG	406	183	-7	0	0	582
Cancer Support Group, YMW	303	120	-84	0	0	339
Investment Gains	660	0	0	0	-328	332
Madog Community & Hospital	135	0	0	0	0	135
General Fund, Llandudno	130	0	0	0	0	130
General Fund, YG	130	0	0	0	0	130
Cardiology Department, YGC	114	9	0	0	0	123
Gynae Services – West	105	5	-2	0	0	108
Staff Development Fund	155	0	-24	-65	0	66
Palliative Care Fund, YMW	104	9	-55	0	0	58
Other Funds	1,547	854	-1,243	-246	193	1,105
	4,404	**1,277**	**-1,428**	**-305**	**-135**	**3,813**

The objects of each of the unrestricted funds are to benefit the patients of the area, department or service stated in the funds' name, in accordance with the Charity's overall objectives. There is one fund listed above that is not aligned to a specific area:

- The Investment Gains fund holds the unallocated and unrealised gains and losses on the investment portfolio. This fund is used to protect the other designated funds from fluctuations in the investment values.

The General Funds include all donations for which a donor has not expressed any preference as to how the funds shall be spent. These funds are applied for any charitable purpose to the benefit of the patients of the Health Board, at the discretion of the Trustees.

The Trustees have set an opening or closing balance of £100,000 or above as the threshold for the separate reporting of material designated funds. In the interests of accountability and transparency a complete breakdown of all such funds is available upon written request.

NOTE ON THE ACCOUNTS

22 POST BALANCE SHEET EVENTS

The following have not been adjusted for in the accounts:

The accounting statements are required to reflect the conditions applying at the end of the financial year. No adjustments are therefore made for any changes in the market value of the investments between the 1st April 2020 and the date the accounting statements are approved. The market value of the investments held by the Charity as at the 31st March 2020 have increased by a material amount in the intervening period as follows:

	31 March 2020 £000	26 November 2020 £000	Movement £000	Movement %
Investments	7,673	9,393	1,720	22.42%

The charity was notified at the end of March of potential funding from NHS Charities in response to the COVID-19 pandemic, however the sum to be received was not disclosed at this point. £164,500 was received in the first quarter of 2020-21.

STATEMENT OF THE TRUSTEE'S FINANCE REPRESENTATIVE'S RESPONSIBILITIES

As the Trustee's Finance Representative for the Charity, I am responsible for:

- The maintenance of financial records appropriate to the activities of the funds.
- The establishment and monitoring of a system of internal control.
- The establishment of arrangements for the prevention of fraud and corruption.
- The preparation of annual financial statements which give a true and fair view of the Charity and the results of its operations.

In fulfilment of these responsibilities I confirm that the financial statements set out on pages 29 to 45 attached have been compiled from and are in accordance with the financial records maintained by the Trustee and with applicable accounting standards and policies for the NHS.

Trustee's Finance Representative
8th December 2020

STATEMENT OF THE TRUSTEE'S RESPONSIBILITIES IN RESPECT OF THE ACCOUNTS

The Trustee's Representatives are required under the Charities Act 2011 to prepare accounts for each financial year. The Welsh Government, with the approval of HM Treasury, directs that these accounts give a true and fair view of the financial position of the Charity. In preparing those accounts, the Trustee's Representatives are required to:

Apply on a consistent basis accounting policies laid down by the First Minister for Wales with the approval of HM Treasury.

Make judgements and estimates which are reasonable and prudent.

State whether applicable accounting standards have been followed, subject to any material departures disclosed and explained in the accounts.

The Trustee's Representatives confirm that they have complied with the above requirements in preparing the accounts.

The Trustee's Representatives are responsible for keeping proper accounting records which disclose with reasonable accuracy at any time the financial position of the Charity and to enable them to ensure that the accounts comply with requirements outlined in the above mentioned direction by the Welsh Government. They are also responsible for safeguarding the assets of the Charity and hence for taking reasonable steps for the prevention and detection of fraud and other irregularities.

By order of the Trustees.

Trustee's Representative **8th December 2020**

Trustee's Finance Representative **8th December 2020**

AUDIT REPORT TO THE TRUSTEE OF THE BETSI CADWALADR UNIVERSITY HEALTH BOARD CHARITY

ACCOUNTS FOR THE YEAR ENDED 31 MARCH 2020

Report on the audit of the financial statements

Opinion

I have audited the financial statements of the Betsi Cadwaladr University Health Board Charity for the year ended 31 March 2020 under the Charities Act 2011. These comprise the Statement of Financial Activities, the Balance Sheet, the Statement of Cash Flows, and related notes including a summary of significant accounting policies. The financial reporting framework that has been applied in their preparation is applicable law and United Kingdom Accounting Standards, including Financial Reporting Standard 102 The Financial Reporting Standard applicable in the UK and Republic of Ireland (United Kingdom Generally Accepted Accounting Practice).

In my opinion the financial statements:

- give a true and fair view of the state of affairs of the charity as at 31 March 2020 and of its incoming resources and application of resources for the year then ended;
- have been properly prepared in accordance with United Kingdom Generally Accepted Accounting Practice; and
- have been prepared in accordance with the Charities Act 2011.

Basis for opinion

I conducted my audit in accordance with applicable law and International Standards on Auditing in the UK (ISAs (UK)). My responsibilities under those standards are further described in the auditor's responsibilities for the audit of the financial statements section of my report. I am independent of the charity in accordance with the ethical requirements that are relevant to my audit of the financial statements in the UK including the Financial Reporting Council's Ethical Standard, and I have fulfilled my other ethical responsibilities in accordance with these requirements. I believe that the audit evidence I have obtained is sufficient and appropriate to provide a basis for my opinion.

AUDIT REPORT TO THE TRUSTEE OF THE BETSI CADWALADR UNIVERSITY HEALTH BOARD CHARITY

CONTINUED FROM PREVIOUS PAGE

Conclusions relating to going concern

I have nothing to report in respect of the following matters in relation to which the ISAs (UK) require me to report to you where:

- the trustees' use of the going concern basis of accounting in the preparation of the financial statements is not appropriate; or
- the trustees have not disclosed in the financial statements any identified material uncertainties that may cast significant doubt about the charity's ability to continue to adopt the going concern basis of accounting for a period of at least twelve months from the date when the financial statements are authorised for issue.

Report on other requirements

Other information

The other information comprises the information included in the annual report other than the financial statements and my auditor's report thereon. The trustees are responsible for the other information in the annual report and accounts. My opinion on the financial statements does not cover the other information and, except to the extent otherwise explicitly stated in my report, I do not express any form of assurance conclusion thereon.

In connection with my audit of the financial statements, my responsibility is to read the other information to identify material inconsistencies with the audited financial statements and to identify any information that is apparently materially incorrect based on, or materially inconsistent with, the knowledge acquired by me in the course of performing the audit. If I become aware of any apparent material misstatements or inconsistencies, I consider the implications for my report.

AUDIT REPORT TO THE TRUSTEE OF THE BETSI CADWALADR UNIVERSITY HEALTH BOARD CHARITY

CONTINUED FROM PREVIOUS PAGE

Matters on which I report by exception

I have nothing to report in respect of the following matters in relation to which the Charities (Accounts and Reports) Regulations 2008 require me to report to you if, in my opinion:

- the information given in the financial statements is inconsistent in any material respect with the trustees' report;
- sufficient accounting records have not been kept;
- the financial statements are not in agreement with the accounting records and returns; or
- I have not received all of the information and explanations I require for my audit.

Responsibilities

Responsibilities of the trustees for the financial statements

As explained more fully in the statement of trustee responsibilities, the trustees are responsible for preparing the financial statements in accordance with the Charities Act 2011, for being satisfied that they give a true and fair view, and for such internal control as the trustees determine is necessary to enable the preparation of financial statements that are free from material misstatement, whether due to fraud or error.

In preparing the financial statements, the trustees are responsible for assessing the charity's ability to continue as a going concern, disclosing as applicable, matters related to going concern and using the going concern basis of accounting unless deemed inappropriate.

AUDIT REPORT TO THE TRUSTEE OF THE BETSI CADWALADR UNIVERSITY HEALTH BOARD CHARITY

CONTINUED FROM PREVIOUS PAGE

Auditor's responsibilities for the audit of the financial statements

I have been appointed as auditor under section 150 of the Charities Act 2011 and report in accordance with regulations made under section 154 of that Act.

My objectives are to obtain reasonable assurance about whether the financial statements as a whole are free from material misstatement, whether due to fraud or error, and to issue an auditor's report that includes my opinion. Reasonable assurance is a high level of assurance but is not a guarantee that an audit conducted in accordance with ISAs (UK) will always detect a material misstatement when it exists. Misstatements can arise from fraud or error and are considered material if, individually or in the aggregate, they could reasonably be expected to influence the economic decisions of users taken on the basis of these financial statements.

A further description of the auditor's responsibilities for the audit of the financial statements is located on the Financial Reporting Council's website www.frc.org.uk/auditorsresponsibilities. This description forms part of my auditor's report.

Adrian Crompton
Auditor General for Wales

24 Cathedral Road, Cardiff
CF11 9LJ

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THE ADDRESS OF THE CHARITY AND THE CORPORATE TRUSTEE'S PRINCIPAL OFFICE IS:

Awyr Las
Ysbyty Gwynedd
Penrhosgarnedd
Bangor
Gwynedd
LL57 2PW

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Cyfarfod a dyddiad: Meeting and date:	**Audit Committee 17/12/2020**
Cyhoeddus neu Breifat: Public or Private:	Public
Teitl yr Adroddiad Report Title:	Schedule of Closed Claims Over £50,000 - 2020/21 Quarter 2
Cyfarwyddwr Cyfrifol: Responsible Director:	Matthew Joyes, Acting Associate Director of Quality Assurance
Awdur yr Adroddiad Report Author:	Matthew Joyes, Acting Associate Director of Quality Assurance and Claims Managers
Craffu blaenorol: Prior Scrutiny:	Review by the Acting Associate Director of Quality Assurance
Atodiadau Appendices:	Schedule of closed claims and financial value for quarter two of 2020/21 (over £50,000)

Argymhelliad / Recommendation:

The Audit Committee is asked to receive this report for assurance.

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

Sefyllfa / Situation:

The attached report sets out total payment information for any claims against the Health Board with a spend over £50,000 closed during Quarter 2 (July - September) of the 2020/21 financial year. This report formally summarises to the Audit Committee, the authorities given by the Health Board's Claims Managers, Directors Executive Team and Board.

This report is presented to the Audit Committee to support the discharge of its responsibility to ensure the provision of effective governance.

Cefndir / Background:

All Health Boards in Wales contribute to a liability fund and have a risk share agreement, known as the Welsh Risk Pool (WRP).

The Health Board employs a team of Claims Managers who sit within the Patient Safety and Experience Department. These legally trained staff were recruited to strengthen the management of claims. Clinical negligence and personal injury claims are managed by the Health Board on the basis of legal advice provided by the Legal and Risk Services Department of NHS Wales Shared Services Partnership. The Welsh Risk Pool will reimburse the Health Board for all losses incurred above an excess of £25,000 on a case by case basis.

To ensure that learning and improvement is commenced and implemented at the earliest possible stage the Welsh Risk Pool has amended its reimbursement procedures to bring the scrutiny of learning much earlier in the lifecycle of a case. These changes become effective from 1st October 2019. The new WRP procedures introduce a Learning from Events Report (LfER) and a Case Management Report (CMR). These are used by the Health Board to report the issues that have been identified from a claim and to determine how these have been addressed in order to reduce the risk of reoccurrence and reduce the impact of a future event. The trigger for an LfER is related to the date of a decision to settle a case (even if the loss incurred is under £25,000) and the Health Board has sixty working days to submit a report from this date. A CMR is then submitted four months after the last payment on a claim is made, detailing how quantum was decided, if delegated authority was used and confirming that senior leaders have been advised of the claims. The LfER needs to provide a sufficient explanation of the circumstances and background to the events which have led to the case, in order for the WRP Committee to scrutinise and identify the links to the findings and learning outcomes. Supporting information, such as action plans, expert reports and review findings can be appended to the LfER to evidence the learning activity.

Should the Audit Committee require it, there is a learning document available for the cases listed within the schedule attached.

In all cases, claims have been managed by the Claims Managers within the Patient Safety and Experience Department who are all legally trained. All claims have been managed with the support and involvement of the Legal and Risk Services Department of NHS Wales Shared Services Partnership (NWSSP) and evidence of case management and learning has been, or will be, submitted to the Welsh Risk Pool.

The Quality, Safety and Experience Committee receives a separate quarterly Patient Safety Report to provide assurance on the learning and improvement following claims. This report to the Audit Committee provides assurance on the correct authorisation of payments as shown on the attached schedule for claims over £50,000.

Additionally, the Audit Committee is reminded that an annual internal audit of claims management is also undertaken which provides additional assurance on systems and process.

Asesiad / Assessment & Analysis

Please see the attached schedule for detail of individual claims. The data provided has been taken from the Datix software system through which claims are managed.

Ref	Type	Area	Specialty	Incident Date	Opened Date	Closed Date	Description	Damages Authority Provided By	Damages Financial Payment Approval By	Costs Authority Provided By	Costs Financial Payment Approval By	Total (Payment summary)	Notes
C18-3705	Clinical Negligence	BCUHB Central	Adult Community Mental Health Services	28/04/2011	08/11/2018	14/09/2020	Treatment and care of patient in the Tawelfan unit. Failure to assess the Claimant's risk of falls following the first fall on 29 April 2011 and to place her on a falls pathway.	Claims Manager	Dr Kath Clarke - Int Asst Director of Service User Experience	Claims Manager	Claims Manager	£51,500	
C13-1085	Clinical Negligence	BCUHB Central	General Surgery (Secondary)	12/08/2011	11/04/2013	14/09/2020	Alleged delay in advising and/or conducting a hernia repair by laparoscopy and that a laparoscopy procedure was not contemplated prior to 2011.	Claims Manager	Dr Kath Clarke - Head of Concerns	Claims Manager	Claims Manager	£66,391.04	
W16-2314	Clinical Negligence	BCUHB West	Emergency Department (Secondary)	19/08/2013	21/06/2016	23/07/2020	Pt admitted to YG diagnosed with cluster headache on 19/8/13, no CT or MRI scan undertaken. Visited GP 21st and 23rd August. Had seizure on 27th August, scan revealed she had bleed on the brain and transferred to Walton Hospital. Pt has suffered brain damage.	Deborah Carter, Associate Director Quality Assurance and Tony Uttley, Interim Director of Finance	Gary Doherty, Chief Executive	Deborah Carter, Associate Director Quality Assurance	Matthew Joyes, Associate Director Quality Assurance	£2,720,716.26	
E11-448	Clinical Negligence	BCUHB East	General Surgery (Secondary)	01/09/2009	22/11/2010	22/09/2020	September 2009 - Left nephrectomy; nerve damage sustained around the time of the procedure leading to paraplegia.	Deborah Carter, Associate Director Quality Assurance	Gary Doherty, Chief Executive	Deborah Carter, Associate Director Quality Assurance	Matthew Joyes, Assistant Director of Patient Safety	£3,226,061.93	Costs payments made as lower more frequent interim payments
CLA16-2397	Clinical Negligence	BCUHB East	Emergency Department (Secondary)	01/06/2015	16/08/2016	30/07/2020	Alleged missed fracture of the acetabulum in hip.	Claims Manager	Kath Clarke, Head of Patient Safety	Claims Manager	Matthew Joyes, Assistant Direc	£111,050.47	
W14-1728	Clinical Negligence	BCUHB West	General Surgery (Secondary)	12/03/2012	29/10/2014	23/07/2020	Damaged ureter during surgery to remove tumour and resect bowel on 12.3.12	Gill Harris, Executive Director of Nursing and Tony Uttley, Interim Director of Nursing	Sue Hill, Director of Finance	Claims Manager	Matthew Joyes, Assistant Director of Patient Safety	£367,212.97	
CLA16-2536	Clinical Negligence	BCUHB East	Emergency Department (Secondary)	01/01/2013	29/12/2016	30/07/2020	Alleged failure to treat a cat bite appropriately including referring to Orthopaedics.	Claims Manager	Matthew Joyes, Assistant Director of Patient Safety	Claims Manager	Julie Ward-Jones, Deputy Head of Incidents	£56,616.87	
C11-20	Clinical Negligence	BCUHB Central	Paediatrics (Area)	27/11/1990	25/05/2011	29/07/2020	Claim relates to an alleged failure to diagnose a condition called hyperkerplexia, aka startle syndrome between the years of 1992 and 2007. During this time, the claimant had incorrectly been diagnosed with epilepsy and cerebral palsy.	Tony Uttley - Interim Finance Director	Anne Hall - Interim Assistant Director of Service User Experience	Robin Andrews - Finance Director	Matt Joyes - Assistant Director of Service User Experience	£873,746.64	Numerous Interim payments
C11-96	Clinical Negligence	BCUHB Central	Obstetrics (Secondary)	19/09/2005	12/05/2008	29/07/2020	Delay in proceeding to emergency Caesarean section. Claimant suffered bradycardia leading to a brain injury	Gary Doherty - Chief Executive Officer	Gary Doherty - Chief Executive Officer	Tony Uttley - Interim Finance Director	Gill Harris - Executive Director of Nursing & Midwifery	£5,751,238.91	Numerous Interim payments
W15-1947	Clinical Negligence	BCUHB West	GP Out of Hours Service (Secondary)	01/03/2014	11/06/2015	23/07/2020	claim in relation to management of an infected wound on claimants left foot by nurse in GP OOH there are 2 claims for this person: 1. eyes W14-1434, 2. Foot W15-1947 (Claim Linked ID 1434 - see Datix Linked Records)	Gill Harris, Executive Director of Nursing and Russ Favarger Director of Nursing	Gary Doherty, Chief Executive	Gill Harris, Executive Director of Nursing and Russ Favarger Director of Nursing	Barbara Jackson, Deputy Director of Corporate Services	£1,031,334.30	
W16-2356	Clinical Negligence	BCUHB West	General Surgery (Secondary)	23/06/2014	20/07/2016	15/09/2020	Claimant sustained an injury to her ureter during colorectal/gynae surgery to repair a rectal and uterine/vaginal prolapse on 23 June 2014	Claims Manager	Dr Kath Clarke, Interim Assistance Director of SUE	Claims Manager	Yvonne Williams Deputy Head of Complaints	£129,193.31	
ZG-E14-1578	Clinical Negligence	BCUHB East	Obstetrics (Secondary)	01/07/2013	13/06/2014	30/07/2020	Failure to diagnose and treat an infection in the mother resulting in the baby's death.	Claims Manager	Kath Clarke, Head of Patient Safety	Claims Manager	Julie Ward-Jones, Deputy Head of Incidents	£212,729.01	
CLA18-3444	Clinical Negligence	BCUHB West	Emergency Department (Secondary)	10/08/2015	21/06/2018	23/07/2020	Claimant developed and infection after being treated with I.V. Steroids	Claims Manager	Matthew Joyes, Assistant Director of Patient Safety	Claims Manager	Yvonne Williams Deputy Head of Complaints	£79,508.95	

Cyfarfod a dyddiad: **Meeting and date:**	**Audit Committee** **17th December 2020**
Cyhoeddus neu Breifat: **Public or Private:**	Public
Teitl yr Adroddiad **Report Title:**	Ablett Redevelopment
Cyfarwyddwr Cyfrifol: **Responsible Director:**	Interim Director of Governance/Acting Board Secretary
Awdur yr Adroddiad **Report Author:**	Interim Director of Governance Acting Board Secretary
Craffu blaenorol: **Prior Scrutiny:**	Acting Chief Executive
Atodiadau **Appendices:**	Appendix 1 – Extract from Board Minutes – January 2019 approving the Strategic Outline Case Appendix 2 – Ablett Unit – relevant information timeline

Argymhelliad / Recommendation:

That the Committee note:-

(1) the Capital Investment Group which has met twice and will provide monthly reports to the Executive Team and specifically highlight any changes in assumptions etc. or any schemes that might be off track;

(2) the role of Senior Responsible Owners has been clarified by the Executive Team and SRO reporting into the Executive Team is being formalised;

(3) that the Finance and Performance Committee has reverted to having a standing agenda item on progress against approved capital projects; and

(4) that any future planning consultations will specifically be drawn to the attention of Board Members well in advance of their publication, in the same way as service consultations.

Please tick as appropriate

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

Sefyllfa / Situation:

Some members of the Health Board have expressed concern that they became aware of the change in the project board's preferred option (the proposal to develop a new facility on the YGC site, together with the associated multi-storey car park), through the media briefing associated with the nationally mandated, newly introduced pre-planning application process. They are concerned that there may have been a failure of governance.

Cefndir / Background:

The applicable governance framework is the BCUHB's Procedure Manual for Managing Capital Projects as approved by the Finance and Performance Committee (version 10, approved in October 2018). This manual is intended to be used for the management of capital expenditure associated with all types of project with a capital value over £1million.

Summary roles and responsibilities from the framework, Finance and Performance (F&P) Committee Terms of Reference, and Scheme of Reservation and Delegation (SoRD):

Project management

- Senior Responsible Officer:
  - The ownership of the project shall be vested in the Senior Responsible Officer who shall be the appropriate Executive Director as selected by the Chief Executive.
- Project Board
  - The membership of the Project Board shall be the Project Director, the Senior User, the Senior Supplier and the Financial Lead.
- Project Director
  - The primary decision maker responsible for the overall governance and direction of the project.

Project oversight

- The Executive Director of Planning and Performance is the lead director.
- The Executive Director of Finance is responsible for ensuring robust financial management for capital projects.
- Capital Programme Management Team:
  - To oversee the delivery of the in-year capital programme
- Executive Team:
  - Capital Business case approval £0.5million to £1million
  - To oversee preparation and scrutiny of business cases as contained in the capital programme
- Finance and Performance Committee:
  - To oversee business cases that are subsequently subject to formal scrutiny by the Welsh Government.
  - To approve and monitor progress of the Capital Programme
- Board:
  - Capital Business case approval over £1million
- Welsh Government:
  - Capital Business case approval over £1million (in advance of contract planning)

Aligned to the NHS Wales Infrastructure Investment Guidance, there are three key stages in the development of a project business case. These are:

- the Strategic Outline Case (SOC);
- the Outline Business Case (OBC); and
- the Full Business Case (FBC)

The SOC establishes the strategic context; makes a robust case for change; and provides a suggested way forward based on a preliminary analysis, rather than a definitive preferred option. This paves the way to work up a more detailed OBC.

The OBC identifies the preferred option that optimises value for money; prepares the scheme for procurement; and puts in place the necessary funding and management arrangements for the successful delivery of the scheme.

The FBC sets out the negotiated commercial and contractual arrangements for the deal; demonstrates that it is 'unequivocally' affordable; and puts in place the detailed management arrangements for the successful delivery of the scheme.

The Strategic Outline Case (SOC) for the redevelopment of the Ablett Inpatient Mental Health Unit at Ysbyty Glan Clwyd (YGC) was approved by the Health Board in January 2019 (see extract from January 2019 Board Minutes attached as Appendix 1) and subsequently noted by Welsh Government (WG) in March 2019.

The SOC detailed the case for change setting out the proposed service model; the requirement to respond to the recommendations of the HASCAS and Ockenden reviews and inspections by Health Inspectorate Wales; and the deficiencies of the existing facility and impact on clinical services, patients, staff and carers. The SOC argued the benefits of co-locating all inpatient services within Conwy and Denbighshire on to a single site and proposed the re-location of Older Persons Mental Health inpatient beds from Bryn Hesketh hospital. It identified four potential options:

- Option 1 - Do nothing.
- Option 2 - Remodel the existing Ablett Unit but retain OPMH inpatient services at Bryn Hesketh.
- Option 3 - Remodel the existing Ablett Unit including re-locating inpatient services from Bryn Hesketh.
- Option 4 – A new build on YGC site including re-locating inpatient services from Bryn Hesketh.

The SOC identified Option 3, remodelling the existing Ablett Unit including services from Bryn Hesketh, as the preferred option based on the preliminary analysis and identified an indicative capital cost of £25.75m.

The WG NHS Wales Infrastructure Investment Guidance issued in 2018 requires Health Boards and Trusts to confirm approval of outline planning consent of design and proposed use by the local planning authority as part of the business case submission. This is the first OBC that the Health Board has prepared since this requirement was introduced.

The Planning Act (Wales) requires all specified planning applicants to undertake a pre-planning engagement with neighbouring property owners and specified statutory consultees together with making the draft application publicly available for a period of 28 days prior to submission to the planning authority. The regulations require the applicant to publicise the process.

It should be noted that the pre-planning engagement is limited to consideration of the development's design and proposed use. The information published to date does not include any information related to potential service change.

Strategy Implications

Following approval of the SOC, BCUHB progressed the procurement of external support. The Finance and Performance Committee approved appointment of the Supply Chain Partner, Project Manager and Cost Advisor in August 2019. The Director of Mental Health and Learning Disabilities (MHLD) became the scheme's SRO.

The Project Board (Chaired by the SRO) progressed the development of the Outline Business Case (OBC). A series of 21 engagement events were undertaken from October 2019 to January 2020 to discuss, develop and review the service model and consider each of the potential options (as detailed above). These events included staff (including social care staff), service users, carers, family members, mental health and care charities, third sector organisations, statutory partners and WAST. A number of events were led by Caniad and Hafal. These included people with lived experience and carers. Wider public engagement was also undertaken to discuss proposed changes to older person's mental services in Conwy and Denbighshire.

The outcome of this engagement highlighted the importance of a wider/holistic therapeutic approach, both active and passive. Within the care process, this necessitated a review and subsequent increase in the required therapy, support accommodation, and highlighted further deficiencies within the existing accommodation.

The consequence of the above was to increase the scope of the project and thereby adversely impact upon the risk/viability of developing the existing facility whilst maintaining clinical services.

The engagement indicated support for the relocation of inpatient services from Bryn Hesketh and argued that the needs of patients, carers and staff would be better met in a new build rather than redeveloping the existing Ablett Unit. The then SRO (Acting Director of MHLD) also met with the Community Health Council in January 2020 to discuss the proposed service change (the relocation of services from Bryn Hesketh to the new Ablett site and outcome of the engagement to that date which indicated that a new build was the preferred option).

Linking the pre-OBC planning requirement to the BCUHB procedures it was interpreted that the statutory timetable for the pre-planning engagement, planning application, and its subsequent consideration and approval was a technicality and as such that the process was required to commence before scrutiny of the OBC. This resulted in a difficult situation where information was in the public domain before the Health Board and its Executives and committees had the opportunity to scrutinise the business case. This difficulty was exacerbated by the development of option 4 rather than option 3 following consultation.

The BCUHB Procedure document is silent on change protocols between SOC and OBC; however, it does not preclude inserting an additional step to gain both Executive Team and F&P Committee approval before engaging with planning authorities.

Option development

Following the conclusion of the engagement the Project Board facilitated a formal option appraisal workshop on 17th January 2020, comprising clinical staff, patient and carers' representative, senior divisional staff and members of the project team. This workshop identified option 4, a new build on YGC site, including re-locating inpatient services from Bryn Hesketh, as the preferred option. The Project Board formally supported this at the meeting of 24th January 2020. The Project Team then

developed potential locations for a new build at YGC including cost and impact. The Executive Team at this point should have been informed by the formally appointed Senior Responsible Officer for the project that the preferred option was now a rebuild and that the capital costs had materially increased - confirmed as £63.234m (as at August 2020).

There is evidence, from Project Board minutes, to indicate that the SRO would raise the change in direction with the Executive Team, but no evidence to suggest this happened.

In addition, a capital report to February's Finance and Performance Committee represented a missed opportunity to advise the Committee of the change in the Project Board's thinking.

In April 2020, the Project Board noted that the "best" option appeared to be to develop the existing car park adjacent to the Pathology department, which would necessitate the re-provision of approximately 350 existing parking spaces. The design was developed further in support of the OBC and included the re-provision of 400 car parking spaces within a three story structure located on the existing "north end" front car park adjacent to Sarn Lane.

Conclusion

In terms of the overall governance arrangements, the process outlined in the BCUHB Procedure Manual for Managing Capital Projects was followed (with the exception of appointing an Executive Director as SRO).

There were missed opportunities (written reports did not include direct reference to the changed thinking of the best option) to inform the Executive and Board that following consultation and engagement the preferred option to be developed into an OBC had changed from option 3 to option 4.

There were missed opportunities within line management structures, One2One's etc. (in planning, finance and mental health) to inform the Executive that following consultation and engagement the preferred option to be developed into an OBC had changed from option 3 to option 4.

There are limited financial implications, Welsh Government capital funds are not allocated until an OBC is approved, however staff time and resource was spent developing a proposal that potentially would not get Executive and Board approval.

There is potential for further reputational damage engaging in the planning process for a project that may not get Executive and Board approval.

It will be important to ensure that a repeat of the situation outlined above does not take place. To this end, it is worth noting the establishment of the Capital Investment Group, which has commenced monthly reporting to the Executive and highlighting specifically any changes in assumptions etc. or any schemes that might be off track.

In addition to this, the Executive Team have recently agreed the roles and responsibilities of the SRO in future projects and agreed to review current SROs. The Executive Team have also determined thresholds for the level of seniority for SROs based on the capital amount, complexity and risk.

The Finance and Performance Committee has reverted to having a standing agenda item on progress against approved capital projects (following a pause during the temporary Covid-19 response arrangements), this will facilitate reporting of material changes to the Committee.

Findings & Recommendations

1. The Finance and Performance Committee approved BCUHB's Procedure Manual for Managing Capital Projects.

   Recommendation 1: That the Executive Team approve procedures of this sort, to enable independent members to be independent of process when queries, concerns or issues are raised.

   Recommendation 2: The Procedure Manual for Managing Capital Projects should be updated to reflect the recommend changes below (in progress – Lead officer – Executive Director of Planning & Performance).

2. This project did not have an Executive Level SRO.

   Recommendation 3: The SRO for all projects should be reviewed and a process put in place to ensure appropriate SROs are in place should be developed (in progress – Lead officer - Executive Director of Planning & Performance).

3. Public engagement undertaken on plans that had not been reported to or reviewed by the Executive and Board.

   Recommendation 4: Executive Team and Board (through the F&P) should give OBC approval, subject to any planning considerations, before planning authorities are engaged.

   Recommendation 5: Any future public consultations (whether capital or other) should have Executive approval and be specifically drawn to the attention of Board Members in advance of their publication.

4. Oversight of the development of this project from SOC to OBC appears to have been reliant on issues being escalated through line management and the SRO, rather than pro-active management.

   Recommendation 6: An executive led group is established to have full and proactive oversight of capital projects at all stages from project initiation and development of SOC to completion. This group should routinely report and make recommendations to the Executive, and provide evidence for Executive reports to the F&P Committee. Exception reports should include significant changes at each stage of the developing a capital business case (SOC, OBC, FBC) (in progress – Lead officer - Executive Director of Planning & Performance).

5. The principle of "no surprises" was not applied by senior officers of the Health Board

   Recommendation 7: The Acting Chief Executive to reinforce this requirement and expectation in accordance with Health Board HR policies.

Financial Implications

None at this stage - as the Project Board's recommendation has neither been presented nor approved by the Executive Team.

Risk Analysis

The Project Board approved the Project's Governance Framework in November 2019. The governance framework identified the project structure and established a Project Board supported by a Project Team together with work stream groups responsible for the service model; stakeholder engagement and communications; decanting and commissioning arrangements; and the capital scheme. It confirmed that the Project Board would report to the Executive Team via the Senior Responsible Owner. The governance framework was in accordance with BCUHB's Procedure Manual for Managing Capital Projects as approved by the Finance and Performance Committee (version 10 as approved in October 2018).

Reference has been made to previous recommendations made following the Ysbyty Glan Clwyd (YGC) refurbishment to ensure there was a clear decision making and governance framework for capital projects and to the more recent WAO report on YGC. The following may be noted:

- All recommendations identified in the 2014 YGC audit (referenced within the WAO report) have been implemented and confirmed as closed.
- The Procedural Manual for Managing Capital Projects has been developed and amended as necessary to incorporate audit recommendations as appropriate and subsequently approved by the Finance and Performance committee.
- BCUHB have commissioned NHS Wales Shared Services Partnership – Audit and Assurance Services to undertake an annual programme of capital audits.
- Recommendations identified within all capital audit reports are tracked and monitored by the Audit Committee.

Legal and Compliance

The project governance arrangements are in accordance with BCUHB's policies and procedures and satisfy the requirements of previous audit recommendations. There has been no breach of SFIs as the OBC has yet to be presented to the Health Board.

However, there has clearly been a failure in terms of communication and the current situation does not reflect good governance in the wider sense. Whilst not excusing the current situation, the following should be noted:

- The Senior Responsible Owner chaired the Project Board and supported the preferred option.
- The Project Team briefed the SRO on the developing business case, there is no evidence that the SRO then reporting this higher
- WG policy lead appraised of the project and visited the existing unit to understand its therapeutic and clinical limitations
- The WG policy lead for Mental Health and Learning Disabilities supported the preferred model.

It is acknowledged that there has been a fracturing of a number of communication routes due to changes in key personnel (notably the SRO); the impact of the pandemic and the standing down of the Health Board sub-committees and business as usual reporting during the key period of development of the revised preferred option; and changes within the Executive Team and committee reporting requirements. However, it is recognised that the above do not negate the requirement to report major variances by exception

Impact Assessment

Due to the nature of this report, no impact assessment is required.

Extract from January 2019 Board Minutes **Appendix 1**

19.17 Redevelopment of the Mental Health Inpatient Unit at Glan Clwyd Hospital – Strategic Outline Case [*Mr Ian Howard was in attendance for this item]*

19.17.1 The Director of Mental Health & Learning Disabilities presented the paper. He reminded members that there was a recognition that the Ablett Unit was not fit for purpose and that whilst a range of investments and improvements had been made, there remained basic flaws in design and environment. He confirmed that the strategic outline case being considered was aligned to the wider direction of travel for delivery of healthcare within BCUHB, and had been developed with the support of clinicians and stakeholders. He highlighted various sections within the paper which set out the objectives for the coming year, the strategic context, the case for change, the developing models of care and benefits and outcomes. Members were informed that the Finance & Performance Committee had endorsed the strategic outline case at its meeting on the 22.11.18.

19.17.2 A discussion ensued. There was consensus that the development was a significant step forward for the organisation and was in line with organisational priorities, although there would be challenges associated with meeting the recurring revenue costs. The Chair of the Stakeholder Reference Group noted that the coversheet referred to an increase in the index used nationally to estimate capital costs and enquired as to what the wider implications of this would be for other projects within BCUHB. The Chair asked that this be confirmed outside of the meeting. The Chair of the Information Governance & Informatics Committee highlighted that there would be an impact on health records storage that would need to be taken into account as the business case progressed. The Chair of the QSE Committee noted that reference was made to space being adapted for future changing needs and enquired how that would be managed as the needs of people within mental health units could vary significantly. The Director of Mental Health & Learning Disabilities confirmed that the newly built unit would be planned to be flexible as part of a move away from bed- based acute care. The known population demands would be built into the design. The Executive Director of Workforce & OD suggested that it would be important for the outline business case to include clear detail of benefits realisation.

19.17.3 It was resolved that the Board approve the Strategic Outline Case for submission to Welsh Government.

Ablett Unit Redevelopment – Relevant information timeline Appendix 2

Date	Description	Report to	Report from
January 2019	Director of Mental Health & Learning Disabilities appointed as Senior Responsible Officer (SRO)		
24/01/2019	Strategic Outline Case (SOC) – approved	Board	Assistant Director - Strategic and Business Analysis/ Director of Mental Health & Learning Disabilities/ Executive Director of Planning and Performance
22/08/2019	Capital Programme M4 Report– BCU have been successful in procuring the project manager, cost advisor and supply chain partner.	Finance & Performance Committee (F&P)	Assistant Director of Planning and Performance – Capital / Financial Accountant: Tax and Capital / Executive Director of Planning and Performance
26/02/2019	Capital Programme M10 Report – silent re Ablett	F&P	Assistant Director of Planning and Performance – Capital / Financial Accountant: Tax and Capital / Executive Director of Planning and Performance
26/03/2019	Capital Programme M11 Report– silent re Ablett	F&P	Assistant Director of Planning and Performance – Capital / Financial Accountant: Tax and Capital / Executive Director of Planning and Performance
24/04/2019	Capital Programme M12 Report– silent re Ablett	F&P	Assistant Director of Planning and Performance – Capital / Financial Accountant: Tax and Capital / Executive Director of Planning and Performance
23/05/2019	Capital Programme M1 Report– no exception re Ablett	F&P	Assistant Director of Planning and Performance – Capital / Financial Accountant: Tax

			and Capital / Executive Director of Planning and Performance
25/06/2019	Capital Programme M2 Report– no exception re Ablett	F&P	Assistant Director of Planning and Performance – Capital / Financial Accountant: Tax and Capital / Executive Director of Planning and Performance
29/07/2019	Capital Programme M3 Report– no exception re Ablett	F&P	Assistant Director of Planning and Performance – Capital / Financial Accountant: Tax and Capital / Executive Director of Planning and Performance
22/08/2019	Brief on the procurement of external support for the design and construction of the proposed redevelopment of the Ablett Unit.	F&P	Neil Bradshaw/ Mark Wilkinson
November 2019	SRO changed to Acting Director of MHLD		
04/12/2019	Capital Programme M7 Report– note that the Project Board have reviewed the original programme assumptions within the Strategic Outline Case without specific details.	F&P	Assistant Director of Planning and Performance – Capital / Financial Accountant: Tax and Capital / Executive Director of Planning and Performance
23/01/2020	Capital Programme M9 Report– silent on Ablett	F&P	Assistant Director of Planning and Performance – Capital / Financial Accountant: Tax and Capital / Executive Director of Planning and Performance
24/01/2020	Project Board confirmed “option4” - new build on YGC site including re-locating inpatient services from Bryn Hesketh as the preferred option	Project Board	
January 2020	Line management of Acting Director of MHLD changed from Chief Executive to Executive Medical Director		
18/02/2020	WG Capital update	WG (cc Executive Director of Planning and	Assistant Director of Planning and Performance – Capital

		Performance) (cc Financial Accountant: Tax and Capital)	
28/04/2020	Project Board confirms preferred location and requirement to re-provide displaced parking spaces.	Project Board	
23/06/2020	Interim Discretionary Capital Spend report - Welsh Government have confirmed that funding will be made available to support … the Ablett Unit in 2020/21	Executive Team	Assistant Director of Planning And Performance – Capital / Executive Director of Planning and Performance
18/08/2020	WG Capital update	WG (cc Executive Director of Planning and Performance) (cc Financial Accountant: Tax and Capital)	Assistant Director of Planning and Performance – Capital
24/08/2020	Press release issued re pre-planning application consultation		Assistant Director of Planning and Performance – Capital / Programme Director for the Ablett Redevelopment / Financial Accountant: Tax and Capital / Executive Director of Planning and Performance
27/08/2020	Capital Programme M7 Report 4- referred to the fact that the outline business case for the Ablett unit was expected to be submitted to the Finance and Performance Committee in October. Verbal update provided on change of preferred option. This was the next opportunity to report the Option change following the return to business as usual in the light of COVID	F&P	

Cyfarfod a dyddiad: **Meeting and date:**	**Audit Committee** **17 December 2020**
Cyhoeddus neu Breifat: **Public or Private:**	Public
Teitl yr Adroddiad **Report Title:**	Performance and Accountability Framework
Cyfarwyddwr Cyfrifol: **Responsible Director:**	Mark Wilkinson Executive Director of Planning and Performance
Awdur yr Adroddiad **Report Author:**	Simon Evans-Evans Interim Director of Governance
Craffu blaenorol: **Prior Scrutiny:**	Executive Leadership Team Board (for comment)
Atodiadau **Appendices:**	Performance and Accountability Framework

Argymhelliad / Recommendation:

The committee are asked to note the implementation of the Performance and Accountability Framework.

The committee are asked to review the impact and effectiveness of the framework in September 2021.

Please tick as appropriate

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

Sefyllfa / Situation:

The Terms of reference of the Audit committee state that:

The Committee, in respect of its provision of advice and assurance will and is authorised by the Board to:

- ensure the provision of effective governance - by reviewing the Board's Standing Orders, and Standing Financial Instructions (including associated framework documents, as appropriate);

To achieve this, the Committees programme of work will be designed to provide assurance that:

- there are effective arrangements in place to secure active, ongoing assurance from management with regard to their responsibilities and accountabilities, whether directly to the Board and the Accountable Officer or through the work of the Board's Committees;

The Performance and Accountability Framework is a key management framework that will provide the Executive, Board and Committees with assurance. This paper is to inform the Committee that the

Executive Team have now implemented the Framework.

Cefndir / Background:

The Performance and Accountability Framework was developed with support and contributions from the Executive Leadership Team, Jo Whitehead and other senior managers.

In summary the framework is designed to have:

- A team focussed framework overseen by Executive Group (Performance Oversight Group)
- A performance cascade and escalation via
    - Monthly Performance Review Meetings – Executive led.
    - Monthly team led Performance meetings
- Broad definition of performance covering
    - the 'what'
        - Outcomes for Patients – NHS Wales Delivery Framework
        - Avoiding Harms associated with Covid
        - Responsibility to deliver **or** support delivery of BCUHB strategic, tactical and operational targets (directly or indirectly)
        - Sustainability
    - and the 'how'
        - Corporate requirement to deliver BCUHB priories **or** if not applicable to support teams that do
        - Identification of areas of excellence
        - Development of Impact Improvement Plans as necessary
- Formal escalation processes – escalation does not automatically equal change of ownership
- Accountability and Assurance Agreements for Senior Managers
- Links to individual performance and accountability
- Links to All Wales Pay Progression and All Wales Capability policies
- Links to Recognition for excellence.

The draft framework was shared with the Independent Members of the Board on 30 October 2020. The Executive Directors approved the framework on 11 November 2020.

The Assurance and Accountability Agreements are being issued to Tier 1 and 2 managers, these agreements also address the need for Senior Managers to deliver on BCUHB strategic, tactical and operational deriving from the Q3/4 plan seen by the Board, they also address behaviours, link to the values, and stress the corporate responsibility to deliver the plan.

The first Performance Review Meetings took place on 26 November 2020. Informal feedback suggests that these meetings were well received and provided a positive baseline for future.

Each Divisional representative and Executive has been asked to contribute to an evaluation of the first meeting; this is to ensure that the process will is improved in line with the organisation's needs.

The Executive Director of Planning and Performance has approved a schedule of meetings until April 2020 (subject to operational pressures arising from the second wave of Covid-19). The POG will take place in early January (to enable the new CEO to further contribute to the process) to review feedback performance and plan for future meetings.

Year-end meetings are planned for April 2021 to assess overall performance in 20/21, but more

importantly set out the Accountability Review plan for the year.

A standard reporting format throughout BCUHB to support line of sight from Board to place based teams needs to be developed.

Asesiad / Assessment & Analysis

Strategy Implications

The framework is designed to give evidence of impact / delivery of the Health Board's corporate and performance priorities.

Options considered

None. The framework was developed consultatively.

Financial Implications

The Framework includes accountability for financial management.

Risk Analysis

The PRM cover risks.

Legal and Compliance

n/a

Impact Assessment

The framework is currently being translated, before publication on the Health Board's website.

Version & Reference Number 1.09 - Final

Performance and Accountability Framework

Author & Title	Simon Evans-Evans Interim Director of Governance				
Responsible Dept / director:	Workforce and Organisational Development Sue Green				
Approved by:	Executive Leadership Team				
Date approved:	11/11/2020				
Date activated (live):	11/11/2020				
Documents to be read alongside this document:					
Date of next review:	31/03/2021				
Date EqIA completed:	n/a				
First operational:					
Previously reviewed:					
Changes made yes/no:					

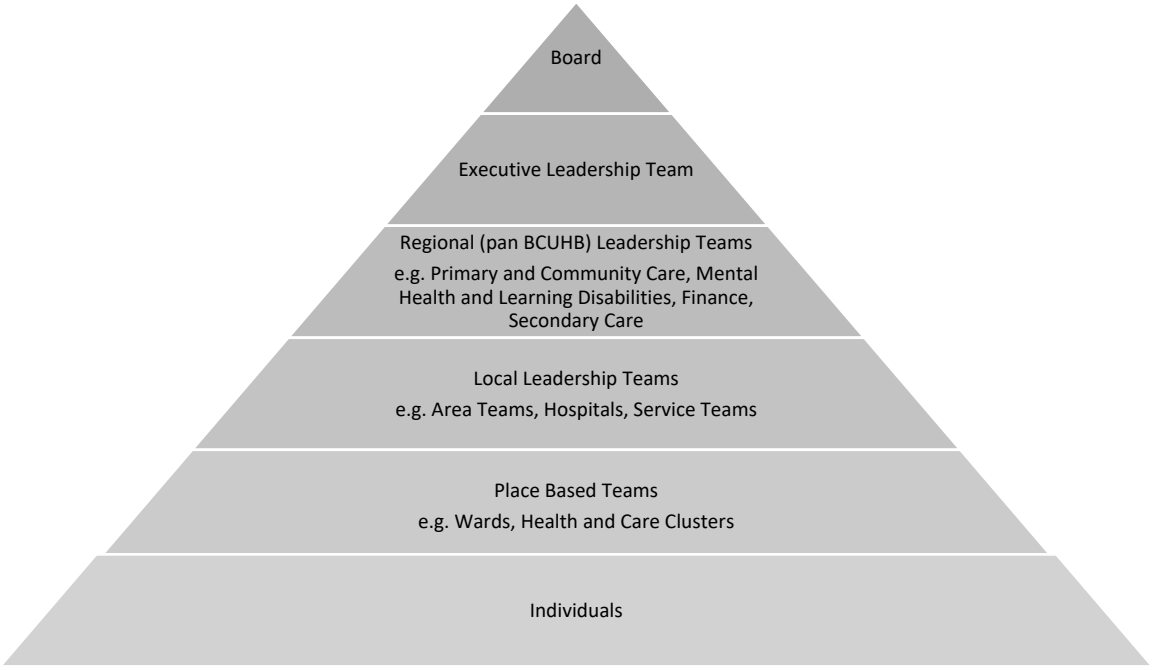
N.B. Staff should be discouraged from printing this document. This is to avoid the risk of out of date printed versions of the document. The Intranet should be referred to for the current version of the document

Contents

1. The Performance and Accountability Framework

1.1. What is the Performance and Accountability Framework?

The Performance and Accountability Framework sets out the means by which the Health Board can easily identify areas of excellence for wider sharing and celebration and areas where additional support may be required. It is the framework by which the Board, Executive Leadership Team, hospitals, community & primary care area leadership and specialty teams, and corporate functions are held to account for their performance.



Summary Performance and Assurance Management Cascade

This framework is designed to hold teams to account for delivery of team targets; it is aligned to the Personal and Developmental Review (PADR) process.

Team and individual objectives are aligned to the Performance and Accountability cascade outlined above:

- The Welsh Government has laid out the national Strategy for A Healthier Wales;
- The Board develops strategies that deliver for “A Healthier North Wales”:
- The Executive Leadership Team develop detailed plans to implement the strategy, clearly laying out the responsibilities of teams for delivery.
- Team plans then inform individual performance targets

1.2. What do we mean by Performance?

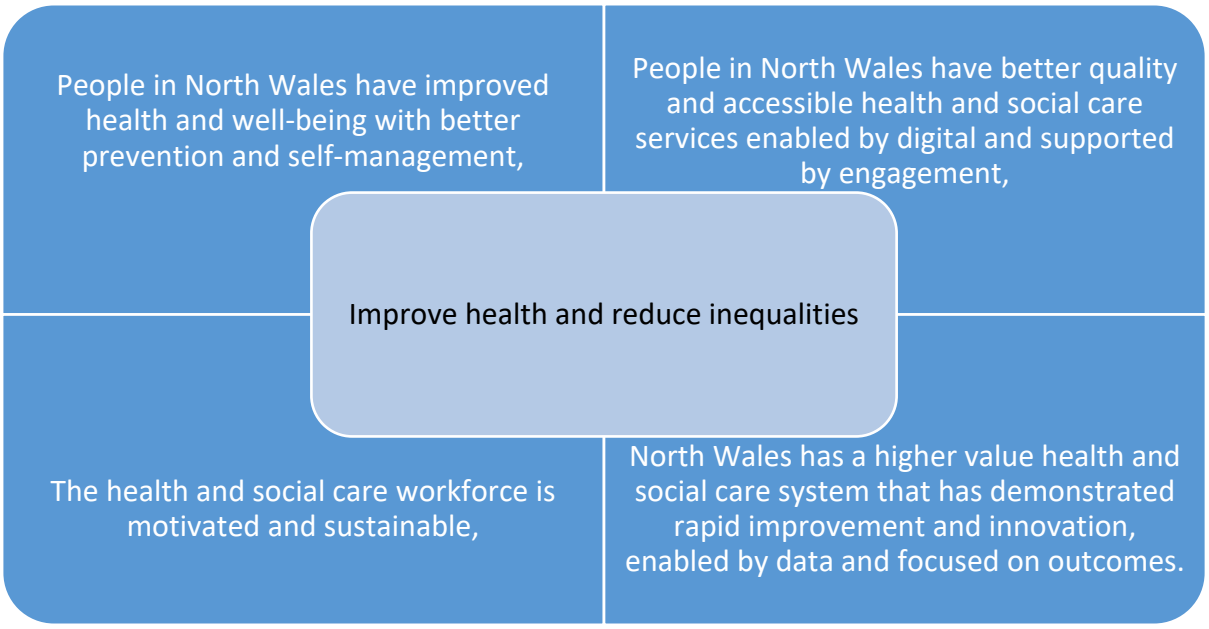
The health board seeks to provide the highest quality services to our patients; performance is a multi-faceted term and covers both **what** teams are delivering and **how** they deliver.

1.2.1. How do we measure what teams are delivering?

1.2.1.1. Outcomes for Patients

From a National perspective, our performance is viewed through four domains reflected in the NHS Wales Delivery Framework 2020-2021 (as amended from time to time):

- People in North Wales have improved health and well-being with better prevention and self-management;
- People in North Wales have better quality and accessible health and social care services enabled by digital and supported by engagement;
- The health and social care workforce is motivated and sustainable;
- North Wales has a higher value health and social care system that has demonstrated rapid improvement and innovation, enabled by data and focused on outcomes.



1.2.1.2. Learning and response to Covid-19

Our performance, corporately and as teams is also measured against the impact of Covid-19 on the communities we serve to avoid:

- Harm from Covid itself;
- Harm from overwhelmed NHS and social care system;
- Harm from reduction in non-Covid activity;
- Harm from wider societal actions/lockdown.

1.2.1.3. Delivery of our strategy for North Wales

Teams will have targets set to contribute to the delivery of BCUHB strategies and strategic priorities and plans.

1.2.1.4. Sustainability of Health Care in North Wales

While living within their financial allocation must be a fundamental priority for managers, the Performance and Accountability Framework is explicit in its intent that performance be managed across the four domains set out above

1.2.2. How do we measure how teams are delivering?

Performance meetings and reports will also focus on how teams deliver; this will include:

- How teams work together and support each other to deliver performance for our patients;
- How teams work with other teams to deliver joint performance targets for our patients;
- How teams work with other teams to support them deliver performance for our patients;
- Areas of excellence and learning;
- How teams develop improvement plans to address areas of non-delivery, including the quality of those plans and identification of any support required; and
- How effectively teams are proactively using the integrated governance framework to identify and manage risk, escalate issues and share learning.

The emphasis in the Performance and Accountability Framework is on recognising areas of excellence and on improving performance at all levels in the Health Board.

1.3. What do we mean by Accountability?

Accountability is about ensuring that those making decisions and delivering services are answerable for them, although the range and strength of different accountability relationships varies from function to function. Effective accountability is concerned with not only reporting on actions completed, but also ensuring that stakeholders are able to understand and respond as the entity plans and carries out its activities in a transparent manner.

2. Accountability for Performance

2.1. Accountability structure

The accountability structure replicates the cascade laid out in section 1.1 and is set out below:

1	Place based teams are **accountable to** local leadership teams.
2	Local leadership teams are **accountable to** Regional leadership teams.
3	Regional leadership teams are **accountable to** Executive Directors.
4	Executive Directors are **accountable to** the Board **via** the Chief Executive and the Board Assurance Committees.
5	The Board is **accountable to** Welsh Government.

2.2. Accountable Managers

Executive Directors, regional, local and place based leaders are considered Accountable Managers for their areas of responsibility. They are therefore fully responsible and accountable for the managing their teams and for services they lead and deliver.

Accountable Managers are required to have formal performance management arrangements in place with the individual services they are responsible for, to ensure delivery against performance expectations and targets.

2.3. What are managers accountable for?

It is the responsibility of Accountable Managers to identify proactively issues of underperformance and to act upon them promptly and to the greatest extent possible to avoid the necessity for escalation within the organisation.

- Accountable Managers and teams have responsibility and accountability for all aspects of service delivery;
- Accountable Managers and teams have responsibility and accountability for the performance of services and the outcomes for patients within their allocated budget;
- Accountable Managers and teams have responsibility and accountability in relation to the identification and management of risk;
- Accountable Managers and teams have responsibility and accountability in investigating and disseminating learning from incidents;

- Accountable Managers have responsibility and accountability to report on their team's performance, areas of excellence, development of Impact Improvement Plans or the nature of support or interventions to achieve targets.

Accountable Managers will each be provided with a budget to deliver the services set out in the Health Board's Annual Plans and in their service level Operational Plans. They are accountable for their performance in delivering against these plans, within budget and for any specified performance improvements.

Once *realistic and achievable measures for performance and performance improvement have been set and agreed*, these will form the basis for performance monitoring and management.

It is acknowledged that in a minority of cases, achieving performance against plan may not be fully within the operational control of an individual Accountable Manager. Where this is the case, Line Managers are required to clearly identify and quantify these issues and share accountability for both the Impact Improvement Plans and actions required to address these challenges. Once these issues have been identified and quantified, they will be specifically reflected within the relevant Accountability and Assurance Agreements. These shared accountabilities will be the exception rather than the rule and will not dilute the accountability of Accountable Managers for delivering on their overall budget and plan.

2.4. What is an Accountability and Assurance Agreement?

Senior managers at Executive and Regional levels are required to sign an Accountability and Assurance Agreement. These agreements, between the Chief Executive and individual Senior Managers set out the scope of what they are responsible for and against which they will be held to account including the specific budget and staffing levels to achieve the deliverables agreed and such agreement shall not be unreasonably withheld.

The Accountability and Assurance Agreement is written confirmation that Senior Managers;

- Accept responsibility and accountability for producing and delivering their operational, impact improvement, quality, governance and financial plans.
- Accept the regime of supports, interventions and sanctions set out under the Performance and Accountability Framework.

3. What is the Performance Management Structure?

The management of performance is primarily through performance conversations within teams, holding themselves to account for delivery and developing Impact

Improvement Plans as necessary, reporting and holding to account for delivery will be in line with the cascade outlined in section 1.1.

3.1. What is the Performance Oversight Group [POG]?

The Performance Oversight Group (POG) is the key performance and accountability oversight and scrutiny process for the Health Board to support the Chief Executive in fulfilling their accountability responsibilities.

It is the responsibility of the Performance Oversight Group as a part of the overall accountability process, to scrutinise the performance in all areas of the Health Board, to assess performance, understand key risks, investigation and learning from incidents and Health Board specific targets and priorities. The POG will also identify areas of excellence and best practice for sharing and dissemination.

The POG meets on a monthly basis to review performance across the Health Board.

The standing membership of the Group is the;

- Deputy Chief Executive and Executive Director of Nursing (Chair)
- Executive Medical Director
- Executive Director of Workforce and Organisational Development
- Executive Director of Planning and Performance
- Executive Director of Primary Care and Community Services
- Executive Director of Finance
- Executive Director of Therapies and Health Sciences
- Executive Director of Public Health
- Executive Director of Mental Health and Learning Disabilities
- Interim Chief Operating Officer

POG will routinely meet with each regional team individually every 3 months to hold them to account for their performance, risk and learning from incidents.

POG will decide whether to hold additional monthly or bi-monthly escalation meetings with the team where a regional or local team has one or more areas of performance at escalation level 2 or above. POG will decide whether the meeting will cover all areas of performance, risk and learning (full POG) or only those in escalation (part POG).

In addition, POG may hold thematic reviews of performance where there are similar concerns across a number of teams, or the actions of one team are adversely affecting another.

Individual Accountable Managers will be required to attend routine POG meetings and additional meetings when required for performance issues or escalation.

3.2. What other performance oversight processes will be in place?

3.2.1. Monthly Performance Review Meetings

The relevant Executive Director will hold individual Performance Review Meetings (PRM) monthly supported by two other relevant Executive Directors or their deputies and the Performance Team. The PRM will cover:

- Patient safety, quality and compliance (including key learning from incidents and events)
- Service performance against patient outcome targets
- Service performance against BCUHB strategic, tactical and operational targets
- Financial and workforce performance
- Governance (including top risks)
- Celebrating success
- Impact Improvement Plans
- Contribution to BCU corporate priorities
- Other agenda items as agreed

3.2.2. Annual Performance Review Meetings

As part of the normal POG cycle of business formal Performance Review Meetings (PRM) will be held annually, the purpose of these meetings will be to:

- Review organisational performance for the previous year against the annual Accountability and Assurance Agreements;
- Plan for the set-up of the coming year in advance of the annual Accountability and Assurance Agreements being signed.

3.2.3. Exceptional Performance Review meetings

Both the Finance and Performance Committee and the Quality, Safety and Experience Committee may request or the Chief Executive may decide to convene Extraordinary Performance Review Meetings with specific Accountable Managers and their teams where significant performance issues are identified.

3.2.4. Service level performance management processes

It is a core responsibility of each Accountable Manager to manage the delivery of services for which they have responsibility.

Each level of management is accountable for the service they manage, for which they are required to:

- Keep performance under constant review;
- Have in place a monthly performance management process that will include formal performance meetings with their teams aligned with the accountability structure;

- At these meetings agree, monitor and report on actions to address underperformance;
- Take timely corrective actions to address any underperformance emerging and develop Impact Improvement Plans;
- Assess the effectiveness of team working.

Key points
- Accountable Managers are responsible and accountable for the performance of the teams and services they manage before during and after escalation.
- Senior Managers are required to sign an Assurance and Accountability Agreement.
- Accountable Managers are expected to have in place, a monthly performance management process that will include formal performance meetings with their next line of managers aligned with the accountability structure.
- Monthly Performance Review Meetings will be led by an Executive Director, supported by relevant Executive Directors or their deputies and the Performance Team
- POG is responsible for monitoring and scrutinising performance and will hold performance review meetings on a risk based approach

4. Describing performance expectations and reporting

4.1. Describing performance expectations

4.1.1. National

NHS Wales Delivery Framework 2020-2021 is in effect the annual contract, setting out the type and volume of services, between the Health Board and the Welsh Government, against which the Health Board's performance is measured.

Headline indicators for the health service performance are captured in the framework, which represents performance through four domains. The four domains are set out in section 1.2.

4.1.2. Corporate

The Board's Annual Plan sets out the strategic direction of the Health Board as well as the framework for managing risks and learning from incidents.

4.1.3. Operational Plans

Detailed operational plans at service levels are developed to give effect to the priorities set out in the Annual Plans.

4.2. Reporting on performance

4.2.1. Monthly Performance Information:

Monthly performance information is provided to Accountable Managers and the POG for oversight of performance and use in internal performance meetings.

4.2.2. Monthly Performance Profile

A monthly Performance Profile is produced setting out monthly performance against the National and Corporate targets. The Profile forms the basis of the POG performance oversight process.

4.2.3. Monthly Performance Report

Relevant performance reports will be compiled and presented to the Quality, Safety and Experience Committee, the Finance and Performance Committee and the Board and published on the Health Board's web site.

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Key points
• The Operational Plans set out the performance priorities and targets for the year. • Performance information is produced on a monthly basis.

5. The Performance Escalation process

5.1. Escalation

Under the Performance and Accountability Framework, there is provision for the formal escalation of teams that are not achieving performance expectations.

Escalation reflects an increased level of concern in relation to performance that requires more intense focus, action and scrutiny in order to bring about improvement.

Underperformance also includes performance that:

- Harms patients or service users;
- Does not meet the required standards or targets for that service;
- Departs from what is considered normal practice;
- Derives from ineffective team or joint working.

5.2. The levels of escalation

Performance management and the operation of the Performance and Accountability Framework is expected to be a process managed primarily at the level of the relevant Accountable Manager.

Level 0 Accountable Manager	**Steady state** Performance is being achieved against plan.	Performance subject to routine performance monitoring by the

		relevant Accountable Manager
Level 1 Accountable Manager	**A variance emerges.** A variance from plan is identified and intervention and support in response to early signs of difficulty is managed at an Accountable Manager level	A decision to escalate an area of underperformance in individual services under their remit is made by the Accountable Manager
Level 2 Executive Director	**The problem persists**. It becomes harder to fix and potentially spreads or affects other areas / teams of the Health Board. Intervention and support are required.	A decision to escalate an area of underperformance by the relevant Executive Director.
Level 3 POG	**The problem becomes critical or where prolonged underperformance puts quality, safety and financial sustainability at risk**. The performance issue persists and the Accountable Manager has been unable to reverse underperformance. Significant intervention is required.	A decision to escalate an area of underperformance is made by the POG. External supports, interventions or sanctions may be required.
Level 4 Board	**Significant governance or organisational risks are identified that affect the functioning or reputation of the Health Board** The actions determined by POG do not achieve the necessary impact Board action may be required	A decision to escalate the significant governance or organisational risks is made by the Chief Executive

The levels of escalation **do not** necessarily indicate the seriousness of a particular performance issue but rather the need for the organisational response to be led at a more senior level. This may reflect either the capacity or capability of other levels to manage the improvements required. For example, performance issues at LEVEL 1 may be as serious as performance issues at LEVEL 4; however, there is confidence that the relevant Accountable Manager is managing these issues appropriately.

5.3. Escalation where remedial actions do not work

Where remedial action is not possible or is not achieving the required correction, it must be discussed with the next level of management for the purpose of further advice, support or intervention as necessary. Managers in the first instance will be responsible for initiating corrective actions.

The Performance and Accountability Framework envisages that performance issues may be escalated to a more senior level of management where;

- There are concerns that the appropriate level of management are not taking the appropriate actions to address underperformance;
- There is a lack of engagement by teams or managers with the performance improvement process;
- The actions required to address underperformance lie outside of the control of Accountable Managers.

When an area of performance has been escalated, primary responsibility for managing performance remains with relevant Accountable Manager unless this authority has been removed.

Key points

- Corrective actions should be taken as soon as underperformance is identified.
- Where remedial actions do not work, an Impact Improvement Plan will need to be put in place.
- The Performance and Accountability Framework envisages that performance issues may be escalated by a more senior level of management where specific conditions are met.

5.4. Is escalation primarily the responsibility of the Executive Director or POG?

No. Performance is expected to be managed on a day-to-day basis by Accountable Managers. Managing performance requires managers to review performance data and meet formally with their teams on at least a monthly basis to review performance and decide upon actions to address variances in performance.

Levels 1 and 2 escalations should be the first line of the performance escalation process and lie within the responsibility of the Accountable Managers.

5.5. When is escalation by the Executive Director triggered?

The Executive Director triggers Level 3 Escalation when there is:

- A serious concern related to service delivery, quality and safety of care and/or organisational effectiveness or financial performance arises.
- When other levels of management responsible for performance levels have failed to reverse underperformance.

5.6. When is escalation to Board triggered?

Level 4 Escalation to or by the Chief Executive is expected to be a very rare occurrence. It will be triggered where significant governance or organisational risks are identified that are expected to severely affect the functioning or reputation of the health service.

5.7. What are the 'thresholds' for escalation?

Thresholds for performance escalation will be agreed by the POG. These thresholds **do not** indicate an automatic escalation of services. They merely act as a trigger for review of specific areas of performance. A decision in relation to escalation is based on the outcome of this review of performance at the appropriate level.

For example, two services may have the same performance levels, one is not escalated because there is confidence that the actions being undertaken to address underperformance are adequate, while another service may be escalated as the actions being taken are inadequate, or are not achieving the required improvement in performance.

These thresholds combine a specified variance from target at a point-in-time as well as a specified timeframe over which underperformance has been noted. This means that in most cases an in month variance may not be a cause for concern, whereas the variance continuing over three months may be. Details are set out in Appendix 2.

5.8. Is Board level escalation invoked regularly?

No, it should be the exception that the Chief Executive invokes the formal escalation process to Board level.

In some cases, issues may be escalated to Board because the resolution of the performance issues lies outside of the control of an individual Accountable Manager or because an organisation does not have the capability / expertise available locally to fully solve the issues.

5.9. What happens when performance is escalated by the POG?

The POG will seek assurance that services are delivering against performance priorities and targets. The POG will explore whether appropriate and timely remedial actions are being taken to address areas of underperformance.

The POG will:

- Identify areas of underperformance,

- Require a formal diagnostic to be undertaken to assess whether a service is underperforming or whether there are factors outside the control of the service or team that are affecting performance levels.
- Require additional remedial actions to be put in place or an Impact Improvement Plan to be developed.
- Commission an external performance or governance review
- Provide assurance to the Board on performance outcomes and performance management processes.
- Recommend specific courses of action to the Board as appropriate.

5.10. Does escalation mean individual managers are no longer responsible or accountable?

No. In instances where underperformance has been escalated this;

- **Does not** mean the transfer of responsibility or accountability to a higher level of management;
- **Does not** remove or dilute the full accountability and responsibility of the Accountable Manager or their team nor does it alter their responsibility or accountability;
- **Does** provide for a graduated response to underperformance that may take the form of support, intervention or sanction;
- **In exceptionally rare circumstances, escalation to level 3 or 4 may mean that responsibility / reporting lines for a particular service will be changed to ensure effective and speedy action is initiated in response to the problem.**

5.11. Is all underperformance treated in the same way?

No. It is expected that there will be a differentiated response taken to performance by ensuring that individual services that contribute to underperformance are clearly identified and that high performing services will not automatically be the subject of escalation actions. Poor performance will be addressed through the agreement and implementation of explicit, time bound actions and more rigorous performance management of the specific services where the underperformance lies.

The Board is committed to providing support to managers and services who are struggling to achieve improvements. This support and any form of escalation must however always enhance rather than remove or blur individual or team accountability and avoid diffusing responsibility or passing it upwards.

Consequences or sanctions will be considered if reasonable improvement is not achieved and further detail is set out in Sections 6.4 to 6.6 below.

5.12. What is an Impact Improvement Plan?

Where significant and sustained underperformance has been identified and where remedial actions have not been successful, the POG may request the

development of an Impact Improvement Plan. The Plan will be required at a minimum to contain the following elements.

- A full analysis and diagnostic identifying the reasons for poor performance.
- Detailed actions for improving performance. These actions should be specific and measureable.
- The planned improvement trajectory, with targets set out by month and showing how long it will take to achieve the national target or the desired level of improvement as determined by POG. This information together with the agreed improvement actions will be used to assess the success of the Plan.
- Actions will have clear, named owners who will be accountable for delivering on the actions.
- The plan may also describe how the Board's Performance and Accountability Framework will be invoked where actions are not delivered and performance does not improve in line with the Plan.

5.13. When is an issue deescalated?

Escalation **is not** intended to be an end in itself. Performance issues should be in escalation for as short a period as possible. Services are not escalated or deescalated based on a single month's performance and the period of escalation will vary from issue to issue.

It is expected that performance areas will be deescalated as soon as the actions taken to address them are shown to be achieving the desired result. Therefore, escalation is only sustained until:

- There is a return to the required performance level or,
- There is a credible Impact Improvement Plan in place and,
- The trajectory of improvement is being sustained over an agreed period.

Key points

- Performance is expected to be managed on a day to day basis by managers
- There are 4 levels of escalation. It is expected that the majority of performance issues will be managed at Level 1.
- Thresholds for performance escalation will be agreed by POG with decisions on the appropriate level of escalation made through Accountable Managers, Executive Directors and/or POG.
- Where underperformance has been escalated, this does not mean the transfer of responsibility or accountability to a higher level of management.
- Poor performance will require explicit, time bound actions and more rigorous performance management of the specific services where the underperformance lies.
- Where a service or service issue has been escalated, Accountable Managers are expected to ensure that managers reporting to them are

notified that the issue is the subject of escalation and that the appropriate remedial actions are being taken and monitored.
- Where remedial actions have not been successful, the POG may request the development of an Impact Improvement Plan.

6. The consequences of escalation

6.1. What happens if performance does not improve?

Accountable Managers are required to ensure that a graduated and appropriate regime of;

- Support,
- Intervention and
- Sanction, is in place for managers and services where performance does not improve.

6.2. What support is available?

Where remedial actions are not working sufficiently to address underperformance, Accountable Managers may need to put in place additional support for teams reporting to them. Similarly, Accountable Managers may also seek support from their line manager, support may include:

- Assistance to form the Impact Improvement Plan including diagnosis, actions, milestones and timelines
- Specialist resources to work with them and their teams.
- Mentoring and advisory support

In cases where additional supports are provided, the Accountable Manager or manager will be required to reaffirm their agreement to and ability to meet the commitments set out in their Accountability and Assurance Agreement or operational plan.

The Accountable Manager to whom support is being provided will be expected to meet with their line manager on a regular basis in line with what is considered appropriate in terms of timescales agreed as part of any improvement plan.

6.3. What do you mean by interventions?

If following on-going monitoring and support, performance does not improve, or where plans are not being delivered, the relevant Accountable Manager, Executive Director, or Chief Executive may put specific interventions in place. These interventions may include:

- Enhanced monitoring through formal review meetings with the relevant line manager.
- Additional controls being put in place.
- Setting out the explicit performance requirements, arrangements for monitoring and consequences where performance does not improve.

- Commissioning of an external improvement initiative, performance or governance diagnostic review.
- Performance meetings with the Executive Director, or Chief Executive culminating in a set of performance expectations and requirements. These may be additional improvement actions and expectations, supports, interventions or sanctions.

6.4. What type of sanctions can be applied?

While the focus of the Escalation process will be on supporting managers to improve performance, the Performance and Accountability Framework also provides for sanctions to be applied in the case of continued underperformance where despite remedial plans, supports and interventions being in place, performance does not improve. Sanctions can be applied at both the team level and the individual level.

6.5. What type of organisational level sanctions can be applied?

6.5.1. Service Level

In the first instance, sanctions may be applied to services, that is individual area teams, hospitals, or corporate functions where performance does not improve after appropriate supports and interventions are taken. These sanctions could include the following.

- A formal Performance Notice will be issued to the relevant service from the appropriate Accountable Manager. Performance notices will specify the reason for the notice, the performance improvement expectation, timeframe, accountability arrangements and consequences where there is insufficient improvement.
- An Impact Improvement Plan will be required.
- A decision to issue any Performance Notice must be ratified by the POG.

Performance Notices signal a significant level of concern in relation to the delivery of performance improvement. As such, they should be issued sparingly. All normal performance management processes should be exhausted first.

6.5.2. Publication of Performance Notices

Performance Notices issued will be reported on to the Board in public session

6.6. What type of individual level sanctions can be applied?

6.6.1. Performance / Capability Process

Where there has been no improvement in performance within the specified timeframe and where organisational support and interventions do not result in improved performance, this is likely to become a matter of personal performance for named managers or team members.

In these cases, the All Wales Pay Progression Policy and / or the All Wales Capability Policy may be invoked (for the latest versions please see the BCUHB intranet pages).

Key points

- A graduated and appropriate system of supports, interventions and sanctions are in place for managers and services where performance does not improve.
- Where remedial actions are not working sufficiently to address underperformance, Accountable Managers may need to put in place additional supports for managers.
- If following on-going monitoring and support, performance does not improve, or where plans are not being delivered, specific interventions may be put in place.
- While the focus of the escalation process will be on supporting managers to improve performance the Performance and Accountability Framework also provides for sanctions to be applied in the case of continued underperformance.
- In the first instance, sanctions may be applied to services, where performance does not improve.
- The issuing of Performance Notices is an important part of the escalation process. Performance Notices can normally only issued once they have been ratified by the POG
- Where there has been no improvement in performance this is likely to become a matter of personal performance for named individuals.

7. The consequences of excellence

In the same way that poor performance is recognised, excellence should also be recognised for teams and individuals. At each regular meeting, where appropriate, the POG will identify an area of outstanding excellence to be reported to the Board, the Chair of the Board and the Chief Executive will jointly send a letter of commendation to the relevant team.

Areas of outstanding excellence will be aligned to our values:

7.1. Put Patients first:

- Outstanding levels of patient care;
- Delivered Transformation programmes that enable re-investment in patient care.

7.2. Work together:

- Outstanding team or partnership working improving outcomes for patients.

7.3. Value and respect each other:

7.4. Learn and innovate:

- Improvements in care leading to significant improved outcomes for patients.

7.5. Communicate openly and honestly:

Consideration will be given to creating a formal Reward and Recognition programme.

Appendix 1: NHS Delivery Measures

Quadruple Aim 1: People in Wales have improved health and well-being with better prevention and self-management	
People will take responsibility, not only for their own health and well-being, but also for their family and for people they care for, perhaps even for their friends and neighbours. There will be a whole system approach to health and social care, in which services are only one element of supporting people to have better health and well-being throughout their whole lives. It will be a 'wellness' system, which aims to support and anticipate health needs, to prevent illness, and to reduce the impact of poor health.	• Percentage of babies who are exclusively breastfed at 10 days old • Percentage of children who received 3 doses of the hexavalent '6 in 1' vaccine by age 1 • Percentage of children who received 2 doses of the MMR vaccine by age 5 • Percentage of adult smokers who make a quit attempt via smoking cessation services • Percentage of those smokers who are CO-validated as quit at 4 weeks • European age standardised rate of alcohol attributed hospital admissions for individuals • resident in Wales (episode based) • Percentage of people who have been referred to health board services who have • completed treatment for alcohol misuse • •Uptake of influenza vaccination among: 65 year olds and over; under 65s in risk groups; • pregnant women and; health care workers • •Uptake of screening for bowel, breast and cervical cancer • Percentage of health board residents in receipt of secondary mental health services who • have a valid care and treatment plan (for those age under 18 years and 18 years and over) • Percentage of people in Wales at a GP practice (age 65 years and over) who are estimated to have dementia that are diagnosed

Quadruple Aim 2: People in Wales have better quality and more accessible health and social care services, enabled by digital and supported by engagement.	
There will be an equitable system, which achieves equal health outcomes for everyone in Wales. It will improve the physical and mental well-being of all throughout their lives, from birth to a dignified end. Services will be seamless and delivered as close to home as possible. Hospital services will be designed to reduce the time spent in hospital, and to speed up recovery. The shift in resources to the community will mean that when hospital based care is needed, it can be accessed more quickly.	• Qualitative report detailing evidence of advancing equality and good relations in the day to day activities of NHS organisations • Qualitative report detailing the achievements made towards the implementation of the all Wales standard for accessible communication and information for people with sensory loss • Qualitative report detailing the progress against the 6 actions contained in the Learning Disability – Improving Lives Welsh Government Programme • Qualitative report detailing progress against the 5 standards that enable health and wellbeing of homeless and vulnerable groups to be identified and targeted • Number of patients with Hepatitis C who have successfully completed their course of treatment in the reporting year • Percentage of GP practices that have achieved all standards set out in the National Access Standards for In-hours GMS • Percentage of children regularly accessing NHS primary dental care within 24 months • Percentage of Out of Hours (OoH)/111 patients prioritised as P1CHC that started their definitive clinical assessment within 1 hour of their initial call being answered • Percentage of emergency responses to red calls arriving within (up to and including) 8 minutes • Number of ambulance patient handovers over 1 hour • Percentage of patients who spend less than 4 hours in all major and minor emergency care (i.e. A&E) facilities from arrival until admission, transfer or discharge • Number of patients who spend 12 hours or more in all hospital major and minor emergency care facilities from arrival until admission, transfer or discharge • Percentage of survival within 30 days of emergency admission for a hip fracture • Percentage of patients who are diagnosed with a stroke who have a direct admission to a stroke unit within 4 hours of the patient's clock start time • Percentage of patients who are assessed by a stroke specialist consultant physician within 24 hours of the patient's clock start time • Percentage compliance against the therapy target of an average of 16.1 minutes of speech and language therapist input per stroke patient • Percentage of stroke patients who receive a 6 month follow-up assessment • Percentage of patients newly diagnosed with cancer, not via the urgent route, that started definitive treatment within (up to and including) 31 days of decision to treat

Quadruple Aim 3: The health and social care workforce in Wales is motivated and sustainable.	
New models of care will involve a broad multi-disciplinary team approach where well-trained people work effectively together to meet the needs and preferences of individuals. Joint workforce planning will be in place with an emphasis on staff expanding generalist skills and working across professional boundaries. Strategic partnership will support this with education providers and learning academies focused on professional capability and leadership	• Average rating given by the public (age 16+) for the overall satisfaction with health services in Wales • Percentage of adults (age 16+) who reported that they were very satisfied or fairly satisfied about the care provided by their GP/family doctor • Qualitative report providing evidence of implementing actions to deliver the Welsh language objectives as defined in the More Than Just Words Action Plan • Overall staff engagement score • Percentage of headcount by organisation who have had a Personal Appraisal and Development Review (PADR)/medical appraisal in the previous 12 months (excluding doctors and dentists in training) • Percentage of staff who have had a performance appraisal who agree it helps them improve how they do their job • Percentage compliance for all completed level 1 competencies of the Core Skills and Training Framework by organisation • Qualitative report providing evidence of learning and development in line with the Good Work – Dementia Learning and Development Framework • Percentage of sickness absence rate of staff • Percentage of staff who would be happy with the standard of care provided by their organisation if a friend or relative needed treatment • Evidence of how NHS organisations are responding to service user experience to improve services • Percentage of complaints that have received a final reply (under Regulation 24) or an interim reply (under Regulation 26) up to and including 30 working days from the date the complaint was first received by the organisation

Quadruple Aim 4: Wales has a higher value health and social care system that has demonstrated rapid improvement and innovation, enabled by data and focused on outcomes.	
Delivering higher value in health and social care will focus on outcomes that matter to the individual and making our services safe, effective, people centred, timely, efficient and equitable. This will bring the individual to the fore and consider the relative value of different care and treatment options, in line with Prudent Health. Research, innovation and improvement activity will be brought together across regions – working with RPBs, universities, industries and other partners. Alignment of funding streams and integrated performance management and accountability across the whole system will be in place to accelerate transformation through a combination of national support, incentives, regulation, benchmarking and transparency.	• Number of patients recruited in Health and Care Research Wales clinical research portfolio studies • Number of patients recruited in Health and Care Research Wales commercially sponsored studies • Crude hospital mortality rate (74 years of age or less) • Percentage of deaths scrutinised by a medical examiner • Percentage of in-patients with a positive sepsis screening who have received all elements of the 'Sepsis Six' first hour care bundle within 1 hour of positive screening • Percentage of patients who presented to the Emergency Department with a positive sepsis screening who have received all elements of the 'Sepsis Six' first hour care bundle within 1 hour of positive screening • Percentage of patients (age 60 years and over) who presented with a hip fracture that received an orthogeriatrician assessment within 72 hours • All new medicines recommended by AWMSG and NICE, including interim recommendations from cancer medicines, must be made available where clinically appropriate, no later than 2 months from the publication of the NICE Final Appraisal Determination and the AWMSG appraisal recommendation • Total antibacterial items per 1,000 STAR-PUs (specific therapeutic age related prescribing unit) • Number of patients age 65 years or over prescribed an antipsychotic • Number of women of child bearing age prescribed valproate as a percentage of all women of child bearing age • Opioid average daily quantities per 1,000 patients • Quantity of biosimilar medicines prescribed as a percentage of total 'reference' product including biosimilar (for a selected basket of biosimilar medicines) • Percentage of adult dental patients in the health board population re-attending NHS primary dental care between 6 and 9 months • Percentage of critical care bed days lost to delayed transfer of care (ICNARC definition) • Number of procedures postponed either on day or the day before for specified nonclinical reasons • Agency spend as a percentage of the total pay bill • Percentage of clinical coding accuracy attained in the NWIS national clinical coding accuracy audit programme

Appendix 2 – Performance Oversight, Escalation and Thresholds

Level 3 Escalation

Level 3 escalation is subject to oversight and intervention by the Executive Director

The Performance Oversight Group will review performance if:

- Performance is reported to be more than 5% away from target / expected activity (YTD) over a period of 3 consecutive cycles or more and /or
- Performance that is outside the parameter set out above will result in a review of the performance results. A decision to escalate to Level 3 will be based on this review of performance.

Level 4 Escalation

Level 4 escalation is subject to intervention by the Board.

Level 4 escalation will be considered if there is a significant governance or organisational risk.

The Chief Executive with POG will base consideration whether to recommend Level 4 escalation, on an assessment.

Committee report

Cyfarfod a dyddiad: Meeting and date:	**Audit Committee December 2020**
Cyhoeddus neu Breifat: Public or Private:	*Public*
Teitl yr Adroddiad Report Title:	2020/21 Clinical Audit Plan (draft – endorsed by QSE)
Cyfarwyddwr Cyfrifol: Responsible Director:	Prof A Guha (Acting Executive Medical Director)
Awdur yr Adroddiad Report Author:	Dr Melanie Maxwell (Senior Associate Medical Director/ Improvement Cymru Clinical Lead)
Craffu blaenorol: Prior Scrutiny:	*QSE November 2020 – plan endorsed.*
Atodiadau Appendices:	*1. Draft 2020/21 Clinical Audit Plan*

Argymhelliad / Recommendation:

The Committee is asked to please approve this draft ***2020/21 Clinical Audit Plan*** for BCUHB.

Please tick as appropriate

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

Sefyllfa / Situation:

The draft BCUHB Clinical Audit Plan 2020/21 includes the prioritised projects to be conducted within the Health Board in 2020/21.This consists of those projects included within the Welsh Government's National Clinical Audit & Outcome Review Plan 2020/21 (Tier 1) and those prioritised by Executive Directors in relation to service areas falling within their remit (Tier 2).

Cefndir / Background:

This draft plan was first presented in March 2020. However, at the time we had not received official notification from Welsh Government confirming the tier 1 audits and the expectation was this would be represented in September 2020. In addition Committee members asked that consideration was given to audits related to claims within the tier 2 plan.

Due to the Covid pandemic, most tier 1 audits were stood down and there was no confirmation of any changes to the existing programme other than to introduce a Covid 19 respiratory audit for a limited period (now passed). Most tier 2 activity also ceased.

The plan has been updated to reflect changes in leadership, any new tier 2 audits and the expected completion dates (some audits have been delayed due to the Covid 19 pandemic). The issue of claims audits has not been addressed as there is limited opportunity to add additional audits within current capacity. However we will identify audits within the 2021/22 plan.

Asesiad / Assessment & Analysis

Strategy Implications

The draft document closely relates to the breadth of topics embraced by the Welsh Government's NCAORP Plan. Also in terms of the implications for BCUHB planning and use of resources, governance, monitoring and reporting:

- Leadership and governance.
- Strategic and service planning.
- Mental health.
- Primary Care, including out of hours services.

Options considered

Not applicable

Financial Implications

None noted within the document. The delivery of the audit plan is considered to be achievable within existing resources. However, this is delayed because of staff being redeployed to support the Covid 19 effort.

Risk Analysis

The Tier 1 element of the 2020/21 Clinical Audit Plan relates to mandatory projects as prioritised by Welsh Government within their NCAORP. Tier 2 includes some projects which are required for accreditation, regulation and licensing; along with management of risk, quality, safety and patient experience. Resourcing to support activity corporately is currently under review and is recorded within the Risk Register (reference: 2961) at with a current tier 2 risk rating of 12.

Legal and Compliance

Compliance with the plan is being monitored through quarterly reports to the Clinical Effectiveness Group (Q1&2 reported in November 2020). In addition the Group now received an escalation report monthly highlighting any delays in data capture, responsiveness to Welsh Government reports on outlier status (Part A) or improvement plans (Part B) related to clinical audit.

An annual Clinical Audit report is provided to JAQS Committee in November.

Impact Assessment

An Equality Impact Assessment (EqIA) has been completed for the recently approved BCUHB Clinical Audit Policy which relates closely to participation with the Tier 1 and Tier 2 elements of the 2020/21 Clinical Audit Plan.

Reference:	Title of National Audit	BCUHB Lead	East area Lead	Central Area Lead	West Area Lead	In year Data Submission	In year Report
NCAORP/2020/01	National Joint Registry	No BCUHB lead at present	Mr Ian Wilson (Consultant Orthopaedic Surgeon)	Mr Madhusudhan Raghavendra & Mr Balasundaram Ramesh. (Consultant Orthopaedic Surgeon's)	Mr Koldo Azurza (Consultant Orthopaedic Surgeon)	Yes	Yes
NCAORP/2020/02	National Emergency Laparotomy Audit	Dr Stephan Clements (Consultant Anaesthetist)	Mr Duncan Stewart (Consultant Surgeon) / Dr Sianedd Elliott / Dr Kiran Dasari (Consultant Anaesthetists)	Mr Richard Morgan (Consultant Surgeon) / Dr Magdy Khater (Consultant Anaesthetist)	Dr Stephan Clements (Consultant Anaesthetist) / Mr. Nik Abdullah (Consultant Surgeon)	Yes	Yes
NCAORP/2020/03	Comparative audit of critical care unit adult patient outcomes (casemix) ICNARC	No BCUHB lead at present	Dr Andy Campbell (Consultant Anaesthetist)	Dr Richard Pugh (Consultant Anaesthetist)	Dr Alison Ingham, (Consultant Anaesthetist)	Yes	Yes
NCAORP/2020/04	Trauma Audit & Research Network (TARN)	No BCUHB lead at present	Dr Ben Sasi (Anaesthetics Associate Specialist)	Dr Tom O'Driscoll (Emergency Medicine Consultant)	Dr Leesa Parkinson / Dr Rob Perry (Consultants: Emergency Department)	Yes	Yes
NCAORP/2020/05	National Diabetes Foot care Audit	Gareth Lloyd Hughes (Head Of Podiatry & Orthotics - East Area)	Dr Anthony Dixon (Consultant Physician) & Nicola Joyce (Podiatrist)	Dr Aye Nyunt (Consultant Physician)	No Medical Lead at present & Jamie O'Malley/Iola Roberts (Diabetic Podiatrists)	Yes	Yes
NCAORP/2020/06	Diabetes Inpatient Audit (NaDia)	No BCUHB lead at present	Dr Stephen Stanaway (Consultant Physician) / Cheryl Griffiths (Diabetes Specialist Nurse)	Dr Stephen Wong (Consultant Physician) / Kirstin Clark (Diabetes Specialist Nurse)	Dr Muhammed Murtaza (Consultant Physician) / Ceri Roberts (Diabetes Specialist Nurse)	Yes	Yes
NCAORP/2020/07	Pregnancy in Diabetes Audit Programme	No BCUHB lead at present	Dr Stuart Lee (Consultant Physician), Lynda Vergheese (Locum Physician) , Gill Davies (Diabetes Specialist Nurse), Rao Bondugulapati (Consultant Physician)	Dr Steven Wong (Consultant Physician), Miss Maggie Armstrong (O&G Consultant), Kirstin Clark (Diabetes Specialist Nurse)	Dr Leela Ramesh (Consultant Physician), Dr Noreen Haque (Registrar),Dr Tony Wilton (Consultant Physician), Ceri Roberts (Diabetes Specialist Nurse)	Yes	No - Reports are biennially
NCAORP/2020/08	National Core Diabetes Audit: (Primary / Secondary Care & Insulin Pump elements)	No BCUHB lead at present	**Primary Care element**: Dr Gareth Bowdler (Area Medical Director) Insulin Pump Element: Dr Rao Bondugulapti (Consultant Physician)	**Primary Care element**: Dr Liz Bowen (Area Medical Director). **Insulin Pump element:** Julie Roberts (Lead Diabetes Specialist Nurse), Dr Minesh Shah (Associate Specialist)	**Primary Care element:** Dr Bethan Jones (Area Medical Director) Insulin Pump element: Dr Muhammed Murtaza (Consultant Physician)	Yes	Yes
NCAORP/2020/09	National Paediatric Diabetes Audit (NPDA)	Dr Michael Cronin (Consultant Paediatrician)	Dr Kamal Weerasinghe (Consultant Paediatrician),	Dr Pramod Bhardwaj (Consultant Paediatrician)	Dr Michael Cronin (Consultant Paediatrician)	Yes	Yes
NCAORP/2020/10	National Asthma & COPD Audit Programme (NACAP): Children and Young People Asthma	No BCUHB lead at present	Dr Liz Richards (Locum Consultant)	Dr Lee Wisby (Consultant Paediatrician)	Dr Mair Parry (Consultant Paediatrician)	Yes	Yes
NCAORP/2020/11	NACAP: Adult Asthma	No BCUHB lead at present	Erin Humphreys (Interim Deputy Head of Nursing)	Dr Daniel Menzies (Consultant Physician)	Dr Claire Kilduff (Consultant Physician)	Yes	Yes
NCAORP/2020/12	NACAP: COPD	No BCUHB lead at present	Erin Humphreys (Interim Deputy Head of Nursing)	Dr Sarah Davies (Consultant Physician)	Dr Claire Kilduff (Consultant Physician)	Yes	Yes
NCAORP/2020/13	NACAP - Pulmonary Rehabilitation workstream	Dr Daniel Menzies (Consultant Physician)	Michelle Owen (Clinical Specialist Physiotherapist / Pulmonary Rehab Coordinator)	Ann Ellis (Respiratory Occupational Therapist)	Ffion Edwards (Occupational Therapist) & Caerwyn Roberts (Physiotherapist)	Yes	Yes
NCAORP/2020/14	Renal Registry	No BCUHB lead at present	Dr Stuart Robertson (Consultant Physician)	Dr Mick Kumwenda (Consultant Physician)	Dr Mahdi Jibani (Consultant Physician)	Yes	Yes
NCAORP/2020/15	National Early Inflammatory Arthritis Audit (NEIAA)	No BCUHB lead at present	No lead at present	Dr Alessandro Ciapetti (Consultant)	Dr Yasmeen Ahmed (Consultant Physician)	Yes	Yes
NCAORP/2020/16	All Wales Audiology Audit	Paediatrics: Dafydd Hughes-Griffiths (Head of Paediatric Audiology) Adult Rehabilitation: Jane Wild, Head of Adult Audiology (BCU) Susannah Goggins, Head of Adult Rehabilitation and Balance, Audiology, BCU	Adult Rehabilitation: Anna Powell, Head of Adult Rehabilitation & Balance (East)	Adult Rehabilitation: Suzanne Tyson, Head of Adult Rehabilitation & Balance (Central)	Adult Rehabilitation: Heidi Turner, Head of Adult Rehabilitation and Balance (West)	Yes	Yes
NCAORP/2020/17	Stroke Audit (SSNAP)	Dr Walee Sayed (Consultant Physician)	Dr Walee Sayed (Consultant Physician)	Dr Krishnamurthy Ganeshram (Consultant Physician)	Dr Salah Elghenzai (Consultant Physician)	Yes	Yes
NCAORP/2020/18	Falls & Fragility Fractures Audit Programme: National Hip Fracture database	No BCUHB lead at present	Mr Ian Starkes (Consultant Orthopaedic Surgeon)	Mr Amir Hanna (Consultant Orthopaedic Surgeon)	Mr Ashok Goel (Consultant Orthopaedic Surgeon)	Yes	Yes
NCAORP/2020/19	Falls & Fragility Fractures Audit Programme: In-patient Falls Audit	No BCUHB lead at present	No lead at present	Dr Geralt Owen (Consultant Physician)	Eleri Evans (Interim Head Of Nursing For Medicine - YG)	Yes	Yes
NCAORP2020/20	Falls & Fragility Fractures Audit Programme: Fracture Liaison Service	No BCUHB lead at present	No FLS Service	No FLS Service	Dr Swapna Alexander (Consultant Physician: Care of the Elderly)	Yes	Yes
NCAORP/2020/21	National Dementia Audit	Dr Indrajit Chatterjee (Consultant Physician) Interim	Dr Sam Abraham (Consultant Physician)	Dr Indrajit Chatterjee (Consultant Physician)	Dr Conor Martin (Consultant)	Yes	Yes
NCAORP/2020/22	National Audit of Breast Cancer in Older Patients (NABCOP)	Mr Walid Samra (Consultant Surgeon)	Mr Tim Gate (Consultant Breast Surgeon)	Miss Mandana Pennick, (Consultant Breast Surgeon)	Mr Ilyas Khattak (Consultant Breast Surgeon)	Yes	Yes
NCAORP/2020/23	National Audit of Care at the End of Life (NACEL)	Dr Helen Mitchell (Consultant Palliative Medicine)	Mrs Geeta Kumar (Deputy Hospital Medical Director - Q&S)	Dr Tania Bugelli (Deputy Hospital Medical Director - Q&S)	Dr Karen Mottart (Hospital Medical Director - West)	No - Suspended until Apr 2021 due to COVID 19 pandemic	Yes
NCAORP/2020/24	National Heart Failure Audit	Dr Richard Cowell (Consultant Cardiologist)	Fiona Willcocks (Heart Failure Specialist Nurse)	Dr Mohammad Aldwaik (Consultant Cardiologist) / Andy Bennett (Heart Failure Specialist Nurse)	Dr Mark Payne (Consultant Cardiologist) / Nia Coster (Heart Failure Nurse)	Yes	Yes

NCAORP/2020/25	Cardiac Rhythm Management	Dr Richard Cowell (Consultant Cardiologist)	Dr Rajesh Thaman (Consultant Cardiologist)	Dr Mohammad Aldwaik (Consultant Cardiologist)	Dr Mark Payne (Consultant Cardiologist)	Yes	Yes
NCAORP/2020/26	PCI Audit (previously Coronary Angioplasty Audit)	Dr Paul Das (Consultant Interventional Cardiologist)	N/A	Dr Paul Das (Consultant Interventional Cardiologist)	N/A	Yes	Yes
NCAORP/2020/27	MINAP	Dr Richard Cowell (Consultant Cardiologist)	Dr Richard Cowell (Consultant Cardiologist)/ Lucy Trent (Nurse Practitioner)	Dr Eduardas Subkovas (Consultant Interventional Cardiologist)	Dr Mark Payne	Yes	Yes
NCAORP/2020/28	National Vascular Registry Audit (inc. Carotid Endarterectomy Audit)	Mr Soroush Sohrabi (Clinical Director – North Wales Vascular Network) & Joanne Garzoni (North Wales Vascular Network Manager)	Mr Soroush Sohrabi (Clinical Director)	Mr Soroush Sohrabi (Clinical Director)	Mr Soroush Sohrabi (Clinical Director)	Yes	Yes
NCAORP/2020/29	Cardiac Rehabilitation	Catrin Warren (Cardiac Rehabilitation Physiotherapist)	Jacqueline Cliff (Cardiac Rehabilitation Nurse Lead)	Catrin Warren (Cardiac Rehabilitation Physiotherapist)	Dale Macey (Cardiology Rehab Lead Specialist Nurse) / Iorwerth Jones (Exercise Physiologist- Cardiac Rehab)	Yes	Yes
NCAORP/2020/30	National Lung Cancer Audit	Dr Ali Thahseen (Consultant Respiratory Physician)	No lead at present	Dr Sakkarai Ambalavanan (Consultant Physician)	Dr Ali Thahseen (Consultant Respiratory Physician)	Yes	Yes
NCAORP/2020/31	National Prostate Cancer Audit	Mr Kyriacos Alexandrou (Consultant Urologist)	Mr. Iqbal Shergill (Consultant Urologist)	Mr. Kingsley Ekwueme (Consultant Urologist)	Mr Kyriacos Alexandrou (Consultant Urologist)	Yes	Yes
NCAORP/2020/32	National Gastrointestinal Cancer Audit Programme	**Bowel**: Dr Claire Fuller (Consultant Oncologist) **Oesophago-gastric** Mr Andrew Baker (Consultant Surgeon)	**Bowel:** Mr Micheal Thornton (Consultant Surgeon) **Oesophago-gastric:** Mr Andrew Baker (Consultant Surgeon) / Dr Thiriloganathan Mathialahan (Consultant	**Bowel:** Mr Andrew Maw (Consultant Surgeon) **Oesophago-gastric:** Mr Richard Morgan (Consultant Surgeon)	**Bowel:** Dr Claire Fuller, (Consultant Oncologist) & Mr Anil Lala (Consultant Surgeon) **Oesophago-gastric:** Dr Jonathan Sutton (Consultant Gastroenterologist)	Yes	Yes
NCAORP/2020/33	National Neonatal Audit Programme (NNAP)	Mandy Cooke (Neonatal Services Manager)	Dr Brendan Harrington (Consultant Paediatrician)	Dr Geedi Farah (Consultant Paediatrician), Dr Mohammed Sakheer Kunnath (Consultant Paediatrician)	Dr Shakir Saeed (Consultant Paediatrician)	Yes	Yes
NCAORP/2020/34	National Maternity & Perinatal Audit	Fiona Giraud (Director of Midwifery and Women's Services)	Maureen Wolfe (Womens Lead, Clinical Risk & Governance)	Dr Niladri Sengupta (O&G Consultant)	Fiona Giraud (Director of Midwifery and Women's Services)	Yes	Yes
NCAORP/2020/35	Epilepsy 12 - Clinical	Dr Kathryn Foster (Consultant Paediatrician)	Dr Praveen Jauhari (Consultant Paediatrician)	Dr Mohammed Sakheer Kunnath (Consultant Paediatrician)	Dr Kathryn Foster (Consultant Paediatrician)	Yes	Yes
NCAORP/2020/36	National Clinical Audit of Psychosis	Dr Mike Jackson (Consultant Psychologist)	No EIP service	No EIP service	Dr Mike Jackson (Consultant Psychologist)	Yes	Yes
NCAORP/2020/42	National Covid-19 Audit	No BCUHB lead at present	Dr Liz Brohan (Consultant Physician)	Dr Daniel Menzies (Consultant Physician)	Dr Claire Kilduff (Consultant Physician)	Yes	No
NCAORP projects not applicable to BCUHB: (due to commissioned services elsewhere):							
NCAORP/2020/37	National Adult Cardiac Surgery Audit						
NCAORP/2020/38	National Congenital Heart Disease Audit						
NCAORP/2020/39	Paediatric Intensive Care Audit (PICaNet)						

Project Ref Number	Project Title	Int/ext guidance	Corporate policy	External review	Reaudit / continuous	Risk Register	Which BCUHB priority does this support?	Proposed Start Date	Proposed Finishing Date	Objectives	Responsible Corporate Group	In year Data Collection	In-year Report	Risk Assessment *(see key below)*
Acute/20/01	Ward Manager Weekly Audit			Y	Y	Y	Highly reliable clinical care	1st July 2020	Ongoing - no end date	Data is owned by wards for own quality improvements	Secondary Care Quality Group	Yes	Yes	Critical
Acute/20/02	Shine Tool (Emergency Department Safety Checklist)	Y		Y		Y	Reduce patient harms	Wxm Jun-20	Wxm Jul-20	The importance of completing the ED safety checklist to be discussed during documentation study day.	Secondary Care Quality Group	Yes	Yes	Critical
Acute/20/03	Patient assessment for suitability to outlie		Y			Y	Reduce patient harms	Wxm Jul-20	Wxm sep-20	Completion of outlier matrix to assess suitability of patients who have been outlied for non-clinical reasons	Secondary Care Quality Group	Yes	Yes	High
Acute/20/04	Oxygen Competencies	Y	Y			Y	Highly reliable clinical care. Reduce patient harms	Across financial yr 20/21	Mar-21	Ensure Compliance	Medical Gases Committee	Yes	Yes	High
Acute/20/05	IV Morphine (compliance against guidelines and record keeping)		Y		Y	Y	Highly reliable clinical care. Reduce patient harms	Across financial yr 20/21	Mar-21	Ensure Compliance	Professional Advisory Group (PAG) / Safe Medication Steering Group	Yes	Yes	High
Acute/20/06	Enhanced care observation audit	Y		Y		Y	Highly reliable clinical care	Wxm Sep-20	Wxm Sep-20	Education package being developed for BCU with particular focus on delirium 10 measure	Secondary Care Quality Group	Yes	Yes	Medium
CORP/04/20	Ward Accreditation Monthly Metrics	Y		Y			Highly reliable clinical care. Reduce patient harms	Ongoing	Ongoing - no end date	Data is owned by wards for own quality improvements	Senior Nursing Team	Yes	Yes	Critical
IP&C/20/01	Hand Hygiene audits	Y	Y	Y	Y		Quality and Safety. Reduction in healthcare associated infections	Across financial yr 20/21	Ongoing - no end date	Reduction in healthcare associated infections	Local IPG. Infection Prevention Strategic Group (IPSG)	Yes	Yes	High
IP&C/20/02	Decontamination Audits	Y	Y	Y	Y	Y	Quality & Safety. Reduction in healthcare associated infections	Across financial yr 20/21	Ongoing - no end date	Reduction in healthcare associated infections	Exceptions to Strategic Decontamination Group then IPSG	Yes	Yes	Critical
MH&LD CEG/2020/01	Side effects of patients on long acting antipsychotic medication	Y			Y		Reduce patient harms. Quality and Safety.	Across financial yr 20/21	Ongoing - no end date	Reduce patient harm	MH&LD Clinical Effectiveness Group	Yes	Yes	High
MH&LD CEG/2020/02	Physical health monitoring	Y	Y	Y			Reduce patient harms. Quality and Safety.	TBC	TBC	Reduce patient harm	MH&LD Clinical Effectiveness Group	Yes	Yes	High
MH&LD CEG/2020/03	Introduction of scale to monitor depression	Y					Highly reliable clinical care. Reduce patient harms. Quality and Safety.	TBC	TBC	Reduce patient harm	MH&LD Clinical Effectiveness Group	Yes	Yes	High
MH&LD CEG/2020/04	PPE within MH&LD	Y			Y		Reduce patients harm. Quality and Safety	Across financial yr 20/21	Ongoing - no end date	Reduce patient harm	MH&LD Clinical Effectiveness Group	Yes	Yes	High
CORP/01/20	Record Keeping	Y	Y		Y		Highly reliable clinical care. Reduce patient harms	Across financial yr 20/21	Ongoing - no end date	Reduce patient harm	Secondary Care Quality Group	Yes	Yes	Critical
Corp/OMD/Consent/20/01	Informed Consent within Secondary Care – A Retrospective Re-audit of Consent forms.	Y	Y		Y	Y	Highly reliable clinical care. Reduce patient harms	Across financial yr 20/21	Ongoing - no end date	Ensure that consent to treatment processes are compliant with Welsh Language Legislation	Consent and Capacity Strategic Working Group	Yes	Yes	Critical
RES/20/01	2222 Audit	Y	Y	Y	Y	Y	Highly reliable clinical care. Reduce patient harms. Quality and Safety	Dec-20	Ongoing - no end date	Establishment of uniform process for emergency call responses across all sites of BCUHB in line with existing BCUHB Resuscitation Policy	BCUHB Resuscitation Committee, & Rapid Response to Acute Illness Learning Set (RRAILS), sepsis and Acute Kidney Injury (AKI) Steering Board	Yes	Yes	High

HTA/HA/2020	Auditing compliance with the Human Tissue Act - Human application	Y		Y	Y		Highly reliable clinical care.	Apr-20	Apr-21	Individual audits on a rolling schedule to monitor continual compliance	Pathology Management and Stem Cell Service	Yes	Yes	Critical
HTA/PM/2020	Auditing compliance with the Human Tissue Act - Post Mortem Sector	Y		Y	Y		Highly reliable clinical care.	Apr-20	Apr-21	Individual audits on a rolling schedule to monitor continual compliance	North Wales Managed Clinical Services (NWMCS) Quality Committee	Yes	Yes	Critical
BSQR/2020	Auditing compliance with the Blood Safety and Quality Regulations	Y		Y	Y		Highly reliable clinical care. Reduce patient harms	Apr-20	Apr-21	Individual audits on a rolling schedule to monitor continual compliance	NWMCS Quality Committee	Yes	Yes	Critical
ISO15189/2020	Annual audit calendar (minimum 12 audits per site/service) Auditing compliance with ISO 15189. Blood Science service on 3 sites, and Cellular Pathology service on one site.	Y	Y	Y	Y		Highly reliable clinical care. Reduce patient harms	Apr-20	Apr-21	Individual audits on a rolling schedule to monitor continual compliance	NWMCS Quality Committee	Yes	Yes	Critical
MedPhys/2020	Accreditation and on-going compliance with ISO9001:2015 Quality Management System. External accreditation on 36 month cycle, each section has tailored internal audit schedule.	Y	Y	Y	Y		Highly reliable clinical care. Reduce patient harms	Across financial yr 20/21	Ongoing - no end date	Consistently provide products and services that meet our service users and applicable statutory and regulatory requirements	NWMCS Quality Committee	Yes	Yes	Medium
IRR/2020	BCU Ionising Radiation Protection Regulations compliance audits (Minimum 2 a year performed by Head of Quality & Governace and Medical physics expert at any site or department in BCUHB where imaging takes place)	Y	Y	Y	Y		Highly reliable clinical care. Reduce patient harms	Across financial yr 20/21	Mar-21	To ensure compliance in the field hospitals and within the radiology departments with current radiation regulations.	Overarching Radiation Protection Committee	Yes	Yes	Critical
IRMER/PI/2020	Radiology Ionising Radiation (Medical Exposure) Regulations {IR(ME)R} compliance Audit - Patient Identification completed annually for each Radiology service	Y	Y	Y	Y		Highly reliable clinical care. Reduce patient harms	Across financial yr 20/21	Mar-21	To ensure compliance in the field hospitals and within the radiology departments with current radiation regulations.	NWMCS Quality Committee	Yes	Yes	Critical
IRMER/RPD/2020	Radiology Ionising Radiation (Medical Exposure) Regulations {IR(ME)R} compliance Audit - Recording of Patient Dose completed annually for each Radiology service	Y	Y	Y	Y		Highly reliable clinical care. Reduce patient harms	Across financial yr 20/21	Mar-21	To ensure compliance in the field hospitals and within the radiology departments with current radiation regulations.	NWMCS Quality Committee	Yes	Yes	Critical
IRMER/PS/2020	Radiology Ionising Radiation (Medical Exposure) Regulations {IR(ME)R} compliance Audit - Pregnancy Status completed annually for each Radiology service	Y	Y	Y	Y		Highly reliable clinical care. Reduce patient harms	Across financial yr 20/21	Mar-21	To ensure compliance in the field hospitals and within the radiology departments with current radiation regulations.	NWMCS Quality Committee	Yes	Yes	Critical
IRMER/RP/2020	Radiology Ionising Radiation (Medical Exposure) Regulations {IR(ME)R} compliance Audit - Recording of Practitioner completed annually for each Radiology service	y	y	y	y		Highly reliable clinical care. Reduce patient harms	Across financial yr 20/21	Mar-21	To ensure compliance in the field hospitals and within the radiology departments with current radiation regulations.	NWMCS Quality Committee	Yes	Yes	Critical
QSI/2020	Annual audit calendar (minimum 6 audits per site) Auditing compliance with Ionising Radiation (Medical Exposure) Regulations, Ionising Radiation Regulations, requirements for clinical audit and audits of the service as part of the requirements for Quality Standards in Imaging Accreditation	Y	Y	Y	Y		Highly reliable clinical care. Reduce patient harms	Across financial yr 20/21	Mar-21	To ensure compliance in the field hospitals and within the radiology departments with current radiation regulations.	NWMCS Quality Committee	Yes	Yes	Critical
P&MM/20/01	Antimicrobial Point Prevalence Audit (Inpatients)	Y		Y	Y	Y	Safe, Clean, Care. Keeping People Safe from Avoidable Harm	Nov-20	Nov-20	Keeping people safe	Antimicrobial Steering Group	Nov-19	May 2020 (by Public Health Wales)	High
P&MM/20/02	Antibiotic Review Kit (ARK)/Start Smart then Focus audit via Public Health Wales tool	Y		Y		Y	Safe, Clean, Care. Keeping People Safe from Avoidable Harm	Apr-21	Mar-22	Training development package for Junior Doctors	Antimicrobial Steering Group	April 2020 provided PHW tool available	Awaiting report scheduling from PHW (May 2021 suggested)	High
P&MM/20/03	All Wales Inpatient Medication Safety Audit	Y		Y	Y	Y	Keeping People Safe from Avoidable Harm	Across financial yr 20/21	Mar-21	Ensuring safety and following compliance	Safer Medicines Steering Group	Ongoing monthly audit	Ongoing monthly audit	High
P&MM/20/04	Safe and Secure Handling of Medicines in Clinical Areas	Y	Y	Y	Y	Y	Keeping People Safe from Avoidable Harm	Across financial yr 20/21	Mar-21	Ensuring safety and following compliance	Safer Medicines Steering Group	Ongoing	Yes	High
P&MM/20/05	Controlled Drugs: storage, handling and record keeping in pharmacies and clinical areas	Y	Y		Y		Keeping People Safe from Avoidable Harm	Across financial yr 20/21	Rolling 6 months	To audit compliance in relation to: Storage/Security/Record Keeping	Controlled Drugs Local Intelligence Network	Ongoing quarterly audit	Quarterly	Critical
P&MM/20/06	Compliance with the BCUHB Unlicensed Medicines Policy (MM42)	Y	Y		Y		Keeping People Safe from Avoidable Harm	Across financial yr 20/21	Mar-21	Ensure Compliance	Drug & Therapeutics Group	Yes	Yes	High
P&MM/20/07	Assessment of BCUHB Homecare Service compliance with the Royal Pharmaceutical Society Professional Standards for Homecare	Y		Y			Highly reliable clinical care. Care closer to home.	Apr-21	TBC	Ensuring compliance with RPSP Standards for homecare	Pharmacy and Medicines Management: Secondary Care Group	Mar-20	Yes	Medium
P&MM/20/08	Audit of Prescribing Standards within Cancer Services	Y	Y				Keeping People Safe from Avoidable Harm	TBC	TBC	Awaiting update	Pharmacy Cancer Services group	Yes	Yes	High
Research 20/01	Audit and monitoring of hosted studies (for high a nd medium risk categorised studies) following Assess, Arrange, Confirm process	Y			Y		Highly reliable clinical care. Reduce patient harm	Across financial yr 20/21	Mar-21	To review study procedures and research documentation to determine whether the approved study protocol, Good Clinical Practice, BCUHB SOPs and Sponsor specific SOPS have been followed as appropriate for the study type.	Research senior management team group	Yes	Yes	Low

Research 20/02	Audit and monitoring of sponsored studies	Y			Y		Highly reliable clinical care. Reduce patient harms	Across financial yr 20/21	Mar-21	To review study procedures and research documentation to determine whether the approved study protocol, Good Clinical Practice, BCUHB SOPs and Sponsor specific SOPS have been followed as appropriate for the study type.	Research senior management team group	Yes	Yes	Low
Research 20/03	Research policies and Standard Operating Procedures (SOPS)	Y			Y		Reduce patient harms	Across financial yr 20/21	Mar-21	Review and compare practice against the standards and procedures as detailed in the Betsi suite of research SOPs and any applicable research policies.	Research senior management team group	Yes	Yes	Low
Q&S20/01	Compliance with relevant LocSSIPs in each specialty	Y		Y	Y	Y	Avoid never events	Across financial yr 20/21	Mar-21	Ensure Compliance	Q&S site leads	Yes	Yes	High
NICE20/21	Compliance with NICE Quality standards/Clinical pathways linked to NICE guidance	Y		Y	Y	Y	Safe Value-based health care	Across financial yr 20/21	Mar-21	Ensure Compliance	BCUHB NICE Assurance Group	Yes	Yes	High

Risk classification criteria:	
Critical	Control weakness could have a significant impact on the system, function or process and achievement of organisational objectives in relation to compliance with laws and regulations or the efficient and effective use of resources.
High	Control weakness could have a significant impact on the system, function or process but does not have an impact on the achievement of organisational objectives (as above)
Medium	Control weakness has a low impact on the achievement of the key system, function or process or a low degree of risk associated with exposure.
Low	Control weakness has no impact on the achievement of the key system, function or process objectives; however, improved compliance would improve overall control.